"Language, practices and record-keeping: A reflective consultation and some changes that resulted from it." Human Systems, 7(2-3):103-116, 1996. Also as a chapter in Alan Cooklin Ed.: Changing Organizations: Clinicians as Agents of Change. London, Karnak Books, 2000.

LANGUAGE, PRACTICES, AND RECORD-KEEPING
A reflective consultation and some institutional changes that resulted from it

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Prologue: A personal anecdote

A long time ago, in 1956, when I was still in medical school, I was assigned to do a clerkship in emergency medicine at a neighborhood public hospital in Buenos Aires. It was a small facility with only two in- and out-patient sectors, namely, emergency medicine and maternity. One day, as I was passing by one of the delivery rooms, I heard what sounded like a major brawl and shouting match. Out of curiosity I entered the room and witnessed a free-for-all wrestling match between an extremely agitated, violent, terrified woman well in the midst of the process of childbirth, and a nurse midwife and two aids trying to contain her on the delivery gurney. Now it happened that, out of professional curiosity, a couple of evenings before this event I had attended a conference on "Fearless/painless childbirth", introducing to the audience the by-then pioneering work of Lamaze and of Reed. On the basis of that information alone, and with the omnipotence fitting a soon-to-be-physician, I jumped into the scene and improvised a form of intra-delivery mini-Lamaze preparation: during the free intervals between contractions, I talked soothingly to the lady, educating her about the whole process of delivery (drawings included!) of which she was totally ignorant, and inviting her to become an active participant in the process by

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teaching her to pant-breath and later to push, explaining to her how that would help her in terms of analgesia and the baby in terms of oxygenation. I also reassured her that I would accompany her and coach her on those tasks until the end of the delivery. In a short half hour, and to the amazement of the midwife and nurses--and, indeed, to my own marvel--, this woman, until then totally wild, became a collaborative, friendly, participant, wholly concentrated in making the best of the experience, and extremely grateful when it finished successfully with the reward of a beautiful baby.

After it was all over, the midwife and nurses, rather excited by what they had witnessed, managed to pump my imagination with the idea that that type of service should be offered at the hospital on a regular basis. Following the saying "In the kingdom of the blind, the one-eyed is king," I took it as a call. I proceeded to read whatever I could find on "fearless childbirth" (by then there were, I remember, a total of three books on the subject, of which only one was translated into Spanish), I designed a blueprint of a painless childbirth program, I invited a couple of fellow-medical students and friends to join me in the endeavor and, a week later, I presented the idea to the chair of the Obstetrics Service, requesting his authorization to offer, off-hours, a voluntary "Fearless Childbirth" program for pregnant women and their mates. After examining our protocol, he accepted "as long as it didn't interfere with the regular activities of the Service." I then organized a presentation of this project to the whole contingent of midwifes and nurses, and affixed a small notice in the outpatient clinic inviting parents-to-be to join the program. Within three months we were conducting four staggered groups in training, with a total of some thirty couples. One of the three of us was always on call and ready to cross town toward the hospital with our scooters whenever one of the women from our program arrived to the hospital to deliver, in order to coach them during the process. Thus opened the first "Fearless Childbirth" program in a public hospital in Buenos Aires, and probably in Latin America. The experience was glorious, enlightening for the staff, a blessing for the parents-to-

be, and enormously gratifying for me and my team, not only authors of this successful endeavor but officiants in the never-ending miracle of natural birth.

Six months later, however, there was a change in the leadership of that Department of Obstetrics, and the new chair informed me that he would no longer authorize our program, "as we were not yet physicians, and therefore our activities were not endorsable." Needless to say, we were crushed, our patients-trainees were crushed, and so were the midwives and nurses, who had seen their work transformed by our program. But, fortunately, through those six months midwifes and nurses had shared our work and had learned the new ethics, the new language and the new practices and procedures. A qualitative change had taken place in their way of conceiving of their professional identity and in the way they conducted their daily work. In their own words, "they couldn't picture a maternity service the way it was before." As a result, they not only coached the pregnant women but they themselves, as insiders, within a few months, requested authorization from the new chair to develop a(nother) "Fearless Childbirth" program, following the pattern of the one we had created, and permission was granted. That program is still being offered today. So, not only the staff experienced a transformation, the institution as a whole was qualitatively transformed by a process that was serendipitously initiated (my having passed by the delivery room while that brawl was taking place, my having attended a presentation on "Fearless Childbirth" two days before, and, even more important, my having had the audacity of putting into action knowledge held by then with pins, yet shifted the role of the staff, the role of the women in their own delivery, as well as the role of the physicians. The result was an epistemological shift that started almost subversively (change frequently does), shifting the balance of power by and in the circulation of new knowledge and new ways of speaking.

Introduction

Health agencies, mental health agencies, and institutions in general, are systems in permanent change. Change may take place so slowly as to seem non-existent, or it may take a rapid, revolutionary pace. It may be generated by the institution's own developmental needs (a growth or a downsizing), by the pressures and needs of the context in which the institutions operate (be it changes in the community, the political situation or the overall economy), or by sheer chance. Indeed, most institutional changes occur by a combination of all those undercurrents, a prime example in practice of the principles of Chaos Theory (cf. ,e.g., Gleich 1987).

However, one cannot wait for those ingredients simply to appear. More specifically, one of those ingredients, serendipity, by definition cannot be orchestrated. There are, however, consultative methodologies that foster creative thinking, collective responsibility and qualitative changes in the participants and, frequently, in the institutions of which they are a part. This paper will illustrate the effect of one of those methodologies, namely, “reflective conversations”.

The nineties is an era of reduction of access to public services and a shrinking of what in the US is known as entitlement funds--i.e., public funds for the payment of health services provided at non-public institutions for the poor and the disenfranchised. In that climate, in which public and private non-profit organizations compete and fight for survival just as a private corporation would, mergers and consolidations are a not infrequent strategy for not-for-profit health and mental health agencies, as they allow for a reduction in the duplication of managerial positions and of overall support services and increase what, in the new lingo, is known as "control of the market share". Those periods of consolidation--an unsteady period for all the staff, as it is perceived as threatening the security of their jobs-- are ideal for the introduction of changes "from the top-down" (changes feared but expected by everybody when the sign "Now Under New Management" is posted). And those changes generally start

with the institutionalization of new procedures and the reorganization of personnel. But, unless the management is very savvy and generates opportunities for a safe grass-roots expression of ideas, initiatives and needs, it is a bad time for any change attempted "from the bottom-up". The latter have more chances of success if they are initiated during non-crisis period and, definitely, when they are packaged as non-critical to the management, as paranoia freezes any managerial good will and disposition to even consider change.

Most institutional transformations, as most evolutionary processes, take place discontinuously, in bursts, alternating with periods of steady state. Change is frequently preceded by crisis, i.e., by an increasing tension between the morphogenetic (shape-generating) and morphostatic (shape-retaining) tendencies that escalate until it upsets the unsteady equilibrium between them. But it may also take place during non critical, calm, periods, when change may not be perceived as mandatory nor as threatening. Regardless of how change is initiated, qualitative transformations that affects a whole institution will always be systemic in nature and include change in institutional goals (i.e., in the very mission and objectives of the institution), a change in a given institutional practice (i.e., in the way procedures are carried on), a change in language (i.e., in the way participants talk about goals and practices), and a change in protocols or record-keeping formats (i.e., in the way events are registered).

An example of a change in goal could be a shift in defining as a mission to "improve patients toward an early discharge" to "helping the patients to reach his/her own potentials, regardless of discharge." An example of a change in practices in an inpatient unit is to begin to include patients in their own treatment planning or discharge planning conferences; or a decision to place experienced clinicians in charge of responding to initial telephone calls of prospective patients, with the goal of redefining the motive of the consultation from “symptoms” to “problems” (from intra- to inter-personal) before the first face-to-face consultation.

Example of a shift in language would be the introduction of solution-oriented, strength-based rhetoric in lieu of (or as a second language in addition to) symptom-based, problem-oriented rhetoric. And example of a change in protocols / record keeping may be the replacement of symptom-based admission sheets for ones that may guide the interviewer to explore (more) centrally situational-contextual variables. Change in any one of these dimensions will favor change in others.

Once the process of change has been triggered and resonates at another level, a cascade effect takes place by which these levels reciprocally impact each other. Changes may start at one level in the system (sometimes almost serendipitously, as was the case of the introductory anecdote) but, through reverberations and ripple effects characteristic of complex systems/processes, they may affect other levels, and be affected by their change in turn, reconstituting and consolidating each other at another equilibrium point of the system. Hence, at a given moment it may become impossible or at least only arbitrary to pinpoint the original trigger of the change. But because organizations are living systems, morphostatic processes all too often block those ripples, reconstituting the previous knowledge/power relationships.

Unless a change in a given level reverberates and is complemented by changes at another level, the transformative process will in all likelihood stall. It can be drowned into a halt by lack of resonance at other levels, poor timing, ideological incongruency, or vested interests in the status quo. For instance, one may introduce as change in the institution's rhetoric (for instance, in its statement of "Mission" or "Vision"), but unless it is supported by simultaneous changes in its daily practices and/or in modalities of record-keeping, the likelihood that that shift in language will result in a qualitative change at the level of the whole institution is rather remote. Qualitative change is a culture change, a shift in the discourse and practices that glue together interaction and relationships.

Instanciation of new discourses/practices require a learning which, in turn, depends upon the possibility of reflective conversation.

The clinical consultation discussed below contributed to trigger reflective conversation leading to qualitative changes in a mental health agency, changes that permeated goals, languages, practices and record-keeping. That institutional shift happened in this case not by design but as a spontaneous, if not unavoidable, process following a series of clinical consultations that were themselves reflective conversations. Guided by systemic principles, these consultations were carried on following a consultative style that empowered the consultees and enhancing their own resourcefulness. The systemic view, rather than preached, was (co-)constructed and enacted with the participants, generating the proposal for a shift in some institutional goals and a change in some practices: "things happened", that is, a qualitative change took place, anchored, by a felicitous change in record-keeping that demanded daily practices that, in turn, replicated (and reminded) the newly spelled-out goals.

A clinical consultation with the staff of an agency [2]

The director of a residential agency invited me to conduct monthly two-hour consultations for his staff. This facility provided evening and night structured living care for ten chronic psychiatric patients who, during the day, were engaged in other community activities--most of them participated in therapeutic programs for chronic psychiatric patients, some of them worked, some just wandered around town. This residential (therapeutic) community was part of a medium size not-for-profit private agency contracted to provide those services by the regional Department of Mental Health. Two years ago the residential agency expanded to include a nearby day hospital that served the same population.

During one of those consultations, the consulting group--five enthusiastic and dedicated staff members, including the director of the evening facility, all with abundant front-line experience but with a low level of formal training--began to discuss their frustration with one of their residents, a 48-year old man named Bruno. Bruno had a loaded history as a chronic psychiatric patient, starting in late adolescence.. He had spent some ten years in a psychiatric hospital and then followed many cycles of the revolving door between community and psychiatric hospitalizations, and currently had enjoyed a rather steady-state for the past year-and-a-half, living in town in a protected environment that included chiefly both this residential community and the day hospital. The essence of the staff's frustration was that Bruno's social behavior would consistently improve in the course of several months, during which he would conduct himself in an increasingly pleasant, responsible and collaborative fashion, but at a given moment , quite sudden and unexpectedly, he would shift to antisocial and irresponsible behaviors that baffled everybody.

Examples of those behaviors went from the sublime to the ridiculous: Bruno would, for instance, sneak into the pantry of communal supplies and steal boxes of candies or pastries to gorge himself, a behavior that not only exasperated the staff because of the bad example it provided to other members of the community but also placed him at risk, since Bruno was a diabetic that required a rather strict diet. In addition--and this was one of the main sources of vexation for the staff-- Bruno would, rather unprovoked and unexpectedly, escalate into diatribes filled with profanities and offensive behavior toward the staff (for instance, "mooning", that is, defiantly displaying his bare rear end to indicate contempt or displeasure), which took place during what was usually perceived by everybody else as low-intensity interactions. The staff couldn't

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[2] This consultation has also been discussed in chapter III of Sluzki 1996, where, subtitled "There's nothing like home", examplifies the key role played by the staff of mental health institutions as inhabitants of the personal social network of psychiatric patients.

figure out what triggered those episodes nor they were able to obtain a cogent explanation from Bruno himself.

I began by exploring what would be the consequence of those outbursts. They explained that it would be a reconsideration of his status at the house in terms of duties and privileges, a demotion of sorts that would relieve him of some of his community responsibilities and, indeed, delayed the plans for his "graduation" into a less restricted, more independent living environment, which had been defined as the agreed-upon goal. I requested more details of those discharge plans, and was told that this patient had lived in the residence already for almost two years and the personnel was guided by the reasonable criterion that patients should progress, and that an improvement in the patients social skills would signal that he was ready to undertake the challenge of moving into in a less structured facility, namely, a community-based housing where he would enjoy less control and more autonomy. I explored who else was involved in Bruno's care and was informed that during the daytime he, as most of the other residents, participated in the day hospital, a program that included therapeutic and educational groups and various recreational activities. That day hospital, of which I heard for the first time in a rather casual way during this conversation, had been, as mentioned above, incorporated two years ago into the overall administrative and fiscal structure of the agency, that now managed both. I explored again whether Bruno had any relatives and was informed that he has had no contact with his family for over 20 years and that, in terms of his personal social network, his only relationships of consequence were the inhabitants of the residence and the staff and patients of the affiliated day program.

At the end of this consultation, I suggested that we some staff members of the day hospital for our next consultation , with the intent of facilitating a conjoint conversation centered on the puzzle of Bruno. After some hesitation (that was soothed when I assured them that the consultation series would still be defined as "theirs"), the staff accepted this idea, and agreed to invite the staff of the day

hospital. One of the participants was designated to convey the invitation, and a tentative appointment was made for two weeks later.

Eight staff members attended the next consultation, equally divided between personnel of each of the two programs, the residence and the day hospital. After a round of introduction and a general reminder of the clinical focus of the consultation, I explored with the personnel of the day hospital what difficulties, if any, they had with Bruno. They answered that, from their perspective, this patient didn't present any problem. When I asked them what were their goals and expectations for him, they stated that their hope was to help him maintain the level of socialization he had achieved already, which they consider a satisfactory plateau reached as a result of important progress made by him since he joined those programs. I asked whether they assumed that Bruno could "graduate" from the residence and, much to the surprise of the staff of that house, they labeled the idea of Bruno's graduation as wishful thinking: they saw him as a psychiatric patient heavily impaired by chronicity, and therefore their goal was only to maintain his current status.

I redefined "wishful thinking" as an important and sometimes necessary virtue to be able to keep on working with difficult populations such as the one represented by this patient, and explored with the residence team what would happen if Bruno would not be released, more specifically, whether there was any institutional regulation that precluded the possibility of any patient remaining in the residence for an indefinite period of time. After an animated debate among them, they answered that "graduation" was a programmatic goal but, as far as they knew, there was not any institutional regulation that mandated a graduation or punished the lack of it with expulsion. The collective discussion that followed crystallized the realization that Bruno may have been trapped between contradictory expectations and hence contradictory messages conveyed explicitly or implicitly by both teams. As a first reaction to their own formulation, both teams voiced the complaint that their agency's administration has been

ineffective in terms of circulation of information, and that, as a case in point, the two teams didn't meet on a regular basis to discuss the many patients in common, which made congruent patient planning rather difficult. I reminded them that this consultation was being procured and paid for by their agency's administration, which indicated a certain good disposition or at least a good organizational moment. I invited them to suggest how would they propose to structure those inter-agency meetings on a regular basis in ways that would not disturb the routine of the current programs; we also discussed who would have the decision power in each agency to formalize such meetings, and the complaint evolved into a plan of action to propose those meetings as a regular part of clinical practice.

Returning to the conversation about Bruno's predicament, another "damn-if-you-do, damn-if-you-don't" situation became apparent, this time not between the expectations of the staff of two agencies but within those of the residential facility: this patient's socially appropriate, "good", behavior triggered plans toward what the staff defined as a "reward", namely, the graduation; this predicament was, in turn, probably perceived by the patient as akin to an expulsion from his home and de facto family. Correspondingly, the response of the staff to Bruno's "bad" (or "mad") behavior, namely, his demotion and the consequent delay of any talks of discharge was defined by the staff as a negative reinforcement while there were good reasons to assume that the patient may experience it with relief. However, the reactive behaviors of the staff to Bruno's relapses--disappointment, anger, decrease of interest in him, and reduction of his participation in activities and responsibilities that would define him as member of the "family"-- deprived him of the much needed social/emotional nourishment from his primary group, and entailed a social pressure that motivated him to behave once again in responsible, "healthy" ways, to reinitiate the cycle.

Through this evolving conversation we were developing a new consensual description of this patient's predicament. The residence was, for all purposes,

Bruno's home. The residence's staff and to great extent that of the day hospital constituted for him his most meaningful personal social network. And, because of unclarified contradictory expectations between the staff of both institutions and between them and Bruno himself, he was enveloped in two sets of incompatible messages/behaviors, with an unavoidable paralyzing, if not crazy-making, effect, in the best style of the "double bind" trap.[3] One set stemmed from the conflicting assumptions between the teams, one of them expecting evolution and change and behaving according to this expectation, while the other expecting steady maintenance and behaved according to that assumption.[4] .The other set was lodged in the incompatibility between the assumptions of the overnight therapeutic community and those that may have been guiding Bruno: what the residence personnel considered a reward - the "graduation" of the patient to a less restrictive residence for chronic psychiatric patients-- meant for the patient the loss of a great part of his rather feeble meaningful surrogate family and close social network.

I commended all the participants (myself included) for having generated collectively such a sophisticated field hypothesis and suggested a method to test it, namely, that they invite Bruno to a formal meeting and, in a rather ceremonial way, pose to him that, upon much deliberation, they have reached the conclusion that they have been in error when suggesting to him his possible move to another house; instead, they now thought that it would make more sense that he consider living in the current house indefinitely. If Bruno would agree with this change of plans, they should tell him, he would have to assume a series of responsibilities, to indicate his status as permanent member of the community. I

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[3] A rather universal pathogenic situation, as discussed in Sluzki and Veron 1967, following the landmark theory proposed in Bateson et al. 1956. The ingredients of the double-binding experience include the presence of two (or more) contradictory injunctions placed at different logical levels (for instance, one explicit and one implicit, or one at the level of a class and another at the level of a member of that class), taking place in a meaningful context and a relation of dependency--entailing the impossibility to leave the field--, inability to clarify the contradiction--situations in which those attemops are in turn punished or contradictions that are not perceived as such by the sources--, and, alas, a reiterated experience. The one-on-one match between this set of ingredients and those of Bruno's predicament will not escape the reader.

[4] Reminiscent of Weakland's 1960's discussion on the the double bind and three-party interaction

underlined to the team that this proposal was not to be considered a "paradoxical intervention", aimed at obtaining a contrary effect, but an actual redress to the previous ambiguous situation.

I explored which responsibility could be appropriately assigned to Bruno so as to increase his chances of success; they concluded that he had always shown interest and ability in being in charge of the house's pantry, and therefore he could be in charge of food supplies, maintaining an inventory of goods and making the weekly shopping lists. The fact that this flew in the face of the previous experiences of inappropriate actions by Bruno precisely in that very area didn't escape anybody, and was the source of many jokes and of some serious discussion about risks of this idea, but they all ended up by agreeing that it was worth the try. The consultation ended in a cordial and rather jovial tone.

Bruno was never again the focus of our consultations in subsequent meetings. A follow-up discussion on the subject one and six months later showed that Bruno was still living in the residence, that his unpleasant behaviors were sporadic and minimal, that he was a responsible pantry-keeper, and that his diabetes was under control. I reminded the house staff to make occasional comments to the patient that would reaffirm (to him as well as the staff!) the notion of the stability of his citizenship as member of that community.

The staff also informed me a month later that a new process had been formally established in the agency, namely, meetings twice-a-month between the personnel of both sectors in order to circulate information and elaborate conjoint plans about their many patients in common. Obvious as it may be ex post facto the advantage of scheduling meetings on a regular basis between members of sectors that share patients and of unifying records between agencies with an overlapping population of patients , this new activity was described by the consultees as a revolutionary change in the culture of their institution. Even further, it took place in what was perceived by them to be an

amazingly easy fashion: they made the suggestion to the upper echelons, who found the request very reasonable, and it was instituted. Also, and as a grassroots change of policy, the staff of both sectors decided to make themselves available in each other's on-call list: whenever there was a need to cover a turn because somebody in one of the sectors was unavailable --sick, on leave, or whatever--, instead of resorting to a larger on-call list of per-diem personnel. This was not only economically advantageous for those who wanted additional work but explicitly done in order to increase their familiarity with the other sector's routines and challenges. Last but not the least, they also informed me with pride that the directors of both sectors and the director of the umbrella agency had agreed to establishment of a unified record system for all patients that would collate information from both sectors, including goals and objectives (formulated in terms of assets and strengths, as we were doing consistently during the consultations) and including detailed family and network resource variables (also following an emphasis followed during those meetings).

The latter represented the presence of a perhaps more subtle change that became apparent in the participants: a comfortable and meaningful change in their language and logic signaled the incorporation of a systemic slant in dealing with patients. Questions along the line of "why now?", "in which way are we participating in generating or maintaining the problem?", "how can we formulate the problem in a more constructive way?" , "who else is part of the daily network of this patient?" begun to permeate their practice, with a concurrent noticeable reduction of the utilization of psychiatric categories and labels when referring to patients.

Not surprisingly, the overall director of this consortium of agencies joined us as a visitor in one of the subsequent monthly consultations "just for the pleasure". In fact, she participated very lucidly and constructively in the case discussions and I praised her both for the quality of the staff and for the solid evolution that the consortium was showing under her aegis. During the year that

followed she joined the consultation group rather frequently--which remained focused on the residency but included on a stable basis members of the day hospital.

Discussion

What different levels of transformations could be specified throughout these series of consultations and their institutional effects?

At the most story-specific level, the team shifted their original narrative about Bruno. The original story that placed all the participants in a bad light, unable (the staff) or unwilling (Bruno) to achieve the staff's original goal. This failure entailed that there was somebody there that had to be blamed (the staff, the staff of the other agency, the patient, or the administration). That story was transformed throughout the consultation into one where, within his own limitations, Bruno was in fact being trying to be consistent both with his own needs and the community's expectations, and his oscillating responses were a reasonable expression of alternative compliance with those contradictory expectations. As the social ecology of Bruno acquired center stage, he--and, hopefully, the rest of the patients or former patients they served--ceased being conceived by the staff as individuals-in-isolation. The new story contained new problems and hence new solutions and placed them all--patient and staff alike--in a reasonably competent position. One of the correlates of all this was a transformation in their rhetoric from one that was contingent upon diagnostic labels to one that is based on interpersonal processes, conjoint responsibility and attainable goals--hence shifting the responsibility of failures and success regarding the patient's disorder to the collective calibration of objectives: success or failure becomes everybody's responsibility. Another correlate of this shift has been, indeed, a change in the staff's own behavior, as they generated a solution

that was empowering for all in lieu of a description that entailed incompetence or failure.

At broader level, the team experienced itself as able to think: the consultation entailed conceptualizations and favored the enactment of behaviors that go beyond their description of themselves as "just front-line doers", as following other people's designs. As a result of this shift in professional identity, they begun to take the responsibility of promoting a change in procedures that furthered their professionalism, namely, the inter-agency case conferences, organized under the aegis, and acting as reminder, of what they called their new way of thinking about and acting with their patients. In turn, this resulted in what may be considered an anchor of this epistemology, namely, the unified record-keeping, which reflected and required psycho-social, integrated, systemic thinking as it contained many variables explicitly eliciting the new language and practices. An in all this, the patients benefited from participating in therapeutic environment that was more empowering, respectful, participative and non-oppressive.

This consultation, hence, had as one of its effects the empowerment of the counsultees. It should be noted that this was facilitated by a reflective stance of the consultant that favored the generation of potential solutions to difficulties by the consultees themselves, rather than by the consultant. This is in fact not a new creed. System therapists have in recent times enacted their dominant epistemological shift toward social constructionism by means of behaving during the consultations according to a set of principles: transparency, that is, avoiding aloof/disengaged stances and the use of privileged information and, in general, knowledge as power--an evolutionary offspring of the original interactional-strategic notion of "one-down" (Watzlawick et al., 1974; cf. also Furman, 199); curiosity, that is, maintaining the assumption that descriptions are hypothesis, without any one being intrinsically correct (Cecchin 1987)--in turn an evolution of the concept of "neutrality" (Selvini Palazzoli et al., 1980), akin to that of "multi-

parciality" (Boszormengy Nagy and Spark, 1973) or "poly-ocularity" (De Shazer, 1985)); positive connotation or assumption of good intent, an active effort on the part of the interviewer to place all participants in locus within stories that are favorable to them without being unfavorable to others--a powerful stance that has been facilitated by the powerful tool of "circular questions" developed by the Milano team (Selvini Palazzoli et al., 1980; Penn, 1982, 1985, Tomm 1985, 1987, 1988) and a series of other tools--such as reframing and relabeling-- that have evolved in the field of family therapy to facilitate the co-construction of new, qualitatively transformed stories by all the participants (Sluzki, 1992). The overall style emerging from those principles is was has been identified above as “reflective conversations”.

It may be proposed that the true change in the organization described in the prologue took place not when we started the new program but when the language and the experience of those processes became part of the participants' assumptions about themselves and about the goals and practices of the organization. The same may hold true in the case of the clinical consultation: the organizational change begun to materialize when the participants' newly acquired language-epistemology (and the embedded ethics that included empowerment and a new definition of self as co-participation in institutional processes) became enacted in practices and record-keeping procedures that reconstituted that epistemology, and, which is even more important, kept alive the reflective conversation among staff members, and with their patients.

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REFERENCES

Bateson, G., Jackson, D.D., Haley,J. Weakland, J.H. (1956) Toward a theory of schizophrenia. Behavioral Science, 1(4):251-264

Boszormeny-Nagy, I. and Spark, G.M. (1973): Invisible Loyalties: Reciprocity in Intergenerational Family Therapy. New York: Harper & Row

Cecchin, G. (1987): "Hypothesizing-circularity-neutrality revisited: An invitation to curiosity". Family Process, 26(4):405-413

De Shazer, S. (1985): Keys to Solutions in Brief Therapy. New York, W.W.Norton

Furman, B. (199): "Glasnost in family therapy". The Family Therapy Networker ,

Gleick, J. (19887): Chaos: Making of a New Science. London/New York, Penguin.

Penn, P. (1982): "Circular questioning". Family Process, 21:267-280

Penn, P. (1985): "Feed-forward: Future questions, future maps" Family Process, 24: 299-310

Selvini Palazzoli, M.; Boscolo, L.; Cecchin. G. and Prata, G. (1980): "Hypthesizing-circularity-neutrality: Three guidelines for the conduction of the session". Family Process, 19(1): 3-12

Sluzki, C.E. (1992): "Transformations: A blueprint for narrative change in therapy." Family Process, 31:217-230

-------(1996): La Red Social: Frontera de la Terapia Sistemica. Barcelona, Gedisa (in Spanish); and Rio de Janeiro, Casa do Psicologo (in Portuguese) (to be published in English in 1997)

Sluzki, C.E. and Veron, E. (1971): "The double-bind as universal pathogenic situation" Family Process, 10:397-410

Tomm, K (1985): "Circular interviewing: A multifaceted clinical tool." In D. Campbell & R.Draper (Eds.): Applications of Systemic Therapy: The Milan Approach. London: Grune & Stratton

--------(1987): "Interventive interviewing: II Reflexive questions as a means to enable self healing." Family Process, 26:167-183

--------(1988): "Interventive interviewing: III. Intending to ask linear, circular or reflexive questions." Family Process, 27: 1-16

Watzlawick, P; Weakland, J.H. and Fisch, R. (1974): Change: Principles of Problem Formation and Problem Resolution. New York, W.W.Norton

Weakland, J.H. (1960): The "double-bind" hypothesis and three-party interaction. In Jackson, D.D. (Ed.): The Etiology of Schizophrenia. New York: Basic Books.