

“the art of the present tense”

Therapeutic work with families creates dramatic possibilities. When people in the room - therapists and clients alike - are caught up in the moment, new experiences are possible. Change in the therapist precedes change in the family.

The struggle for true positive connotation (1994)

Paradox has led to great advances in therapeutic technique, but it entails a remarkably strenuous discipline which turns out not to be so paradoxical at all. Long ago, Truax and Carkhuff (1967) identified the ingredients of good counselling. One of these, genuineness, cannot be faked, but paradoxically it requires technique to be able to be genuine in the presence of an anxious or angry family. Here is an example.

A trainee psychiatrist and I saw a woman who brought her adolescent son as the problem. Two other younger boys of hers also came along. The identified patient is 17. He had been arrested, for taking and driving cars, but was later discharged, without punishment. He had been involved in petty theft. Mother had been so exasperated by this that she threw him out. She sent him to live with his father. But here he is today with her in the clinic. Father is not expected. Mother says she cannot communicate with her son, he refuses to acknowledge her, he will not do any work for his exams, and is thoroughly exasperating. She went on and on about it, while he kept his cool quite patiently. Eventually she succeeded in provoking him into an argument with her. This is one of those occasions in which the family therapist is put to the test. In the old days I would energetically have taken up a position as an honest broker and tried to referee the dispute between the two, with the aim of bringing it to a rapid end. This is not difficult to do and for some time I thought that this was the purpose of family therapy. Now I understood that the argument between the mother and son was not the problem, but the solution. They do this all the time and although it is quite disturbing for a newcomer to witness, they are used to it, it is routine. To follow this process without intervening we had to believe that what was happening was in some way useful and necessary, to see, for example, how the identified patient was being helpful to his mother.

As the argument felt like a familiar marital squabble, this was the moment to enquire about the young man's father. It soon became clear that, although absent from the home, he is an important and active member of the family. The couple had split up twelve years ago but from the way mother was speaking about him, I took the risk of asking one of the other boys if he thought that mother was still in love with father. Without much hesitation, he said "yes, she is" and mother started to cry. Through her tears she said how she wished she could speak to him but he refuses to do so, and refuses to come to any meeting such as this. From then on I naively thought that the problem was simply mother's - that she could not let go of her former husband, and that her sons had got caught up in this. The meeting ended amicably, and mother was keen to return.

Several weeks later she came with only one of the younger boys, the one who had agreed that she was still in love with father. The older one, the originally referred

patient, had firmly decided to stay with father, and neither would come to the clinic. I had the same impression, only more so, that mother was some kind of hysteric, who would go on and on about the father and how much she needed him. I had visions of her needing years of individual therapy to get over this love of her life. As the interview wore on, however, and with the help of my trainee, the family background became clearer. The mother's father had lost his father in the first war, and her own father had left home when she was young. Because of this she had been determined at all costs not to leave her boys without a father. I wrote down during the interview a series of phrases that described my impression of this woman. In my initial irritation she seemed to be putting on an unnecessary theatrical performance, but as the story unfolded it became more interesting - a dramatic narrative. I then became quite enthralled and began to see it as an evocative family script about fathers. I ended my conversation with the view that here was a woman who had achieved a triumph. In spite of the breakup of her marriage she had reversed the trend of several generations of disappearing fathers. She had done this for the love for her boys. "I didn't want these children to be fatherless" she concluded. The transformation in my thinking was quite palpable. I felt annoyed with her at the beginning of the interview, but by the end I admired her determination to hold on to this man, for her children's sake. I explained this to her, reading out some of the words I had written. She said that the meeting had been extremely useful and that she saw no need to return.

The change in this session took place in me before it took place in the family. If I had gone on being irritated by her I would have failed her. Mutative interventions require a change in the therapist before there can be a change in the patient or family^{1, 2, 3}. In my view, this principle applies to all kinds of dynamic psychotherapy. Looking at irritating or disturbing behaviour as if it has a valuable function is a key idea in systemic thinking. This allows the therapist to think about the effects of behaviour rather than the causes. In the systems revolution, looking for the cause was regarded as an old fashioned and unhelpful exercise. The word 'cause' itself became unusable. Systems theory was hailed as the end of linear thinking, which meant the end of seeking causes for people's problems, and therefore the end of blaming anyone for them. Psychoanalysis was written off by family therapists as an outdated theory which explained mental disturbance in terms only of the patient's past experiences, especially the earliest ones at mother's breast. Given the state of psychoanalysis in the 1950s, this might have been a forgivable misjudgement. But no one should now be in any doubt that the central therapeutic principle of psychoanalysis is that, whatever happened in the past, change depends on what happens in the room.

¹ "...the doctor must change himself if he is to become capable of changing his patient ..." Jung, C.G. (1954) The practice of psychotherapy. *The Collected Works of C. G. Jung, Volume 16* [trans. R. F. C. Hull]. London: Routledge & Kegan Paul, p.73. First published as 'Die Probleme der modernen Psychotherapie,' in *Schweizerisches Medizinisches Jahrbuch*, 1929.

² "While [positive connotation] 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*. New York: Basic Books.p. 7.

³ "... the only person the therapist changes in the therapy consultation is himself or herself" Anderson H., Goolishian, H. (1988) Human systems as linguistic systems: preliminary and evolving ideas about the implications for clinical theory. *Family Process*, **27**: 371-393. p. 384.

The Method

Family therapists are subject to great forces which are rarely talked about in conferences and articles. In particular too little attention is paid to the drama of it⁴. It is so clear that a group of people sitting together in a room with a serious task to perform are going to create an atmosphere that is potentially theatrical, and quite primitive too. While some members of the family, especially the identified patient and the parents, probably feel nervous before their first interview, it is the therapist or therapists who really suffer first night nerves. This is as it should be, because much is expected of them. In the hope of a solution, preferably magical, every move is under intense scrutiny of the family-audience. For it is the therapist's manner, timing, physical presence, gaze and voice that make a difference to the effect of what is actually said. The advice given to actors over fifty years ago by the great Stanislavski is remarkably appropriate for family therapists too. "Truth on the stage is whatever we can believe with sincerity, whether in ourselves or in our colleagues." "In ordinary life truth is what really exists, what a person really knows. Whereas on the stage it consists of something that is not actually in existence but which could happen." "Everything that happens on the stage must be convincing to the actor himself, to his associates and to the spectators. It must inspire belief in the possibility, in real life, of emotions analogous to those being experienced on the stage by the actor. Each and every moment must be saturated with a belief in the truthfulness of the emotion felt, and in the action carried out by the actor" (Stanislavski, 1937, pp129, 130)

Compared with one who works with individuals the family therapist's task is far closer to that an actor. After all the ultimate refinement of therapy with individuals is psychoanalysis, in which the analyst is invisible most of the time, sitting in a chair behind the couch. Although some family therapists may not like to admit it, they are bound to take more active control over the interview than in individual work. A family is a more primitive system than an individual (Kraemer, 1983). A group cannot think as a single mind does: it really cannot think at all. (Bion's well known text on groups (1961) refers to a *working* group, not a thinking one. When it functions well it is guided by a primary *task*.) The individual human thinking mind is perhaps the greatest achievement of evolution. A family, in contrast, is a much more basic organisation which is primarily for doing things, such as bringing up children. It is not designed for thought, but for action. This is why it is sometimes quite appropriate to set tasks for families in therapy. But this adds to the risk of omnipotent acting out, as opposed to effective acting, in the family therapist.

⁴ Carl Whitaker is a notable exception (Neill & Kniskern, 1982). Salvador Minuchin, one of the original and most influential of all family therapists, for many years emphasised the link between theatre, dance and therapy: "...the therapist asks the family to dance in his presence." ... "Problems as well as alternatives thus become available in the present and in relation to the therapist" (Minuchin, S. & Fishman, HC, *Family Therapy Techniques*, Harvard 1981, pp.79, 80), but his writings have been to some extent eclipsed by later systemic and social constructivist work. Those who do write about drama (eg Andolfi, 1981) tend to see the therapist as director, not as directed. Amongst psychoanalysts, John Klauber saw how illusion was at the heart of the analytic process: "The illusion ... makes the patient feel more real" (Klauber, 1987, p.8) In his work he also looked for positive factors within the personality.

Unlike an actor, a therapist does not have a script. It is the family who provide the script (Byng Hall, 1988), but it has been obscured by the crisis they are in, and must be deciphered from moment to moment. Being surprised, that is moved⁵, by the effect on oneself of a positive connotation is one form of decipherment. There is sometimes a little time for preparation but most of the work is likely to be improvised if it is to be in touch with what is going on in the room. The truth of what you are saying may only become apparent while you are actually saying it. And sometimes it is barely believable, or acceptable, before that. Almost sixty years ago the psychoanalyst James Strachey, writing about the act of therapeutic (mutative) interpretation, said "...there must be some quite special internal difficulty to be overcome by the analyst in giving interpretations.there seems to be a constant temptation for the analyst to do something else instead..... giving a mutative interpretation is a crucial act for the analyst as well as for the patient, and he is exposing himself to some great danger in doing so" (Strachey, 1934).

from *the Promise of Family Therapy* ⁶ <http://bit.ly/2aD5RHT>

Gossip about ourselves (2006)

The therapeutic relationship becomes more alive when the participants can push at the boundary, like boxers on the ropes. There may be eye contact, not necessarily friendly. A sense that this relationship can stand a bit of stress - that it has resilience - is established. Creating, challenging and repairing a therapeutic alliance have powerful effects (Safran et al., 1990). The relief and surprise when contact is made is sometimes accompanied by tears or laughter or may barely be noted; "something that may be imperceptible to either patient or analyst except, perhaps, for a sense of increased well-being when in each others company" (Fonagy, 1998). Being attuned, then losing it and recovering it again replicates the 'good enough' relationship of infant and caregiver⁷. In cognitive behavioural therapy, too, the 'here-and-now' is important. In a major study of CBT for chronic depression "the single best predictor of psychotherapy outcome ... was the overall degree of emphasis therapists placed on discussing the patient-therapist relationship" (Vocisano et al., 2004). In general, reflecting on the relationship could be anything from saying "am I asking the right questions?" to a psychoanalytical transference interpretation. It is gossip about ourselves. This brings the experiences of the participants firmly into the present.

⁵ There is, of course an older tradition of psychotherapy than psychoanalysis. From the earliest times, in almost all cultures, there have been healers who took the problem over from the patient, thus transforming it into something manageable. Shaman is derived from a Tungusic (Siberian) word, saman, meaning "one who is excited, moved, raised" (Eliade, 1964, Kakar, 1982).

⁶ Kraemer, S. (1994) *The Promise of Family Therapy* *British Journal of Psychotherapy* **11**: 32-45.

⁷ "The miscoordinated state is ... a normal interactive communicative error" (Tronick & Weinberg, 1997, p. 63) "successful reparations ... are associated with positive affective states" "In normal dyads, interactive errors are quickly repaired Normal interaction is a process of reparation" (p. 64)

Like drama, therapy is live. Though speech is the 'official' language of both theatre and therapy the occasions that make a difference, particularly in family therapy, can be moments of seeing, feeling or touching. "Just look at that expression on his face. Do you think he believes a word you are saying?" "You two seem pretty cosy there; there's not much room for anyone else". Here the therapist is like a stage director. The playwright Arthur Miller wrote "Drama is the art of present tense par excellence" (1957). 'Learning from experience' means being affected here and now. And, as in the theatre, where the actors bow at the end to show that the event is over, we can mark therapy's boundaries in a formal way. I always shake hands with everyone in the family who is old enough, which also highlights a hierarchy of social skills.

from *Something happens; elements of therapeutic change*⁸ <http://bit.ly/105fHyk>

"Why do you do this to each other?" asked out of genuine curiosity (2002)

The family therapists who followed Minuchin and his colleagues were increasingly preoccupied with families who seemed stubbornly unable to change. Their adolescent children suffered from appalling problems; eating disorders and other bizarre symptoms. Where parents were clearly helpless and apparently at the mercy of their disturbed offspring a new strategy was required. Rather than pressing families to change, the Milan team⁹ saw that in these resistant cases it was far more effective not to try. The 'positive connotation' contained elements of the paradoxical techniques of the Mental Research Institute and of the hypnotic methods of Milton Erickson, but the state of mind of the therapists was different (Kraemer, 1994). It was much closer to that of a psychoanalyst. The family were told that they should not expect, nor even try, to change. They learned, with some amazement, that the symptom which had so far baffled every therapist and psychiatrist who tried to shift it was actually necessary for the family's functioning. No doubt a better arrangement could be found in due course but 'for the time being' it had to be accepted. The therapeutic attitude required to work this way is one of heroic neutrality. An obligation to understand the present state of the family in all its complexity has to take precedence over the wish to get rid of the offending symptom. The Milan therapists made much of neutrality, and how one must be trained to achieve it - "to see the system, to be interested in it, to appreciate this kind of system without wanting to change it" (Cecchin, 1987, p152).

But this is not a new idea. Almost eighty years ago Freud wrote of the analyst's obligation to have "evenly suspended attention" in the presence of the patient, "....to avoid so far as is possible reflection and the construction of conscious expectations, not to try to fix anything

⁸ Kraemer, S. (2006) *Something happens; elements of therapeutic change Clinical Child Psychology and Psychiatry* **11**: 239-248.

⁹ as reported in *Paradox and Counterparadox*, the second masterpiece in systems therapy (Selvini Palazzoli et al, 1978). The first was the original description of the double bind hypothesis; Bateson, G., Jackson, D. D., Haley, J., Weakland, J. H. (1956) Towards a theory of schizophrenia. *Behavioral Science* **1**: 251-264.

that he heard particularly in his memory, and by these means to catch the drift of the patients unconscious with his own unconscious” (Freud, 1922). No one in Western medicine or psychology had ever before suggested anything so radical. The conventional attitude of a healing practitioner was, and usually still is, to try to work out what is wrong with the patient and then try to change it. Freud’s instructions still read like a message from another culture, from the East rather than the West. The British psychoanalyst Wilfred Bion took up the theme with his dictum that the analyst should “inhibit dwelling on memories and desires” (1970, p 41) Later (1987) he spoke of the effort required to get to therapy, and advised analysts to be impressed by the very fact of the patient’s attendance. There is a clear continuity between this approach and the later developments of Milan systemic therapy. Gianfranco Cecchin’s reflections (1987) on the mental state of systems therapists - ‘an invitation to curiosity’ - have become a classic in the family therapy literature. But neither neutrality nor curiosity can exist without a secure base of theory.

Of course Freud was a nineteenth century man, and even Bion, though he died in 1979, could be regarded as a creature of a lost age. He had, after all, fought (aged 19) in the first world war. In contrast, modern systems therapists are proud of their acute consciousness of the influence of culture on judgement, but this does not mean that we are free from such influences. Indeed it may even become a restraint if you try to censor your observations for fear of being derogatory or prejudicial. What is curiosity? If you are curious about something you want to know more about it. Cecchin, demonstrating his approach in a 1992 conference discussion, emphasised the urgency and compulsiveness of this state. Presenting work with a couple who are in a violent relationship, he asks them “why do you do this to each other?”. This seems to be just the sort of question that anyone might ask. How is this different from the similar-sounding comments made by the couple’s friends and relatives? One important difference is that the therapist is actually struggling to be more interested in finding an answer than in stopping the offending behaviour. The usual reason for asking such a question is less out of curiosity and more a way of saying “why do I have to put up with this?”, which is not the same question at all.

Though neutrality is a goal to be aimed at, it is not achieved by ignoring one’s prejudices. It is necessary to have some very ordinary emotions as a therapist, including rather innocent ones - as a small child might wonder about why people do what they do. Curiosity in a therapist requires an active exploration of ones own states of mind. Much of the material presented to us in clinical settings is quite upsetting, sometimes disgusting. The activity of seeking to answer the simple question “why?” must entail some kind of self-analysis. How else is it possible to know what to ask? One would not get very far, in Cecchin’s case, if one had not oneself been in a potentially violent situation with a loved person.

from *Tribal processes in psychotherapy* ¹⁰ <http://bit.ly/2am8hJM>

¹⁰ Kraemer S. (2002) *Tribal processes in psychotherapy: the stand-off between psychoanalysis and systems*. In (eds) Patrick Nolan & Inger Säfvestad Nolan *Object Relations and Integrative Psychotherapy. Tradition and Innovation in Theory and Practice* London: Whurr.

The future tense I: symptom as early warning device (1983)

The patient is a nine-year-old Pakistani girl who was referred to me after an urgent admission to the ward for investigation of abdominal pain. She had a history of ureteric reflux, which had been diagnosed when she was two, and for which she had been on prophylactic antibiotics since then. There had been two hospital admissions for urinary tract infections, one when she was five and the other when she was seven years old. Three months previous to this referral she had had that mysterious condition, Bell's Palsy, which had fortunately completely remitted with steroid treatment. All medical investigations on this occasion were negative and I saw the child in a side room off the ward, together with her parents and the Pediatric Senior Registrar. What emerged was what I now regard as a classical picture, the patient being one of the younger children in a family where the eldest are leaving home and getting married, and where there is illness in one or more grandparents.¹¹

Our patient is the youngest of four girls: the eldest has left home and is recently married; the second eldest is married with a child and still lives at home, but is planning to emigrate. The father is a successful businessman, a member of an aristocratic caste in the Pakistani hierarchy, and the mother is a housewife who does not work outside the home. After a detailed inquiry about the pain and the family's reactions to it, I asked about the rest of the family and heard about the two eldest sisters. I asked the child which parent would miss the eldest children the most and she said, without any hesitation, that mother would since, as father was so often away on business, she relied on them so much for company. I also heard that the father's mother was quite ill in Pakistan and that both parents were naturally worrying about that. I suggested that the pain this child had was like a very busy person who wanted to do all sorts of jobs, like being a doctor for the grandmother, and a companion for the mother.

She would usually become unwell at night and would be taken into bed with her parents. I asked her what her pain should be called and what animal it would be like. She gave it the name Timmy and said he was a bear. The fact that it was a male immediately led father to talk of his desire for a son; they had had two daughters, then after a gap of nine years had planned to have another child. They had a third girl and finally yet another, our patient with the pain. For this proud, aristocratic Islamic man, no son was quite a blow, so I could say that the pain was a royal pain (the joke was lost on the family) that was trying to be a boy for the father, which he clearly now would never have. But the next stage was the most important: I advised the child that Timmy was too much for her to deal with and that she should give him to the parent of her choice, whichever she thought would be best able to cope with him. So when she had a pain during the night she was to go to her parents' room, leave it there, and return to bed. Father got into the spirit of this right away and announced with finality that his daughter had stolen his pain and that he wanted it back, she had no right to keep it, he and his wife could take care of it themselves. I thanked the father for his innovative idea and soon we ended the session. I should say that sessions last well over an hour, so that I am summarizing quite drastically.

¹¹ My clinical impression is that these families with physical symptoms have had more than their fair share of premature deaths, particularly in the grandparental generation. (In the Pakistani family, father lost *his* father when he was 14. Mother lost hers when she was 20. All three older brothers of father are dead, the third having been murdered.) The connection could be that parents who miss a developmental stage through illness or death of their parents have difficulty in handling that stage in their children. It is a good idea for paediatricians to make a three-generation family tree a routine part of history-taking.

At the follow-up meeting a month later only father and daughter attended and they reported, in father's words, "95% improvement" in the pains. A further follow-up meeting two months later showed that there had been only one bad episode of pain and the child had been seen in casualty, only to be sent home immediately because she was already well.

If parents find that there is something they can do to effect a change in the symptom, then there is a chance that one of the child's principal anxieties, namely that the parents are not going to be able to cope, is eased and the symptom diminishes; this sets up a benign spiral in place of the vicious one that preceded it.

.....

A useful piece of research by Crossley (1982) shows, amongst other things, that children admitted to hospital with abdominal pain, but who turn out not to have appendicitis (or any other organic disease), have many more family problems than those with appendicitis. The sort of problems he means are serious quarreling between the parents, serious mental or physical illness in one of the parents, chronic handicap in one of the siblings, and father living or working away from home most of the time. So in some cases, the presence of other problems is relatively easy to detect, although you may have a hard time making the link between them and the symptom you are being asked to treat. But when somatisation is the principal problem you are less likely to find problems like these. The family atmosphere seems to be very nice and nobody wants to complain about anything, except of course about the symptom.

If you do ask what possible stresses or anxieties might be affecting the child, sometimes the parents would have a theory about difficulties at school, that the child had been bullied, for example. They may have even considered changing school, but very rarely, in my experience, will they volunteer difficulties in the family itself. Yet the difficulties are there and are not hard to find. The reason why they are not considered relevant is that they are just normal processes, like the death of a grandfather, for example. I am talking about the natural stages in the family's life cycle.

It is precisely because these are natural events that they do not come into people's minds when they are asked if there is anything that could be worrying the child, but it is a good strategy to try to make a link between the child's symptoms and these essentially normal difficulties of family reorganization. Of course, it is possible to search for and to find more sinister processes, such as deep dissatisfaction in the parents' marriage, or even a depressive state in one of the parents. Parents are, however, inclined to put up a resistance to looking at their own problems, since it is their child they have brought for treatment, and they do not expect to be offered treatment themselves. The psychiatrist is likely to be more successful if the child's stubborn and insoluble problem is linked not to an equally insoluble parental problem, but to something which, though it may be a serious difficulty for them, offers the parents a chance to demonstrate their superior competence in dealing with it, once the connection is made.

Although connections between symptom and family life event may seem obvious to an outsider like myself, there are several good reasons why they are not obvious to the family.

First, the symptom, if it has held the family in its sway for weeks or even months, has done its job well and put other anxieties in the shade. Second, these anxieties are often not discussed in front of the children in any case, so the parents quite reasonably assume that the sick child knows nothing of them. The third and, in some ways, the most powerful reason why the family are unable to think of any problem that might have triggered the psychosomatic symptom is that *the problem has often not yet occurred but is still in the future*. So although they can tell you about the engagements of the elder children or the illnesses or deaths of the grandparents, it may not yet have dawned on them what fundamental changes these will eventually bring to the family. But anxiety about these changes is revealed to the children in subliminal ways.

The psychosomatic symptom in such cases is all alone ahead of the field. Even its owner, the child, cannot say what is going on, but the symptom has become a sort of early warning device for the family as a whole. In the short term this works quite well so that any anxieties about the future are quickly replaced by anxieties about the child. The symptom literally takes everyone's minds off other problems. But time and development wait for no one, and any attempt to turn the clock back, or to hold it still, will eventually collapse.

Casting the symptom in this light reaches in a very compelling way the grandiose notions of these loyal and conscientious children, who at some level secretly believe that it is possible to control time and resist changes that are in fact inevitable. In addition, and more important for the effectiveness of this therapeutic strategy, it also gives the parents a chance to show that they know better than the children about the passage of time and that they can learn to deal with their own difficulties.

from *Who will have my tummy ache if I give it up?*¹² <http://bit.ly/1OZUt6i>

The future tense II: Theatre in the round, and the next act (2017)

When the clinical process with families is alive and engrossing, I may suggest that we are in a play and invite the family to consider how the next act will go. "You've told me about act 1, this is act 2 but what could happen in Act 3?" This puts them in the position of an engaged audience, for a moment loosening them from the grip of their present predicament¹³.

Having, after many decades, become reacquainted with a reflecting team in a regular family clinic, I note how the presence of extra colleagues in the room enlarges the possibilities for theatre.¹⁴ At any point in the session the therapists may engage in a short conversation with each other, while the family listen and watch; a play within a play. Any idea that therapists own the truth is dissolved. What matters is their contrasting positions, which encourages

¹² Kraemer S (1983) Who will have my tummy ache if I give it up? *Family Systems Medicine* 1:51-59

¹³ "Questions about the future, in conjunction with positive connotation, put families in a metaposition to their own dilemmas and thus facilitate change by opening up new solutions for old problems." Penn P. (1985) Feed-Forward: Future Questions, Future Maps. *Family Process* 24: 299-310, (p 299)

¹⁴ "Reflecting team as theatre". Jim Wilson, *The Performance of Practice*. Karnac, 2007, p. 101.

the exploration of differences between family members; “a third position then comes into existence from which object relationships can be observed.”¹⁵

During the rest of the session anyone, family or therapists, can speculate about the various impacts of forthcoming life events on its members. These become circular questions¹⁶ involving all those present.

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¹⁵ Britton, R. (1989) The missing link; parental sexuality in the Oedipus complex. In: Britton, R, Feldman, M. & O'Shaughnessy, E. (eds.) *The Oedipus Complex Today: Clinical Implications*. London: Karnac. (pp. 83-101)

¹⁶ “Circular questions undermine the family's belief system by using the language of relationship, not of "what is." This may be done by "if" questions and by future-oriented questions (for example, "If your mother decided to stop worrying about you, what would your father do"?). These questions imply patterns, not facts. The moment a question undermines the belief system, it creates opportunities for new stories.” Cecchin G (1987) Hypothesizing, circularity, and neutrality revisited: an invitation to curiosity. *Fam Process*. 26(4):405-13, p.5