

The Promise of Family Therapy

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INTRODUCTION AND SUMMARY. The process of family therapy unleashes forces which are powerful, primitive and potentially theatrical. Family systems therapy has evolved with little acknowledgement, and even disparagement, of the influence of psychoanalysis. In doing so, it has had a revolutionary impact but also one which has diminished the role of experience, particularly in the therapist. There are signs of convergence between modern psychoanalysis and systems therapy, and both have refined techniques that foster the primary task of therapy, which is observation through participation. In order to achieve this, family therapists require their own special skills to protect them from being stage struck by the family/audience (who also provide the script). The *positive connotation* is just one of these techniques, and I try to unravel its workings from my own experience. Positive connotation is effective when it provokes a transformation in the therapist, which precedes any change in the family. It is a promising technique but it can lead one astray.

True and False Promises

I want to recommend some aspects of family therapy that are valuable and warn against others. These are the true and the false promises of family therapy. The true one is that family systems therapy has something to offer in all areas of clinical work, even if there is no family interview. Simply stated, thinking systems means thinking not only about the family and its environment but also about oneself and the agency in which one works. As Gregory Bateson put it years ago, if you stick a probe into a system, the other end of it is sticking into you. This process is not exclusive to family therapy. It is true of all psychotherapies involving the personality of the therapist, but over the past thirty years or so systemic and strategic therapy have provided a much clearer picture of what it is about therapy that actually makes a difference, particularly through trying to work out what makes paradoxical and other strategic interventions effective. Unless the process is understood, such techniques lend an excitement to the scene that can fill the therapist with theatrical potency in which it is easy to become inflated and out of touch. This is a serious and dangerous risk. The false promise of family therapy, then, is that it can offer an escape from having anything to do with painful experiences, and a magical solution to the clinician's nightmare of not being able to help. The true promise of family systems therapy is that it leads to self observation by the therapist and the therapist's colleagues.

Almost any family in crisis will give a therapist the benefit of the doubt for at least half an hour in a first meeting. They are full of hope that something powerful is available to help them and this expectation is rapidly transferred to the therapist who may begin to feel like some kind of god. This power can be harnessed but only by

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reversing the projection. The therapist is effective precisely because he or she is unable to help the family. This is what paradox is really about. The only real power any therapist can have is observation, but it is easily dimmed by performance anxiety. In the drama, which is the audience and which the players? I think it is the therapist who is most likely to be the principal actor, but one who is under the control of the audience.

Paradox

The technique that sets this process going is the positive connotation, first described by Mara Selvini Palazzoli and her colleagues in the 1970s - the Milan group, as they then were (Selvini Palazzoli *et al* 1978, ch 7). Originally positive connotation was a device to avoid siding with any one in the family in particular. The therapist who is trying to redefine the symptom, for example anorexia, as a virtuous behaviour is in danger of saying to the family, 'your daughter is good and you are bad'. Many will be familiar with the gut feeling that this is so, that the patient is a victim and it is all the parents' fault. (This is often what the adolescent patient appears to be saying, too.) The Milan therapists quite early on saw that when families are in trouble, members of the family tend to take sides. Typically the parents will be on opposite sides, but not always. But in every case the family therapist is confronted by a group of people who are divided, each side wanting the therapist to support them in an alliance against the other. What the Milan group then realised is that the positive connotation is not directed just at the symptom itself but at all the behaviour of the family put together. That is to say they wanted to show the family that it was trying collectively to do something which was honourable, namely to save itself, the whole family, from disaster. The positive connotation does not say that bad is good, it does not tell patients to continue with dangerous or evil behaviour. What it does is to say that, in spite of the apparent meaninglessness of the symptom, there is some value in it, and in the rest of the family's response to it. There is method in the madness, as the old saying goes.

What inspired me about the work of the Milan group was the notion of sacrifice. Instead of having some mysterious illness or just being very wicked, the adolescent is seen as a kind of desperate saviour of the family. I often invoke the role of Jesus Christ in this context because he also suffered in order to save. The difference is that the adolescent's efforts are neither recognised by anyone, nor particularly effective. The Milan method in its original form saw the identified patient, who was most often an adolescent with severe behavioural disturbance, such as anorexia nervosa or psychotic symptoms, as someone trying desperately to rescue one or both of the parents from their pain. The problems of the parents were the familiar ones - marital, psychiatric or even medical. Furthermore, this adolescent had always had a specially close relationship with the parent in question, usually the mother.* To most observers she would indeed be regarded as in need of help in her own right. She was depressed, or

*The origin of this tie is often to be found in a coincidence around the time of the identified patient's birth, for example, the death of the mother's mother or a serious illness in the newborn child himself, necessitating, for example, placement in a neonatal intensive care unit. In many cases the mother becomes depressed following the birth of this child, whatever the circumstances, with lasting consequences (Murray 1992). Various approaches to the aetiology and maintenance of serious mental disorders converge on the subsequent process of entanglement between parent and patient - the double bind (Bateson *et al* 1956), invisible loyalty (Boszormenyi-Nagy & Spark 1973), enmeshment (Minuchin 1974), anxious/insecure attachment (Patrick *et al* 1994, Sroufe 1989) and high Expressed Emotion (Leff & Vaughn 1985).

suffered from chronic psychosomatic problems. This is typical of the family of anorexic adolescents and others who damage themselves slowly and menacingly. It also occurs in the families of some psychotic adolescents. In such families the parents commonly stay together, however unhappy they may be (Stierlin 1989).

One aspect of the positive connotation consists in the refraining of the adolescent's disturbance as something which is meant to be useful. Instead of saying that the patient is ill and has symptoms which have to be removed, the therapist identifies them as having a function, which up to now no one has been aware of. In effect this is an interpretation of an unconscious fantasy, but the language of family therapy did not recognise such a phenomenon, a matter to which I return later. The function, or fantasy, is one of sacrifice and of rescue. 'I will suffer in order to save you, my suffering parent'. The family therapeutic interpretation of the young person's symptoms is that he or she is trying to make something, or someone, better. This often turns out to be an attempt, still unconscious, to make up for the deficiencies of one of the grandparents. In effect, the family tree has been turned upside down. Because of their special position in the family, these young patients are enrolled as guardian of one or both parents. They become full-time resident family therapists. It might be the mother who has been deprived in her own childhood. Now, having married someone just like her mother, she looks to one of her children to make up for what was missing. Any young person is capable of volunteering for the part, but in these cases the urgent wish to make mummy better has taken over completely, and the poor child has given up any other kind of ambition such as learning to grow up.

A therapeutic theory is effective in so far as it allows the therapist to think, and keep his or her head in order to be observant. But in order to observe, one has to be changed by what one sees. That is to say the therapy does not change families, it changes therapists. One of the goals of family therapy is that parents must somehow be empowered by it. They are, after all, ultimately responsible for their offspring's health and safety, and change in the adolescent is unlikely to occur unless the parents take the lead. As they are likely to be failing badly it is hard to see how to promote this. It is much easier to attack them, and they might even encourage it. A family therapist runs an enormous risk in taking the adolescent's side. Perversely this will not only alienate the parents, it will also put off the young person who is afraid that the therapist is going to humiliate them. This is so, in spite of the fact that the adolescent will already have done all sorts of evil things to shame them and bring them down - far worse than anything a therapist can do. It is surprising that bad or mad young people should turn out to be so concerned about their parents, but this is the secret which, if it was not actually discovered by family therapists (see Searles 1979, Winnicott 1958), was made by them into an effective tool. The perversity of the disturbed young person has an ingenious and magical quality. It is often quite breathtaking.

But how can one support parents who are making such a mess of the job? Reassurance is a very poor therapeutic tool. The positive connotation, in contrast, is not reassuring at all but can lead to a new understanding. What it helps to find is a secret mission which may actually have failed. The self-centredness of the child that parents find so irritating and imperious is also the source of his conviction that the parents' only problem is himself. The secret fantasy of the child and adolescent is the grandiose idea that he can sort them out. If he fails to do so, then that it is his dreaded depression. Therapeutic interventions in families can exploit this tendency. By exposing the young person as well-intentioned but incompetent, family therapists can

give the parents an opportunity to show their children that they actually know better. And they can at the very least be congratulated for producing a loyal and devoted child.

The Escape from Psychoanalysis

The original promise of family therapy was that it could reach parts that other therapies could not reach, but what it also offered to many disaffected therapists was an opportunity to be powerful and effective in a relatively short space of time. Many early texts on family therapy (e.g. Haley 1963) went on about the defects of traditional therapy, by which they usually meant therapies derived from psychoanalysis. The objections to this kind of work were (a) that it fostered dependence, which is apparently a bad thing, (b) that it took too long, (c) that it was therefore very expensive and (d) that other members of the patient's intimate network (that is mainly the family) would, as soon as any worthwhile change became evident, do all they could to reverse the process because they had investments in the *status quo*. This was the notorious homeostatic tendency in families that pulled them back to the way they were. It was the enemy of the family therapist and the main reason why he or she needed such powerful techniques. Homeostasis was another word for resistance, but in those revolutionary times no old fashioned words were allowed (Leupnitz 1988).

One of Freud's most important discoveries was that if the patient violently objected to what he was saying, the analyst was probably on the right track. Critics of psychoanalysis, family therapists among them, pointed out reasonably enough that this in effect gave psychoanalysts permission to bully patients who disagreed with them and a perfect justification for never being wrong. Back in the 1950s it is quite likely that psychoanalysis in the United States had become quite institutionalised and conservative. Only doctors, usually male, were allowed to be analysts and the prevailing model was a relatively unreconstructed version of the original, in which the patient was meant to receive interpretations as if they were injections of the truth. Rebellion against this kind of patriarchy was inevitable, and it is significant that many of the originators of family therapy were themselves analysts or closely identified with psychoanalysis. In the revolutionary process, as is so often the case, even the terminology of the old model became contaminated and could not be used at all. It had to be thrown out, the baby with the bathwater. The language of systems and structures promised a different kind of therapy and a different view of people's problems. This was very inspiring indeed. The new idea was that problems did not belong to individuals at all but could be passed round the circle, mainly the family, but also to others trying to help such as a doctor or nurse. Of course this was known before, indeed the notion of projection is fundamental to psychoanalysis too, but it was not put into clinical practice in the same way. While individual dynamic psychotherapy is concerned primarily with the patient's experiences, of himself, his family and his therapist, the new therapy was primarily concerned with the patterns of interaction between intimates and not with their experiences at all. This therefore removed the centre of gravity of the analytic endeavour which is the transference to the therapist. Family therapists were not really interested in what their patients thought of them. Their primary goal was to change the way family members reacted to each other.

The trouble with this development is that it allowed family therapists to give up one of the most important technical disciplines of dynamic therapy, which is to be attentive

to one's own experiences while working with a patient. In the revolutionary rush to be powerful and effective the new therapists became rather scornful of the old and saw no need to think of themselves at all. My own early steps in family work seemed like a blessed relief from all that sensitive monitoring that I had been trained to do while working with individuals. As a family therapist in those days I felt omnipotent and out of touch, and I know I was not the only one. One of the promises of family therapy, then, was an escape from experience. Instead of having to be patient and thoughtful one was offered the opportunity to be businesslike and effective. I remember being shocked by a supervisor, just flown in from the USA, who said in response to one of my Tavistock observations about a mother's depression'. .. to hell with her depression, what's she going to do with this damned delinquent boy of hers!' or words to that effect.

The problem is how to remain in touch with the individuals in the family while getting a picture of its organisation as a whole. It is not possible to do both at the same time. Those who are watching family interviews from behind a one way screen can decipher the patterns quite easily, but will not experience the exchange of subtle emotions in the room. Instead they witness a drama in which there is a struggle for control between individuals and subgroups. They see how the interviewer is manoeuvred into less effective positions. The family members are asking for help but the message they give is quite clearly 'take away the pain, and do it painlessly!' As soon as the therapist tries to get at something behind the symptom, such as a relationship in the family, there is a closing of ranks. At this point the therapist, however experienced, does not seem to the viewers to be dealing with this at all, and the onlookers get quite impatient with him: 'Get on with it, can't you!' The fact is the actual performance is far harder than it looks from afar. The screen allows the viewers to look quite closely at what is going on but to be emotionally distant from it. (There is a similar difference between the experience of the audience in the theatre as compared to the cinema.) The therapist is struggling in the syrup of real relationships, not in clear fresh water as it appears from outside. He is slowed down because he has to respond to the demands of the individuals around him. If he does not do so, they will feel that he is neglecting them.

The Struggle for True Positive Connotation

Paradox has led to great advances in therapeutic technique but 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 break-up 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 contemptuous of 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. 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.

Even now, however, the two kinds of therapists cling to their misperceptions of each other, and rarely read each others' work. Yet there is an interesting convergence in the language* coming to be used on both sides, which has had little chance of detection. One of these is the idea that a therapist is entitled, indeed obliged, to be curious, stated by Wilfred Bion the psychoanalyst (Bion 1967) and Gianfranco Cecchin the systems therapist (Cecchin 1987). Both have stressed the importance for the therapist of being prepared not to know what is the matter. This means being ready to learn from the patient (Casement 1985), but also being prepared to remain in ignorance of why change might have taken place. The thing to be most curious about, and impressed by, is how the patient or family have managed to get to the session at all (Bion 1987). Particularly at a first interview, therapists often underestimate the effort that this requires, probably because they are more preoccupied with their own anxiety. Although there are a few scattered signs of recognition between the two rivals, there has been little acknowledgement of the pre-systemic roots of family therapy.** Many of the early pioneers were analysts or influenced by analysts, but the new language of family therapy showed no sign of this.

The Milan therapists, for example, were all psychoanalysts themselves. They had become disappointed with psychoanalysis (Selvini Palazzoli 1974), but they did not therefore throw all their hard-learned attitudes away. They just threw the words away. One good reason for this revolution was that it was not possible at the time to get out of the traditional model of thought if one used the same traditional language. So much of our thinking is determined by the words we use. If we talk about the patient's symptoms in the language of experience we will be organised to think primarily about that patient's experience and not to see its circular connection with the behaviour of others. It is very hard to think on two levels at once, to think about one person's struggle for survival, at the same time as thinking about the whole family's attempt to do the same.

The language of positive connotation seemed at first rather earnest; it was heroic and humourless, like a grand opera. Words like dedication, duty, honour, responsibility, protection, rescue, meaning, noble sacrifice, loyalty and mission would

*There is also a parallel preoccupation with *aesthetics* in the two traditions (Meltzer 1988, Keeney & Sprenkle 1982). Analysts and family therapists alike are interested in beauty as a mental quality necessary for healing and health.

**A good Freudian interpretation of the mood of the first family therapists, and I think a correct one, would identify the Oedipal struggle between the new generation and the old, that results in the obliteration of the patriarch. In doing so, however, family therapists adopted many patriarchal ideas of their own, until brought to their senses in the 1980s (Goldner 1985).

occur again and again in the carefully prepared interventions. Messages were issued in a deadpan manner but there was an unmistakable scent of mischief in the air. When I began to practise positive connotation at first I could not quite believe it. I tried hard to be serious and to make proper links between the young person's dreadful behaviour and some previously unconnected family anxiety, but my heart was not always in it. I noticed that I felt a little unreal. I was effectively imitating the Italian therapists I had seen in action. When talking with colleagues about paradoxical interventions one often had the feeling of having to suppress laughter. This is a peculiar state which is, I think, due to the fantasy that one is secretly fooling the family. Paradox and positive connotation seemed to some of us in those days not to be true statements at all but to be tricks or just plain lies. No wonder that the sense of power we felt was potentially perverse because it was derived not from respect but from mockery or even contempt. Soon I came to see that family members were not so disturbed by these interventions as I expected. When it was accurately formulated, the positive connotation actually makes sense. It is a relief. Sometimes people's jaws would drop, others might laugh, but there was soon some nodding around the room and implicit assent, which was very surprising to me. I no longer feel that being effective depends on having a secret technique,* though it does sometimes depend on being a surprise to them that one is curious to understand how the family can exist in such a state, in spite of the pain it may be causing. It is usually a shock to discover that the therapists are not attempting to change anything, merely to observe it.

The original Milan method was to interview the family carefully and systematically and then take a break, after which the intervention containing the positive connotations would be given. Palazzoli and her team acknowledged how they had to work hard to reach this point (Selvini Palazzoli *et al* 1978). They experienced all sorts of emotions as a result of the interview, from rage to pity. If a family in trouble does not arouse strong feelings in the therapist, something is missing. The search for positive connotation is now woven into all my clinical work. For me it has become an essential tool for observation. Without some such technique any therapist is under pressure to remove painful problems before looking at them and trying to make sense of them, like an impatient surgeon who cuts out anything that offends. Therapy as I understand it is the search for meaning, not for cure (Rycroft 1966).

'Marco'

To get started in family therapy of this kind, it seems to be necessary to get out of the traditional gravitational field of individual psychopathology and go into a kind of systemic orbit. But as I have indicated, there is the risk of going into an emotional orbit too - a risk of becoming quite ruthless about the suffering of individuals in the family while pursuing the magical nugget of therapeutic gold that will unlock them all from their bonds. My experience with Marco was instructive.

Marco was 17 when he was referred to me by a neurologist in the hospital where I work as a liaison psychiatrist. He had had headaches for twelve months but there was no medical abnormality to be found. The neurologist thought that Marco was very tense, lonely and even possibly suicidal. I invited the family to come, and he came with

*It can be useful, when working with the one way screen, to reverse the set up and offer the family a view of the clinical group at work, to see and hear them talking about the interview that has just passed (Andersen 1987, 1990).

his mother. Immediately Marco made a bid for me. 'I don't smile much' he said with a smile on his face. He is a tall, dark-haired young man with an odd expression and plenty of eccentric charm. I could see he was extremely anxious and often had to ask him, or actually tell him, to be quiet. His interruptions seemed to me to be attempts to solve all the problems in the family. He has a younger brother of 16 who is doing well at school. They cannot stand each other, according to Marco. Both parents are 57 and father works in a cafe. Mother is very passive, as if she had long ago learned how to be the virtuous madonna. Marco says of her that she can take anything, but then adds that she is going to die of loneliness. He says that when he lies on his bed he can hear Jesus telling him that he has to look after his parents. They come from a Mediterranean country, hence the name I have made up for the young man, whom I really think of as a boy, in spite of his age and size. The parents came over in the 1950s to get work and Marco is preoccupied with their relative poverty. He wishes that they could be back in their home country living in a big house, just like father's father did, until he died four years ago. This grandfather was also called Marco. I heard very little about headaches, but Marco and his mother made it clear to me that he suffers all the time with stress and that he cannot do anything at all because of it. Here was an adolescent on the verge of adulthood who appeared to be getting more and more disturbed as he approached the moment when he would have to leave. According to my view, such young people are usually, if not invariably, held back by a secret wish to save the family from disintegration. Instead of getting ready to leave, they get ready to stay, which can be achieved by almost any kind of developmental failure, disturbance or breakdown (Kraemer 1982). In Marco's case there was a possibility that the parents would separate if he left home. He jumped at my idea that he was preoccupied with his parents' lives and with their relationship. Referring to me, he said to his mother, 'this man has got the right idea' or words to that effect. Of course I was flattered. This is not the best position from which to do effective therapy.

At the next meeting both parents attended with Marco, who seemed very close to his father and touched him often. With only a little questioning about his view of the future it became clear that Marco was convinced that his parents would in due course separate. Father wants to return to their home village while mother does not. I explained to Marco that in my view he was trying to prevent this from happening but that he would not be able to do so. If the couple wanted to they would do it in any case. I was told that Marco had recently been called up into the army of his home country. He would not need to go provided he completed some papers. I said that he was afraid of becoming eighteen, and of growing up and leaving home, and that it would be better for the time being if he did not try to change himself, because he could not be sure that the family would remain intact in his absence. He was rather surprised by what I said but I could now see that he was also rather mad. He told me that a drug addict had once wiped his neck with sandpaper and had thereby put drugs into his body.

The next time I saw Marco it was on his own. He told me that he lived in his parents' 'inner space', and that he had been looking after them since he was at secondary school. He wished he could have a girl friend but is too shy to talk to a girl. He thinks that he has to ask his mother if he can have a girl friend. All this seemed to me to confirm the view I held, that Marco was married to his parents, particularly mother, and that he could not leave them. I still think that this is a useful therapeutic hypothesis but I was not able to work with it. A week after this meeting I was asked to see him again by his parents and he was clearly psychotic. My attitude changed quite

remarkably. Up to then I had been playing the role of the family therapist, that is, someone who is curious, even puzzled; someone who takes no sides but is on all sides at the same time. But now Marco was telling me that there were planes above the clouds spying on him, and that poison had been put into the tap water. I at once became the psychiatrist and sent Marco out of the room. I explained to his parents that he was mentally ill and that he would have to see an adult psychiatrist who would be able to offer him drug and hospital treatment. I was very surprised by this change in me, and only then realised that my family therapy self had not been quite in touch. There had been plenty of hints about psychotic processes but instead of thinking about what I should do for this family, I became somehow like Marco - no wonder he made such a bid for me! I was infected with his omnipotence. I felt that I could treat them on my own, which was precisely what Marco thought about his parents, with equally little evidence. I had failed to see the enormity of this process and had failed to get help from colleagues to deal with it. I was playing with a favourite idea of mine, and therefore with the family, while a catastrophe was looming.

Working with families can be an exciting and entrancing experience. I was carried away during these meetings. I knew that there was a risk of Marco becoming psychotic but I did not take appropriate action until I had to. The principal mistake that I made was in trying to do this work alone. Families in which a member is very disturbed are impossible to manage single-handed. Had I been working with colleagues, either behind a one-way screen, or in the room with me, we would have been able to acknowledge what Marco was suffering. It is dangerous for any therapist to claim that he can cure psychotic disorders, but it is equally wrong to swing the other way and say that these are simply brain illnesses that come out of the blue, as if life events had nothing to do with the onset. We now know a lot about the sorts of stress in family relationships that can predispose vulnerable young people to have psychotic breakdowns. The brilliant work started by the Milan systemic therapists in the 1970s (Palazzoli *et al* 1978) has been developed further by Boscolo and Cecchin (Boscolo *et al* 1987) with fundamental importance for our understanding of psychotic processes, and how to manage them in general psychiatric settings.* A team approach could have involved the adult psychiatric services earlier on. Part of the power of family therapy lies in its capacity to go beyond the family into the relevant system. In clinical work 'system' refers to a network of people and agencies that can become part of the problem in any serious behavioural or mental disorder. The systemic task is to expose the pattern of relationships between all the participants, effectively to give it meaning. It is a total misunderstanding of family therapy to use it to save families from their fate. This is precisely the omnipotent fantasy that I allowed Marco to put into me. He and I were effectively in competition to do an impossible job. The wisdom of systems family

*Cecchin reports a remarkable controlled study of twenty families with members aged between 18 and 25 who had been schizophrenic for at least two years (Cecchin *et al* 1992, pp. 68-71). The families were asked if they would take part in a research project to establish 'why has this particular person in this family become a patient?' Research family interviews were conducted monthly for 45 minutes, using only circular questions, ending the session with 'see *you* in a month'. Both groups were monitored by 'expressed emotion' (EE, Leff & Vaughn 1985) researchers. After six months there were 62% fewer relapses in the experimental group, most of whom also remained in the trial. Besides having far more readmissions to hospital the control group also showed a higher rate of dropout from the trial. This is powerful evidence of the therapeutic power of observation, without 'memory or desire' (Bion 1970).

therapy is that it does not try to go against the grain. Just as marital therapy is not for saving marriages, so family therapy is not for saving families.

Several months later I saw Marco again with his mother. He had been seen in psychiatric outpatients, he spent four days each week in the day hospital, and had regular injections in the meantime. He was calmer but no more capable of learning anything nor of leaving home. He had become tired and preoccupied with the injections which he believed were meant to make him stronger, but they were not working. He was not at all curious about how or why he had been ill. He seemed dull and lifeless. He said he felt old. But he did become excited when talking about the future. If he were to leave home his father would leave also and go to his home country. 'So if you stay, as you seem to be doing, father won's go either?' 'Yes.'

I was curious about Marco's tiredness and learned that his grandfather, the one with the same name, had spent the last ten years of his life in bed, as young Marco seemed to be starting to do now. There are therapeutic issues to work on, as well as the necessary rehabilitation of a broken young man just passing the time of day in the day hospital. He comes to life when there is talk of his parents and grandparents. Otherwise he is nothing.

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 it.* 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 also quite primitive. 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 (Stanislavski 1937, pp. 129, 130):

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.

*Carl Whitaker is a notable exception (Neill & Kniskern 1982). Salvador Minuchin, one of the original and most influential of all family therapists, has for many years emphasised the link between theatre, dance and therapy (Minuchin & Fishman 1981), but his writings have been to some extent eclipsed by later systemic work. His approach, however, probably remains embedded in the clinical practice of practising family therapists everywhere. Those who do write about drama (e.g. Andolfi 1981) tend to see the therapist as director, not as directed. Amongst psycho-analysts, the late 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.

Compared with one who works with individuals the family therapist's task is far closer to that of 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.

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 moved,* 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 (1934), 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.

Conclusion

The primary purpose of this paper is to describe a shift that I have observed in myself countless times, a rapid transformation** from something like irritation and contempt to something like hope and admiration. Occasionally the process goes wrong, as in the case of 'Marco'. Besides retaining the capacity to think, a technique similar to an actor's is necessary to reach it. Positive connotation is the discipline of deliberately struggling to see what could be remotely heroic or courageous about the behaviour of the family, or of particular members of it. Note that to get to this position it is necessary to do more than acknowledge their suffering. That might make people feel they have been noticed but it does not show that they are being understood. To make sense of it, we have to strain to see the virtue in that suffering.

*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). **I am grateful to Dr Sue Davison for her observation that this process is based on *projective identification* as described by Melanie Klein and elaborated by Wilfred Bion (Hinshelwood 1989). The helpful transformation that can take place is the containment by the therapist of bad feelings put into him by the patient. At first the therapist feels bad too but, if he is able to make sense of them, can offer the patient a different view of the matter. This is more likely to be sad than simply bad. A paranoid state is thus converted to a depressive one, with the therapist in the lead.

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