A Systemic Approach to Psychological work with Families

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Abstract. The author points out in the present work the general lines of psychological work with families. This work includes some fundamental assumptions: the absolute inseparability of intra-psychic and relational phenomena, the concept of human reality on four levels of the Quadrilateral, the concepts of Hypothesising, Circularity and Neutrality as guidelines for conducting sessions with a family. The paper describes the construction of a Systemic Hypothesis for a case and the intervention project that follows in order to describe the parameters to be used as indicators of change.

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Introduction

All psychological work for resolving problems presented by clients seeks to change. Every theory of change in Psychotherapy derives from the hypothesis that clinical work embraces four dimensions: a) the theory of the mind and its interactions with the world / b) how the experience of having a problem is generated within these interactions / c) how such a problem becomes a symptom / d) which methods can resolve the problem, and the techniques for implementing them.

In this paper, we will attempt to summarise, albeit briefly, how these dimensions are combined in psychological work with families under a Systemic Approach.

Theory of mind and the genesis of a problem/symptom according to the Systemic Approach

The Assumptions

The history of the Systemic Approach proposes, with regard to the aforementioned points a), b) and c), concepts that connect human iterations in four dimensions: 1) Problem Presentation (Narration) 2) Intrapsychic Conflict or Individual Discomfort (Personal) 3) Communicative Inconsistencies (Communications) 4) Unresolved Relational Conflicts (Relationships). Several years ago, we linked these four dimensions into a structure that we called the "Systemic Quadrilateral" (Mosconi, 2004; Mosconi, 2008; Mosconi, Tirelli, & Neglia, 2013).

Table 1

The four dimensions of "Systemic Quadrilateral"

	Individual Dimension	Relational Dimension
Descriptive Phenomenologica l Dimension	PROBLEM PERSONAL EXPERIENCE (NARRATION) level: individual phenomenological	INCONGRUENCY COMMUNICATIVE (COMMUNICATIONS) level: phenomenological relational
Dimensions of generators processes	CONFLICT INTRAPSYCHIC AL (PERSONA) level: individual generator	CONFLICT UNRESOLVED RELATIONAL (RELATIONSHIPS) level: relational generator

The left side highlights the Individual Dimensions of the problem and the right side the Relational. In addition, the upper section describes the visible Phenomenological Dimension while the lower section describes the unseen but "Generating" Dimension.

We have available therefore four descriptive levels:

- Individual Phenomenological (Narration of the problem)
- Individual Generators (Individual Operators)
- Relational Phenomenological (the Communicative method of the system)
- Relational Generators (the history and developments of the System)

The Systemic Approach, as we said at the start, reaches a full description of all the points in fields a), b) and c) mentioned above[1], in which an absolute circularity and INSEPARABILITY between the INTRAPSYCHICAL AND RELATIONSHIPS is defined.

As you may have already guessed, and we will delineate later, for the Systemic Approach to work in Therapeutic Tasks to Change Families, it must take place on all four levels.

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1   a) theory of mind and its interactions with the world; b) as it generates the experience of having a problem in such interactions; c) when such a problem becomes a symptom;

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Psychological work with families for Change in Therapy under the Systemic Approach

Now, we will discuss, within the limits of this paper, point d): what are the methods for solving and techniques for implementing this approach.
The SYSTEMIC APPROACH recursively undertakes: individual NARRATION and FAMILY GAMES. These are also the levels of problem resolution.

Four guidelines are involved in working with families:
1. the change can be triggered by actions that intervene at any of these levels
2. a change at one of the levels is inevitably reflected at the other levels, pushing them in turn, towards a change
3. interventions that act simultaneously at several levels are more likely to induce changes in the fastest way
4. a change cannot be considered complete until all these levels have been modified

For a systemic therapist, each individual therapy is also one of the family system therapies.
Change is designed in two stages:
Change 1: a reduction or containment of the problem
Change 2: a modification in reports from the Individual, and in the Relational Games within the Family System (Watzlawick, Weakland, & Fish, 1974).

At level 1 therefore, we use work tools that do not attempt to change the rules of relationships, but rather to implement a containment of the problem: drugs, hospitalisation, psychological support, etc., whilst at level 2, all the therapies that involve a level reflection are included.
The types of intervention used in systemic therapy refer to the circularity that exists between the levels which we considered earlier, and then cover all of the fields of interaction, from conversational-type work to role playing activities during the sessions, and those that need to be carried out at home (Mosconi et al., 1996).

Family systems have their own energy, which originates in the relationships that bind people together and make them interested in each other, which is why someone else's behaviour, as an influence in generating a problem, can also influence the search for solutions.

Hypothesizing, Circularity, Neutrality

The article "Hypothesizing, Circularity and Neutrality: three

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guidelines for the conductor of the session" (Palazzoli, Boscolo, Cecchin, & Prata, 1980) unambiguously defined how to construct a Systemic Hypothesis with the family regarding its functioning, basic therapeutic actions and established the structural characteristics:

1. To include all family members and provide a guess about *global relationship functioning*.
2. To describe the relationships.
3. Positively, and without apportioning blame, to make notes about the different behaviours, connecting them to each other to demonstrate reciprocity.
4. To include symptomatic behaviour, highlighting *positivity* to maintain the overall balance of the system.

Only in this way can a therapist's activities give meaning to relational patterns and serve in the sense of being informative. It is not, therefore, a banal history, but a history that is constructed according to specific systemic criteria.

Clinical example of this hypothesis and the construction of an intervention project

This clinical case was reported at a Supervisors meeting that I chaired at a Psychiatric Day Hospital. The team was made up of professionals who belonged to different specialisations, so it was also a great example of how a systemic hypothesis, built on a Quadrilateral, allows a range of approaches to be integrated together. The Supervisor's observations, which we will call "Axes" are connected and integrated into the Systemic Hypothesis. Based on these, the intervention plan was constructed.

G's PROBLEM AND HIS RELATIONSHIP WITH THE CENTRE

Giuseppe (hereinafter named as G.) was reported to the CSM by a family friend who was a Psychiatrist, who was concerned that, for several months, G., aged 23, has dropped out of University and his peer group, lived locked away in his room, was very dirty, only left his room for meals with his parents, washed his hands constantly, to the point of incurring serious bruising and would not accept any kind of help.
G. was invited to attend the DHT, which was described as a place where children could mix with their peers. After much uncertainty G. arrived on time on a Monday morning for the Psychotherapy group. G. was fascinated by the possibility of being listened to that the group gave him, and began to

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hang around every day, which indicated some redundancies in his behaviour. His speech appeared, at times, uncontrollable, and with a rigid adherence to certain ideas about people's duties, he manifested a visible difficulty with the psycho-motor and art therapy groups. G. refused to touch his companions or put his hands into the clay. When the bonds between G. and his teammates seemed to be more structured, and the coupling phase seemed consolidated, the team decided to hold some family sessions, to learn more about the system and to construct a full Systemic Hypothesis. This resulted in the following picture.

Figure 1

Systemic Hypothesis of G's family
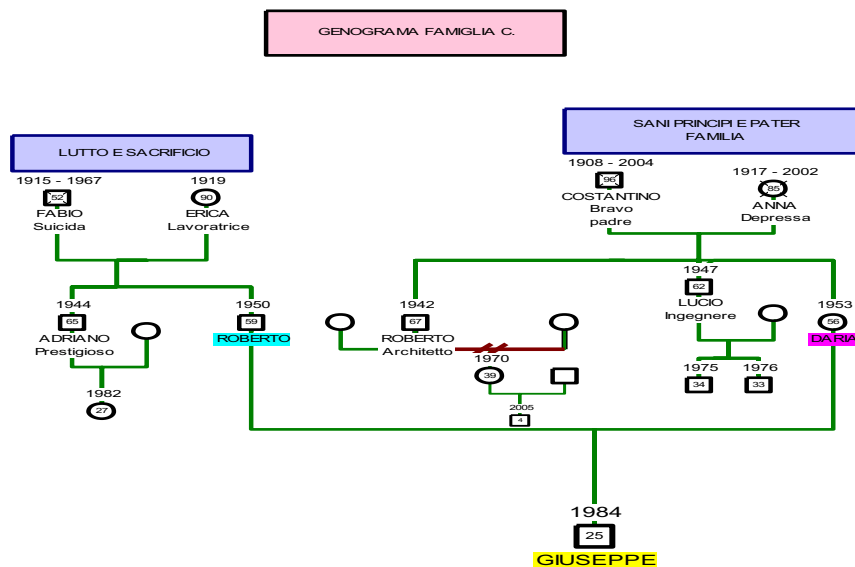
HISTORY OF THE FAMILY, ORIGINS OF G.'s FATHER

Roberto (R.) (1950) was born from the marriage between Mr. Fabio (F.) (1915-1967) and Mrs. Erica (E.) (1921), six years after their first child Adriano (A.) was born (1944).
The history of the R. family was tragically marked by the suicide of his father, who hanged himself at the age of 52 years old when R. was 17. Mr. F., a Social Security Inspector, and militant in the Communist Party, had

suffered disappointment in the field of work and politics. Mrs. E., a Science Teacher, reacted to her husband's suicide by dedicating her life to working to support their children and giving them the opportunity to continue with their studies. The eldest son (A.), graduated in Physics and moved to Milan. A. was described by R. as a successful man. R. graduated in medicine and aspired to a university career, but had to be content as a surgical assistant. R. pointed out that: "... *we must respond to grief and disappointments by sacrificing aspirations to parenting duties, like my mother did* " showing, that he too had embraced the myth of sacrifice in his own family of origin.

HISTORY OF THE FAMILY OF ORIGIN OF G's MOTHER

The father, Mr Constantine (C.) (1906-2004), was an engineer and had a very successful business that closed when he reached the age of 70, when he could no longer manage it. He was described as "an upright man", gruff and honest. His wife Mrs. Anna (A.) (1914-2002) was a housewife and was often ill. They had three children: Robert (Ro.) (1942) who graduated in architecture; Lucio (L.) (1947) who graduated in engineering, but did not want to work in his father's company, which is why it is closed; Daria (D.) (1953) the youngest and female, studied the humanities, incongruent with the family myth that women are fragile and totally dedicated to the maternal role. In the discussions, D. showed a lot had been invested in being the mother, and in this, she expressed having in fact, the myth of health principles and "pater familiae" which seemed to be a characteristic of her system.

HISTORY OF THE PARENTAL COUPLE

R. and D. met in Padua in 1974. Both were studying at the University, he – medicine, she – languages. The two married after about three years, ending their academic journey. Initially they moved to Bologna where R. found work as a researcher in the faculty of medicine. However, after about two and a half years he lost the job and the couple returned to Padua as guests of E., mother of R. After some time, she started working as a teacher and R. was hired as a surgical assistant in a hospital.
G. was born in 1984, 10 years after they first met. D. wanted to stop work to be a mother, but her husband did not agree, believing that every adult should be independent economically. Thus a marital conflict began. In 1995, after the marital infidelity of her husband, D. had a very bad depression that required a long hospitalisation. Thereafter her husband "allowed her" to work part-time. G., was then 11 years old. Since then, a

kind of family balance was restored up to the time G. reached 15, when his first difficulties began.

G's HISTORY AND HIS PROBLEM

G. was born in 1984, by a premature birth necessitating antibiotic therapy and intubation for about a month as an in-patient. The mother returned to work when G. was one year old. The mother remembers being hyper-protective at that time because her son was "fragile and tiny." At the age of six, a psychomotor intervention was suggested for G., which the parents refused, fearing this might label the child as "handicapped". Even at that age, G. was "a special child," not inclined towards games, manual activities or meeting peers (as the mother said "*he wasn't interested in going to the park to chat up the young ladies, playing football or being a goal keeper, stepping in dog's mess, he was just walking down the street on tiptoes for several years*"). At school he had good results and although he continued to have few friends, his parents were reassured. Towards the age of 15, however, there has been a worsening of his phobias and obsessive rituals: the doors had to be closed to protect G. from the neighbours staring at him, his parents were obliged to have dinner ready at the time their son wanted to eat, and had to eat whatever he saw fit, they had to give up red meat as a result of the cases of mad cow disease. The home-regime became increasingly more burdensome. Whenever the father tried, by furious discussions, to react, the mother just passively accepted. After finishing high school with honours, G. enrolled in the Faculty of Computer Sciences where, with difficulty, he finished his first year exams. He did not leave the house, and the obsessive rituals increased: it was impossible for him to use the internet as it was a harbinger of viruses and material to download illegally; no one could touch his father when he returned from work to avoid contamination with the bacteria he had come into contact with during surgeries; the soles of his shoes had to be washed as soon as he returned home; G. had to wash his hands every time he made contact with any object that was not part of his own room. G. gradually lost more and more contacts with the outside world while the obsessive rituals increased, right up to the day he was reported to CMS.

PROBLEM THE TEAM SHOULD BEAR UNDER SUPERVISION

At the time of the agreed supervision, teams agreed to ensure that G. could trust the group. They remained, however, puzzled that the symptomatic mode continued, especially at home, and also felt the need to

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understand their own emotional resonances. To this end, a decision was taken with the supervisor to reflect on all the data collected by the team, along with that gathered by CSM operators.

USING SYSTEMIC QUADRILATERALS TO STRUCTURE INFORMATION IN THE CASE OF G.

The Supervisor asked the team to connect the data that emerged at different levels, trying out analogies according to the known formula "and .....and" not "or.....or" and charting the observations on a Systemic Quadrilateral Polarity.
The result is the synthesis that we expand on below.

OBSERVATIONS ON INDIVIDUAL DIMENSIONS

The problem that G. was burdened with is described in DSM-IV as Obsessive Compulsive Disorder with Poor Insight Axis I and Axis II, such as Borderline Personality Disorder. On the Psychodynamic, Cognitive and Systemic Axes, it is interesting to note that he displayed a set of perfectly complementary observations. The observed rigidity of defence mechanisms when managing emotions and impulses, aggressive and sexual types, the strong tendency to sublimate the same, the rationalisation and projection on the outside world, lead G. to reinforce an idealisation of himself, which gives a weak cover for his relational insecurity. All these elements reinforce each other and support ritual behaviours where psychotic anxieties are managed by obsessive defences. They seem to hold up the ideal ego game, which imposes itself on others before collapsing, if challenged, giving way to depression and paranoia, and a quasi- psychotic closure. Cognitively, this reinforces basic self-help in relationships. By linking the Cognitive Axis and the System Axis, one can see how G.'s functioning corresponds to that observed by Ugazio (1998) who studied self-polarisation amongst struggling phobic and obsessive-compulsive patients. In fact G. oscillates between immobility and the subsequent irrationality of being bound to a bizarre reflective circuit, which is characteristic of those who have obsessive symptoms: one image of the self as good, sacrificial (and therefore deadly), and the other is a bad self, who is not sacrificial (and is therefore at risk of losing the love of significant others). All this agrees with what was detectable on the purely Systemic Axis. The definition of self in relationships contains, pragmatically, a paradox: G. with rationalisations etc. trying to define himself as "up", but the difficulty in managing emotions aroused by his attempt to make relationships symmetrical with

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each other, end up with him feeling "down" all the time. In addition, the solutions found by adopting the aforementioned defensive mode, end up being "solutions that reinforce the problem" because it does not change the source, the definition of self in the relationship. This seems to reinforce the subjective experience of constriction and responsibility, weakness and difficulty entering into intimate relationships with others, by the control and excessively checking emotions, observed in this type of disorder (Mosconi, & Gallo, 2011).

OBSERVATIONS ON RELATIONAL DIMENSIONS

Moving on to the relational dimension, we can observe mutual communicative inconsistencies that seem to correlate to the intra-psychic conflict. The paradoxical self-definition of G. and his parents who seem to respond in an equally paradoxical way.
To summarise information about the Relational Dimension, we suggest preparing a list of Questions for the Progressive Construction of a Hypothesis (DPCI):

A) Who were the father and mother in their own system, what ideas of self do they share, and what is their "prevailing relational pattern" (PRP)? (Mosconi, 2014)
R. - The Father: The family genogram and the comparison between different relational styles, allowed us to assume that R. seemed to have borrowed a relational style similar to his fathers, as idealistic hero, and as a loser, which was, probably, the closest. He remained curious about how the mother could bear this way of being shared by the husband, without some toll being borne. If this were the case, it could be that the heaviest burden in the family fell on R. rather than his brother A. who was, perhaps, closest to the mother. He lost his father at 17 when he committed suicide, and R. gave way to A., his older brother. This, if it had not done so before, allowed him to become the "prestigious son" (Palazzoli, Cyril, Selvini, & Sorrentino, 1988) with the support of the mum. This therefore, turned into *"a family with a hard life which we have to cope with,"* – a family in which the father, by committing suicide, abandoned his children, pushed his wife out to work and became a person from a mythical time who was distant from his family. R. continued with his script as the son of a lost father but, in doing this, made the part of the mother figure more admirable through the suicide of her husband. He, therefore, could not be taken away from his family with such an *"enormous need to be supported and valued, and difficulty bearing the conflicts"*.

<u>D. - The Mother</u>: D.'s family seemed to be dominated by the difference between mum and dad: industrial "gruff and upright" He, weak and submissive sick She. The family myth is: *"The Rossi family, sound principles"* where his father laid down his own rules about the family's livelihood and education. This probably subtended a marital conflict. None of the children seems to have sympathised, especially with the father, no one followed him into his profession, so much so that he had to close the factory. D. seems to have borrowed the way of being of her mother, to whom he was perhaps closest. If he hasn't, he has come "*prepared to be submissive and imprisoned* ".

B) What assumptions can be made about their "quid pro quo of coupling" and what implicit paradox could be hidden?

Their "quid pro quo" may be of the type: *Sustaining relationship "down – down" or "the life raft"* (Mosconi & Gallo, 2008). This characterises a relationship that develops between two people who are "losers in their own family" and find that in their family, they are "good, but unhappy" a common element that leads them to give each other safety and support. Sometimes, in such relationships, one of the two takes the lead over the other. An increase in marital problems often begins with the birth of a child. The couple is faced with the paradox: "how can I argue with those who are weak, like I am." On such occasion, in fact, one of the partners withdraws from the contract of solidarity between them, finds themselves having to deal with the child, and leaves the other devoid of support. This gives rise to conflicts that are often covert and unspoken that, given the relationship style of the partners and their "quid pro quo" "*down - down*"*, tends towards one choosing a symptom as a manifestation of the discomfort.

C) What are their major conflicts and when they are generated?

For R. and D., the birth of G. activated the conflict. R., as I said, tried affective compensation with D. which, because of his history, was available in the relationship with him, in the down position. It may be that the couple had, at first, found their balance, based on their experiences as students and flatmates, like two 'unhappy children' who supported each other. Parenthood, however, forced them to negotiate their own myths of belonging to what were, on the other hand, firm anchors; myths and antagonists meanings: "The *Rossi family, the ones with the high principles* " versus *"The family who have had to cope with a hard life."* D. gave birth to a sickly child, and devoted all her attention to the tiny one all week. Therefore, R. at the start, had to put up with the dependency and his wife's inability to support him when facing the world. D. was to return - albeit briefly- to the teaching job she had left, in '95. But '95 was also the year in which R., after a strenuous renunciation of his university career, could not

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pass his exams in hospital, and was also the year of R.'s marital infidelity, of D.'s nervous breakdown and her request to go part-time. Perhaps R., weighed down by what was happening, could no longer tolerate the dependency of his wife and found consolation in an extramarital affair. D. managed to regain her husband's attention with her bouts of depression. However, this forced her to loosen the over-protective relationship with her son. At the same time G. was 11 years old and entering adolescence. In this way, the birth and growth of G. became "the straw that broke the camel's back"; already full of divergent ideas caused by economic difficulties, failures at work, R.'s return home, these were divergent ideas about how to be the father and mother of this family.

D) What place and functions has the patient taken in their conflicts and how does their problem interact circularly with them?
With his difficulties, G. gradually assumed a central position in the parental conflict. The father and the mother defined their relationship with G. in a contradictory way: the mother expected G. to stay at her side, and it *was as if she had told him "You are more important to me than your father, you would never have existed if it hadn't been for me"; the father instead telling him*: *"It is time you started exploring the world outside, like I did as a young man, despite my father's suicide"*. It is as if both of G.'s parents were saying through this son: D.:*"I want a better companion than my father to lean on, so I can be a mother and wife, like my own mother and raise our child. I want a father who is more nurturing towards our son"*. And, to this, R. answers: *"I wanted an independent partner like my mother who has always worked and who knew how to get along with their children, even after my father's suicide, and not one who is dependent on me and spoils our son"*. What it is described as a gift by one appears to be defined as a defect by the other. In addition, they also seem to ask their child to do things that are inappropriate for his age, which give him an image of immaturity and ineptness. G. also seems to receive the paradoxical message suggested by Sluzki and Veròn (1971) *"Be independent, because, of course, you are incapable of being so"*. Strength is also the semantic for well / ill, good / bad in this family. In this family there appears to be an acceptance of a "subtractive" concept of goodness, in which the good ones are those who renounce their own desires and interests, those who sacrifice themselves (Ugazio, 1998). G. has long been experiencing a symbiotic bond exclusively with the mother. In the period between 11 to 15 years however, from '95 to '99, he found himself with a more distant mother, because she was depressed and bustling to win back her husband. In these years, in fact, the pair attempted a rapprochement. G., feeling excluded, tried to be independent without, however, really gaining the ability. One can also

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speculate that G. as a teenager, had viewed vital issues such as sexuality, self-affirmation, and involvement with people or things that were unfamiliar, as arousing feelings of guilt and disgust, in his interactions with the semantic structure of his household, where the polarity of purity and innocence (maternal instance) had not found a suitable compromise with that of self-abnegation, and renouncing instincts (paternal instance). Thus, to resolve the conflicting feelings that he has found in himself, G. begins to accentuate ritualised and control behaviours. But these are, as mentioned, solutions that strengthen the problem, and he encounters symptomatic escalation. The mother was again involved in a very close bond with the child and the father, who was trying to take his place beside his wife, and was kept very distant from the "rules" of G. R., at this point, could be welcomed back, and the family might consider how to manage the child's symptoms.

The language and the semantics of the symptoms seem to be perfectly coordinated with those of the system: G. is afraid of being contaminated, that is, afraid of coming into contact with viruses in the house, especially those his father "collects" when he exercises his profession as a surgeon, that could cause infections. In this way, G. becomes central. The problem for him is to curb his psychotic anxieties and, for the system, to staunch the anguish of their own confrontational break-up.

OBJECTIVES OF THE THERAPEUTIC COURSE

The supervisor suggests a reflection about how to construct the best "Strategic Coordination for Interventions" (Mosconi, 2010). It is this, and its subsequent use, that forms the Systemic Quadrilateral. This concept underlines the need for interventions proposed by a team to be thought of as a system of patterns of communication, organised strategically at different levels to affect the nodal points that connect the individual problem displayed with the relationships that characterise the system.
General considerations:
1. The DHT program is well-organised and covers all polarities.
2. More attention should be given, however, to maintain a connection between professionals working on individual aspects, and those who work on the relational aspects, so the ways that one can encourage the other are highlighted.
3. G. For the underlying message that will frame the entire intervention project will be: "You're working hard to be tiny, in an attempt to give meaning to the lives of your parents. To protect them, but keeping

everything under control, what has it cost you? How many times do you still want to take your life? "

<u>Considerations on an individual dimension (levels A and B):</u>

1. It is important that experiences at the Day Hospital allow G. to integrate an idea of reality and, in relationships with others, that are less demanding on him and divide him less between "sound principles" and "a hard life".

2. It also seems important not to be fascinated or annoyed by the childish aspects that G. proposes. So the team must, on the one hand, be less warm and motherly, and should urge G. to experiment in the outside world, and on the other hand, return a positive image of any failures, in order to encourage him to re-acquire a positive self-image.

3. It will be important to take into account that G. is more skilled with words, and therefore in verbal activities, and less so with the body and emotions. This should be used as a resource to build on. Bodily and projective activities (manual work, art therapy, psychomotor tasks) are certainly the most important in order of change and acquire new skills. There is a need, therefore, to give him the time to access it with patience. On these issues, the group's encouragement can be very important.

<u>Considerations on relational dimensions:</u>

1. On the level of " communicative inconsistency "it will be important to confront G. with the paradox that, the more he streamlines and hides emotions for fear of failure or sanctions, the less he solves his problem. This restructuring work must be the focus they point towards in both bodily and projective activities in the minutes of group therapy sessions.

2. In order to facilitate this delicate transition or redefinition, there is a need to involve the parents in a timely manner. It is absolutely essential that they understand the therapeutic project, its premises and its objectives. They must take into consideration that their divergent ways of communicating with their child is not beneficial to him. From these considerations, however, it is clear the team has to be well programmed for such meetings, and they can only take place after G. has lowered his defences and established a good relationship with the group.

3. In terms of "relationship conflict," this will also allow one to touch on the theme of the unity of couples. This will be the forum in which, probably, one may also have to address possible conflicts related to G's future life choices.

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4. It is important that, throughout this process, the team focuses on splitting the tasks and very clearly defines who, in the home, will deal with the activities of therapeutic work with individuals, and who will deal with activities on the system. In times of struggle for change, this will prevent the system breaking up, and "familiarise" the team with their conflicts. Obviously, operators involved will exchange information and hold these routes together. Operators involved at an individual level may, if necessary, intervene in family sessions.

5. The Supervisor should suggest that ideally: a) one or two meetings are convened so assumptions can be made, and the foundations for the program can be laid, b) starting with the work on individuals would also be useful to improve the verbalisation and meta-communications abilities of the patients, c) there is a resumption of family therapy meetings to proceed with a co-evolution approach, with individual work being careful to keep the two pathways connected.

6. The techniques used by the parents will firstly be psychoeducational, in the time the patient is working on their relational modes, and then Systemic (work dedicated to the history and relationships) when the two pathways are running in parallel.

7. In the Strategic Coordination of the Interventions, it is important that the Team Meeting maintains the same direction as the overall pathway.

8 Parameters that serve as change indicators in Systemic Therapy

Any hypothesis and any intervention method must have indicators that can be used to identify the effectiveness of the method used. The Systemic Approach has debated long and hard about this, and no final agreement has yet been established. Our choice is to document the co-evolution of individual and system chances using 8 parameters that are consistent with the polarity of the Quadrilateral.

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Table 2

8 Parameters as Change Indicators

Indicators of Change in Systemic Therapy	Individuals	Family members
1. The symptom and/or problem (Phenomenological Dimension/Individual and Relational descriptors)	Regression of symptoms and/or problems (DSM diagnosis use of therapies, the patient's narrative, tests)	Recognition of regression of the problem and behaviours associated with the system. Regression of dysfunctional patterns of gaming the system (Narration of the system components, tests)
2. Other symptoms and/or problems (Dimensions of Process Generators, Individual and Relational)	Non emergence of other problems (DSM diagnosis use of therapies, the patient's narrative, tests)	Non emergence of other patients in the system (Narration of the system components, tests)
3. Biological life cycle (Description of Phenomenological Dimensions and Individual and Relational Process Generators)	Restarting the machinery for their life choices (narratives, VGF scale)	Restarting the machinery for the life choices of the system (narratives, VGF scale)
4. Idea of self-, and relationships with others life cycle (Description of Phenomenological Dimensions and Individual and Relational Process Generators)	Change the idea of themselves and their own relationships with the family and with the world (restructuring the ideas of self- and relationships with others) (narratives, tests)	Changing ideas about the identified patient and the family (Narration of the system components, tests)

The choice was that of alternating "hard" and "flexible" parameters, in addition to which, it was decided to use the same 4 parameters for the family and the system in order to simplify the assessment of co-evolution. A discussion follows, even if only briefly.

1. **The symptom and/or problems**. This parameter is an indicator for Change 1 and therefore involves the Individual and Relational Descriptive Phenomenological Dimension. The individual and system NARRATIVES no longer include accounts about suffering, etc. This can be evaluated using the DSM or rating scales and/or tests, both individual and systemic.

2. **Other symptoms and/or problems**. This parameter implies a Change

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2. The fact that no other problems have emerged, indicates that the structure of the patient has been changed, along with that of the system. This change involves the Dimensions of Individual and Relational Processes Generators.

3. **Life cycle**. The concept of a system's Life Cycle is widely documented in the literature (Walsh, 1995). The constitutent parts of the Life Cycle are the lifestyle choices of the system's components. When the NARRATIVE includes new life choices, it is a sign that a change has also occurred at the other poles of the Quadrilateral. It can also be assessed using scales like the VGF of DSM, involving the Phenomenological Dimension Description and Individual and Relational Process Generators, and involves a Change 2.

4. **Idea of self- and relationships with others**. The idea of self and relationship with others is closely related to the ability to define yourself within a relationship (Liotti, 1994; Mosconi, 2014). This parameter is detectable in both individual and system NARRATIVES, and can be displayed with the help of rating scales or tests. It is particularly important when assessing Change 2, and covers both the Phenomenological Dimension description as well as Individual and Relational Process Generators.

Conclusions

There is still a lot to discuss because the problems that arise in psychological work with families are complex. We hope with this work to have shown at least the essentials in an effective way.

Notes

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