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10 + 1 GUIDELINES OR GUIDE-QUESTIONS. AN OUTLINE OF A SYSTEMIC CLINICAL THEORY [1]

KURT LUDEWIG [2]

After acknowledging its origins in Milan, a systemic clinical theory is outlined. This begins with a clarification of the term 'systemic' and of the scientific prerequisites to be fulfilled by systemic theories. In presenting the actual outline of the theory, particular attention is paid to a formal and operational definition of (psycho-sociat) therapy. These thoughts are then formulated into 10 + 1 "guidelines" or "guide-questions" for the therapist's practical orientation.

From Hamburg to Milan: the Milanese heritage

In psychiatric institutions for children and adolescents, working with social systems rather than single patients is literally unavoidable. Thus, in the adolescent' s psychiatric ward of the University Clinic Eppendorf in Hamburg, we have been working with families for decades. I myself, for example, started in the ward as a tight-rope walker by using therapy concepts more appropriate to individuals in working with families and other social units. Yet I somehow managed to avoid a conflict or even the realisation that I was mixing apples and oranges. However, in 1978 after a good deal of internal difficulties had taken place in our work context, I came across a book which seemed to me at that time to promise "wonder cures". It was "Paradox and Counter-Paradox" the first main work of the Milan-group centered on Mara Selvini-Palazzoli (1978). Two days after beginning to read this book, I had devised my first

[1] This paper is the further development of one originally written in 1984 and rewritten several times since then without being published. The original title was "Ten Commandments (plus One) A Brief Outline of a Systemic Theory of Therapy, Practice, and Evaluation".

[2] This paper is the result of uncountable hours of therapeutic work and theoretic discussion. In place of all those from and with whom I have learned I wish to thank here the following friends: Rosemarie Schwarz, Rudolf Duerr, Hans Kowerk, Ludger Diekamp, Ulrich Hausa, as well as Humberto Maturana, Harry Goolishian, Steve de Shazer, and Heinz von Foerster.

"paradoxical" intervention and sent it to the parents of a patient; two weeks later, I and my co-workers at the time, Rosemarie Schwarz and Rudolf Duerr had formed a working team for systemic family therapy. From then on, for several years, we spoke "Italian" (but with German words) to our patients, wrote letters to family members who had stayed horne, etc. And the results, if I may call them that, were not half bad (cf. Ludewig et al., 1984). "Clinically", our work together consisted of one aftemoon a week which we considered a learning context. We concentrated on families of psychotic youths who were under our care as inpatients at the time, but we also worked with families with various other problems. Many of our colleagues have participated in the working group, which still exists today. It has become a permanent part of the structure of our department, which certainly cannot be said of its initial period. We were ignored, opposed, and even called "the Gang of Four" for a time. Things had changed, and we did not know how to deal with the changes. The wards began to empty out because we were releasing patients too soon. Our non-academic co-workers were annoyed by our having lost interest in so-called therapeutic community and milieu therapy and concentrating instead on ambulatory treatment. We were probably over-enthusiastic about the new methods and so, a bit over-zealous and blind to our own work context (cf. Ludewig & von Villiez, 1984).

In 1982, we ventured our first publication in the field. This added a new aspect to our work which made it necessary to formulate our ideas more precisely and reflect on their clarity. It was no longer enough 10 simply adopt the latest from Milan - e.g. Selvini-Palazzoli, 1980 - and see what resulted. We had put ourselves in a position which necessitated finding and developing terms and concepts appropriate to **our** work. This marked the start of a slow drift away from loyalty to Milan, which took on a clearer direction after our first meeting with Paul Dell in Zurich in 1981 (cf. Dell, 1985). The trend continued as we came to terms with several papers published in 1982 in *Family Process* on aesthetics in therapy (cf. Allman, 1982; Keeney & Sprenkle, 1982), on the epistemological aspects of therapy (cf. Keeney, 1982), on the "coherent" use of such concepts as homeostasis, information and causality (cf. Dell, 1982) and on cooperation, rather than symmetry or "resistance" , as the basic attitude of the patient (cf. de Shazer, 1982). At that point, meeting with Humberto Maturana and Heinz von Foerster had become inevitable. This occurred in Calgary in 1984. During this trip we also met Harry Goolishian and, later on, Steve de Shazer.

Also in 1984, the working group founded the Institut fuer systemische Studien in Hamburg, making it possible for us to learn and teach independently form the University “at our home”. Humberto Maturana and Francisco Varela came to Hamburg in 1985, bringing us the knowledge of knowledge (cf. Maturana & Varela, 1987), and later that year Steve de Shazer demonstrated for us his art of brief therapy (cf. de Shazer, 1985). Tom Andersen, creator of the "reflecting team" (cf. Andersen, 1985), and Harry Goolishian, inventor of the "problem-determined system" (cf. Goolishian & Anderson, 1988), followed in 1986, as in 1987 did Paul Dell, who had made important theoretical contributions to systemic therapy (cf. Dell, 1986), and Heinz von Foerster, the amiable philosopher of cybemetics (cf. von Foerster, 1985). And in spite of our apparently increasing distance from Milan, it was interesting that each time I met with Luigi Boscolo and Gianfranco Cecchin I found we had drifted even closer to each other.

Against the background of this briefly sketched journey from Milan to Hamburg, this paper draws together the principle features of our current understanding of psycho-social therapy. It traces a path laid by earlier works (cf. e.g. Ludewig, 1983, 1987a, 1987b, 1988a) and follows on a thorough treatment of our understanding of the causes leading up to therapy, i.e. the *problem-system* (cf. Ludewig, 1988b). After briefly presenting what we take to be a "systemic view”, and

embedding this in the broader context of scientific thought, we will outline the basic principles of a systemic clinical theory, i.e. a general theory of psycho-social clinical activity [3]. In setting up an operational framework for the therapist's work in the form of 10 + 1 guidelines (or guide-questions), a proposal results for the operationalisation of therapy and therapist which avoids the extremes of a sterile methodologism or an arbitrary subjectivism. These comprehensive formulas are intended to be both theoretically congruous with systemic thought and a practical aid to the therapist. The paper concludes with an empirical "postscript" describing a first pragmatic inquiry into the operational utility of the guidelines.

The adjective 'systemic'

The adjective 'systemic' is used today with so many different meanings that it threatens to lose its meaning entirely. In the field of psycho-social therapy, the term seems to coincide loosely with various schools of family therapy drawing their theoretical basis more or less explicitly from Gregory Bateson (1979) and/or Humberto Maturana (1982). Strictly speaking, i.e. when concepts begin to be operative, and so, meaningful, the term 'systemic' shows little clarity. In order not to contribute to this lack of clarity, this paper begins by delineating what will be meant by the term. 'Systemic' will be understood here to refer to a general way of seeing and thinking which takes systems as its units of thought. This view implies a theory of being, of knowledge, and of becoming which serves as orientation for the praxis of living. For simplicity, this orientation can be summarized into the following six propositions.

(1) Everything said is said by an Observer

With this aphorism, the Chilean biologists and epistemologists Humberto Maturana and Francisco Varela express the central proposition of their theory which in the final analysis, becomes a theory of the observer. From this apparently selfreflexive, tautological proposition there is no escape by means of operations on the sentence itself. Every operation necessarily leads back to the original statement, e.g. "who says that?" or "the statement is false!" are both said by an observer. To this extent, the proposition only becomes meaningful once its components, i.e. that said and the observer, are themselves specified by an observer.

(2) The observer is a 'languaging' living being

Maturana (1982) proposes to define the observer through two essential properties; he is a living being in-language, i.e. a "languaging" organism[4]. This characterizes the observer as an entity which, as a living being, satisfies all the requirements of a living organisation, i.e. the properties of and restrictions on biological systems (cf. Maturana & Varela, 1987), and, as a being "in language", it produces a domain of structural coupling with its likes which, once established, is inescapable: the domain of human socialisation. Without going too deeply into details (for which

[3] The terms 'clinica1' and 'clinician' are used here in a general way to refer to the diagnostic and or therapeutic activities of all those in psycho-social help professions, be they in clinics or other institutions such as counselling centers or private practices.

[4] The term 'languaging' (span. "lenguajear") was coined by Maturana as distinct from 'speaking' or participating in something previously existing, such as "a language". Languaging is meant to imply a specific way of realizing the biological structure of human beings, i.e. by "doing" or living it.

we refer the reader to the original literature), the observer is seen here as a structure-determined,operationally closed entity whose organisation results from the autopoiesis of its elements. As such the observer's organisation is autonomous, it can neither be "instructed" nor determined from without; at most, it may be perturbed. This characterisation of the observer implies not only the ability to coordinate its behavior with that of other organisms; an ability inherent in any living being. But it also implies that the observer can, by means of symbols, coordinate its actions *about* coordinations of actions. This meta-coordination, in which the direct coordination of behavior is supplemented by the use of symbols (words, gestures), results in a realm of coupling permitting uncountable combinations and extensions, i.e. the "languaged" world, which characterises the realm of human existence. The observer - the human being - comes into being only in language; only against the background of "languaged" co-existence is the communication, the topic of which is observation, possible.

(3) Everything said is brought forth by the observer in communication

The definition of the observer as a living being in the sense described above implies a view of cognition as the product of inner correlations in a system operating in closure rather than as the inner representation of an external constellation of stimuli (cf. Maturana & Varela, 1987; von Foerster, 1985). Cognition arises out of the process of drawing distinctions - unities - from a background on the basis of the mode of operation of a cognitive structure which thereby maintains its stability. From the observer's point of view, cognition is present when an organism is "seen" to act "effectively", i.e. to live (cf. Maturana & Varela, 1987). That observers are not solipsistic beings existing alone in a closed world-for-themselves is shown by the fact that they are linguistically coupled with others of their kind. The world of observers is the result of the linguistic coordination of individually created cognitive worlds. It is therefore a con-sensually produced unity of multi-versal "views", rather than an objectively tangible uni-verse.

(4) Reality is therefore = (reality)

If everything said is brought forth in communication between observers who have no sure means of representing external circumstances (cf. Maturana & Varela, 1987), and if the spoken realm (according to proposition 1) is ineluctable, then the observer's world, in spite of all the certainty assigned to it, constitutes a (reality) - in parenthesis. Here, Maturana's suggestion to put objectivity in parenthesis is extended to reality in order to point out that, in spite of the fact that we see ourselves as living in one universe, there are no means of apprehending "a" universal world. If one accepts this epistemological proposal, (reality) must be seen as a "computed" aggregate of "multi-versa". Hence the parenthesis around (reality), which point out that every explanation ultimately rests on consensus rather than on independent existence.

(5) A system is a unity brought forth by an observer who sees it as a composite unit

In keeping with the principles of constructivist ontology and epistemology presented, a system can be defined as the product of cognitive activities of the observer who distinguishes a unity from a background and sees it as a complex of interrelated elements. A system is therefore a construction by the observer.

(6) 'Systemic' refers to a point of view which takes systems as its objects

Inasmuch as proposition (6) refers to the observer and the observer's statements, (6) leads back to (1). In order, for example, to determine what is meant by "systemic therapy", one can work from proposition (6) up to proposition (1) as follows. One can say that 'systemic' here refers to the knowing, practical handling of a social phenomenon defined as therapy, which occurs as a social system. Systemic therapy deals with systems, in which, in the course of their communicational interaction and with the therapist's help, the constituting members (see below) replace a mutually constructed (reality) considered to be a problem with one less burdensome. So therapy may be termed 'systemic' if both problem and solution are seen as communicational structures produced within social systems i.e. if the therapist reflects upon his work from a systemic "way of thinking".

Prerequisites of a systemic science

In following the account given above of "systemic", we quickly find ourselves outside the presently accepted realm of scientific theory. The observer, for instance, with no certain means of comparing his assumptions to "the one" reality to confmn their validity, must do without objectivity, the basic criterion of validity for traditional science. The systemically minded scientist must therefore establish criteria of validity which are congruous with his own ideas. In response to this new situation, constructivists have re-oriented their understanding of science, shifting focus from the search for truths to the utility of (particular) knowledge, from description to problem solving, from the demand for objectivity to the inter-subjectivity produced in linguistic interaction (cf. Schmidt, 1987). The traditional distinction between natural science, social science, and Arts and Letters also becomes untenable since the objects of these disciplines can no longer be distinguished; all three refer to statements by observers. The main constructivistic criterion for the validity of scientific knowledge has become the utility, "fit", or viability of the methods employed or results achieved (cf. von Glasersfeld, 1986; Varela, 1986). Maturana and Varela propose limiting scientific statements to the formulation of concepts which describe or prescribe the generation of observable phenomena in an acceptable way. Since objectivity has been seen to be unreachable, scientific knowledge can no longer be considered as anchored in an absolute reality; thus scientific propositions fall back onto their authors or to those willing to accept them. The rules of play in the scientific community are in need of revision. Rules are needed which limit the plausibility of pre-determined utility and the inter-subjective acceptance thereof.

In the field of psycho-social therapy, utility and viability have a long tradition adopted from the field of medicine. Something is usua1ly seen as useful when the problem is no longer present. Even so-called systemic therapists and researchers continue to evaluate their "therapy results" according to the usefulness of their measures or the effects thereof, of course, in terms of more or less "safe", causal or final attributions. However, the questions "when does change count as change?", "are all changes equal?", and "how high can the price of change be, and it still be desirable?" usually appear only in the margins. The danger of an utilitarian activism is not smal1. If therapy were really only concerned with viability, theorists could concentrate on inventing new technologies, the control of which, in order to optimise viability, should at best be withheld from the patients. The therapist, being concemed only with usefulness, would be relieved of any personal responsibility; all he would have to do is to apply techniques properly.

It is in this light that we find, in recent years, systemic oriented therapy itself raising aesthetic objections to mainly pragmatic technologies such as "paradoxing" (cf. Allman, 1982; Keeney & Sprenkle, 1982; Stierlin, 1983; Ludewig et al., 1984).

Systemic therapy, at first little concerned with balancing utility in its pioneer enthusiasm, had to suffer the misunderstanding of being taken for a mere technology (cf. Hoffman, 1985). However, as with all polar controversies, this one between pragmatics and aesthetics can be resolved at a higher level of abstraction. We suggest evaluating systemic therapy on the basis of both pragmatic considerations of utility and the aesthetics of the therapy process within a larger, ethical framework embracing both of these aspects (cf. e.g. Ludewig, 1988a). In these terms, therapy may be considered successful when, in the course of more humane and aesthetic interaction, the defined problem is brought closer to solution. These criteria, however, by no means establish absolute standards, since utility, beauty, and goodness are values dependent on the person making the judgment. Whether a particular lobotomy, stereotaxy, electro-shock or psycho-pharmacological treatment may be considered a successful therapy in these terms must be determined with respect to the work context of and the justification given by the therapist. There is simply no other way of evaluating these, or any other, measures. The problematic illusion that we only need to demonstrate efficiency can thus be given up.

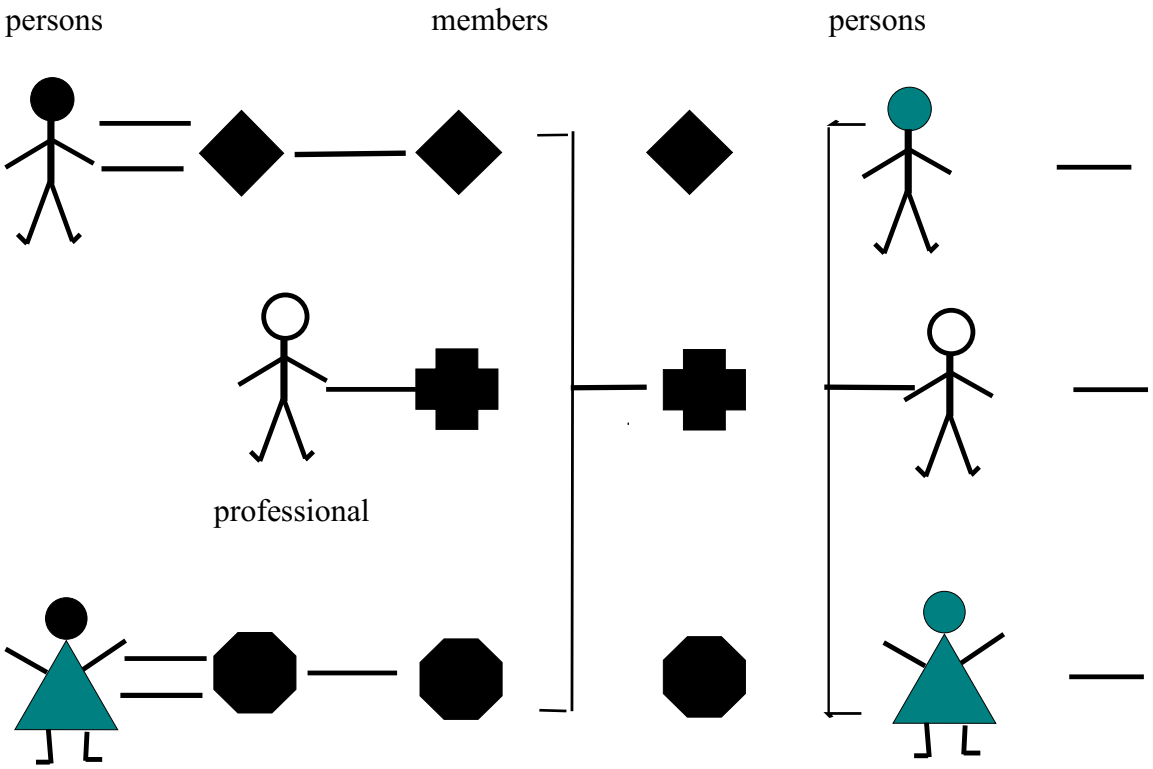
A clinical theory therefore demands descriptions, explanations and methods whose validity does not depend on absolute truths. Whether its utility needs to be complemented by aesthetic and ethical aspects, or whether the theorist sets other criteria for his work, the criteria on which the theory is to be judged must be made explicit. Without being able to fall back on objectivity, every theory ultimately remains tied to its author, i.e. to his decisions and responsibilities. A value-free theory is therefore impossible since precisely a theory's value stands as criterion of its validity. The clinical theory outlined below represents an attempt to describe clinical activity which is useful, aesthetic, and humane.

Outline of a clinical theory

A systemically based clinical theory in the psycho-social field must put the phenomena belonging to the realm of clinical work into a coherent and practicable relation to one another. It will need to incisively describe the circumstances leading to the clinician's activities, i.e. problems. The theoretical clarification of this question will form basis of any following theoretical or practical considerations. The resulting mode of operation will vary according as problems are seen e.g. in analogy to organic illnesses, defects or dysfunctions, or as expressions of inner-psychic or family conflicts, defects, deficits, dysfunctions, or simply as problems of living. This then will lead to corresponding versions of diagnostics, etiology, pathogenesis, and pathology, as well as a suitable type of therapy.

A comprehensive clinical theory must, in addition to describing the problems leading to the clinician, provide an explanation of their origin (etiology, pathogenesis), a way of recognising them (diagnostics) and treating them (therapy), and a way of controlling these measures themselves (training, supervision, evaluation). The following figure 1 presents an attempt at putting all of these elements together into one easily grasped diagram (see fig.). As with any description, the observer must be at the start. The observer, who may also be one of the two "persons" involved, evaluates according to appropriate criteria the two observed persons as members of a common social system. He employs criteria, according to which the behaviour of the three appear congruous to each other's to some extent and which allow him to communicate this coherently to (an)other observer(s). Without going too deeply into details - for which we refer the reader to Ludewig (l987a, 1988b) - it is assumed that each of these two persons (from the observer's point of view) generates an independently definable social operator, namely a "member" whose only relevant operation is to implement its appointed contribution, i.e. to

Figure 2. **Foundations of a systemic clinical theory. Operations during the development and disintegration of a therapy-system.**



Type of system:	problem-system	clinical system	therapy system	dissolution
Course:	***Beginning***	— — — — — — — —		***End***
Theme:	Problem	Coordination of help	Assignment of therapy	

contribute communicatively in a way that is capable of adhering to the contributions of othermembers (cf. Luhmann, 1984). By *"member"* we mean an independently definable social entity, the description of which, however, requires reference to at least one operation performed by another member of a common system. The minimum requirement is fulfilled by the statement "I am a member of..." or by paying membership dues to a club. At the other extreme, the description of the person coincides almost full with the description of the member he/she generates ("embodies"), e.g. under the exceptional conditions of intense experiences such as being in love or psychotic crises. In all cases, however, the member performs the operations of membership in communicational acts. And since the member's basic operation is communication, his existence presupposes that of at least one other member together with whom he comprises a social system. A member is therefore a social entity whose existence is tied to the generation

of a "senseful" social context[5]. Other than "man", "person", etc. a member cannot exist in isolation. Member, communication, and sense-boundaries (cf. Luhmann, 1984) present aspects of a social system which depend upon, and are conditions of, one another. Their respective existences are inseparably tied to those of the others (cf. Ludewig, 1988b). A member can only be generated by a human being; the definition of a member, however, does not overlap with that of a person or a human being[6]. Member, person, and human being are distinctions made by an observer that specify different realms of phenomena. Member does neither overlap with "role" nor "role-taker", a "role" meaning a general programme description leading the implementation of specific memberships, e.g. the therapist as a role leads the work of the therapist as a member of this specific therapeutic relationship.

Social systems represent contexts of meaning (sense) which can only be recognised in the time dimension, i.e. temporally and not spatially. The communication occurring between members - their "link" - can only be recognised as belonging together by considering the topic connecting them. Thus the illustration of the processes involved in a social system given by figure 1 differentiates that system according to the possible topic which determine it. A social system may have a problem as its topic or it may have something else. In order that something be termed a problem, an observer must have deemed it so; the observer may, of course, also be a member of the system that has developed the problem. Two conditions must be met for the identification of a problem:

a) the evaluation "problem" must be actualised, either expressly or implicitly, e.g. in terms of having sought someone "responsible for solving the problem" (otherwise the problem is only an "experienced" one having no social relevance and so, none for a clinical theory);
b) the evaluation (as annoying, painful, unbearable, etc.) must be accepted or confirmed by someone else, i.e. it must be fixed in communication (otherwise it remains socially irrelevant, though stated).

If these two conditions are fulfilled, the result may be termed the problem-system (cf. Goolishian & Anderson, 1988; Luhmann, 1984; Ludewig, 1987a, 1988b). A *problem-system* is defined as a social system whose members' communication concerns the topic "problem". The concept of a problem-system permits the formulation of a clinical theory free of an "understanding" descriptive or prescriptive diagnostics usually required yet untenable from a systemic standpoint (cf. Ludewig, 1987a). If, namely, problems are seen as the topics of certain social systems, unique neither in their organisations nor in their structures, then the helpers' task is to devise and apply appropriate methods for the (dis)solution of the systems and thus of the problems. Thus he no longer needs to make hypotheses about his patients according to nosology or typology, the usefulness of which would have been questionable. He only needs to decide whether he feels himself capable of dealing effectively with the problem entrusted to him. If a problem-system has turned to a clinician for help, and if the latter decides to take up communication with the

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[5] "sense" - German: "*Sinn*", cf. Luhmann, 1984 - is meant here as a mode of selection under conditions of social complexity which enables one to distinguish what pertains to a particular social system against the background of all other social actions occuring simultaneously. Although related to it, 'sense' differs somewhat from "meaning" which is more semantical and less formal than "sense". "Sense" cannot be further differentiated since it refers to whatever "makes sense".

[6] Later on, we started using the notion of "embodiment" instead of "generation" as a means to describe the fact that all "members" need and make use of the biological und psychic structures of a human being in order to exist.

members of the former, then a clinical system has formed. If the clinician offers therapy as a means of problem-solving, the clinical system becomes a therapeutic system. If the therapy then achieves its ends, the participants' membership dissolve. Otherwise, "therapy-genic" problems have arisen, or the problem-system remains intact.

This simple scheme of a "therapy-genesis" (rather than pathogenesis) calls accordingly for a formal and substantial specification of this phenomenon from the systemic standpoint discussed above. With respect to the aspects training, supervision and evaluation not dealt with here, we refer the reader to Ludewig (1985, 1988a).

Therapy

Generally speaking, therapy in the psycho-social field can be described as the social system resulting when two or more people come together, and one or more of them tries to solve a problem with the help of a therapist. Accordingly, at least three formal conditions on their meeting must be fulfilled before the resulting social system can be regarded as therapy:

a) At least one of the participants must define his membership as that of the therapist, i.e. according to his interpretation of the therapist's role.

b) At least one of the other participants must accept the therapist as such, explicitly or implicitly (e.g. by presenting a problem or by being present), and adjust his actions in response to the therapist's communicational offers, i.e. display the behaviour appropriate to a patient (client, customer).

c) The situation described by the conditions above must be of limited duration as a matter of principle.

Thus, therapy represents the communicational context produced, maintained, realised, and terminated by persons in the roles of therapist and patient. Therapy can be seen formally as the further development of a clinical system to a therapeutic system with the goal of its own dissolution. As a social system in which a problem system evolves, therapy occurs in a conversational process, i.e. a dialogue or "polyphonic" process, the goal of which is to avoid the very thing for which other systems strive, namely the establishment of the continuity of a long-term communication. Therapy per definition strives to allow a conversational process to come into being; however, this process is not to become communication as described by Maturana (1982) since such communication becomes more and more redundant and so yields nothing new.

The therapist's task can thus be reduced to four main areas as follows. He is to contribute to the generation, conservation, realisation, and termination of the therapeutic system. The therapist must make sure that a therapeutic system can come into being; he does so by offering himself as therapist. He must then behave in such a way that his patients continue with the process as long as necessary rather than breaking it off prematurely. He also has the function of facilitating "significant" change, i.e. changes considered significant with respect to the goal of the therapy. Finally, he is responsible for recognising the proper point at which to dissolve the therapeutic system.

Reflection on method

For the orientation of his practices, the therapist needs a methodological framework. Training, supervision and evaluation would be impossible without a conception of method; their application would be arbitrary and incomprehensible. Developing a method appropriate to

systemic thought, however, presents a series of difficulties for the systemically oriented theorist The first, most fundamental difficulty arises from the systemic-constructive understanding of the structure of human beings as "non-trivial machines" (cf. von Foerster, 1985), according to which they are not accessible for "instructive" interaction as a result of their cognitive operational closure and basic autonomy (cf. Maturana & Varela, 1987). According to this view, human beings can, at most, be "perturbed"; they cannot be determined. Whether and to what degree a perturbation occurs is determined by the structure of the "perturbed" alone. Therefore, the assumption that the therapist has a causal influence on his patients proves untenable. The claim that interventions are effective only expresses an attribution by the person making the claim; it says nothing about the process itself. If, however, therapy is to be more than a mere proceeding, and causal effectiveness is impossible, then the theorist of therapy (as well as the therapist, each time anew) is faced with an apparently unrealisable imperative, i.e. the dilemma:
"Act effectively without ever knowing in advance how or where the measures taken will lead".

A methodology of therapy must therefore find a way out of this dilemma; otherwise, therapy would have to either ignore this fundamental difficulty and act as though causal interaction were possible or run the risk of getting lost in a fruitless nihilism. Reviewing the solutions to this dilemma proposed by the various schools of therapy, one finds that they can all be arranged on a one-dimensional scale running between the poles "be yourself' and "follow the instructions". According to the particular view of therapy in question, it will be seen primarily either as left to the therapist's more or less trained humanity or as the exercise of refined methods which attempt to tune out this very element of subjectivity. The effects of therapy will then be attributed accordingly to characteristics of the therapist or of the methods employed.

In the following, a proposal is made which attempts to integrate both aspects. The first step will be to examine the following aspects of therapy to see which will best serve as a methodological and operational foundation: the results of therapy, the predetermination of the type of interactions which are to take place, the duration of the process, and/or the operational predetermination of the participants' (therapist and/or patient/client) membership.

The operationalisation of therapy on the basis of its results requires the assumption that therapeutic measures achieve their effects both causally and with sufficient definiteness that they may be related back to those measures. Under this assumption it would be possible, after the fact, to distinguish effective from ineffective measures by correlating them with the results. Since, however, this assumption rests on an input-output model of simple linear causation, it "trivialises" the participants in therapy along with their problems by viewing them as "trivial machines" (cf. von Foerster, 1985). This approach seems to oversimplify to an unconvincing degree.

The next approach would be to decide in advance on the way in which the therapist is to act in order to achieve the greatest success. This approach does not necessarily trivialise the participants, but it does set norms for the therapist in such a way that he simply reproduces predetermined standards and is hindered from responding to what occurs in the particular therapy session. And there seems to be no reason to limit the therapist in this way.

A characterisation of therapy in terms of some arbitrary duration to be determined at the start seems more than problematic. The only remaining alternative is to describe therapy in terms of some structural aspects of the participating members. Of the two possibilities available - therapist or patient - the latter (the problem-system) may be to be disqualified, since any attempt

to base a conception on the patient would depend upon some selection regarding the different possible patients. This would call for a qualifying diagnostics to evaluate the quality of the available problems and/or the "adequacy" of the patients in question for therapy. There is no plausible necessity for such, to say nothing of the morality involved. There remains only the therapist as the complex which should serve as a starting point for a systemic methodology of therapy.

10 + 1 guidelines or "guide-questions" for the therapist

In the discussion above, I have tried to show that the only sensible way of characterising therapy is by means of the therapist's activities. A therapeutic method will therefore need to specify a framework for the membership in a therapeutic system as a therapist. In order that therapy can occur, the (inner) structure of a specific, to be defined, membership in a social system must be performed within that system, i.e. a methodological programme is called for. Therapy is performed by one who acts as a therapist. To the degree, however, to which therapy per definition constitutes a social system in which, in addition to the therapist, one or more patients (members of a problem-system) participate, the implementation of the role of the therapist depends expressly on his acceptance as such by his patients. The following ten suggestions should serve to outline the framework in which therapist and therapy occur (see fig. 2). They represent an attempt to formulate what seem to be the essential aspects of the theory presented here into brief, yet comprehensive and theoretically congruent imperatives and questions relevant to the practice of therapy. The result outlines the operator "therapist" in a way which take account of both the demands of this role and the personal capacities of the person accepting that role, of both the responsibilities of the therapist - generation, conservation, realisation, and termination of therapy - and the goal of therapy - to promote a social milieu conducive to problem solving. The 10 + 1 statements present a solution to the above mentioned dilemma which is specific enough to provide orientation for therapy, yet general enough to leave room for the peculiarities of each specific case. These 10 statements received their first formulation in 1984 (that there are ten and not nine or eleven clearly has something to do with some tradition in rules of conduct: ten is a round number!). Their construction was based, in addition to the points already mentioned, on the following criteria: they should promote therapy which is useful, aesthetic, and humane.

As can be seen from the table in figure 2, the 10 + 1 guidelines for the therapist's orientation and the corresponding 10 + 1 questions for the therapist to ask himself are arranged into the four main areas of responsibility of the therapist. In using the guidelines in courses and workshops, it has been my experience that they can be discussed at various lengths. Their point, however, is not to be achieved by their being interpreted in the way intended by the author, rather they become significant only when applied by a therapist in a particular therapy context. For that reason they will not be treated here in detail; a few orientating comments are, however, called for.

Statements 1 and 2 concern the reciprocal relationship between person and role; 3 - 6 encourage the therapist to cooperate with the patients; 3 stresses the importance of the patients' structure; 4 points out that social systems, including problem-system, flawlessly follow their own inner logic; 5 warns against attempting to conduct "therapy-genic" therapy; 6 points out that patients change when they change, and not when the therapist wants them to change. 7 - 9 suggest to the therapist ways of reaching the goal of therapy - problem solving - as quickly, directly, and with as little disturbance as possible. Finally, the indefiniteness of 10 inevitably leads back to 1 or to the therapist as the only determinant of his activities. Statement +1 finally qualifies the other 10 -

Figure 2. 10 + 1 guidelines orienting the work of the therapist or 10 + 1 Guide-questions for the therapist to ask him/herself

Tasks in the therapy system	Guidelines	Guide-questions
Generation of a therapy system	1 Define yourself as a therapist!	Do I take responsibility as a therapist?
	2 Respect yourself!	Do I stand to my possibilities?
Conservation of the therapy system	3 Orient yourself on your clients!	Do I start from the client(s)?
	4 Value positively!	Do I look for openings?
	5 Restrict yourself!	Do I limit myself to what is necessary?
	6 Be modest!	Do I see myself as a cause?
Realisation of therapy as such by stimulating significant change	7 Remain flexible!	Do I shift my perspective?
	8 Ask constructively!	Do I ask questions that elicit further questions?
	9 Intervene sparingly!	Do I "perturb" cautiously?
Dissolution of the therapy system	10 Terminate in time!	Is it already time to terminate?
... and	+1 Submit never blindly to guidelines!	Did I apply them within this therapy context?

could it be otherwise? - with respect to the therapist's evaluation of his current dealings with particular patients in a particular therapy situation.

Empirical postscript

The utility of the 10 + 1 guidelines as a means of describing systemic therapists' way of working was recently investigated by Claudia Woerpel (1986) in the context of a research project led by the author. She operationalised the first nine guidelines on a rating scale of 17 items. These items proved useful to the degree that five observers with limited training were able to evaluate therapeutic activities with a high level of agreement and adequate conceptual accuracy. Each of the five observers evaluated on different days video tapes of three initial sessions from four different therapists, all working systemically. The results show, among other things, that the items can best be represented by three factors. The first two factors correspond to dimensions often found in such experiments involving inter-personal interaction, be it in developmental psychology (e.g. Schaefer, 1959: control vs. autonomy and love vs., hate) or in more recent family research (e.g. Olson et al., 1983: rigid to chaotic ways of adapting and enmeshed to disengagement). Such dimensions are apparently basic forms of human semantics. Hofstaetter (1966), a German social psychologist, related them to the stereotypical aspects of male (instrumental) and female (emotional) self-understanding. In the present research project, they

were termed *role acceptance* (structuring, professionalism, independence, active questioning, etc.) and *attention* (cooperation, neutrality, good working environment, acceptance, etc.). The two factors accounted for 36 and 12 percent of the total variance respectively. The third factor seemed to refer somewhat more specifically to the technical understanding of systemic therapy, particularly to *systemic intervention* (positive connotation, sparing intervention, reframing). And yet these items do not seem to be that specific to "systemic therapists". Apparently different therapy approaches appear to outside observers much more similar than we might like to believe.

The main value of such an operationalisation is to be found elsewhere. The items made it possible to compare and evaluate the four therapists with respect to the similarity of their conceptions. To this end, the therapists profiles with respect to the three factors were compared over the three therapy sessions and their ways of working were checked for internal consistency over all of the sessions. The results are not surprising: the observers found that, in spite of their great similarity, the therapists neither rigidly implemented the same conception of therapy - personal styles come through - nor were they internally consistent throughout the therapy sessions - the context makes itself clearly visible. The practical value of these results is that the therapist receives operational feed-back about how his work as viewed by others, and that facilitates learning.

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