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Making Numbers Talk: Language in Therapy

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Do you want to learn the sciences with ease? Begin by learning your own language.

-ÉTIENNE CONDILLAC

The metaphor of therapy as conversation is simultaneously useful and dangerously misleading. The danger lies in what is probably an inevitable vowel shift from *a* to *i*, that is, from “therapy as conversation” to “therapy *is* conversation.” The vowel shift marks a transformation from metaphor to metaphor disguised as concept.

Since conversation is a normal and natural activity for two or more people in the same place at the same time to do together, we automatically make the assumption that we know what we are talking about when we use the word *conversation*. It seems so simple and obvious that we do not even need to know anything about conversations to participate in them. With the inescapable vowel shift from *a* to *i* (which is already happening, at least in workshops and training sessions) a pronouncement develops-“Therapy is conversation” - and we reasonably begin thinking that therapy equals conversation. Thus, through a grammatical transformation we mistakenly and inadvertently lead ourselves into thinking that we know all there is to know about doing therapy, that it primarily requires the skills involved in maintaining a conversation or continuing a dialogue. We thus mistakenly think that it is the conversation itself that is the therapy, that talking together is the curative factor. Like the expression therapeutic *relationship*, which preceded it, the pronouncement “Therapy is conversation” seems to explain what therapy is all about and yet is so vague that it actually tells us nothing.

On the other hand, the fact that doing therapy can be seen as a conversation reminds us of the interactional aspects of the endeavor. First, for therapy to be seen as a conversation, it must involve two or more people. Second, conversations happen within language, and language is what we use to have conversations. Thus, the slogan points to Condillac's idea that we need to learn our own language in order to learn about therapy (and, in fact, to learn about conversations or any other human endeavor).

The notions developed from viewing therapy as a conversation, as an activity involving two or more people, tend to threaten or corrupt (or perhaps to counterbalance) the traditional meanings of the word *therapy* (from the Greek, meaning "to nurse, to cure"), which certainly can mislead us into thinking the therapist operates upon the patient or client. Consider, for instance, the following dictionary definition of *therapeutic*:

serving to cure or heal; curative; concerned in discovering and applying remedies for diseases. That part of medical science which relates to the treatment and cure of diseases.

"Therapy as conversation" seems to be a useful contradiction in terms in that it leads us into seeing the doing of therapy and the using of the term *therapy* in ways that undermine and contaminate the usual dictionary definitions of therapy (which the term, unfortunately, automatically carries with it).

LANGUAGE: FOUR VIEWS

Certainly, our readers, like Condillac's, believe they know their own language, and we as authors want to believe we have a similar understanding of our language. After all, we use it all the time, particularly when talking, listening, reading, and writing. Using one's own language seems to be a simple, uncomplicated thing.

All common sense relies on a naive view of language as transparent and true. The commonsense assumption that language is a transparent medium expressing already-existing facts implies that change does not come about in language. Language is assumed always to reflect changes that occur prior to the changes in language. Authors or speakers are seen as able to perceive the truth of reality and to express this experience through language, thus enabling the reader and listener to know exactly what they mean. However, it is not so simple. There are at least three other distinct ways to think about how language works.

In traditional Western thought (which is related to the commonsense view), language is usually viewed as somehow representing reality. This is based on the notion that there is a reality out there to be represented. Therefore, language can be studied by determining how well it re-presents

that reality. This belief, of course, is based on the idea that language can represent “the truth,” the revelation of which is the goal of traditional Western science. Furthermore, this belief leads to the idea that a science of meaning can be developed by looking behind and beneath the words, an approach usually called structuralism (Chomsky, 1968, 1980; Saussure, 1922), which was explicitly used by Bandler and Grinder (1975) to look at hypnotherapy and psychotherapy. The entire history of psychotherapy from Freud to Selvini Palazzoli to Minuchin involves structural thinking, that is, looking behind and beneath the surface of what is being investigated.

Buddhists, on the other hand, would say that language blocks our access to reality (Coward, 1990). Since they too think there is a reality out there, this point of view leads Buddhists to the practice of meditation, which they use to turn off language and put themselves in touch with reality.

There is yet another view, which is usually labeled *poststructuralism* (de Shazer, 1993; de Shazer & Berg, 1992; Harland, 1987), that suggests, simply, that language is reality. To put this in terms more familiar to therapists, this idea that our world *is* language suggests a view related to what is called *constructivism*. This way of thinking suggests that we need to look at how we have ordered the world in our language and how our language (which comes before us) has ordered our world. This view has led us to believe that we need to study language in order to study anything at all. That is, rather than looking behind and beneath the language that clients and therapists use, we think that the language they use is all that we have to go on. Neither authors (or speakers) nor readers (or listeners) can be assured that they can get at what the other meant with any certainty because they each bring to the encounter all of their previous (and unique) experiences. Meaning is arrived at through negotiation within a specific context. That is, messages are not sent but only received: this goes for the author as well as the reader (and, therefore, the author is only one of many readers). Contrary to the commonsense view, change is seen to happen within language: What we talk about and how we talk about it makes a difference, and it is these differences that can be used to make a difference (to the client).

Over the past 20 years our work with clients has led us from some version of the traditional Western view, through a version of the traditional Eastern view, to a poststructural view. That is, we have come to see that the meanings arrived at in a therapeutic conversation are developed through a process more like negotiation than the development of understanding or an uncovering of what it is that is “really” going on. Given the uncertainty regarding meanings involved during any conversation, misunderstanding is far more likely than understanding. As we see it, it is the therapist’s job to use this misunderstanding creatively and, together with the client, to develop as useful a misunderstanding as is possible.

PROBLEM TALK / SOLUTION TALK

All of the facts belong only to the problem, not to its solution.

—LUDWIG WITTGENSTEIN, *Tractatus Logico-Philosophicus*

For the sake of argument, we will use the terms *problem talk* and *solution talk* as a binary opposition, which will allow us to follow Wittgenstein in setting up another expedient binary opposition between “facts” and their opposite, “non-facts.” *Non-facts* is a conveniently broader term than the perhaps automatic term *fictions*, thus allowing us to include fantasies, hopes, fictions, plans, desires, and so forth, as the opposites of “facts.”

Problem Talk

As we listen to people describe their problems and search for an explanation, “fact” piles up upon “fact,” and the problem becomes heavier and heavier. The whole situation can quickly become overwhelming, complicated, and perhaps even hopeless. This is when a client’s problem is explored in detail and he tells us more and more “facts” about his troubled life, he, as well as the therapist, is led to conclude, reasonably enough, that his could well be a difficult case. After all, these “facts” are what clients, as well as therapists, believe to be real and true. Such “problem talk,” talking more about what is not working, is doing more of the same of something that has not worked; thus, problem talk belongs to the problem itself and is not part of the solution. Simply, the more clients and therapists talk about “facts,” the greater the problem they jointly construct. This is the way language naturally works.

In general, problem talk appears as if it is based on the traditional Western view of truth and reality. As one “fact” follows another in the sequence of conversation, we start to feel forced to look behind and beneath them, forced to assume causal links and interconnections between them. This leads to the idea that the “underlying basic problem”—whatever is behind and beneath—must be worked on first, before the client can tackle other problems (which are on the surface).

However, a poststructural view suggests that the way we use language can and frequently does accidentally lead us astray. It is easy to forget that making a description has to be done in language and that the English language (at least) necessitates a sequential ordering of the words used in a description. Mistaking descriptions for causal explanations is a result of our being imposed upon or even duped by our language to the point that we forget how our notions developed from figures of speech (more formally, it can be said that we accidentally confuse ontology and grammar) and from the interactional process of therapist and client taking turns talking to-

¹This is only a temporary expedient since the “inside/outside” of binary pairs cannot be guaranteed; the boundary is not a barrier.

gether, that is, asking for and being given a description. It is important to remember that neither therapist nor client is doing something wrong when this happens. Rather, the fault -if there is any-lies in language itself.

Solution Talk

It seems quite clear that one cannot solve the problem with the same kind of thinking that has created the problem. Over the years we have learned from our clients that how they judge the effectiveness of therapy is far different from how therapists (and researchers) judge or measure success. Our clients have taught us that solutions involve a very different kind of thinking and talking, a kind of talking and thinking that is outside of the "facts," outside of the problem. It is this talking outside of the problem that we call "solution talk." As client and therapist talk more and more about the solution they want to construct together, they come to believe in the truth or reality of what they are talking about. This is the way language works, naturally.

SCALING QUESTIONS

For a large class of cases—though not for all—in which we employ the word "meaning" it can be defined thus: the meaning of a word is its use . . .

—LUDWIG WITTGENSTEIN, *Philosophical Investigations*

Questions as Therapeutic Tools

In recent years we have come to view questions as tools for therapeutic intervention. Unlike therapists who view themselves as the expert in solution finding, we have come to realize that it is the use of words, thoughts, events, and feelings that shapes the client's reality; perceptions and behaviors. Through the exchange of misreading and misunderstanding we help clients reconstruct and reshape their reality in a way that they see as helpful.

Berg and Miller (1992) have described five kinds of questions that are useful at various times during an interview: (1) questions that elicit descriptions of pre-session change; (2) "miracle questions," that is, those that help define the client's goal(s) and illuminate the hypothetical solutions (de Shazer, 1988, 1991), (3) exceptions - finding questions, (4) coping questions that highlight the often overlooked but critical survival strategies that clients use in even the most apparently hopeless circumstances; and (5) scaling questions. In this chapter we limit our focus to a discussion of scaling questions.

Of course, numbers, like words, can be magic, as anyone who has played around with numbers knows. As is our usual practice, we took a cue from our clients and developed ways to use numbers as a simple therapeutic

tool. Unlike scales that are used to measure something based on normative standards (i.e., scales that measure and compare the client's functioning with that of the general population along a bell curve), the scales we use are designed to facilitate treatment. Our scales are used to "measure" the client's own perception, to motivate and encourage, and to elucidate the goals and anything else that is important to the individual client.

Individual and Relationship Perspectives

As indicated elsewhere (de Shazer & Berg, 1992), all the questions the therapist asks a client are attempts to elicit the following information: (1) the client's views of the problem and of solutions to it, including his or her opinions and the degree of upset, hopefulness, and willingness to work hard to solve problems, and (2) the client's perception both of important persons in his or her life and of their perception of the client. As George Herbert Mead's (1934) perceptive observations suggest, our view of ourselves is, at least in large part, dependent upon our view of how other people see us; thus, questions that help the therapist get some idea about the client's perception of his or her relationship with important people provide useful information, particularly when the client's goal is vague or treatment is mandated.

Scaling questions are used to discuss the individual client's perspective, the client's view of others, and the client's impression of others' view of him or her. (It goes without saying that the therapist asks many other types of questions that are related to scales.)

Clinical Illustration I

The following dialogues between client (C) therapist (T) are verbatim extracts from a first session.

T:² How confident are you that you can stick with this? Let's say ten means you're confident that you're going to carry this out, that a year from now you'll look back and say, "I did what I set out to do." Okay? And one means you're going to back down from this. How confident are you, between ten and one?

C: Seven.

T: Seven?

C: Yeah.

T: Wow!

C: I don't have a choice.

T: That's true. That's true. What do you suppose Charlie's mother would say? About the same question, what do you think she would say?

² Insoo Kim Berg.

- C: She'd give me a lower one.
- T: P r o b a b l y
- C: She'd say we never stick to what we say we are going to do.
- T: How low? What would she say between ten and one?
- C: Four or five.
- T: Four or five?
- C: Yeah.
- T: Okay. What if I asked Charlie about...
- C: Me?
- T: Yeah, about Joan. What would he say? Where would he say you were at? How confident would he say he is that you're going to carry this out?
- C: Three or four.
- T: Three or four?
- C: Yeah.
- T: Lower than his mother. What about your mother? What would she say?
- C: My mom would give me a one. She doesn't let me think anything. [While both Joan and her therapist knew what they mean when they each use the word "confidence," neither knows for sure what the other means when she uses that word (or any other word, for that matter). Similarly, we as authors cannot be certain that we know what our readers mean when they use the term "confidence"; nor can they be certain that they know what we mean. Each of us brings to the use of the word our entire experience with that word. While there is bound to be some similarity, some overlap in what we mean, there is naturally also a vast difference in meaning that may come into play in the conversation. Of course, the more dissimilar our experiences, the greater the chances for creative misunderstanding.
- In our example the scales give the client and her therapist some idea of her degree of confidence in her ability to persist in therapy and provide them with a means of comparing it with the client's views of how other people in her life see her. This gives the therapist an opportunity to compliment the client.]
- T: Somehow you have learned to disagree with all of them.
- C: Uh huh.
- T: And you say your friends help you do this. What if I were to ask your friends, what would they say, on the same scale, about the same question?
- C: They're not so worried that I'm going to be doing the things I want to be doing. They're just worried I'm going to take Charlie back again. So, for the "everything else" [life beyond the decision about Charlie] part, I'd probably get a seven too.

[The scales also help to give both client and therapist some idea of how much support the client gets from her friends. Clearly, from the client's point of view, her friends will be more useful to her in reaching her goals (vis-à-vis the "everything else" part) than will her mother, her husband's mother, or her estranged husband.

While the differences between 7 and 4 or 5, 7 and 3 or 4, and 7 and 1 leave room for us to wonder about how realistic the client's 7 might be, her friends' 7 does give it some support. Furthermore, the 7 within this context also suggests that the client believes herself to be more determined to do what she wants to do than others see her to be, and this comparison with other people may help to reinforce that determination.]

C: They'd probably say that I was going to take Charlie back.

T: So, they're worried about that.

C: Oh, yeah.

T: Oh, they are.

C: They've been calling me every five minutes. I have friends coming over this afternoon and everything because they always are going to say, "If he calls, you're going to talk to him or you're going to let him come over."

T: So, they think Charlie is no good for you!

C: Yeah.

T: They're convinced Charlie is not good for you?

C: Yeah. They hate him.

T: They hate him.

C: Yeah.

T: So, if I were to ask your friends "What are the chances that Joan is going to take Charlie back?" (*client laughs*) what would they say, on the same scale?

C: Ten to one.

[Client switches from scaling to giving odds perhaps in response to the therapist's asking about "chances" and the therapist follows.]

T: Ten to one.

C: Probably.

T: Really? They must be worried about you.

C: Yeah. I'm worried.

T: You're worried.

C: Yeah.

T: What chances do you give yourself?

C: Probably about the same.

T: Ten to one? So, you think not taking him back is good for you?

C: Yeah.

T: Really?

C: Right.

T: You're absolutely sure about that?

C: Positive.

T: Positive. So what do you need to do to increase the odds?

C: I don't know. I always think he's going to change, he's going to be better. He's always promising to do better. And then I sometimes think, well, okay. On the one hand, I am a decent person and this and that. And then on the other one, who's going to take me with three kids? Who's going to care about me, or want to care about them, or want to be with us?

T: So, what do you have to do to increase the odds that you're not going to take him back?

C: I have no idea. *(laughs)*

T: What would your friends tell you?

C: They always tell me that I should find somebody else and if I found somebody who was decent and did treat us decently, then I'd see the difference and wouldn't want him back.

T: That's what they'd say.

C: Yeah. Which makes some sense. but in the meantime... *(laughs)*

T: In the meantime

C: I'm home all day, every day, twenty-four hours. And the phone is right there. And if he calls, I really don't have anything else.

T: That's it?

Constructing Exceptions

C: Well, he called last night. He just made up an excuse ... it was something about his insurance.

T: How come you didn't weaken last night when he called?

C: 'Cause I was busy. I was doing other things. *(laughs)* And I was watching a movie.

T: Why didn't you take him back yet last night?

C: He wasn't asking that. He was just trying to, you know, but I just talked to him like I talk to anyone.

T: So if he calls and asks you to take him back, is that when you're likely to weaken?

C: Yeah. *(laughs)*

T: So if he begs and he promises all this stuff, is that what's going to happen then?

C: Yeah.

T: I see. So that's when your odds are very low.

C: Yeah.

- T: Okay. So, what do you have to do to increase your odds?
C: I don't know. *(laughs)* I don't know.
T: What would your friends tell you to do to increase the odds?
C: They don't know either. They just say I should do something and keep busy and once the baby gets here I'll be able to get out more and do more ...
T: What is a small thing you can do to increase the odds, just a little bit?
C: I don't call him. I haven't called him and usually I would have by now.
T: Is that right?
C: Oh, yeah.
T: So,
C: Whenever he calls, like, it was quarter to eleven when he called ...
T: Wow.
C: He sounded pretty shocked that I hadn't called him.
T: wow.
C: So I was pretty proud of myself.
T: Wow.
C: I feel better. The more he thinks that I'm going to take him back ... and the more he acts like that, the more I feel better, like "Ha, I didn't" you know, it's ...
T: So, your not calling him, that helps. Is that right? And what else helped yesterday! Not give in or not ask him to come back?
C: Um ...
T: Do you ask him to come back or does he beg you to take him back?
C: Both.
T: Both ways. Okay. So, I guess one thing you can do is to figure out how you're not going to ask him to come back.

[At this point some exceptions to Joan's view of herself as helpless against both Charlie's pleas or her own loneliness have been described; thus, both Joan and her therapist know that she knows how to avoid calling and asking Charlie back (which she would usually have already done by this point in a separation), and they know she now knows how to respond when he calls - by being "busy." Since she thinks that not taking him back is good for her, these acts in the direction of her goal (which were performed prior to therapy and are precursors to the goal) can be further constructed to increase the chances for Joan's success and to bolster her confidence that she can meet her goals. Furthermore, these behaviors can be the focus of a homework task that the therapist might suggest to help Joan increase her chances for success since Joan, of course, is capable of doing more of something she already knows how to do.]

- T: Which is harder for you to do: Not ask him to come back or when he begs you to take him back, not to take him back? Which is going to be harder for you, do you think?
- C: Well, he sits there and says, "Yeah, you just do this because you never cared about me" and this, that, and the other. And like, "Yeah, I just pick up any stranger off the street and stay with him for three years. And have my head beat in and have three kids for anybody." You know, and he'll sit there and say, "You don't love me," and he'll come back and he'll start crying and stuff and I'll say, "Well, I don't need it unless you're going to do this, this, and this." "Oh, I will, I will." That's the end; that's it. Because I want to believe him, I really do. There are times he can be a really nice person.
- T: What is the likelihood that he is going to come back to you, promising that?
- C: Pretty good.
- T: Is It?
- C: Basically, yeah.
- T: So, he is not convinced that you mean business this time.
- C: No. And you can't really blame him.
- T: Yeah.
- C: You know ...
- T: Your record isn't too good.
- C: No, it's not!
- T: Right. So this time you have to really do something different to indicate to him that you mean business.
- c: And I don't know what.
- T: Okay.
- C: I mean, I've called the attorney and done all these other things. And that should be good ... enough. And his mom had a fit.
- T: I can imagine.
- c: She started screaming ...
- T: I'm sure she was mad, sure.
- C: "You can't keep my grandkids away from me."
- T: But you didn't back down from that.
- C: No.
- [Going to the attorney's and not backing down with her children's grandmother can be constructed into useful exceptions since they too run counter to Joan's picture of herself as helpless. The therapist might use these examples as focal points for compliments to Joan about her strength and resourcefulness.]

- T: Let me ask you a different kind of question. Let's say ten means you have every confidence that Charlie is going to change, to turn his life around, and one means, you know, the opposite.
- C: I'd give him a two.
- T: A two.
- C: Nothing means enough to him. He'd rather be out drinking. Or he'd rather be out with some fourteen-year-old. And the kids are only good for show when there's a family event coming up or when there's a holiday ... that's usually when he sits and he's really nice.
- T: What do you have to do to stick to your guns this time?
- C: I don't know. *(laughs)*
- T: You don't know.
- C: I've thought about just writing down all the things that he does and just keep looking at them ... Every day I'll write down and say what there is good about him or what he's done good for us and what he hasn't, you know.
- T: That will help you to remind yourself?
- C: I thought it would.
- [Joan's idea about writing down the good and the bad might prove to be a useful focal point for a homework task, particularly since it is her idea. Some clients find writing/reading tasks such as this quite useful for sorting things out when they are not clear about what they are going to do or how they are going to do what they want to do.]
- T: You're saying the likelihood of him changing is about two. What do you have to see him do for you to say maybe three?
- C: Take us seriously and put us as a priority. Right now his job is his priority. It's like he's embarrassed of me. He doesn't take me where he goes with his friends or out with his friends at all.
- T: So what will he be doing different?
- C: He would! He would not be ashamed of us. He would take us with him.
- T: What's the likelihood of him doing that?
- C: Two. *(laughs)*
- T: *(laughs)* Not very high.
- C: As a matter of fact, it could be a one because he's had three years to do it and he's never done it.

Clinical Illustration II

Even seemingly concrete numbers can be fluid and changeable as a consequence of the changing perceptions resulting from the client-therapist conversation. In this case the family's view of the miracle was followed by the therapist's curiosity about whether or not any small pieces of this miracle had ever happened.

Constructing Pre-session Change

During the conversation with the therapist the client may indicate that things are going a little bit better since the last session. In order to affirm, validate, and further query about what has to change in order for the client to feel like the therapy has been helpful, the therapist may find that scaling questions are useful.

The following transcript is from a therapy session with a family.

The first session with the family of three included the mother and her two daughters. The mother was about to be divorced from her second husband (the children's step-father). The family's view of the solution (obtained through the "miracle question") included the children observing their mother smiling more, being happier, and being able to end her phone conversation with their stepfather sooner and without getting upset. Both the mother's and the children's view of what the children would be like when the problem was solved included the children showing their increased happiness by repeating those rare but friendly and normal talks they used to have when the mother's marriage was going reasonably well.

In the course of the conversation it came out that the night before the first session the mother had acted differently on the phone with her estranged husband. The two girls described how their mother was able to "push the fussing aside" and just hang up on her husband and walk away, instead of "getting worked up pretty hard" about what he said. All three of them agreed that it was the first time she had been able to do it since the separation.

The timing of when to ask the scaling question is important. The following conversation between the therapist (T) and family (mother, M, and daughter, D) occurred after a fair amount of discussion concerning successes:

- T: (to *mother*) Let's say ten stands for how you want your life to be when you don't need to come back to see me anymore and zero stands for the worst possible period in recent weeks when you were the most worried about your family. Where would you say you are right now?
- M: I would say I'm at about halfway. About half, as far as I am concerned. I would say it's lower than that for the children, particularly when I'm with them.
- T: What if you take the family as a whole?
- M: I would say about three and a half or four. It's the children I'm concerned about, how this divorce affects them. If it wasn't for the kids, I would walk away from this marriage with no problem. It's the kids that make me caught up in the cycle.
- T: How long would you say you've been at three and a half or four?
- M: Last three or four months.
- T: Wow. (*Therapist then turns to the older daughter.*) What about you? Ten stands for Mom taking everything in stride, like last night, and zero

stands for when she was at the worst period about being able to walk away from getting upset.

D: I would say she is at seven or nine today.

T: So from your point of view Mom has come a long way. Wow. How about the family as a whole? Where would you say the family is, from zero to ten, today?

D: Five or six.

[The difference in perception between the mother and the daughter on how the mother and the family are doing needs to be highlighted as a change. The therapist decided to utilize this as the start of a solution-focused language game (de Shazer, 1991; de Shazer & Berg, 1992). Notice the emerging changes in the mother's perception of how she went about the recent changes and its impact on the children.]

T: *(to mother)* Are you surprised to hear this?

M: No. From their point of view I've come a long way because I held my ground last night.

T: How have you done that?

M: I didn't take him back.

T: So it's been good for you and your children not to take him back?

M: Yeah, they know now I will not take him back, and it's good for them to know that. It's a pretty certain thing for them now. I've gone through being mad at him and now I'm past that. I'm still not taking him back. I will be mad for a while and when I'm okay I'll take him back. I've been okay for a while and I haven't taken him back.

T: So it's a pretty certain thing that you won't take him back?

M: Year, I'm pretty certain.

T: *(to daughter)* What do you think, now does it help you?

D: When she is happier, she is more easygoing.

T: So you could tell when Mom is happier. How does that help you?

D: Yeah, when she is happier, it's better for us.

T: So when mom makes a decision and sticks with the decision, that makes Mom happier. When Mom is happier, it makes things better for you.

D: Yeah. *(Mother looks at her daughter and nods.)*

T: *(turning to mother)* Wow, how have you done this? That must have been very hard.

M: It's hard, very hard. But I noticed in our conversation that after eight and a half years he hasn't changed. He is not going to change. Getting back is not going to make things better.

T: You are convinced of that?

M: I am convinced of that. It's good for me to go on my own. It's also good for the children, too.

It is difficult to know exactly what the mother had in mind when she described herself as at 5 and the family as a whole at 3.5 or 4. It is also not very clear what the daughter meant when she put her mother at 7 or 9 and the family at 5 or 6. Whether or not the therapist knows is unimportant. However, it is important that mother and daughter each seem to know, as far as we can tell, what the other means.

Later in the conversation the mother was asked to describe what she would be doing when she had moved up one point on the scale. The daughters were also asked what differences they thought they would notice in their mother and how those differences would affect their lives.

CONCLUSION

How can I say what I know with words whose signification is multiple?

—EDMOND JABÈS

Scales allow both therapist and client to use the way language works naturally by agreeing upon terms (i.e., numbers) and a concept (a scale where 10 stands for the goal and zero stand, for an absence of progress toward that goal) that is obviously multiple and flexible. Since neither therapist nor client can be absolutely certain what the other means by the use of a particular word or concept, scaling questions allow them to jointly construct a way of talking about things that are hard to describe, including progress toward the client's goal(s). For instance, a young woman thought that she was halfway toward her goal and therefore gave herself a rating of 5. When asked what would be different when her rating was 6, she simply said, "I will feel more sixish." Of course, the therapist would have preferred a more concrete and specific description, but the client was unable to describe things concretely (even though she was sure she would know when she was at 6). Here the scales give us a way to creatively misunderstand by using numbers to describe the indescribable and yet have some confidence that we, as therapists, are doing the job the client hired us to do.

EDITOR'S QUESTIONS

Q: I am intrigued by your notion that the therapist's job is to creatively use the misunderstandings inherent in conversation to enable change to occur. Would you elaborate on this idea?

A: Rather than saying the therapist enables change to occur, our view is that change is constantly occurring, stability is an illusion, and change cannot be prevented. The therapist's job is to use the misunderstandings inherent in conversation to help the client notice differences so that these noticed differences can be put to work. Then these noticed differences can make a difference.

Furthermore, rather than saying that misunderstandings are "inherent in Conversation," our view is that misunderstandings constitute conversa-

tions and that, in fact, misunderstandings make conversation possible. That is, if we simply (radically) understood each other, we would have nothing to talk about.

For instance, if we could *understand* what clients mean when they say “I am depressed,” there would be no reason to ask them any questions. We would know precisely and exactly the past, present, and future of their condition. Without saying a word, we could give them a prescription, chemical and/or behavioral, they would say “Thanks,” and that would be all there was to it. Fortunately, even our field’s most positivistic endeavors (such as the *DSM*) recognize that things are not that clear-cut. So we ask questions because we know that we do not understand what clients mean when they say they are depressed.

Depression is clearly not something simple. Clients’ descriptions usually involve troublesome thoughts, feelings, behaviors, attitudes, and contexts, including other people. None of the words or concepts that clients include in their descriptions are simple; because we do not understand what they say, we are led to ask further questions. And, of course, none of our words and concepts are simple, and clients ask us questions because they do not understand us. All of this conversation is based on the belief that understanding, though perhaps improbable, is possible.

Of course, clients know what they mean (at that particular time), but we cannot know. Suppose you ask a client what she means by depression, and she starts by telling you that she has not been sleeping enough. Can you have any confidence whatsoever that her not sleeping enough has prompted her to choose the term *depressed*? Or was it your question that led to her answer? Regardless, when she starts to make her private meaning public through talking to you about her depression, the meaning that develops is automatically interactional: In the therapeutic setting, meaning is a joint product of the conversation between therapist and client.

As therapist and client continue to talk about the client’s “depression” and the therapist gets more and more details about what the client means by the term, what happens to the therapist? In our experience, after 30 to 45 minutes the therapist also starts to feel and act “depressed” and, if this talk goes on much longer, begins to feel just as hopeless as the client does. And thus the therapist accidentally joins the client in doing more of the same of something that has already failed to work, namely, searching for the meaning of the term *depression*, which in effect constructs its meaning and, at least sometimes, accidentally reinforces the feelings of depression.

In our view understanding, knowing exactly what is meant by the term depression is impossible: Behind and/or beneath every understanding or interpretation lurks another interpretation (see the second part of our answer to the next question). Therefore, searching for “the one true meaning” is useless (when it is not deleterious). As a result, we decided (radically, perhaps) to just accept the situation as it is and thus to use our misunderstanding toward helping the client construct a solution.

Since the meanings of words and concepts are variable, and at times even undecidable (there is no way to decide what they mean with any certainty), critics of our point of view frequently jump to the conclusion that we are saying anything goes, that, for example, *depression* could mean, absurdly, tree. However, logic, grammar, rhetoric (in a classical sense), use, context, and, importantly, the concept's opposite (non-depression) serve as constraints on the range of potential meanings. For example, what depression is not usefully limits the possible meanings of the term. Whatever might be attended to in non-depression we call "exceptions," "miracles," and so forth.

Talking with the client about what the problem/complaint is not (i.e., talking about non-depression) is one of our ways of using misunderstanding in a creative fashion. Focusing on non-depression allows therapist and client to construct a solution, or at least begin to construct a solution, based on the client's experiences that are outside the problem area. Thus, a solution is a joint product of therapist and client talking together about whatever it is that the problem/complaint is not. Of course, we do not and cannot understand what the complaint is not any better than we can understand what the complaint is. Fortunately, talking about whatever the complaint is not (and, again, this is not something simple) seems to be useful and valuable to most clients. As they continue to talk about the non-problem/non-complaint, they are doing something different, rather than more of the same of something that has not worked. The more they talk about exceptions, miracles, and so forth, the more "real" what they are talking about becomes.

Q: Your approach in therapy has been described as "minimalist," and the material you present here certainly fits this description. I imagine your work evolved over time in this direction. Would you discuss this process and also comment on where you see your work evolving in the future. Also, what is required of the therapist in order to stay "simple"?

A: As William of Ockham said, "What can be done with fewer means is done in vain with many." Indeed, our work has evolved, frequently in very unexpected ways, or at least ways we did not expect. Our clients have helped us-or, better, forced us-to continue to simplify our approach. Each step along the way we have always had the mistaken idea that (1) it (doing therapy) can't be this simple and that (2) this is as simple as it (doing therapy) can get. (Of course, just because the approach is simple does not mean that doing it is easy. Far from it.) Clients continue to surprise us, and thus we expect that one of these days a client, by doing something that surprises us more than usual and/or in a different way, will force us to simplify our approach once again. We have no idea in what specific direction this might take us.

Umberto Eco (1992), describing 2nd-century Gnostics' reading of Scripture, might almost be describing our structural urge (both yours and mine), that is, the search for truth:

Each and every word must be an allusion, an allegory. They [the words] are saying something other than what they appear to be saying. Each one of them contains a message that none of them will ever be able to reveal alone. Secret knowledge is deep knowledge (because only what is lying under the surface can remain unknown for long). Thus truth becomes identified with what is not said or what is said obscurely and must be understood beyond or beneath the surface of a text. The gods speak . . . through hieroglyphic and enigmatic messages. (p. 30)

Eco goes on to say that “truth is secret and any questioning of the symbols and enigmas will never reveal ultimate truth but simply displace the secret elsewhere” (1992, p. 35), to somewhere further behind or deeper beneath the surface. The urge to look behind and beneath, to understand and explain, to find the hidden secret, leads to endless iteration because we can never be certain that digging yet another level deeper is not possible. The result, of course, is structural complexity.

However, the whole structural project falls flat on its face when someone proposes the Wittgensteinian question “But what if there is nothing behind and beneath?” What if you’ve got what you’ve got and that’s all there is? Once one simplifies and abandons theory (structural or any other grand design), one is stuck with accepting what one has, however contradictory and cryptic, as all there is to be had. Everything is there on the surface of things, where it has always been.

Simplicity takes a lot of self-discipline. For most of us it is not easy to put aside our highly valued urge to look behind and beneath, to understand and to explain things, and thus to just describe what happens. However, because of the way language works, we can (and all too frequently do) mistakenly think that descriptions are explanations, and a muddle develops.

Q: How can the therapist assess where in the interview to engage the client in scaling questions? For which clinical situations are these questions most useful? What has been your experience using these questions with children and adolescents?

A: Scaling questions were first developed to help both therapist and client talk about nonspecific topics such as depression or communication. All too frequently we talk about topics like these as if the experiences depicted by these terms were controlled by an on-off-switch; that is, one is thought of as either depressed or not and couples are seen as able to communicate or not. However, fortunately, it is not that clear-cut. Even people who say that they have been depressed for years will usually be able to describe times (minutes, hours, days) when they were less depressed. By developing a scale, the range of depressed feelings, and thus the complaint, is broken down into more or less discrete steps. For instance, if a scale is set up on which 0 stands for the most depressed a client has felt in recent weeks (or for how the client felt at the time of the original phone call seeking therapy) and 10 stands for the feeling on the day after the miracle, which includes being free of depressed feelings (or, at least, not being aware of any depressed

feelings and therefore feeling capable of doing something that now seems impossible), then any rating above 0 not only says that things are already better but it also says that progress is being made toward the goal. The goal in this situation, no matter how vaguely and nonspecifically described, is not just the absence of depressed feelings but, rather, the achievement of 10.

Similarly, a couple's perception of how well they communicate with each other varies for each of them from time to time. With 10 standing for communicating as well as is possible for a specific couple to communicate, their joint progress and their different perceptions are simply depicted through their ratings. We frequently ask each partner to guess the other's rating, which again simply depicts progress and differences in perception as well as implying that such differences are both normal and expectable. The question is not "Who is right?" but "what does the one giving the higher rating see that the other one does not?" Thus, no matter how vaguely and nonspecifically the clients describe their situation, scales can be used to develop a useful way for therapist and clients to talk together about constructing solutions.

Scales can also be quite useful in group therapy sessions when the members of the group tend to be somewhat guarded. Scales can be thought of as content-free since only the speaker knows what he or she means by a particular number; the other group members just have to accept this fact. The therapist can discuss how the client's life will be different when he or she moves up from, say 5 to 6. The natural follow-up to this question's response is to ask what the client needs to do to move from 5 to 6. Other questions include the following: "When you move from 5 to 6, who will be the first to notice the changes in you?" "What will your mother do differently when she notices the changes in you?"

Finally, we have found that scales can be used with small children, developmentally disabled adults, and even those who tend to be very concrete. Anyone who grasps the idea that 10 is greater than 0 or that 5 on this sort of scale is better than 4 can easily respond to scaling questions.

For example, an 8-year-old child was brought to therapy following molestation by a stranger in a shopping mall. During the fourth session the therapist drew an arrow between a 1 and a 20 on the blackboard, with 10 standing for the time when therapy was finished. The therapist asked the child to indicate how far she had come in therapy by drawing an *x* on this line. The child drew her *x* at about the 7 mark. She was next asked what she thought it would take to go from *x* to 10. After several minutes, during which time she shifted her weight from one foot to the other, she hit upon an idea and said, "I know what!" "What?" asked the therapist. The little girl replied in a rather somber voice, "We will burn the clothes I was wearing when it happened." The therapist, amazed at this creative idea, said, "That's a wonderful idea!" Soon after this session the child and her parents had a ritual burning and then went out to dinner in a fancy restaurant to mark the end of therapy.

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