ON THE ETHICS OF CONSTRUCTING REALITIES

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ABSTRACT: The author describes the successful use of Solution-Focused Brief Therapy intervention with an 11-year-old female who had been hospitalized for two weeks because she could not walk. He raises some ethical questions about the use of diagnosis "if, or when, we know different and maybe faster and simpler ways to find out what can be helpful?"

KEY WORDS: Solution-Focused Brief Therapy; medical treatment; paralysis; psychiatry.

> A man comes to his tailor to try on his new suit, and complains that the fit isn't perfect over the back. The tailor makes him lean forward and look again, and in this position the suit looks fine. The man complains about the arm and the tailor makes him lift his arm, and a similar problem with the left leg is solved by bending it, and finally the man is satisfied and walks out in his new suit.
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> Bent forward, one arm in the air and one leg crooked, he limps down the street. Two men standing down the road see him coming and one of them says to the other, "Gee, have you seen that, I wouldn't want to be as handicapped as that." The other one looks, nods his accord and says, "Me neither, but—he certainly has an amazingly talented tailor."

In the western world today, we look at emotional phenomena as if they were physical (in the same way as fever, rash and a sore throat). We try to classify, explore, and explain these phenomena in basically the same way as when exploring medical disease. The purpose of the classifications thus created is for the physician/therapist

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to know what to do. There is a basic belief that from the way we group "symptoms" together and call them something: hysteria, neurosis, schizophrenia, alcoholism, enmeshed families, etc., will emerge knowledge of specific treatments, psychological or biological, that will be tailored for the underlying condition causing the specific "illness" thus named. We use the same methods as in medicine, and these methods are not thought of as altering or changing what we are looking at. A sore throat is a sore throat, anxiety is anxiety, schizophrenia is schizophrenia, and the conditions exist independently of how we observe/describe and talk about them. The behaviors thus classified are always indicative of an "underlying" problem, disturbance or disease. "Deviant" behaviour always has underlying causes, individual, contextual, biological, or different combinations of these and finding these causes is essential for treatment.

The disease model (Figure 1) is simple to understand. Someone presents with a problem, say, a sore throat The physician examines the patient, determines the underlying cause—infection—and delivers the appropriate treatment.

At the present level of knowledge in psychiatry it is acknowledged that we may not know the "real causes" of the underlying "diseases," but it is assumed that with more research we will, and this knowledge will bring about specific treatments. This may be right, but it may also be wrong. It is possible that we are on the wrong track. It could be that problems arise and exist in language both

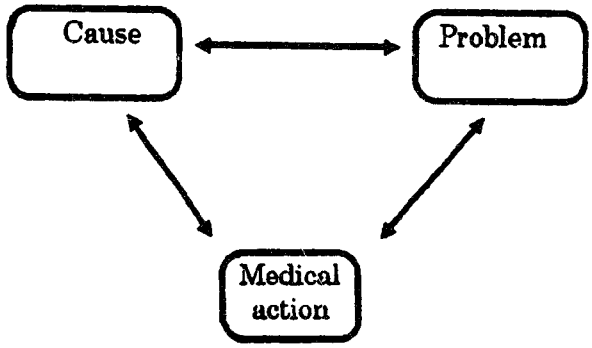

FIGURE 1

The Disease Model

as result, reason, cause and effect as proposed by the post-modern thinkers. If this is the case our efforts today will come to a dead-end.

We can only see what we can describe as we can only describe what we can see. We make sense of the world and of what is happening from how we describe it. The theory we use to make sense of the world decides what we are looking for and when we ask questions we do it to get to the facts that fit with the theory. ('The suit fits fine, just bend a little here and there and you'll see for yourself').

A CASE

Lena is 11 years old and has been in the hospital for a fortnight because she cannot walk. She has been through thorough examinations during those two weeks, and all known possible physiological reasons for her inability to walk have been excluded.

I am called to the pediatric ward as the child psychiatric consultant, and it is clear from the referral sheet that Lena is considered to be a "child psychiatric case":

> Strong suspicion of conversion syndrome. Doesn't seem to be saddened by her condition. Talks with a smile about not being able to walk.

I was once trained in traditional psychiatric diagnostics and assessments. Some 15 years ago I tried learning structural and strategic family therapy, and I have now for nine years done solution-focused therapy in child psychiatry and outpatient drug dependency treatment.

Twenty years ago I would have started the interview with Lena and her mother by trying to penetrate her background and actual social situation, and I would have tried looking thoroughly for 2–3 weeks before the interview to find the reason her unconscious decided at that time it was better not to walk. I would have looked at issues concerned with primary and secondary gain and looked into questions of dependency.

Fifteen years ago I would have started by trying to get an idea of how she and her mother and other important people around her looked at the situation. I would have gotten an enactment started between her and her mother to get an idea about that relationship, and I would have asked many questions about her father in order to

get a clear picture of boundaries and holons in order to understand how the problem fit in the family structure.

With both theories/methods I would have made an effort to get an understanding of the cause for her condition—an explanation, the first being "she has a hysterical palsy" determined by a certain organization of her psyche, the second being a structural diagnosis of the family "enmeshed, blurred boundaries" etc.

Both theories/methods would have permitted a child psychiatric assessment (in Sweden)—an explanation—to be put in my file about her. Both methods would also have guided the treatment. The first would most probably have led to long-term individual therapy; the second to structural or strategic family therapy. Diagnostics done within a certain model of thinking normally leads to treatment within that model.

THE INTERVIEW

When we (an intern and myself) arrive in the pediatrics ward, Lena is in her bed and on the chair next to her is her mother. They both smile politely while we sit down and introduce ourselves as doctors from child psychiatry. I then lift my head toward Lena and ask, "What are you good at?"

She looks at her mother who doesn't say anything, turns to me and wonders, "Do you mean at school, or?"

"Yes," I say. She thinks for awhile, and then answers, "Drawing." She thinks for a while longer, looks at her mother again, and continues, "It's fun to paint too, and I am good at English." I add, "What else?" and she answers, "Bicycling." Turning to mother I ask, "What else is she good at?"

"She is good at taking care of her money. She is good at helping out at home and she is very good at house-cleaning."

I mumble, "Good," take notes, and turn to the girl again, "What is she good at," I ask as I point to mother. "She is good at ruining her hair," says Lena, and mother laughs under a head that obviously comes directly from the hairdresser (permanent), and Lena laughs also. I smile and say, "I understand what you mean," and she smiles back at me.

"Now I want to ask you a very difficult question," I say. "Suppose you go home today and tonight you go to bed and you go to sleep. While you're asleep a miracle happens (she looks questioningly at me,

so I add) "wonder" (and she nods in understanding)—"and tomorrow the problem that made you come here is gone." Lena nods and I continue, "But as you're asleep when the wonder happens, you won't know it happened. What is different tomorrow that will make you think that there has been a wonder?"

She thinks for a long time, and then recounts that she will get up, wash herself, and get dressed. She will then walk (she stresses the word walk which in Swedish means both go and walk) to the kitchen, and she will have her ordinary breakfast. She will then go to school and on the way to school she will meet and accompany her friends.

I nod and ask, "How will they react when they see you're walking?" She immediately answers, "They'll be happy." I wonder if they will be surprised as well, and she confirms, thinks for a few seconds, and recounts that on the way to school she and her friends will surely play, jump in the puddles, and they will have to run the last few hundred meters to school in order not to be late "because it's always like that."

I ponder for a second if she's always late for school or if she always runs the last few hundred meters or both, and I then decide that this distinction is not relevant for the purpose of my interview. So I continue, "What else will be different?"

During class things will not be different, because one just sits anyway, but during the breaks she will play with her friends, she will jump with the skipping rope, play hide and seek, and in the afternoon after school she will go roller-skating, and everyone will be very happy because she started walking again and can join in the play.

To a series of supplementary questions detailing how friends, parents, grandparents, and teachers will react and behave, she describes that she will be proud of herself, her friends will be happy, and her parents and grandmother (who has been very worried) will be very proud of her.

She gets increasingly excited, seats herself more upright in her bed, and about 25 minutes into the interview suddenly says, "I have already started practicing!"

"How?" I ask, and she shows how she has been practicing stretching and plying her legs using her arms. I wonder if she already got so far that she dared trying to stand on "her leg." She answers "no," but accepts a bit hesitantly that I lift her out of her bed and put her on the floor where she succeeds in taking a couple of staggering steps. "Wow!" I exclaim and applaud her. "This is amazing. You can already

start feeling proud of yourself:" She smiles shyly and looks at her mother who is also applauding, even if not as enthusiastically as I am. She smiles again and I help her get back to her bed.

"On a scale from 1 to 10 where 10 means you are certain that you want to work very hard to solve this problem, where are you at?" I ask, and she answers "10."

"How certain are you that you will solve it?

"Seven," she answers. To the same question mother answers 10.

After this we speak briefly about things seemingly going in the right direction, and I then explain that I want to take a break to think and discuss with my colleague how we see the situation and to think about if we have any idea on what could be helpful, and we leave the room.

THE CONFUSION

Everybody knows about dreams. While dreaming the dream is the reality, and no matter how bizarre the dream may seem afterward, it is only very rarely possible to "reality-test" the content of a dream while asleep.

Coming out of the room there is only one thought in my head. "This cannot be hysteria, there isn't even a shred of 'la belle indifference.' Nothing has come out that can be seen as a triggering factor. There are no personality traits pointing toward hysteria. This girl wants to walk on her legs and is working hard for it. The pediatricians must have missed something!" I tell this to the accompanying intern and together we start looking through her medical records. Have they thought of everything?

It is a thick file and we can see that she has been scanned by every possible machine, and every bodily fluid has been drawn and examined. The somatic colleagues have looked for signs of very rare and uncommon causes for palsies, and finally we have to conclude that we are not more clever than our colleagues in orthopedia and pediatrics.

I am very confused. Psychiatry is supposed to be my area of expertise and I have to give some kind of answer to these colleagues of mine. Maybe something is slipping my mind, but at that moment I can't think of what. All I can think of is that I haven't found anything that speaks for a psychiatric diagnosis, and I'm falling into the same trap that we sometimes accuse our colleagues in somatic medicine of

falling into, namely, when you've excluded every possibility that there may be a somatic reason, you then conclude that the illness is a psychiatric one. I am embarrassed. The only relief and bearing for me is that I notice in the file that the physicians see her differently than I do. Phrases like "not concerned by her serious symptom. Smiles when she talks about not being able to walk" do indicate that there may be signs of at least 'la belle indifference,' and I recall that the same thing was said on the referral sheet.

So eventually I make up my mind. The solution-focused interview did seem all right, and I decide that it must be relevant in at least some way, so in order to finish the session I go back to my theory about therapy, and I make my "therapy-diagnosis" from within the framework of "therapy as a system" (de Shazer, 1988).

1. She told me she has a problem.
2. She told me that she wants to do something (at least work hard) to solve the problem.
3. She described what she has already started doing that works.
4. Evaluating the relationship, I believe that if I ask her to do something it is probable that she will do it if it makes sense to her.

My map says: As she has already started doing something that has led to progress, it could be helpful for her to do more of it.

I rapidly prepare a summing-up of the session and return to the room where mother and Lena look at us expectantly.

I turn to mother first and say, "I am impressed by your daughter. Her helpfulness at home, that she can already take care of her money, that she has so many and broad interests, and her strong will to do something about this very serious problem. But I am most impressed by the fact that she has already taken the first steps. That she has found a way to practice that works for her and pays off. " I turn to the girl who is shining. "I would like to suggest that you go home today, do you want that?" She nods. "At home you continue to practice in exactly the same way you started here, and when you feel ready for it, you start going to school again. Then I want to see you at my office in the next building over there in three days. Is that OK?"

She nods, seems satisfied with that, and we set up an appointment.

In what consisted my confusion? At the moment I couldn't understand why I didn't see any "signs" of hysteria. At least I ought to have

seen "la belle indifference." You may see cases of hysteria in psychiatric praxis without "1a belle indifference," and it may exist with certain very heroic cancer-patients (American Psychiatric Association, 1980), but my clinical experience has consistently been seeing those typical traits of character and the signs of hysteria with conversion-hysteria patients. So I was very confused.

A couple of weeks after I saw her the second time I realized what had gone wrong in my head. I had thought of "la belle indifference" as a property of a person, as a trait of character. (If you have a hysterical palsy, you must also have "la belle indifference"—if the man is very handicapped he has a very good tailor.)

My realization was that of course I couldn't see "la belle indifference"—the sign of illness, such things are relational phenomena, not properties or characters of persons.

To claim that there is (exists) "la belle indifference" I have to examine the girl's relationship to her symptom. I am then part of a triangle that could be visualized like Figure 2, and I am of course a part in creating what I am looking for. But I did not examine her relationship to her problem. We were not talking about her problem. We were talking about her goal. Together we were co-creating her preferred future. It appears in Figure 3.

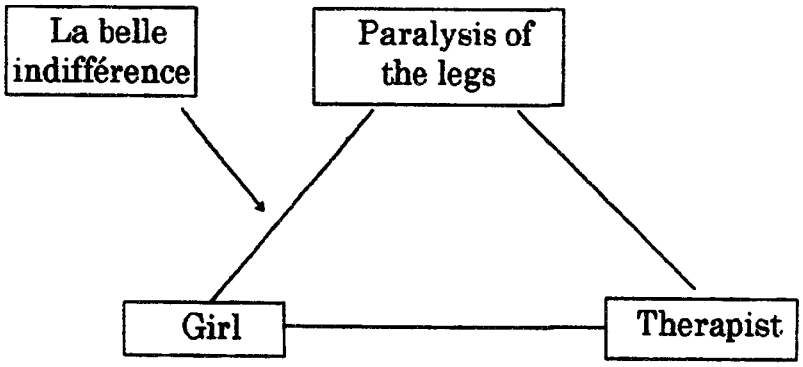

FIGURE 2

La Belle Indifference: Symptoms as Relational Properties, Not Properties of Persons

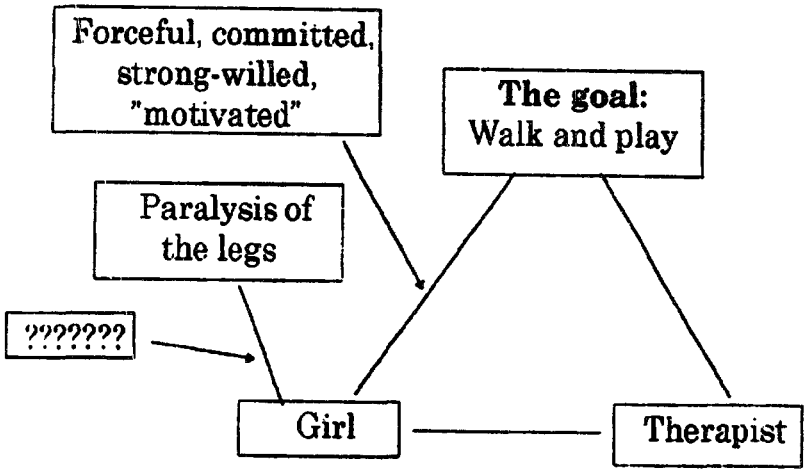

FIGURE 3

Patient's Goal: Co-creating Patient's Preferred Future

In the relationship thus created there isn't a shred of la belle indifference. On the contrary, this little girl is very eager to walk. In our conversation her eagerness seems to grow in relation to the fantasy she has about what will happen in our co-created imagined future about her without the problem.

With this particular case—within that session—I am certain that it would have been impossible for me to do both things: Create the information necessary to make the diagnosis of hysteria and thus have her display beautiful indifference, and then have her change into forceful, committed, and strong-willed in a "struggle" to get well. One type of relationship excludes the possibility of the other existing at the same time. Had I started to examine her relationship with her problem she would have become "hysterical." Talking about her preferred future—and she starts walking within the session.

Of course, one can only speculate as to what would have happened had I done an assessment in a more traditional way. Her paralysis would probably have regressed very quickly no matter what (most diseases heal in spite of treatment). This is at least suggested by her already started training (or was this also co-created in the

session?), but it's easy to imagine Lena and her family in therapy for a long time (which of course is not certain to be a bad thing).

I saw this girl only once more, three days later. She came running in the corridor toward my room. The wonder as she had described it, occurred in minute detail the morning after she was discharged. It was as if she had only to follow her own manuscript and everyone else did.

During a rather short interview I asked her how certain she was that she would be able to continue walking even if it would sometimes become difficult, and she answered "Nine." Mother answered "Seven." I wondered what made her so sure, and she answered, "Well, 'cause next time I am in pain I will know what to do." Mother and I agreed that this was good enough and that they would call if they needed to in the future. One year later I phoned mother and she described a positive development and no problems.

The theory governing how Lena, mother, the intern, and I construct a hypothetical future without the problem (many, many other constructions are also possible within the therapeutic system) contains no elements that are dependent on the girl's personality, her inner structures, or her family situation. The theory is only about coconstruction in the setting of the therapeutic interview. It is a theory about therapy or better; a description of therapy, and it is not a theory about the people in therapy. Within that theory there exists a nosology or classification that can be used to guide the therapist.

Within that frame and with its many limitations the theory is coherent and consistent. One element depends on the other, and together the different parts form a whole, the same way such wholeness is held together within other theoretical systems. Thus it becomes a real alternative to traditional diagnostic thinking in the sense that it helps us decide what to do, even though it does not help us decide what's wrong with a certain person or a certain family system. It only helps us decide what might be helpful.

So to get back to the story of the man leaving the tailors shop. The descriptions, done by the men looking at him, are true, and their descriptions fit together. The man is very handicapped and he has a very good tailor. There is inner coherence or fit between the different parts of the descriptions; if he is handicapped he has a very good tailor, or if he has a very good tailor he is very handicapped. The different parts of the diagnosis fit together and are dependent on each other, simply because one is always deduced from the other.

These men are not wrong. From their perspective the description is correct, even if a description from other perspectives would be di-

ametrically opposite. This man is not handicapped, at least not when it comes to his body, and his tailor is definitely not a good tailor even though he may be good at other things. If one part is true, then the other one is true also, and if one thing is false the other is false also.

THE ETHICS OF IT

We cannot know how the world of this little girl is organized, or how her family is organized, because they will organize themselves within the limitations of the interviewer's theory. Within the theory of the interviewer an inner coherence will exist (or be created). (Overinvolved mother, dependent girl, deduced family structures or psychic structures that can explain her symptom.)

In most psychiatric settings in the world today therapists and physicians conform to the standards of assessments and diagnosis that are predominant in those settings. (This is also true for social services.) Thus relationships are determined not from the possibilities of the persons having problems, but from the theories that guide assessments and diagnosis. These theories may be right or wrong, but as shown in the case above they will determine the existence and nonexistence of certain relationship patterns, and if we believe that the conversations and relationships we have with our clients have some effects on their life, we can only conclude that these theories can exclude certain possibilities for certain clients.

These theories also make it impossible to know for which clients there exist other possibilities than those created within the assessment and diagnosis.

Very practically, should I have stopped the interview on goals and directed it toward her problem in order to get some indications of "la belle indifference," so that I could have put the necessary keywords into her file? Would it still had been possible to make the same intervention? Would the result had been the same?

Is there a choice to be made? Can we continue to diagnose if, or when, we know different and maybe faster and simpler ways to find out what can be helpful?

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