The power of the genogram

Matthew Adam

Introduction

Recently, while working in my professional context, a Tier 4 inpatient hospital, I was struck by a bolt of metaphorical lightning that drew my attention to the seemingly innocuous tool many family therapists use on a day-to-day basis, the genogram (Carter & McGoldrick, 1998).

Throughout my clinical training I understood the genogram's value as an assessment tool, an opportunity to develop an awareness of patterns or scripts in families, often trans-generationally, and to use this feedback as a basis for the formulation of hypotheses which would, of course, form the framework for the therapist's questions to the family. It has only been while working in a Tier 4 inpatient setting that I have been witness to the power of the 'family tree'. For many families, the exercise of telling their stories to the therapist is just an information gathering exercise. But for some, the genogram is an intervention that can be extremely powerful, thus negating it as an exercise in understanding and making it an influential force upon the therapeutic process itself.

In taking a detailed account of a family's history and the relationships that comprise that system, stories lived can indeed become stories told (White & Epston, 1990). In some instances the stories have been recounted before and serve to define the family functioning. But at other times some stories have never before been told to an outsider and the impact of elevating these unspoken narratives may leave a profound and lasting impression upon the family as a whole and for each individual member (Roberts, 1994).

In my work with two complex families, I introduced the genogram as a way of getting to know the family and their history, to 'warm the context' and to prepare the way for the difficult conversations that were certain to be had. Indeed, what actually occurred and what I expected to occur were two very different events. At the time of meeting with these families, I had an awareness of a family protectiveness around difficult stories, but I had little awareness that in being complicit in joining in this intervention, both families would leave feeling exposed and vulnerable and desiring never 'to do THAT' again.

Vignettes

Family 1

'Jessica', a 16-year-old girl, had been sexually abused by her father when she was 11 years old until she was 14 years old. She had been referred to the inpatient unit for deliberate and severe self-harming behaviour and for having made two serious suicide attempts by over-dosing on paracetamol. After a few months Jessica's mood lifted and she developed coping strategies to help her deal with her thoughts of self-harm and it was decided that home leave could begin. Visits home from the hospital seemed to coincide with overdoses in the community and the family often returned Jessica back to the unit distraught and angry.

For the first session with this family, I requested that as many family members as possible be present and Jessica, her mother and younger sister attended the session. Jessica's mother's boyfriend was unable to attend the session, but sent his apologies and hopes that he could attend subsequent sessions. Being conscious that Jessica and her family were ostensibly meeting a stranger and may be reticent to speak about sensitive issues related to the reasons Jessica was struggling, I decided to complete a genogram in the first session in the hope of allowing the family to acclimate to the therapeutic process and to 'take it slow'.

I began by asking Jessica and her family if they would allow me to complete a genogram, explaining the ideas behind the genogram. All family members agreed to this form of story-telling and indicated in no way a discomfort with this method of information-gathering. As the session progressed and the genogram became more complete, Jessica's mother began telling stories that resonated with Jessica's history and which neither daughter had previously heard. Jessica's mother revealed she had an older child whom she had placed up for adoption three years before Jessica's birth. Jessica's mother continued telling her story and explained that this child was conceived when she was raped by a maternal cousin, resulting in her immediate family rejecting her outright and abolishing her from the family home.

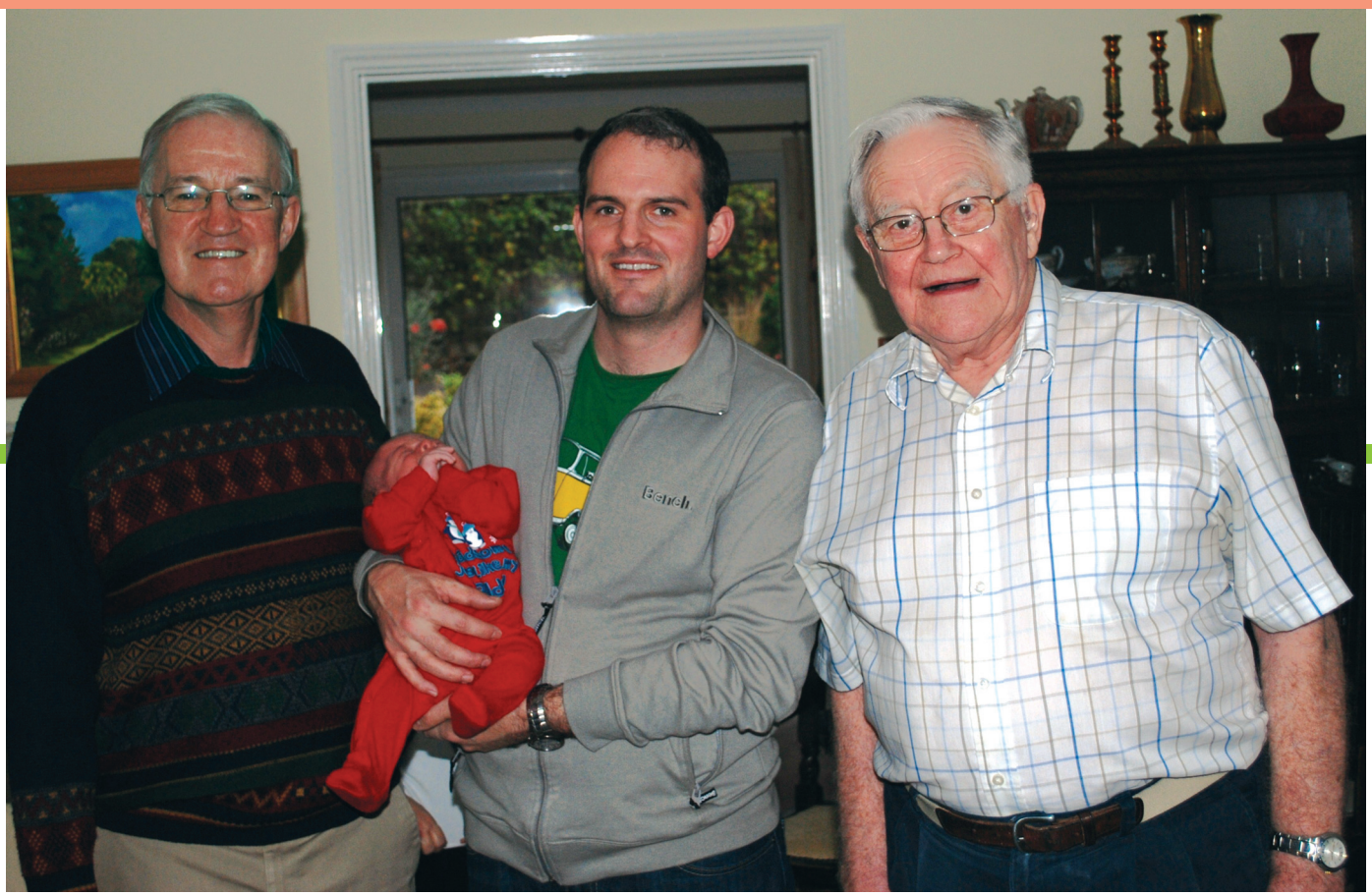
With this new information surfacing Jessica became quiet and agitated and her younger sister quietly sat next to her mother, uncertain about how to react. Jessica's mother stated that while neither of her girls had heard these stories they needed to be told and that she explained that she harboured guilt and responsibility for Jessica's subsequent abuse. The family story had suddenly become overwhelmingly powerful and frightening and the young girls visibly withdrew inside themselves for the duration of the session.

Family 2

'Suzanne', a 16-year-old diagnosed with anorexia nervosa, attended a family therapy session with her mother and sister. The family had attended one session before but had not been able to discuss family relationships in that session. There appeared to be a gap in the knowledge the professional system had about Suzanne's extended family and they were asked if they were happy for me to complete a genogram.

As the session began, Suzanne and her sister, Emily, spoke about how they were protective of each other because of life experiences they had. They spoke briefly about their parents divorce and that this had sent Suzanne's sister 'off-the-rails'. As the family began telling their family narrative I wondered if I might also construct a timeline of events, to help me make sense of the timings of the significant events in the family. They agreed and were soon telling the story of when they began to notice that Suzanne was restricting her diet. These stories were connected to a maternal Aunt who had an undiagnosed eating disorder, which lead the way for Suzanne's mother to tell her stories.

The youngest of three children, Suzanne's mother, Kathy, explained that her birth had been an 'unplanned mistake' and that her earliest memory was of her parents arguing about who had wanted her least. Her father had died when she was 17 years old and she had never shared a close relationship with her mother or sisters. Kathy had stopped seeing her second oldest sister, Sally and her husband after an 'incident' between Kathy's husband and Sally's husband. Both Suzanne and her sister asked their mother to explain what had happened, that they had differing accounts of the story from multiple sources but still did not know what had happened from their mother's story.



Four generations of men/boys in the Adam family.

Kathy refused to explain what had happened and queried what this story had to do with Suzanne's illness. The conversation once again returned to the timeline of events, where Suzanne remarked with a certainty that her illness was the result of her mother's relationship with Michael. Suzanne, Emily and Kathy spoke openly and candidly about Michael and the conflict that had developed between Suzanne and her mother as a result of the inevitable distance this new relationship had created.

The genogram was nearing completion and Kathy briefly stated that her divorce from Suzanne and Emily's father had been messy and taken five years. I summarised the session, stating that the issues about men seemed important to this family when Kathy became visibly agitated and upset, expressed that she felt uncontained and that the subject matter was entirely too difficult to explore and queried what any of this had to do with Suzanne when they should be future focused, before promptly leaving the room in a flood of tears. When Kathy eventually returned she said that she was unsure this process would be helpful and did not believe it should continue.

Reflections

Completing a genogram early in the work with a family is important as it can provide a wealth of information about the family and how they function together as a unit. In my work, I find that if I do not complete a thorough genogram within the first three sessions of my work, the opportunity to assess the family passes and the information is harder to obtain in the later stages of the therapy. There is an argument for delaying the use of this therapeutic tool for later in the work, surely the therapeutic relationship will have developed and trust and safety, both essential to creating a secure base, may beginning to take hold. But perhaps this delay may further entrench a family's desire to 'hold on' to stories that may influence how an outsider might perceive them.

In both my case examples, the genogram was provocative and made an initial impression that family therapy was dangerous, not to be trusted, and uncontainable. I am aware of the gender divide, that in both cases I was the male in a room with three females. Being a male therapist, I may have represented that 'bad' man who had abused his power and taken so much from the women in each session, manipulating my tool, the genogram, to control. I have no doubt that such power differentials developed as a result of implementing this intervention, certainly it was evident before the end of the session with the second family.

The families physical and emotional reactions to the telling of their stories left me feeling anxious and worried. Being aware of this while in the room I tried helping the family move to a more settle and manageable place before letting them leave. But, it would be fair to say that in each case I was left stunned by the power of the genogram. I found myself in a position of disbelief, that the telling of a story would be so powerful as to make the family distrust the therapeutic process. I think it took me taking this position of disbelief to allow me to consider what it was that actually happened. I realise that for me, the genogram placed me in a position of power over the women in the room. The telling of the family history was so powerful and I, having asked these stories to be told, became perceived as part of the oppressiveness of the stories.

Moving beyond the uncontainable

Conflicted in both these cases as to whether the process of constructing a genogram had been helpful to the family, I hoped that I would be able to re-engage the family and help them understand that though difficult, family therapy could be helpful to them. Recognising that sensitivity to the family's vulnerability would be a cornerstone to the development of the therapeutic relationship, I drew on Rudi Dallos's (2004) ideas on 'attachment narrative therapy'.

Creating a secure base in the therapeutic space was not immediate and took time but as the family began to trust in the process they managed to speak openly about subjects that were once 'off-limits'. As the families found their way in understanding themselves they drew on their beliefs and stories of internal and familial strength to carry them through those difficult, but much needed conversations.

These experiences have helped me in recognising that utilising the simplicity of the genogram with difficult and complex families can often render them feeling uncontained, vulnerable and exposed. But in divulging such difficult and painful stories so early on in the therapeutic process, families can draw upon their strengths and resiliencies to get through other difficult and often more complicated conversations.

Much the same as a family sculpt can be too powerful for a family, so too can completing a genogram and the subsequent conversations that accompany it. Respectful appreciation of a family's history and developing an awareness of the potential that each story has for bringing with it powerful emotions are important skills to apply to the genogram.

That a family can enter into an unspoken agreement with their family therapist to divulge the stories that comprise their reality without having agreed upon their influence over when the story-telling should stop, or when a sensitive story is being encroached upon, is an act that is so extraordinarily powerful and potentially harmful that the family therapist should always consider how best to use such a tool.

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Matthew Adam completed his qualification at IFT in August 2008 and moved to Shropshire with his wife. He works as a family therapist at Huntercombe Hospital – Stafford. Since moving in 2008 they have had a recent addition to the family, Felix, who is now five months old.

Working with marginalised families: *"Can you do that without breaking too many eggs?"*

Carlos J. Sanchez

It is an art to develop specific interventions in psychotherapy and family therapy. Sometimes you are a Picasso and sometimes you are a two-year-old with a crayon and a wall. More than patience, discipline and practice are needed to create a context for change. Just because you can identify a problem does not mean you are closer to fixing it. The title of this article is a warning to those working with marginalised families when there are several social/government institutions in their territory.

Usually the low-income families are receptive to the therapist who shows interest in them but this does not imply they want treatment. Jorge Colapinto (1991), in his article *Pretend Therapy*, described how some families manage the presence of many institutions when they are imposed upon them. Colapinto wrote *"…many of these families go through the motions of therapy, keeping at least some of their appointments, minimally answering questions, may be even extolling the virtues of two weeks of treatment, but not really engaging in a therapeutic relationship".*

The literature suggests several avenues for success: the proper utilisation of the self of the therapist; the strength of the therapeutic relationship; the need of the therapist to believe in the effectiveness of a particular clinical model; and the right technique.

What is missing in all of the above is how institutions modulate what is going on.

Traditionally, the point of departure is the family unit. We are proposing shifting the center of attention from the family unit to the "institutionalised families". I use the term "institutionalised" to describe the involvement of several public and private agencies in the functioning of the family. It tends to capture the dependency of the family on the approval of the authorities to validate their own decisions.

As early as 1967 Minuchin introduced the concept of disorganised families to describe the lack of consistency and unpredictability in the interactions of the family living in poverty. He attributed it to psychological deficits the parents and/or authority figures within the family. At that time he did not have the accumulated sociological evidence that we have now. Thirty years later, while working with the foster care system in New York City, Minuchin and Colapinto reported that the external interference of protective services agencies forced some families to adopt a functioning style that reinforced the interference. The family was no longer accountable to its members, but to the representatives of the different agencies/mental health providers.

Things have to be done differently to assist the family in understanding that as a unit they have some degree of accountability in resolving their problems and avoiding the "pretend therapy". The formula requires a different type of joining from the usual pleasantries.

It combines support and confrontation as part of the relationship. The posture of conflict-avoidance tends to perpetuate the same behaviours that brought the family to the attention of the institutions in the first place. Sometimes you have to hang a villager to get the town's attention. Once this therapist admonished a parent who showed up late for a court hearing: *"You are late. These are your children, not mine. You need to be on time; otherwise I can't work with you".*

The extension of support outside the therapeutic time is one of ways to building credibility and trust. The presence of the therapist in court earned him the right to expect punctuality from the client. We can't go around treating these families as if they are going to drop dead any minute