Why worry, why now, what for?

a pocket guide to family systemic consultation[1]

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Summary and Introduction
These notes are for use in family systems consultation or supervision to help focus on the primary clinical task (why worry?) and its connection with feared developments in the family/system (why now?), which have both provoked the crisis of referral and contain the seeds of its solution.

By exposing the problem as a fear of change (what for?) developmental drive is engaged to reduce it, rather than fight it. Natural systems, such as families, are in any case always changing and a therapist, like a bullfighter, needs to know when to step aside not too soon and not too late.

Why Worry?

The problem. What is the problem, and what am I expected to do about it. Why does it matter. What am I being asked to do, and by whom. Can I possibly do so, if not who can. Am I being asked to solve a problem at all, or simply to listen to a story or give information.

What is the primary task of this meeting. Does the family/client know what the problem is, or is it only perceived by the referrer, or someone else i.e. where is the wish for change most urgently located.

If I fail, or do nothing what will happen, what is the worst that could happen. Who would suffer the most, who would be most concerned, who is the most anxious now.

Why here? What am I being employed to do for these people (my legal, professional and clinical responsibilities), do I actually care about them. If not, why not. What did they have to do to get to me. Who else is expecting something (success or failure) from this meeting. Are the relevant people here, should this meeting be somewhere else. Will I have to arrange another one. If so where. If not, does someone else need to. Who should be invited.

When the problem is obscure your formulation may then take the form "how can X convince Y that something can, or must, be done – do they need my help for this".

Typical openers: "How can I help you?", "What needs to change (and what needs to stay the same)", and , a little later, "how will I/you/others know when the problem is gone", "what is it like when the problem is not happening", “if I am not able to help; what then?". Don't expect people to know exactly what they want. Sometimes the problem is how to accept what cannot be changed. If defining it gets too difficult, move on from why worry? to –

[1] notes drafted in 1985/6 when teaching at the Institute of Family Therapy, London; edited with contemporary references in 2013

Why Now?
The system changes. A developmental crisis is the context of the referral. A family tree is a simple place to record many, but not all, of the answers. Put non-family members of the network to one side of the page, doctor, social worker, school counsellor, teacher, youth worker, neighbour, volunteer. For practical purposes the system (= 'the problem-determined system') is all the people, agencies and institutions that are involved in – and quite possibly maintaining - the problem, or are about to be. Change is in the air.

Who is the referrer, and what does he or she want from you or your agency. What prompted this referral now, rather than at some other time, past or future. Are there any significant recent or anticipated ***exits*** *from or* ***entrances*** *into*[1] this family and its network eg in the family: grandparents, other family member (or pet) seriously ill or just died, breakdown (physical or mental), *divorce* or *death,* marriage or re-marriage, retirement, last or first child born, starting/leaving school, leaving home. Social/legal immigration/emigration, passport or permit expired, going into or coming out of care, prison, hospital, children's or old people's home. Network/neighbourhood: key-helper (eg home help, physiotherapist) leaving or moving, change or loss of job, school or home.

Anniversary of any of the above.

Ask: "What was happening to you (parent of Identified Patient = IP) at this stage in *your* life?"

About the potentially alarming event ask: "who is the most/least affected by it?", "who in your extended family, alive or dead, would be the most helpful person now?" how are relationships (always specify which) changing because of it, eg will the IP be more or less anxious about mother's mental health when the elder sibling leaves home.

Don't be afraid to ask about fears of *madness, separation* and *suicide* (the three Bs: *breakdown, breakup and bereavement*) eg "if you recover from this do you think your father will this time succeed in killing himself?"

Any of these changes may be perceived as a serious threat to the family's stability/security/survival *especially by the IP.* He or she will have a point, but may also have got it wrong, in which case parents can put him/her right. The gap, however small, between a child's view of the world and the parents' can be exploited once it has been shown up in the consultation. Parents need the chance to manage their child[2] (In any case even successful development involves loss, as well as gain.)

Why the IP? what is it about the patient that makes him/her so, why is another member of the family not the patient; ask how it would be if they were. Often the answer lies in family circumstances around the child's birth and early years. Mother's mother died, mother became depressed, for example.

Why me? what is it about me that brings the problem here. What part in the family's/system's stage play am I being invited to act.

What For?
The function of the symptom/referral. Finding a link between the presenting problem and the system change: the hypothesis. Remember that a hypothesis is not an explanation but the source of a possible intervention that offers a new view of the problem.

In what obvious, ingenious or perverse way can the problem be said to conceal, reverse or postpone the system change (the '**protection racket'**).

From the IP's point of view who or what is meant to benefit most from this arrangement ie who is protecting whom, and why. Does this expose the secret 'marriage' (anxious attachment/enmeshment) in the system. Parentification[3] is ubiquitous and can be welcomed in small doses, but it can be tragic if the child has abandoned his or her development for an imagined solution to other family members' problems.

Ask circular questions[4] (how do A's actions impact on B's relationship with C) about the benefits of no change and the dangers of development, about the future structure (eg in 10 years time) of the family. How old will you/others in the family be in ten years time. Where will you be and with whom, what will you be doing.

Which grandparent does the patient replace. Does the IP think that by succeeding in life, instead of having a problem, s/he will become 'too good' (eg better educated, higher social class) for one or both of the parents. Can the protected person (usually a parent) conceivably convince the IP to give up the struggle. The IP does not know as much about break up/down or death as the parents ie what can the parents teach the child about life, sex and death. What is the family's rule, script, myth or premise that cannot be questioned or even observed; the taboo. Which symptomatic activity can you identify as a metaphor for the developmental crisis. Can the IP consider being grateful to one or both parents.

The principal differences that make a difference are perceptions: between genders, and between generations past, present and future, between what is expected of you (transference) and what you can actually do, between having the problem and not having it and, fundamentally, between *individuals*, the only sentient beings in the system. No one else is listening to your questions or experiencing your interventions.

Positive connotation[5] is a technique to improve your therapeutic observation of and respect for people's efforts, not a whitewash. It leads to a finer picture of the status quo, which is of course never static, especially in a crisis. As a way of thinking about people in family consultations it obliges you to see the virtue in what may otherwise seem bad or disappointing, eg that the parents can be proud that their child can speak his mind or, more profoundly, that we can see how the presenting problem was needed to bring to light an unresolved family dilemma. The delinquent can be thanked for his (unconscious and omnipotent) attempt to rescue the chosen parent. Sometimes it feels like clutching at straws. (Imagine being a recipient of your own therapy to appreciate the potential for humiliation in family meetings like this).

Whatever else they expect, your clients have the right to your considered opinion.

The power of therapy comes only from the need for change in the system – the developmental imperative, which has biological force and is, like time itself, linear.

The discoveries of systemic/strategic therapy are at their clearest in the family and the system around adolescents in psychiatric crisis, who can be viewed as disappointed saviours of one or both parents, or of the family as a whole; failed messiahs, whose exposure in therapy is both an embarrassing insult and a relief. "Family therapy" runs the serious risk blaming parents. It is a better strategy to leave the problem with the identified patient, suitably reframed as a well meant but hopeless mission, and allow the

family/system to find a solution. If the consultation has changed the way *you* see the family, this may already be happening.

Arranging a further meeting is a therapeutic task or communication in itself. Why meet again? There must always be a good reason for doing so, for the location of the meeting, and for who is expected and who the convenor is. Making plans about further clinical meetings or assessments, or about how the family is going to deal with exits and entrances (from or to another home or country, hospital, prison, children's or old people's home) are also potential therapeutic tasks.

Always look for opportunities to *investigate* or to *celebrate* the status quo, as this must alter it. To ask for a systematic record of the symptom (or simply "discuss what it is that you want *not* to change") is a request for information for a subsequent session, but it is also a paradoxical task. Celebration is also a normal way of marking developmental hurdles.

Conclusion

These are the questions and notes for use in supervision, either alone or with colleagues. They are intended to generate answers which help to formulate the two primary tasks:

a) the therapist's (*why worry?*) which is to make space for therapeutic intervention by defining solvable problems.

b) the family's (*why now?*) which is to overcome developmental hurdles and carry on, without therapy.

The link (*what for?*) is: the function of the symptom/referral as a well-meant but ultimately futile attempt to turn back the clock.

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[1] All the world's a stage,/ And all the men and women merely players. / They have their exits and their entrances,/ And one man in his time plays many parts. *As you like it*, 2.7.139

[2] 'parents' means any arrangement of adults who take responsibility. Haley, J. (1976) *Problem-Solving Therapy*, New York: Harper & Row

[3] "...innate among the human being's emotional potentialities, present in the earliest months of postnatal life, is an essentially psychotherapeutic striving" Searles, H. (1979) The patient as therapist to his analyst. In: *Countertransference and Related Subjects: Selected Papers* (pp. 380-459). New York: International Universities Press. p459.

[4] Cecchin G. (1987) Hypothesizing, Circularity, and Neutrality Revisited: An Invitation to Curiosity. Family Process 26:405-413 DOI: 10.1111/j.1545-5300.1987.00405.x

[5] "even when children are not charged with overt caretaking roles, they may function as cementing agents, holding their parents' marriage together" ... "Seemingly meaningless self-destruction, unfounded violent attacks on the parent, delinquency, or psychosis in the offspring may all result from inalterable, fateful unconscious devotion to the parents" Boszormenyi-Nagy I, Spark G. (1973) *Invisible Loyalties,* NY: Harper & Row pp 155 and 163.

Positive connotation "… aims at changing the family's value system and, hence, the family's model of the world … the insight that every symptom and every form of pathological behaviour fulfills (amongst other things) a stabilizing function; the recognition and positive evaluation of this is the first step towards its dissolution." Simon F, Steirlin H, Wynne L. (1985) *The Language of Family Therapy*, NY: Family Process Press p262

"While this is often taken to be similar to the strategy of positive reframing ... actually it is much closer to a restructuring of the therapist's consciousness" Boscolo L, Cecchin G, Hoffman L. Penn P. (1987) *Milan Systemic Therapy: Conversations in theory and practice*, NY: Basic Books p7

"..positive reframing of my perception of clients *precedes* changes in their perceptions of each other, and positive connotation is a particularly powerful new view because it reaches unexpected depths, particularly the secret love and loyalty that family members in conflict still have for each other." Kraemer S (1988) letter to the editor *Journal of Family Therapy* 10: 412-4

A sample genogram

Males are squares and females are circles
Older siblings go on the left of younger ones
Dead people are crossed out. An abortion or miscarriage without known sex is just a cross
Use simple marks to indicate separations and add any other marks to indicate specially close or conflictual relationships.

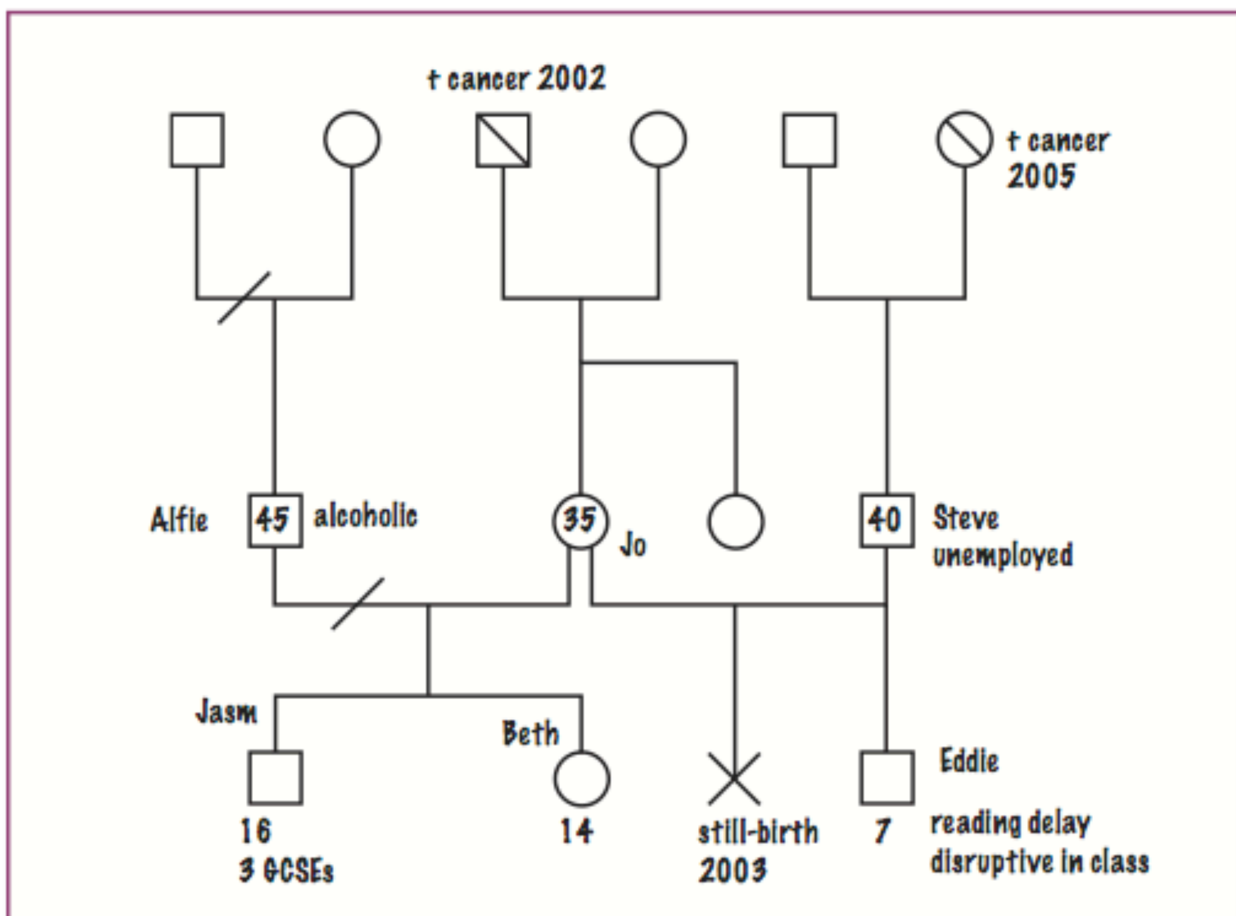

Figure 2. Fictional genogram of Eddie, age 7 years, referred for school problems