Working systemically in a diagnostic field –
Preferred understandings in working with children, youngsters and families in not preferred situations.

Draft

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Summary:

By overlooking the issue of power and control we as systemic people have played a part in marginalizing ourselves as influential professionals. A powerful scenario has been established filled with assessments, diagnoses and objectified descriptions. On the background of critical social-constructionist theory this article will argue for an obligation to take a position in this scenario on behalf of and together with our clients. We are asking for further discussion about the ideas of preferred knowledge and preferred values in the landscape of families, professionals and diagnostic descriptions.

The diagnostic trend

Traditionally, understanding of children, youngsters and even families very often has taken form of diagnostic descriptions, and during the last 2 decades this tradition has for many reasons become even stronger in most western countries. This development is to be understood in a context of the larger societal context of politics as well as economics. E.g. in the US it is well known, that the concept of "managed care" implicates, that mainly clients with a diagnosis can be referred to therapy. And in many western societies it is a fact, that diagnoses are a key to resources, support, special placements and such. This has brought a strong craving for diagnoses and a pressure on professionals for giving these diagnoses.

The diagnostic ideas have been presented as neutral, only phenomenological based descriptions, as a kind of an objective description of reality. They have digital numbers to give it an up-to-date status, like the American DSM-III or -IV and in Europe: ICD-10 (1994). Diagnoses are based on symptom descriptions and on a

deficit or disorder model. E.g. the term “deficit” or “disorder” appears in many formal descriptions of diagnostic conditions.

The diagnoses are presented as neutral, but they are in no way neutral and innocent in the way that they primarily are describing and by that prescribing the problematic appearance and situation that is bringing people to seek help. They appear in their formulations to be global, objectified problem-saturated and pathologically based descriptions, and in this way become prominent parts of the picture of the social and clinical field today.

Different terminologies invites to different ways of acting, claims Gergen (1997): although that the psychological language based on deficits has advantages e.g. in terms of making problems more common and well known it sure has the effect of cultural casualties. The existence of the psychological deficit-language creates a tool for evaluation of individuals, and problems are being handled in professional’s arenas separated from their natural contexts.

The objectified focus on pathology has certainly contributed to an increasing number of children and youngsters been segregated to positions outside of their normal contexts in families, schools, day care institutions etc and into positions, they haven’t chosen themselves. Some are even placed outside home just because there’s no suitable school setting for them. The diagnostic terms are often supporting or even becoming the background for the radical changes in children’s, youngsters and families life situations. It is as diagnosis have a tendency to determine what outcomes in terms of placement, although e.g. Gergen in 1982 (p. 161) already stated that developmental trajectories over the lifespan are highly variable, a virtual infinity of developmental forms seems possible, and which particular form emerges may depend on a confluence of particulars.

Another prominent feature should be mentioned in this connection. In many institutions assessments and the following diagnoses leads to suggestions of placements, attitudes and techniques – meaning that other professionals than the ones giving the diagnosis should carry that out. This implicates an increasing tendency for separating the power of definition and describing from caring, learning and therapeutic arenas.

The number of children placed in special educational settings, in foster families and special institutions and special-educational settings has been growing for many years (see for example Christensen and Ottosen (2002) and www.ARF.dk), so much that people in local and also governmental administrations are worried too. The effects of this way of working has been doubtful, since the efforts themselves often have left

children, youngsters and families labelled and with the same or consequential problems (Börjeson and Håkansson (998), Egelund og Sundell (2001), Christensen and Ottosen (2002).

We as professionals are often brought into this field filled with doubts, distress, pain and risks. It is essential to consider how to manage this invitation to a very central position. We are often asked to take the position of the expert, who can examine the child and describe the problem, and often there recently is a call for defining the problem *inside or within* the child: That's the assumption idea of ICD-10. This is what's called diagnostics.

Our frame of reference and our preferred understanding in the field have a great impact on our way of acting. Working in this field thus holds in it a certain obligation and constantly challenges our understandings of problems and ways to go on. Experts are people who know. The crucial question is: When we are placed in the role of experts, how do we know, what do we know, and: what is the frame of reference for our knowledge? We have to be aware of and to consider how to use our definitional power, our power of knowledge.

Power and knowledge

The issue of power has been an important issue in the history of family therapy and systemic thinking. For many years there has been a huge ambivalence towards the issue of power. Lynn Hoffmann (1985) wrote an important article called: "Beyond power and control". The article was an attempt to create a 2. order cybernetic way of thinking and behaving in the therapeutic room avoiding labelling and diagnostic thinking. Co-creating got to be the central way of thinking. And in the streams of this the social constructionist idea of "not knowing" came to dominate the systemic field for many years.

The problem seemed to be, that by emphasising this idea of not-knowing the area of power and control was left to others, i.e. experts working traditionally and pathology oriented. Outside the therapeutic room the issues of power and control were still there: The power of the social system, the power of the medical industries, and the power of the way of thinking in the dominant culture etc. During the same years the so-called neutral diagnostic systems (DSM and ICD) were introduced and placed in central positions in the field.

People are living in and with these powerful "institutions" no matter how much the systemic trends wanted to be beyond power and control. And a lot of professionals and families as well are even looking at these issues as ways of getting secure ways

of getting on with life – also ways of getting security about handling and intervening in cases with marginalized children and adolescents. This societal context is important to remember when systemic professionals are working with people in socially not preferred positions

Many other kinds of professionals in the field certainly feel the freedom to know and describe. Young people breaking the law and not expressing their regrets are called sociopath or psychopaths. Other youngsters who are very confused about how to go on with their lives and feel very ambivalent about central issues in their lives are named borderlines etc. These definitions will often have enormous influence on their future lives.

Dominant authors in the systemic field have been questioning these issues of power and control. Michael White and David Epston (1990) were the first ones to introduce the French philosopher Michel Foucault (1980) to the field with the ideas of the intimate relationship between power and control. The Just Therapy Team from New Zealand (Waldegrave, 1996, 1997) has questioned the social constructionist ideas and the idea of not-knowing and asked for the necessity to have preferred meanings, preferred values and preferred positions to the benefit of children, youngsters and families. These issues will be further discussed later in this article.

We will, as introduced in the beginning of the article, from a critical social constructionist position try to give a picture of the central societal issues represented into this domain of diagnostic thinking – and upon that establish a frame for our obligations in the field.

The context of therapy and consultation.

The societal context of our work is utterly important to be understood, because it has lots of implications for the themes in work. So what are the main characteristics of the society today in relation to the domain of children, youngsters and families?

A brief historical view tells us, that the context of socialisation of children is changing. Earlier the responsibility of bringing up children was placed primarily in the family. Bringing up children was a private concern. Children were attending school, playing with other kids and so on, but the question of responsibility was never raised. After 2. World war industries were expanding, more capacity for labour was needed, and women came to work outside the family much more than before. That created a boom of institutions for small and older children. Children were now raised in the family and in institutions as well.

The Swedish Lars Dencik has named this phenomena **double socialisation** (1999). This double socialisation might appear different in different countries: In the Nordic countries children are to a very wide extent brought up in togetherness in families and institutions, in other countries private network may contribute with a greater part of this double socialisation.

This phenomena double socialisation has had a great impact. It certainly has changed the context for children's growing up. Some implications of the double socialisation is, that children should be able to function in many different arenas – and that these arenas were to function and work together (Jørgensen, 1999). Some are talking about new characters for children, children who are to act in different worlds not always connected or working together.
Many children manage very well the challenge of growing up in modern societies. Hence, problems arise sometimes when things don't turn out right. In the public arena, e.g. the media, there frequently is an on-going discussion about responsibility when children or youngsters are showing huge problems. All together double socialisation has been part of bringing a feeling of risk and a huge uncertainty into the field of bringing up children.

Today a lot of people, families and professionals, want to do their very best when being together with children and youngsters. They are striving almost to perfection – but they are only a part of something bigger, they are only one part of the double socialisation. This strive towards perfection has many faces for parents as well as for teachers and people working in all kinds of institutions: many books, radio and TV programs about children and how to raise them have come out. Many debates about how to teach children individually in the classroom is carried out too. This thrive for perfection is closely connected to the international economical competition going on and according to that a wish to help children to be successful in this fast changing society.

The problem is, that it's indeed difficult to perfect something that is only **one** part of this double socialisation field. As Bateson (1972) expresses it: The wholeness is more than the total of the parts. And it's especially difficult to handle if you don't realize that you're **only** one part of this bigger issue. There is a great risk of self-blame, blaming of others - and the feeling of powerlessness is close by, too. Worry and dilemmas around responsibility are issues as well.

Uncertainty experienced in the frame of a strive towards perfection brings up many different important questions. How to understand if the child doesn't do well? Who is responsible, when things don't turn out successfully? Who should define what the problem should be called and to define whose problem it is? These questions are

being asked and it is crucial to find the best answers, the answers most helpful to children, parents and professionals.

In this setting we as professionals are often brought into the field. By referrals we are asked to bring about the good answers reducing the uncertainty – hopefully creating a solid way to go forward. This craving for expertise is at the time being bigger than ever, and the underlying message is often: examine the child or the youngster – and tell us what to do. Many experts have grasped this task of creating certainty by describing and then defining what the problem is like –often as something inside the child, inside the youngster: a diagnosis.
The problem is, that these individually based descriptions are given apart from an understanding of the child or the youngster in a wider context – and the dominant part of the description is based on pathology.

In parenthesis, there's still a lot of professional work being done focusing on parents´ shortcomings and inabilities. Sometimes focusing on the individual and pathological issues of the child or the youngster themselves are seen as a kind of a counterbalance to blaming the parents.

Focusing on pathology, focusing on family disabilities and/or focusing on the difficulties in school teaching the children in a differentiated manner has all among other things the imbedded risk of not paying enough attention to the mentioned theme of double socialisation and thereby loosing the complexity of the whole contextual situation.

All this brings a blind loop created and maintained by the strong faith in the so-called neutral and objectified description based on individual pathology. By these kinds of descriptions relational, contextual and resource focused issues are in a great risk of being marginalized – also in the hope of avoiding blame of the parents. The blind loop is shown in fig. 1 and can be explained in this way: People are looking for certainty and at the same time thriving for perfection. From experts they get a lot of descriptions focusing on the pathological signs in the landscape of the individual child. The descriptions open for economical resources from local or governmental authorities. These economical resources create opportunities for support and that creates a way to go on, but a way based on pathology descriptions. These descriptions are creating identity and at the same time threatening the healthy and self-ruling identity: people looking for certainty basically doesn't get what they are looking for.

Children and youngsters are in a risk of being described in diagnostic and pathology based terms instead of being understood and helped to find a way to go on with their lives. Parents and professionals are getting some kind of economical resources but

not highlighting their own possibilities, their own expertise. In this way the diagnostic descriptions, instead of telling a so-called objective truth as they intend, give a very limited and indeed limiting picture of the child or the youngster, the context and the resources imbedded. The hope of creating security, which was the basis for the blind loop, has in a limited way been met, but in another more basic way indeed not. Because of the relative security created the cravings for these reductionistic descriptions, i.e. for diagnoses, are even growing among parents as well as professionals.

This brings a challenge for systemic thinking and practitioners.

Our obligations to be part of the field

We as systemic practioners do have the chance to help creating another kind of security based on people's own resources. We feel obliged to create another scenario based on connecting to the strength shadowed by the problems. This article is going to present another (positive) kind of blind loop (fig. 2) based on a connection between an understanding of the child, family and the enlarged context to resources imbedded but not yet out in the open and of course also connecting to the important relationships in people's lives. It describes, how the insecurity that brings people to us as therapists or consultants is met by a wish to unfold the resources and helping them finding a way further on based on their experiences and our efforts to bring them back to a trust on own resources through dialogue (Hertz and Nielsen, 1999). This does create another kind of identity based on abilities (more than deficits), which opens up a stronger feeling of security – and maybe more dialogues about getting the strength more and more out from the shadows.

Our obligation as professionals is to focus on contexts, relationships and resources in order to help and develop the way people, whom we are working with, are dealing with problems and life situations. This obligation leads us to co-creating ideas and to use our power of knowledge to define problems and solutions in another kind of language. A language based on different ways of understandings, different ways of talking than the one based on pathology. This obligation to help creating another kind of loop is indeed putting special demands on us as therapists and consultants.

Acknowledging what we choose to name our power of knowledge also means, that we have to deal with the notion of marginalisation, because marginalisation is closely connected to this issue of power (McAdam, Lang, 2000, 2002). We have to be aware of **our** ways of dealing with the power of definitions and descriptions. We certainly want to listen to the voices often not heard, e.g. the voices of the children, the voices of parent already victims of stigmatisation or the voices of professionals feeling

blamed and insecure. We certainly also want to listen to the voices of wishes, hopes and strengths.

The dominant ways of working are claiming to be neutral, objective and scientific ways of treating people seeking help. As we have stated earlier in this article this is just part of staying dominate to claim that. Relational and contextual ways of understanding are not the least based on privileged ideas – but are instead emphasising the idea of getting "local" (instead of expert) knowledge and understanding out in the open.

Post-modernistic ideas are claiming, that realities can be described and understood in many ways – a so-called multiversity approach. A critical approach to the social constructionist theory is challenging this way of understanding: if a certain issue could be understood in different ways, which idea or description do we then prefer? This question is crucial when we are talking about describing and understanding individuals.

We use the concept of differently knowing instead of not-knowing to declare openly that we have, what Just Therapy Group calls, preferred knowledge:

- Problems and worries are creating shadows for resources. It's essential to make contexts for listening to hidden resources, central relational themes, hopes and dreams, that our clients also possess.
- The whole is more than the total of the different parts, which imply, that we have to be aware of the contexts, where problems arise, and the contexts, which creates the best conditions for change.
- Individual identity is not something within the person or any other unit but more a social construction mix (Hoffmann, 1992)
- Emphasis on salutogenesis (focusing on the healthy parts, Antonovsky, 1987, 1993, Gjærum et.al., 1998) makes other kinds of changes than pathogenesis.
- Research on resilience places a very strong emphasis on the important issue of coherence and relationships (Antonovsky (1987, 1993), Rutter (1995, 1997), Werner, 1987). So does research on recovery from schizophrenia (Topor, 19).
- Certainty comes from tolerance of uncertainty (Seikkula, 2000) – and from addressing the important issues and the incongruence / the matters not matching each other.

So, being in this societal influenced field enmeshed by power issues it is important to be aware of the preferred knowledge.

When diagnoses in traditional thinking are based on pathology alternative ways of thinking has to take a stand: what frame of reference do we prefer in order to meet this case ? How can we develop descriptions and understandings with solutions included or imbedded ?

So how can we combine our preferred knowledge with the implications of the society context just described ?

The following implications could also be called preferred values :

- We have to be aware of, how definitions are made, definitions participating in liberating and improving processes
- We have to describe individuals, but not in an individualistic manner
- We have to focus on symptoms as guidelines for our actions, staying with the symptom, but not limiting our thoughts and actions
- We have to connect descriptions of the child, relations and contextual matters to the area of resource-oriented interventions
- We have to focus on embedded and embodied hopes, needs and resources so that understandings of the individual will be connected to interventions and the larger contexts
- We have to understand problems in their wider contexts – and involve important relationships in order to understand connections, create witnesses to change and to give relevant persons a common experience how to go on..
- We have to take care of the economic aspects
- We have to address the issues of hope, dreams and safety
- We must be aware not to blame anyone

The implications of these ideas into the field

In the area characterized by double socialisation we have to be aware of the central dialogues with children and youngsters, but also with parents as well as professionals. We are working according to our moral and political responsibility, our ethics to be helpful to everybody involved. We especially as experts have to be very aware of the large and lifelong consequences that our descriptions possibly have – in positive or in negative terms. When we are making examinations, evaluations and examinations for the social system or if the social system asks for our judgements we always invite the ones to be described to stay – together with us – in the process of describing. We do openly tell what our thinking and judgements are, we do it early and on the row – but at the same time we invite people to show us if we are wrong. We don't just send them a copy. We are doing it in this way because we know that our descriptions probably would be very crucial for them and their future possibilities.

Worry and bad conscience make things seem heavy – and make change difficult. We as experts have to address this. We say like Tom Andersen (1994), that the arisen of problems could be understood as the way forward not yet found. We as experts have the obligation to help everybody find this way. To help making people certain about the way forward is the best way to fight worries. People around then know how to take care – and that's the best way to make children and youngsters feel safe.

Working with children of e.g. DAMP/ADHD, Aspergers syndrome etc. is kind of same stuff. These diagnoses only emphasize problem areas. Children with such diagnoses are much more than these problem areas – but paradoxically the resources of the children are about to disappear by this focusing on problems. So diagnoses are heavy stuff. We need to look for exceptions, making thin descriptions thicker and by that creating a ground for different identities away from pathology. But we also have to stay with the tolerance of uncertainty (Seikkula, 2000) trying to understand problems as much more than neurological problems. Neurology is part of life, but by giving it first priority it tends to disappear out of the context it's part of (Hertz 2003).

It's not either – or, it's both – and. And that certainly brings another important example of the diagnostic field, the field of borderline conditions, described as the field, where everything is black or white, close or apart, in or out. These borderline labels easily place the burden on the shoulders of the youngster and at the same time only give very little hope. Identity as borderline – that's certainly not kind of a resourceful story.
Alternative stories and ways to deal with life need to be created on the basis of the above mentioned values so that an understanding becomes much more than - and much different from – a digital code but describes the context, different understandings and thus opens the development of resource-oriented stories and actions (Magnussen, 1998).

Knowing and acting differently would be to look for and try to understand the dilemmas of the youngster and try to understand what kinds of stories or ideas that limits their options. Differently would be to see them as active people trying to find their way. We do need to see the feelings, the ideas and the actions of the youngster in a wider sense and to involve important persons around – of course giving high priority to the voice of the youngster in the very context of the other voices involved. We do have to create with and around the youngster a spirit of collaboration, a feeling of making a difference together. Both-and means irreverently going into the double ness – and knowing that it helps getting out of uncertainty, ambiguity and incongruence and finding different ways of moving forward instead.

Connecting to other professionals too

In this article we have concentrated on the issue of participating in the creation of good and hopeful stories for the clients we meet with. But it's evenly important – in the field of double socialisation – to help the professionals struggling with the issue of trying to help children, youngsters and families finding a way to go on. We usually involve these often very responsibly feeling persons in schools, institutions and the social welfare system in the ongoing process when it's convenient.

Different kinds of research (Egelund and Sundell, 2001, Hertz 1993) have shown, that changes are difficult to achieve, if the important persons involved don't understand and appreciate the central ideas of the ongoing process. We then involve the persons in order to get the best possibilities to get an idea of what kind of presented problems people want us to get in touch with and to get an impression of important relationships surrounding the child or the youngster.
At that point we also get a close flavour of the central ideas in the field of, how the presented problem is understood among the involved people. These ways of understanding differ often a lot from our ways of looking at these issues, but the wishes and the dreams for change are often the same – and the ones to connect to. We are in these dialogues especially occupied with creating a common ground for everybody involved filled with the ideas of hope and good expectations.

We are in these areas occupied with the ideas of witnessing. When people are close, they often feel more responsible and more caring in carrying the ideas created in the therapeutic setting out in daily life. Witnessing means to get an impression of and a better understanding of the good reasons for the problem presented, but not the least of the resources in play. Participating in these dialogues give these other important professionals a feeling of connectedness and a feeling of how to be mostly helpful, because that's what comes out of good dialogues with professionals together with the children, youngsters and families involved. In cases where diagnosis already have been made the above means, that the diagnoses are transformed, re-authored and redefined in resource-oriented ways.

In therapeutic and consulting conversations resources can hopefully be more obvious. Connecting to resourceful ways of looking at the same matters in schools, institutions and social welfare systems make change more appropriate. Economical resources could also for a period of time be effective to ease the process. This economical help would only be achievable when the involved professionals are able to connect to the ideas behind.

Further discussions

In a field strongly influenced by the so called neutral objectified global descriptions focusing on individual pathology it is crucial to find a way not marginalizing oneself to a limited room in the field. Many systemic people have seen diagnoses as an area outside of their professional competence – instead of irreverently questioning these items the same way as other important issues in people's lives.

We are thankful to Michael White, David Epston and their fellows introducing the French philosopher Michel Foucault to the field. Foucault is occupied with the close connection between power and global knowledge, the last often mistaken for truth. This kind of global knowledge marginalizes alternative or local knowledge. Because of that dominating power need to be met with qualification of another kind of knowledge, which must be highlighted in other domains. What is interesting in connection to Foucault, too, is, that he claims, that people themselves in the specific historical and cultural context are living the dominating ideas and by that they are addicted to these ideas and inclined to marginalize themselves other kinds of stories.

According to these issues White (19) are talking against all kinds of expertise, wanting to promote eagerly the marginalized stories, people have. Deconstructing the ideas from the dominant culture brings the possibility of constructing new ideas. The idea of an individual not to be described but to be seen, understood and met as an individual being with influence on his or her own life is – as we see it – a crucial one in working with children, adolescents and families.

In the endeavour to meet these above mentioned dominating ideas with our systemic power we are influenced by and occupied with the idea of the differently knowing position instead of the not-knowing position. We want to put some words to this underlying discussion :

A post-modernistic frame of reference is telling us, that reality can be described and understood in many ways – a so-called multiverse approach. This has given life to the so-called social constructionist frame, a theoretical approach claiming, that living and understanding of life is created through language and social constructed interactions (Gergen, 1997). A critical approach to the social con-structionist theory is challenging this way of understanding : if a certain issue could be understood in different ways, which idea or description do we then prefer ? The idea of a multiverse understanding is met by the important question : which way of understanding is to be preferred (by people themselves and supported by us) in order to be useful in helping people to find their own resources and get a better life ?

In continuation of that we are – as mentioned above – occupied with the ideas of preferred knowledge, preferred positions and preferred values. We use these concepts inspired by Just Therapy Group from New Zealand (Waldegrave, 1997), the group claiming the so called social constructionist ideas to be culture imperialistic, because these ideas seem value-less in a society filled with assumptions deriving from people or theories in powerful positions.

According to these issues we are also occupied with the ideas deriving from research in resilience. These research results come out of very different domains. Rutter (1997) has specified ideas very relevant to the therapeutic field stressing relationships and also personal issues. Antonovsky (1987, 1993) created the concept of Sense of Coherence, which stresses the importances of people's own contribution to finding a way to go on. Topor (1999) has – in his research on recovery from schizophrenia – found out, that what's called spontaneous recovery is not spontaneous at all but based on very specific things that people have been participating in.

These research results stresses the importance of relying on, what Foucault calls the local knowledge and the power of this kind of marginalized knowledge. We have to take care not being the ones fighting this global kind of knowledge on behalf of our clients, but to create the possibility to get people's own ideas of their way out in the open.

Final remarks

This is certainly an invitation to – not only staying on the margins working as family therapists – but moving to the very centre of this field, where the questions must be raised : what kind of thinking should be the dominant one ? which stories should be told about the child or the family ? which not-yet told stories should be promoted in the larger context ?
This is an invitation to be more influential working with the power of identity-shaping definitions. As we see it, we have to stay there on behalf of the clients and our working relations to them.

"Never ever should a story be told as if it were the only one" (Berger, in Roy (1999). Diagnoses are only one way to tell a story. And our hope is, that our preferred knowledge can help create more useful descriptions by looking for other stories, other ways of understanding, other ways of handling the double ness and dilemmas of life.

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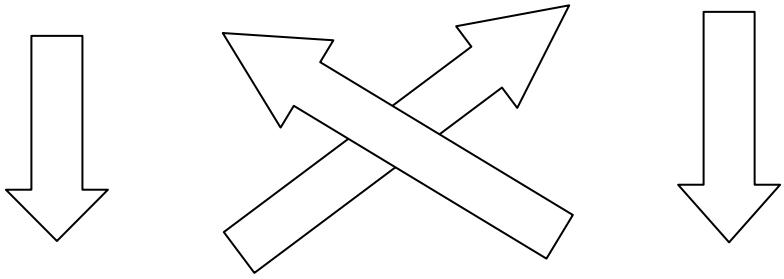
Fig. 1 : the negative blind loop

Looking for certainty
and at the same time
thriving for perfection

creates a way
to go on



Descriptions
based on
pathology

creating and
at the same time
threatening
identity

Opens for economical
resources and opportunities
for support Åbner for økonomiske
ressourcer

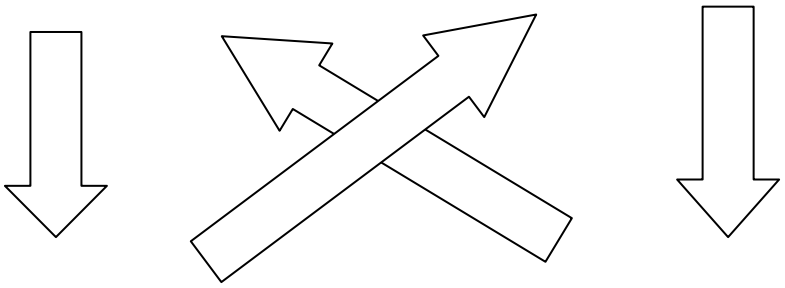
Headline :

A strong faith in the socalled neutral and objectified description

Fig 2 : the positive loop

Looking for certainty
and at the same time
thriving for perfection

a way to go on
based on a trust in
common efforts



A wish to unfold the
resources imbedded
through dialogue

knowledge about
what to do based on
these efforts

Headline :

Faith in the strength of good dialogues with the people involved conducted by a consultant