Editorial
Rx for Certainty in Clinical Work with Families: Insatiable Curiosity

Our ideas about reality shape who we are in our personal and professional worlds, how we think, and how we interact with others. We live in a world where certain a priori assumptions remain largely unquestioned: "There is a single reality"; "There is one right opinion (and it's usually my opinion because what I see is true)"; "There is a right answer." For several centuries we have lived under the influence of a philosophical worldview called positivism-an influence we may not even be aware of. Since the 1600s-the time of the philosopher Descartes (1596-1650}--inquirers of knowledge have asserted that there is an objective reality operating according to natural laws and have believed that the inquirer must be objective and unbiased: questions and hypotheses are stated in advance and subjected to empirical tests under carefully controlled conditions (the classical experiment). When reality is independent from myself as observer, then my claim about reality, i.e., my experience, is the only claim that is valid. Logical positivism has been such a predominant worldview that it has permeated our thinking-down to the level of our bone marrow! The result? The disease of certainty.

Certainty shows itself in many ways. I have observed myself as a parent demand compliance-not about life-threatening or moral issues-but about preferred ways to dress, preferred ways to behave. I've felt misunderstood by others and wished the other person would just see things my way! I have worked with families and believed I knew what was best for them. Underlying this certainty is a more ominous implication: I am not only right and you are wrong, but you must change your ideas to make them like mine. The legacy of certainty that began with Descartes-that there is an objective and observationally independent reality-has invited oppression and even violence. If I am stronger, wealthier, better educated, more expert, and more powerful, my reality is not only more valid than yours, but I can force you to comply with my "truth"-my way of seeing the world.

Emerging philosophical worldviews have questioned the idea of one absolute fixed reality for all people. Defined as postmodernism, these ideas are shaping professional clinical practice with families and knowledge development (Mills & Sprenkle, 1995, Watson, 1995). The world, according to the constructivist paradigm, is no longer the world of the observed. It is now the world of observing systems (Guba, 1990). There is no distinction or separation between the observed and the observer. "There are multiverses, each valid in its own right. None of these exist independent of the observer" (Anderson, Goolishian, & Windermand, 1986, p. 4). Thus, my description of a family becomes only one of many possible descriptions, none more correct than the others.

Maturana, a Chilean biologist, has supported these ideas with his experiments on perception and offers a biological explanation of cognition (Maturana & Varela, 1992). With ideas like structural determinism and objectivity in parentheses, he argues that the mind is not something within the brain. It belongs to the realm of explanations and social dynamics. "If we were to believe that the world everyone sees is not *the* world but *a* world which we bring forth with others through language, it invites us to recognize that the world will be different only if we live differently" (Maturana & Varela, 1992, p. 245).

What does it mean to live differently? If explanation of experience is not validated by reference to an independent reality, one appreciates that people will operate in differently, yet equally legitimate domains of reality. It follows then that the experiences and perceptions of others are valid, real, legitimate, even if they are not equally desirable or pleasant to live with (Maturana, 1988). As a result, one way of living differently is to be very interested in how others see the world, to understand how their experiences have shaped their ideas of who they are and how they make sense of what is "true" for them, rather than discounting their ideas because they do not fit with mine.

In the early 1980s a family therapy team from Milan, Italy, revolutionized clinical practice with families by showing the clinician how to become less invested in whether the family's explanation of a problem is true or false and more invested in generating multiple descriptions and explanations using circular questions and hypothesizing (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1980). To accomplish this, curiosity is an essential characteristic of the clinician. "When we are curious about the patterns of relationships of ideas, people, events, and behaviours, we perturb the system with which we are interacting in ways that are different from perturbations based on our attempts to discover a correct description/explanation" (Cecchin, 1987, p. 408). Several other authors have underscored the importance of curiosity and the ways it can be observed in clinical work with families (Amundson, Stewart, & Valentine, 1993; Hoffman, 1985; Wright, Watson, & Bell, 1996).

In our work at the Family Nursing Unit of the University of Calgary where we teach master's and doctoral nursing students and assist families who are experiencing difficulties with illness, we have observed one characteristic distinguishes an excellent family clinician insatiable curiosity (personal communication, L. M. Wright, 1995). Insatiable curiosity allows the clinician to continuously look for and offer different explanations and descriptions-other ways of seeing family members, beliefs, behaviors, and problems which might generate new perspectives and offer more solution options. At the Family Nursing Unit, we create a context for curiosity to occur through the use of clinical teams, presession hypothesizing, speculative language, interventive questions, and by offering families an opportunity to hear the team talk about them. Exercises like those contained in von Oech's books, *A Whack on the Side of the Head* (1983) and *A Kick in the Seat of the Pants* (1986), offer other creative ways to stimulate curiosity. "Curiosity is an activity. . .that is composed of both the impulse to look beyond assumptions, and the love of surprise." (Dyche & Zayas, 1995, p. 390).

An attitude of permanent vigilance is required to challenge the discourse of certainty (Maturana & Varela, 1992). To this end, one nursing student group of beginning family clinicians made a lapel button similar to the well-known No Smoking logo. The button had the word "CERTAINTY" in a circle with a slash line through it to remind themselves about the important and daring task of stamping out certainty by being curious. Many of those former students, now graduates in advanced nurse clinician positions, still have the button tacked to their bulletin boards-a reminder that insatiable curiosity continues to be a powerful antidote for combating the disease of certainty in our personal and professional lives.

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