Families

'It is worthwhile trying to look at a family not as a collection of individuals, but as a living and developing unit of interdependent members, sharing common internal and external conditions, and showing interactions, reflecting in their life history as witnessed by a family doctor.'
FJA Huygen (1982)

This chapter is about the family dimension in patients' narratives. The first part of the chapter looks at conversations about the family when there is only one patient in the room. The second part is about having conversations with two or more family members at the same time.

Key ideas in this chapter

- For most patients, families play a central part in how they understand and experience their problems. Enquiry into the family dimension of people's lives is an essential part of a narrative approach.
- There are specific techniques for bringing the family into patients' narratives, including circular questions and the use of geneograms.
- Taking geneograms is not a formidable exercise. It can be short, simple and highly effective. Practitioners can easily adopt it as a routine narrative tool.
- Primary care offers enormous scope for working with families, whether the problem is an individual one or a shared family one. Such work can be brief and integrated with everyday care.

Points to consider

- How far is your own way of working oriented around families rather than individuals?
- Do you use family trees and if so, how? If not, might you find them useful?

- What technical problems do you face when you have more than one individual in the room, and how do you usually deal with them?
- Do you have any reservations about extending the family dimension of your work? How might you address these?

alking with individuals about their families

mily stories are nearly always present in the room, even if only one patient is ere physically. Family members are present in the life stories that people carry ide their heads. They are also there in remembered conversations or ima- ied ones. Many consultations will have been rehearsed in advance with meone in the family. Most will soon become the subject of a story told to the nily at home afterwards. Our stories, and our identities themselves, are quin- sentially family ones.

As some of the case illustrations so far have shown, it is often possible to make se of someone's problem only by enquiring into the family conversations at have previously taken place. Some of the most revealing questions in the rrative practitioner's repertoire include the following.

'Who at home is most worried about your problem?'
'Was it your decision to come today or did someone else suggest it?'
'Have you talked about this problem to anyone in your family? What did they make of it?'

ually, it is sometimes only possible to develop or consolidate a new story by ding out who else needs to be involved in the process.

'What would help to reassure your wife that this wasn't a serious illness?'
'How do you think you might explain the diagnosis to family and friends?'
'Who is going to need the most convincing that you're treating yourself properly?'

ere are, however, many consultations when it helps to go beyond such ques- ns and to explore a fuller picture of people's family backgrounds. The rest of is section describes how to carry out that kind of exploration.

xploring personal identity through amily history

ew of us define ourselves by our medical histories. We generally see ourselves ore as the children of our parents, or the parents of our children, or as siblings, spouses or partners. Moreover, illnesses often have a profound impact on the family (Altschuler 1997; Altschuler and Dale 1999). Almost everyone in primary care seems to recognise this as true, and yet many still feel inhibited about making a family enquiry as routine a part of their professional encounters as, say, questions about physical functions or smoking habits. In fact, a careful family enquiry is rarely an intrusion. It can be introduced with a question as simple as: *'Can I ask a bit about your family background?'* or *'Who's at home these days?'* To make it entirely clear that the motive is not one of looking for blame, it sometimes helps to add: *'I find it helps me to understand people more if I know who's around in their lives.'*

Asking questions about the family is a way of moving from the professional's perspective of the story to the patient's (Jenkins and Asen 1992). Asking about the family's wellbeing and their history is therefore a fundamental narrative-making intervention for nearly any consultation. However, it is particularly powerful in developing a new story when other, more conventional methods are proving unproductive. Tomson suggests that a family enquiry is particularly useful with the following: 'depression, somatisation, psychosomatic problems, consultations where the heart sinks, stuckness on either part, behavioural problems, dependency on drugs, alcohol or the doctor, relationship difficulties, failed treatment regimes, unusual health beliefs' (Tomson 1996).

The following case shows how well, and how economically, such an approach can sometimes work.

Case study: Ali A

A nurse said: 'I was struggling to make a connection with a young Kurdish man, Ali A. He was attending for a new patient health screen. He gave one-word answers to all my questions, even though his English seemed quite good. So I decided to stop filling in the computer template for a couple of minutes and asked him about his family instead. He told me that he had left his parents and five siblings behind in Iraq. I asked: "Are they all safe?" He suddenly became highly animated. I felt it transformed the quality of the consultation.'

Geneograms: the basic tool for creating family narratives

Most family therapists take family trees (or geneograms) as a routine. Many people in primary care are reluctant to do so. The main worry seems to be that

they cannot possibly set down the whole family in the time available, so should not start it. This is similar to believing that you should never listen to anyone's heart in primary care because you cannot routinely carry out a full cardiovascular assessment! The analogy works well, because GPs and primary care nurses are extremely good at making pragmatic decisions about how little they need to do in order to carry out any task. If the basic task of taking a geneogram is seen as establishing the most crucial elements of the patient's life story, only a very few questions may be needed to accomplish this effectively. The formal phrase 'taking a geneogram' should not deter practitioners from jotting down an improvised diagram in a few seconds on a piece of scrap paper, which can amount to exactly the same thing.

Case study: Harold B

A GP explained: 'A man of about 38, Harold B, was telling me about unaccountable feelings of sadness and failure. These had appeared fairly suddenly the previous month. Nothing in his circumstances seemed to account for this. Everything in his family and working life seemed to be going so well. His oldest child had just reached the age of ten. I asked him a few questions about his family. He told me that his own father had died just after his tenth birthday – the same age his son had just reached! He was stunned when he made the connection. He burst out with all kinds of ideas. He realised how scared he was of dying himself now. He also said he had no idea of how to be a parent to a child older than ten. It was a quite dramatic consultation.'

The amount and kind of information worth including in a geneogram will depend entirely on the time available and the purpose of the consultation. An example of a geneogram taken down during a consultation appears on page 69.

Trying out a new story

In one way, a geneogram just establishes the bare bones of the patient's life story. However, from a narrative point of view it is the creative act itself – the live construction of a geneogram between practitioner and patient – that is crucial. It not only creates intimacy, but brings about new understanding and indeed new stories about how the past came to influence and determine the present. Giving a coherent account of the past and how it came to influence current

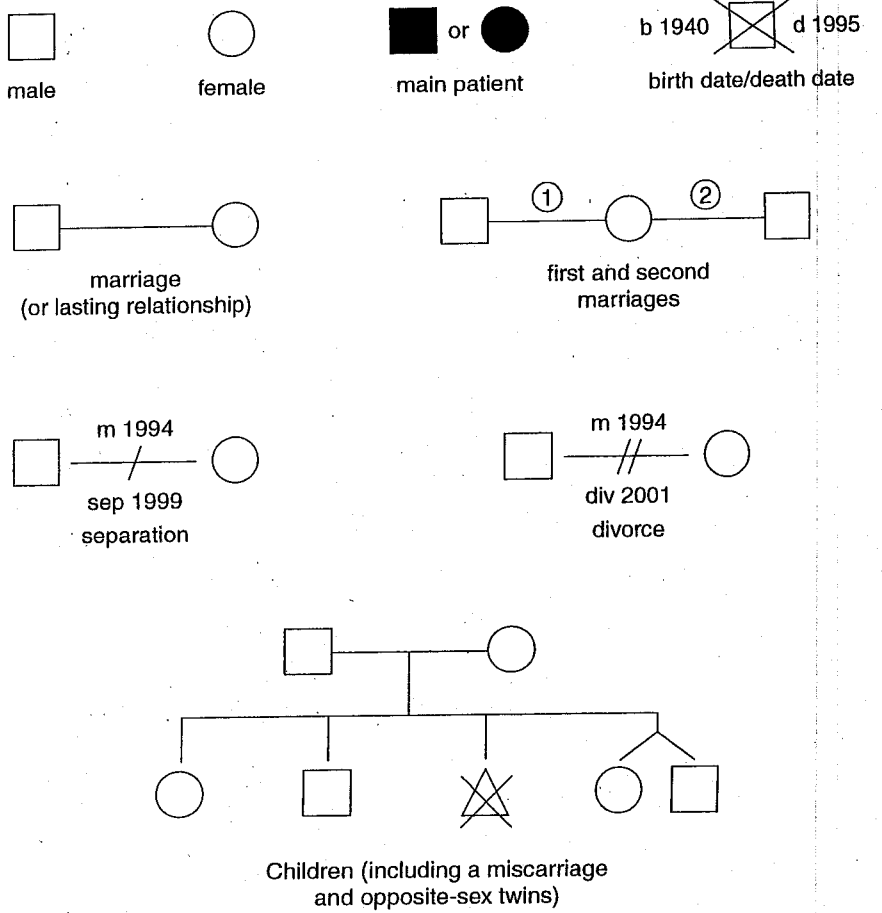

Figure 1 How to draw a geneogram.

difficulties can help people to identify what needs to be changed so that they can create a different story for themselves.

Case study: Karen N

Another GP told us: 'I have been seeing a woman called Karen N regularly while she has been going through a series of treatments for breast cancer. She has had a mastectomy, radiotherapy and chemotherapy. She keeps telling me about how she cannot stop being a 'coper'. She is always looking after everyone else including her husband and two daughters. She finds it impossible to take as much rest as she needs, even though her family seem fairly willing to help. I recently asked her a few questions

about her family of origin. She was the eldest of five children. Her father was confined to bed for all of her teenage years because of spinal tuberculosis. She was effectively brought up as her mother's 'right hand'. She said it was hard to let go of control. We talked about this and she realised that her present family set up is far more supportive than the one she was brought up with. She is going to try to let others do more for her.'

'aking geneograms as a routine

Many GPs will think nothing of taking down elaborate past medical histories or ealth screening information for every new patient they see. Yet most would robably find the idea of taking geneograms systematically a rather intimidatıg one. This need not be the case. It probably takes much less time to elicit the asic family story for many people than it does to fill in the average computer emplate for a newly registered patient. And it may be far more effective in erms of the quantity and quality of information gathered (Tomson 1985).

Doing so leads to a more rounded understanding of the stories of many atients, especially those who are seen mainly in terms of their diseases or ther superficial characteristics. It also makes it possible to see important conections between people who seemed unconnected – for example, married sisers with different surnames, or fathers and their married daughters – and to earn of significant members of the household who have never consulted or are egistered elsewhere. It often produces important stories unexpectedly, especially when a doctor has become so familiarised with someone that he or she as developed an unvarying story about them. Perhaps because of this, routine aking of geneograms seems to produce a strongly positive effect on a doctor's erception of many patients. (It can also sometimes reveal a family history of isease or risk factors, such as diabetes or raised cholesterol, when this has een missed by other routine screening systems.)

Systematic taking of geneograms also helps to focus attention more on amilies with particularly troubling stories to tell. These include:

- early or repeated separations and disruptions in childhood
- the concurrence of two or more serious new diagnoses in the same household in a short space of time
- a family history of widespread major psychiatric disorder, from which the presenting patient might or might not have escaped
- childlessness and consequent isolation in the elderly, particularly useful in cases where the doctor has erroneously assumed that there was another generation of potential family carers
- existence of a previous marriage, and sometimes also of resulting children from whom the patient might now be estranged
- early parental death
- a history of immigration or emigration within the family
- a history of persecution and fleeing, with consequent separation from spouses, parents or children
- unconventional households (for example, elderly single brothers living together).

However, there can also be drawbacks to taking geneograms in an organised way. Like stamp collecting or train spotting, there is a risk that it can turn into an obsession that distracts practitioners from the primary purpose of enlarging their understanding. It requires discipline to recall that the point of taking geneograms in a clinical context is for their power to create new stories, not for the amassing of data in itself.

Case study: Irene M

A GP wrote: 'I saw an adolescent girl, Irene M, whose weight loss strongly suggested the early presentation of an eating disorder. I started her geneogram in the surgery. She became extremely enthusiastic about the idea and went home to construct an enormous six-generation geneogram on a sheet of unused wallpaper. She returned with her mother a fortnight later and proudly showed me the geneogram. We had a long discussion concerning the meaning of eating and food to the various generations of this family. Then her mother asked if I could test the daughter's urine. I did, and it showed three plusses of sugar and ketones.'

Conversations with the family present

People working in primary care have one tremendous advantage from the point of view of exploring family stories. Family members, in their twos and threes, attend surgeries in combinations of their own choosing as a matter of routine: as couples, as parents with young children or as children with old parents. These natural combinations do not need 'convening' – they just happen. There are many occasions when some sort of family conversation is therefore quite possible. All the practitioner needs to do is to notice these occasions and exploit the opportunities they provide for new narratives.

Everyone who enters the doctor's room for a consultation (or is present on a home visit) is in effect a participant in that consultation, even if their 'problem'

is that they are concerned about the identified patient. The family member or neighbour who has apparently only been co-opted as a driver is sometimes the person who, with encouragement, will volunteer the most useful information. It may be worthwhile encouraging all patients, if they want to, to bring their partners, friends or neighbours into the consulting room rather than to leave them sitting in the waiting room because they have a mistaken belief that you might regard them as a nuisance. It may also be worthwhile to tell individual patients that you find it helpful to have somebody else from the family there to give another perspective. The response can be very surprising: a sister rather than a spouse, a neighbour of the same age rather than an adult child, someone from the church rather than from the family. Inevitably, some people will say no to the invitation, and this has to be respected.

Does such an approach lead to an overwhelming increase in workload? Often, the reverse is the case. This is usually because it is possible to elicit a clearer story as a result, or because there are more human resources for exploring a new one. Many experienced practitioners report that they find it easier and more productive to work with couples or larger numbers of people in the consultation than with individuals, because of the energy and the range of possibilities for new stories that this produces. With more than two patients in the room, there is a greater potential for asking questions about different perceptions, beliefs, theories or suggestions for treatment or for change.

However, it is also worth being cautious about actively inviting whole families to attend consultations together, unless one has a special interest in working this way. Although such invitations are standard practice in family therapy, they can seem intrusive in primary care or turn out to be unhelpful. Practical factors (small surgeries, too little time, inadequate materials for toddlers, nervousness about having enough skill) may spoil the encounter unless there is a lot of thought beforehand. It also goes against what people expect of their GP or practice nurse, so it may introduce an unnecessarily formal tone. Certainly, convening a whole family meeting is a very powerful intervention and should be offered with care: by a well-prepared clinician, to a suitable family, at the right time, and possibly with some kind of professional support like an observer or supervisor.

Involving the family in the conversation

Sometimes people come to primary care in twos or threes because there is 'a family problem', but usually this is not the case. They have come for other reasons, and they may want to express their views, but they do not want to go away feeling that they have a problem themselves or are part of the problem.

One way of including whoever is present without automatically casting them as patients is by the technique that family therapists describe as 'joining' a family. This means adopting the systematic habit of greeting everyone who arrives at the start of the consultation, finding out their identity and clarifying why they have come, unless it is perfectly obvious. By doing this, you can avoid discovering at the end of a consultation that the silent onlooker is deeply concerned about the patient and actually has a lot to say or ask. Making eye contact with everyone in the room at regular intervals is another way of indicating a willingness to hear everyone. It may encourage people to be forthcoming without any further prompting.

Although 'joining the family' sounds, and is, relatively simple – and many people in primary care do it instinctively – some doctors report that they have trouble doing it because of habits acquired in the past. These habits include focusing on the individual with the problem, while regarding everyone else as a kind of audience. However, once people have acquired the discipline of involving everyone in the conversation, they can be surprised by the people who speak up. This can include those with learning disabilities, toddlers, elderly people affected by Alzheimer's, and people whose English is poor and usually bring someone to speak on their behalf. Practitioners are also surprised by the variety of perspectives that can be present at the same time and the range of different stories that can come out as a result or turning individual consultations into joint ones. For example, relations are commonly bolder at speaking about the patient's unexpressed fears and may be more direct as their advocates when there is dissatisfaction.

Generally patients are very keen, and very relieved, when those accompanying them are brought into the orbit of the conversation, but sometimes they are not. They may even feel at risk of being upstaged. If this seems a possibility, it is important to ask permission before moving from a one-to-one dialogue into a wider conversation, for example by saying: '*Would you mind if I asked your daughter's view?*' or '*I'd find it helpful to hear what your wife has noticed. May I ask her?*' Such strategies make it possible to hear other descriptions of the problem and other suggestions for dealing with it. They also make it possible to help with a variety of different stories at the same time, for example the story of the worried relative along with the patient's story.

Case study: Eric R

A GP gave this account: 'Eric R and his mother have been registered with me for the past nine years following the retirement of their previous GP. The mother (now 79) has always been a frequent attender and has had cancer of the colon, asthma and osteoarthritis. The son (now 49) has asthma and has not worked since being made redundant from his job as a

shop assistant a few years ago. They live together in a large house and have always seemed to have a close and protective relationship. They had a cat they adored, who died recently. A few months ago the son came to see me complaining of episodes of "spasms" in his throat, which caused difficulty in breathing, speaking and swallowing. He described the sensation as feeling as if someone had their hands round his throat. After these his voice was hoarse for several days. He had a long history of asthma but these symptoms were different.

'I referred him for an ENT opinion and all was found to be normal, including a barium swallow. I also referred him to see a speech therapist to learn relaxation techniques. The spasms continued and got worse. When I questioned him, he said he wasn't depressed or worried about anything. On a home visit the mother expressed concern about these symptoms as similar symptoms in the son's early twenties had resulted in several years of dependency on Valium. I felt I needed to know more about their life, so I listened while the mother talked. She told me how when the patient was five, his father came home after being in prison for several years. Eric had no previous memories of him. The next day they went out and the father became angry with the child while carrying him, as he would not sit the way he wanted him to. He shook the boy violently, and he was terrified and unable to breathe. The mother dates the start of his asthma from that moment.

'From the way she told this story it was obvious it had been told many times over the years and was a very significant family story to them. The son was diagnosed as having "severe nervous asthma" and was taken to see many doctors, both NHS and private, during his childhood. The father was frequently violent towards the mother but it was not until about ten years later, after he had broken her collarbone, that he left. The mother told everyone this was for financial reasons. It is striking how much effect this man, who they have not seen for many years and is probably dead, still has on their lives.

'On my next home visit I asked the mother some questions about the son's illness. I asked her what she thought his symptoms were caused by. She said she thought he had been depressed since the death of the cat a few months ago. The son accepted this idea. He had always denied being worried about his mother's health, so I asked the mother if she thought Eric worried about her. She replied that he did, but it was not necessary, and she had told him not to worry. I said that maybe it was unrealistic for him not to worry given the mother's health problems and maybe he should be allowed to worry. I also suggested that sometimes it was as difficult to watch someone being ill as to be ill oneself.

'I subsequently saw Eric on his own about his depression. I started him on antidepressants but he discontinued these due to side effects. However, over the next few weeks the throat symptoms resolved and he no longer seems depressed. The mother also seems happier, with fewer physical symptoms. My hypothesis was that the death of the cat reminded him that one day his mother will die and he will have to cope with life on his own. I think he is a very lonely person and I guess he may have sexual difficulties but I think this is probably as far as I should go in my enquiries, at least for the moment.'

Conversations with children

One dimension of family conversations requires specific attention. Children are present in a great proportion of primary care consultations but often no one actually speaks to them directly. GPs get no special training in how to engage children in conversations. Unless they have children themselves, they may lack confidence in doing so. Although they may know quite a lot about the development of things like motor skills, GPs may have little idea of the appropriate language and cognitive ability to expect of a child at any particular age. In addition, because the emphasis of medical training is so often on the objective diagnosis rather than the narrative encounter, many GPs may assume that it is enough to talk to parents *about* their children's experiences rather than to find out about these from the children themselves.

Fortunately, children are good teachers. Unlike adults, they will indicate that they have not understood a question by shrugging or looking blank rather than confabulating. This kind of feedback, although it seems rather brutal at first, is a good way of learning whether questions make sense or not. Most children, especially young ones, tolerate fewer questions than adults. On the other hand, making it a principle to ask questions of children in every consultation when they are present (even if the identified patient in the consultation is a parent) will prevent them being bored and unruly. Any child in the room with any level of verbal ability is a patient in his or her own right – and of course one can still communicate with pre-verbal children in other ways.

From a narrative point of view, the child too has a story to tell. It may be a naive story, but it may be all the more honest, vivid and telling because of that. It may contain important information, perhaps by its very contrast from the parent's account. If a clinician is confident and fluent in engaging children in conversation, and has taken the trouble to cultivate this skill, it will provide a good model for parents who want to develop this ability in themselves in order to give their children a clearer voice. Direct conversations with children can also be therapeutic for the children themselves, particularly if they feel as if they have had a chance to put their symptoms and worries into their own

ɔrds, and if their anxieties can be allayed by face-to-face reassurance and planations so that they can take away a better story than the one brought ɔ the surgery (Dowling 1993).

onversations about family problems

ımilies do not speak with one voice. They have many. On most occasions in imary care, these voices support or complement each other, but there are so times when they are in discord. This may be apparent from the beginning the consultation, because they have intentionally come to discuss a relation-ıip problem. On other occasions, the discord becomes apparent as disagree-ents emerge during the conversation itself. The initial story may have been ɔout something like a medical problem, or depression, or a child's behaviour, ıt it then turns it into something else: an explicit family problem.

In dealing with family problems, some of the 'six Cs' concepts presented in ıapter 2 can be particularly helpful. An attitude of *curiosity* conveys that ere is no 'right' or 'wrong' version of the story, and that the role of the doctor nurse is not to adjudicate or choose among competing versions. This in turn licates to the family that the consultation is a safe space for expressing differ-ces and for exploring whether an agreed new narrative is possible.

Another mainstay of conversations with families is the use of *circularity*. ing circularity in this context involves several related techniques:

- allowing everyone an opportunity to speak, by inviting all their views and moving between them as equitably as possible
- indicating a belief that everyone has a continuous effect on everyone else, so that it is unproductive to try and determine 'who started it'
- following a mode of 'circular questioning' that invites people to move away from blaming and towards observing reciprocal effects and patterns.

ıe of the most helpful aspects of circularity is that it transmits the idea that ere may not be a single solution to the family's difficulties, but at least there an evolving conversation and therefore the possibility of changing the story. en if the new story does not emerge in the consultation itself, the conversa-n has provided a model for how old stories become unglued and new stories e created.

Case study: Leo and Briony

A GP reported: 'This case involves a couple, Leo and Briony, both in their early twenties. He is Swedish and does computer work, she is from Wales and is a graphic designer. Leo came to see me saying he was glad I was a lady doctor and could he discuss his girlfriend's problem with me. He explained that it was a sexual matter and that he found it easier to talk to a woman about it. The problem was that his girlfriend of two years standing was no longer interested in sex with him, and for the last nine months would push him away and burst into tears. He talked openly about his worries about this – whether it could be a physical problem of hers or whether it might be all his fault – caused by him being unfaithful one year ago.

'I was curious that he was presenting "her" problem – he explained that she could not make this appointment. I asked him what his girlfriend would say was wrong if she were there. He said "she just says she doesn't know but she is very worried that she will lose me". We discussed his worries that she was upset with him and his frustration that this problem was persisting despite his sympathetic attitude. I suggested they return as a couple for a consultation with me with a view to possible referral for psychosexual counselling. He said they were not interested in a referral but would like to come back and see me anyway.

'Leo returned together with Briony. They sat close to each other holding hands. Briony said that her worst fear was the end of the relationship – they were each other's first sexual partners, and until he had been unfaithful, their only ones. He explained it had only been a one night stand, and that he had immediately telephoned Briony, who was visiting her parents in Wales, to tell her and apologise. I asked about her reaction – she had been devastated and nearly decided not to come back from Wales, but he called so often that she came back to rejoin him. Their sexual relationship initially continued as normal and then the problems began. I asked how she reacted at the time. They agreed she had been very angry initially but expressed it very calmly, which was usual for her. I asked her if she was still angry or upset about his unfaithfulness, and she said yes, she thought of it all the time. Leo then burst out in frustration "I've told you I'll never do it again and I'm sorry, what else can I do?" The couple seemed stuck in this painful state, but terrified of separating. I shared these thoughts with them.

'I was not sure if the discussion had any effect. However, the following month Briony came alone to talk about contraception, and she mentioned the difficulty she had had in expressing anger. She said that on the whole things were improving for them.'

GPs and nurses vary a great deal in how keen they are to tackle couple or family problems of this level of sensitivity in their everyday work. Some have been attracted to their jobs, and to further training, precisely because that is one of their interests. Others feel that they cannot offer the time or the skills to do this kind of work – and yet they recognise that it comes to them willy-nilly. Many

families will not seek the help of any other agency, nor accept an onward referral. For better or worse, primary care is 'de facto' the part of the health service where most actual family therapy happens. Brief work of the kind the GP did with Leo and Briony may achieve more than many practitioners might expect, and certainly more than a referral to another agency that the family does not wish to attend. While staying within the limits of their own interviewing skills and confidence, most practitioners seem to find it possible to extend their experience of such work, and then find it unexpectedly gratifying. Those who go on to acquire some degree of training in this work generally report that it becomes a cornerstone in their way of practising.

Suggested exercises

- In a series of consultations, ask for some basic information about: 'Who's at home?' What difference does this make to the rest of those consultations?
- Choose one consultation when you are not too busy and where it seems appropriate to write down a more detailed geneogram. What light does it shed on the problem and what effect does it have on the story?
- Select two or three other ideas from this chapter (for example 'joining', asking children's views, asking questions of each family member in turn). How well does this fit with your normal practice? What effect does it have?
- Start to experiment with circular questions. Which ones seem to work and which do not?

An extract from the sources

The Canadian therapist Karl Tomm gives the following imaginary example of the difference between asking linear, circular and reflexive questions when interviewing a family. His suggestions are meant to demonstrate these forms of questioning, not to suggest that a real-life interview could or should proceed exactly along these lines.

Linear questioning

Interviewer: What problems brought you in to see me today?
Wife: It's mainly depression.
Interviewer: Who gets depressed?
Wife: My husband.
Interviewer: What gets you so depressed?
Husband: I don't know.
Interviewer: Are you having difficulty sleeping?
Husband: No.
Interviewer: Have you lost or gained any weight?
Husband: No.
Interviewer: Do you have any other symptoms?
Husband: No.
Interviewer: Any illnesses lately?
Husband: No.
Interviewer: Do you have a lot of morbid thoughts?
Husband: No.
Interviewer: Are you down on yourself about something?
Husband: No.
Interviewer: There must be something troubling you. What could it be?
Husband: I really don't know.
Interviewer: Why do you think your husband gets depressed?
Wife: I don't know either, he is just not motivated. He lies in bed all the time.
Interviewer: How long has he been depressed?
Wife: Three months. He has hardly been out of bed in three months.
Interviewer: Did something happen that started it all?
Wife: I can't remember anything in particular.
Interviewer: Does anyone try to get him up?
Wife: Not really.
Interviewer: Why not?
Wife: Well I get fed up after a while.
Interviewer: Do you find yourself getting frustrated a lot?
Wife: Quite a bit.
Interviewer: How long have you been so frustrated?

Circular questioning

Interviewer: How is that we find ourselves together today?
Wife: I called because I am worried about my husband's depression.
Interviewer: Who else worries?
Wife: The kids.
Interviewer: Who do you think worries the most?
Husband: She does.
Interviewer: Who do you imagine worries the least?
Husband: I guess I do.
Interviewer: What does she do when she worries?
Husband: She complains a lot, mainly about money and bills.

Interviewer: What do you do when she shows you that she is worrying?
Husband: I don't bother her, just keep to myself.
Interviewer: Who sees your wife worrying the most?
Husband: The kids. They talk about it a lot.
Interviewer: Do your kids agree?
Children: Yes.
Interviewer: What does your father usually do when you and your mother talk?
Child: He usually goes to bed.
Interviewer: And when your father goes to bed what does your mother do?
Child: She just gets more worried.

Reflexive questions
Interviewer: If you were to share with him how worried you were and how it was getting you down, what do you imagine he might think or do?
Wife: I'm not sure.
Interviewer: Let's imagine there was something that he was resentful about, but didn't want to tell you for fear of hurting your feelings, how could you convince him that you were strong enough to take it?
Wife: Well, I'd just have to tell him I guess.

He writes: 'As the therapist asks questions to identify patterns ... family members who are listening to the answers make their own connections as well. Thus, they may be able to become aware of the circularity in their own interaction patterns. With this increased awareness they may be 'liberated' from the limitations of their prior lineal views and subsequently be able to approach their difficulties from a fresh perspective ... Questions are reflexive in that they are formulated to trigger family members to reflect upon the implications of their current perceptions and actions and to consider new options.'

Karl Tomm (1988)

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