Chapter 11
An Integrative Approach to Systemic Therapy

Alan Carr

11.1 Integrative Systemic Three-Column Framework

The variety of traditions, schools and models of systemic therapy may be classified in terms of their central focus of therapeutic concern, and in particular with respect to their emphasis on

1. Repetitive problem-maintaining behaviour patterns (and associated feelings);
2. Constraining narratives and belief systems which subserve these behaviour patterns; and
3. Historical, contextual and constitutional factors which predispose families to adopt particular narratives and belief systems and engage in particular problem-maintaining behaviour patterns.

In the same vein, hypotheses and formulations about families' problems and strengths may be conceptualized within these three domains. Also, interventions may be classified with respect to the specific domains they target. Our integrative model of systemic therapy is based on these insights. The model evolved in routine clinical practice in Canada, the UK and Ireland starting in the 1980s. It was informed by the clinical and theoretical couple (Gurman, 2008; Gurman et al., 2015; Gurman & Jacobson, 2002; Jacobson & Gurman, 1986, 1995), family therapy literature (Gurman & Kniskern, 1981, 1991; Sexton et al., 2003; Sexton & Lebow, 2016) and empirical research on the effectiveness of systemic interventions which we periodically reviewed (Carr, 2000a, 2000b, 2009a, 2009b, 2014a, 2014b, 2016, 2018,

A. Carr (✉)
Clinical Psychology University College Dublin, Dublin, Ireland

Systemic Psychotherapist at Clanwilliam Institute, Dublin, Ireland
e-mail: alan.carr@ucd.ie

M. Mariotti et al. (eds.), *Handbook of Systemic Approaches to Psychotherapy Manuals*, European Family Therapy Association Series,
https://doi.org/10.1007/978-3-030-73640-8_11

2019). The treatment manual detailing this approach has evolved through four iterations (Carr, 1995a, 2000c, 2006, 2012). There is also a truncated version of the manual specifically adapted for use with families with adult-focused problems (Carr & McNulty, 2006, 2016). If you want to use the model in routine practice, the most up-to-date version for both child and adult-focused problems is Carr (2012), and for adult-focused problems is Carr and McNulty (2016). Carr (2012) is the most comprehensive sources. This third edition of *Family Therapy: Concepts Process and Practice* contains an overview of key ideas and practices from many schools of family therapy; a summary of the evidence-base for systemic therapy; a detailed description of our integrative, systemic three-column model; guidance on how to the model in routine clinical practice; and training exercises that may be used to learn how to use this approach to systemic therapy. Throughout the remainder of this chapter, this source will be referred to as 'the manual'.

In addition to the manual, we have published brief descriptions of the model (Carr, 1994a, 1997a, 1997b, 1997c, 1999, 2005, 2017) and a series of papers describing aspects of this approach to systemic therapy including engagement (Carr, 1990a), formulation (Carr, 1990b), goal setting (Carr, 1993), giving directives (Carr, 1990c), involving children in family therapy (Carr, 1994b; Carr, 2002), working with countertransference (Carr, 1989) and resistance (Carr, 1995b), managing disengagement (Carr, 1996) and training (Carr, 2007). What follows is a brief description of key elements of the model.

11.1.1 Problem Formulation

In routine practice, for any problem, an initial hypothesis and later formulation may be constructed in which the behaviour pattern (and feelings) which maintain the problem are specified, the constraining narratives and beliefs which underpin family members' roles in this pattern are outlined, and the broader contextual factors that predispose family members to have these beliefs and behaviour patterns are given. For example, in the case presented in the second half of this chapter, our initial hypothesis was that the family got involved in regular conflictual patterns of interaction (and negative feelings) in which the children's expression of their needs, the fathers' anger control problems and the mother's panic attacks might have played a part. Our second hypothesis was that the narratives and beliefs which underpinned their roles in these interaction patterns involved the father having views about being entitled to certain things from the mother (in their marital relationship), and the mother believing that she was either in danger or powerless. Our third hypothesis was that these beliefs and behaviour patterns (and associated feelings) had their roots in adverse family-of-origin experiences. These hypotheses were checked out during the assessment interviews and led to the development of the three-column

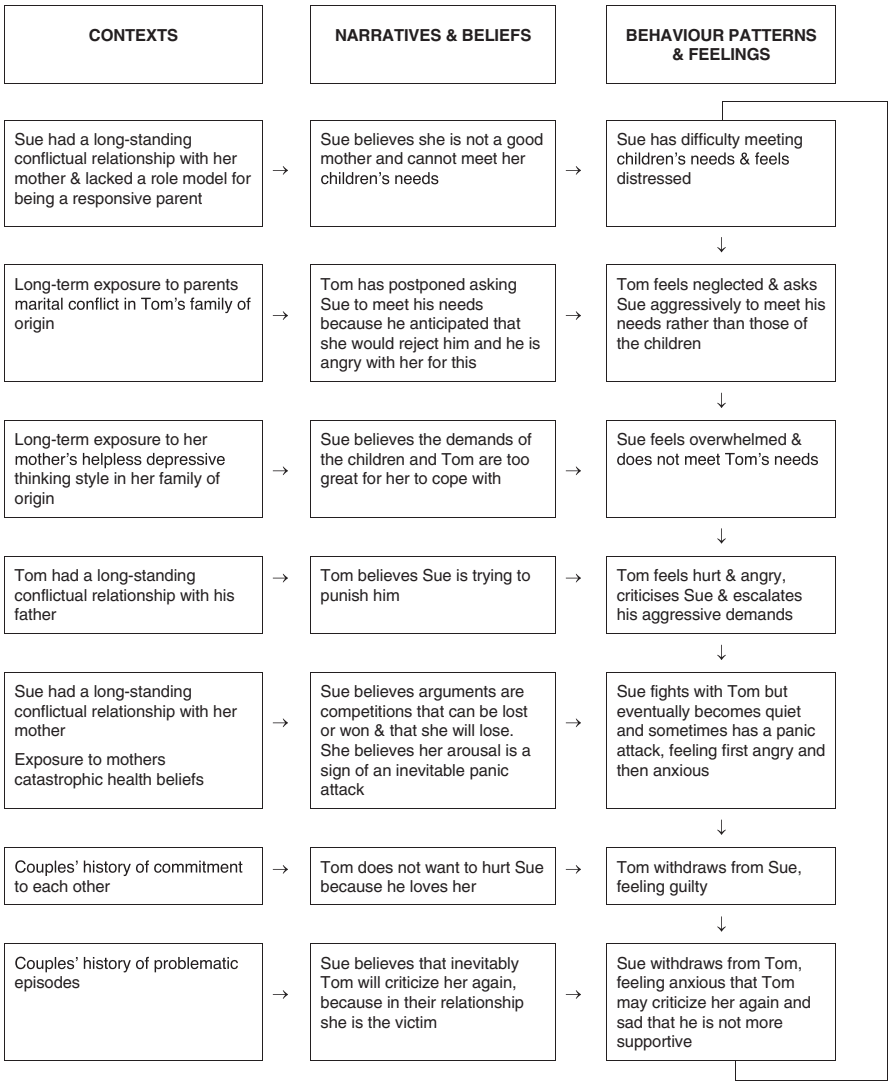

Fig. 11.1 Three-column formulation of Tom and Sue's problematic episodes

problem formulation presented in Fig. 11.1. This specific formulation drew on the general problem formulation model in Table 11.1. A review of the literature on which this model is based, and the types of questions to ask when co-constructing formulations with families is detailed in the manual.

Table 11.1 Problem formulation

Contexts	Narratives and beliefs	Behaviour patterns
Constitutional • Genetic vulnerabilities • Debilitating somatic states • Early illness or injury • Learning difficulty • Difficult temperament **Contextual** • Current life-cycle transitions • Home-work role strain • Lack of social support • Recent loss experiences • Recent bereavement • Parental separation • Recent illness or injury • Unemployment • Moving house or school • Changing jobs • Recent bullying • Recent child abuse • Poverty • Secret romantic affairs • Constraining cultural norms and values **Historical** • Major family of origin stresses 1. Bereavements 2. Separations 3. Child abuse 4. Social disadvantage 5. Institutional upbringing • Family of origin parent-child problems 1. Insecure attachment 2. Authoritarian parenting 3. Permissive parenting 4. Neglectful parenting 5. Inconsistent parental discipline 6. Lack of stimulation 7. Scapegoating 8. Triangulation • Family of origin parental problems 1. Parental psychological problems 2. Parental drug or alcohol abuse 3. Parental criminality 4. Marital discord or violence 5. Family disorganization	• Denial of the problem • Rejection of a systemic framing of the problem in favour of an individualistic framing • Constraining narratives about personal competence to solve the problem • Constraining narratives about problems and solutions relevant to the presenting problem • Constraining narratives about the negative consequences of change and the negative events that may be avoided by maintaining the status quo • Constraining narratives about marital, parental and other family relationships (e.g. differences are battles which can be won or lost) • Constraining attributional style (internal, global, stable, intentional attributions for problem behaviours) • Constraining cognitive distortions 1. Maximizing negatives 2. Minimizing positives • Constraining defence mechanisms 1. Denial 2. Passive aggression 3. Rationalization 4. Reaction formation 5. Displacement 6. Splitting 7. Projection	• The symptom or problem behaviour • The sequence of events that typically precede and follow an episode of the symptoms or problem behaviour • The feelings and emotions that accompany these behaviours, particularly positive feelings or payoffs • Patterns involving ineffective attempted solutions • Patterns involving confused communication • Patterns involving high rates of negative exchanges and low rates of positive exchanges • Patterns involving expression of negative emotions due to fears of attachment needs being unmet • Symmetrical and complementary behaviour patterns • Enmeshed and disengaged behaviour patterns • Rigid and chaotic behaviour patterns • Coercive interaction patterns • Patterns involving inadvertent reinforcement • Patterns involving lack of marital intimacy • Patterns involving a significant marital power imbalance • Authoritarian, permissive, neglectful, punitive and inconsistent parenting patterns • Patterns involving triangulation of children • Patterns including lack of co-ordination among involved professionals and family members

11.1.2 Exception Formulation

Exceptions are formulated by identifying interaction patterns within which the problem might be expected to occur, but does not; empowering narratives and beliefs which inform family members' roles within these exceptional interaction patterns; and broader contextual factors that underpin these competency-oriented narratives and beliefs that provide a foundation for exceptional behaviour (and positive feelings). For example, in the case study presented in the second half of this chapter, our first hypothesis was that occasionally the mother and father became involved in co-operative, rather than conflictual, patterns of interaction (with associated positive feelings). Our second hypothesis was that the narratives which underpinned their roles in these interaction patterns involved the couple's commitment to their marriage and to raising their children together. Our third hypothesis was that these narratives and behaviour patterns had their roots in positive family-of-origin experiences and positive experiences within the family of procreation. These hypotheses were checked out during the assessment interviews and led to the development of the three-column exception formulation in Fig. 11.2. This specific formulation drew on the general exception formulation model in Table 11.2. A review of the literature relevant to exceptions, and the types of questions to ask when co-constructing exception formulations with families are detailed in the manual.

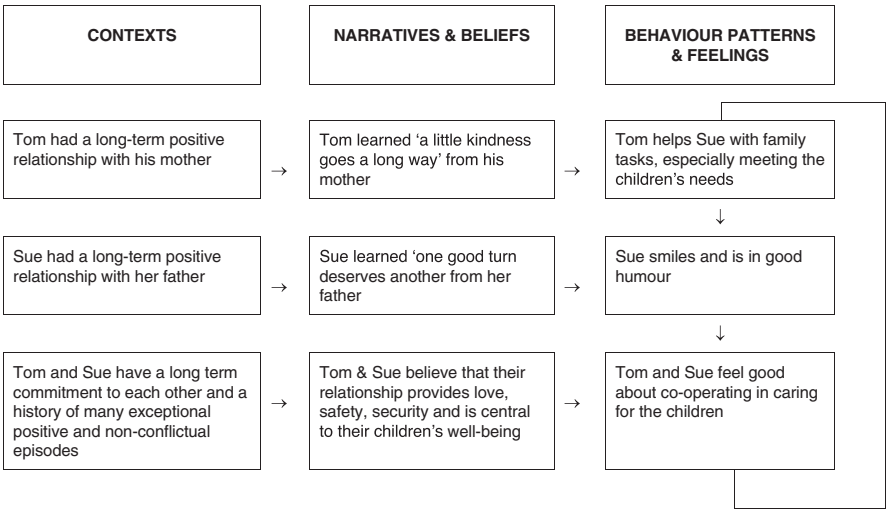

Fig. 11.2 Three-column formulation of Tom and Sue's exceptional episodes

Table 11.2 Exception formulation

Contexts	Narratives and beliefs	Behaviour patterns
Constitutional • Physical health • High IQ • Specific talents • Creativity • Wisdom • Easy temperament • Positive personality traits (stability, extraversion, openness to experience, agreeableness and conscientiousness) **Contextual** • Good social support network • Low family stress • Balanced home and work roles • Moderate or high SES • Positive work environment • Positive preschool or educational placement • Empowering cultural norms and values **Historical** • Positive family of origin experiences • Positive family of origin parent-child relationships • Secure attachment • Authoritative parenting • Clear communication • Flexible family organization • Good parental adjustment • Parents had good marital relationship • Successful experiences of coping with problems	• Acceptance of the problem • Acceptance of a systemic framing of the problem • Commitment to resolving the problem • Empowering narratives about personal competence to solve the problem (self-efficacy) • Empowering narratives about problems and solutions relevant to the presenting problem • Narratives in which the advantages of problem resolution outweigh the negative consequences of change and the negative events that may be avoided by maintaining the status quo • Empowering narratives about marital, parental and other family relationships particularly those which privilege loyalty • Positive or benign narratives about the characteristics or intentions of partners and other network members • Optimistic attributional style (internal, global, stable, intentional attributions for productive behaviour and situational attributions for problem behaviour) • Healthy defence mechanisms 1. Self-observation 2. Humour 3. Self-assertion 4. Sublimation	• The sequence of events that occurs in those exceptional circumstances where the problem or symptom was expected to occur but does not occur • The feelings and emotions that accompany these behaviours, particularly positive feelings or payoffs • Patterns involving effective solutions and good problem-solving skills • Patterns involving clear communication • Patterns involving high rates of positive exchanges and low rates of negative exchanges • Patterns involving clear expression of attachment needs • Emotionally supportive (rather than enmeshed or disengaged) behaviour patterns • Flexible behaviour (not rigid or chaotic) patterns • Patterns supporting marital intimacy • Patterns supporting marital power sharing • Patterns involving consistent, authoritative, co-operative co-parenting • Patterns including good co-ordination among involved professionals and family members

11.1.3 Interventions

In light of formulations of families' problems and exceptions, a range of interventions which address interaction patterns, narratives and broader contextual factors may be considered. Those which fit best for clients and for which there is the best

evidence of effectiveness may be selected. Some interventions aim primarily to disrupt problem-maintaining interaction patterns. In the case example presented later in the chapter, the self-regulation work we did with the father, the graded challenges work we did with the mother, and the parenting skills training we did with the couple fall into this broad category. Other interventions aim to help couples evolve more liberating personal and family narratives. Some such interventions will be mentioned in the case example. These include reframing the family's difficulties in interactional rather than individualistic terms, externalizing the problem, pinpointing strengths and building on exceptions. A third group of interventions aim to modify the negative impact of broader contextual factors, or draw on positive historical, contextual or constitutional resources and factors that may promote problem-resolution. In the case example presented later in the chapter, building support is an intervention that falls into this category. A three-column framework within which to conceptualize a wide range of couple and family therapy interventions is given in Table 11.3. A review of the literature on interventions is contained in the manual.

11.1.4 Therapy Stages

In our integrative approach, the overall strategy is to work collaboratively with families to formulate their problems and exceptional episodes where their problems were expected to occur but did not, using the three-column models outlined above. Once this has been achieved, treatment goals are set, and a therapy plan developed which aims to increase the occurrence of exceptions, disrupt problematic behaviour patterns, transform problematic personal and family narratives, address problem-maintaining contextual factors, and draw on historical, contextual and personal resources.

However, systemic therapy is not that straight forward. Sometimes clients have difficulty engaging in therapy. It is therefore critical to establish who is the primary customer for therapy, and invite them to encourage other members of the family to attend the first session. In the case example presented later in this chapter, the parents probably would not have attended therapy at all, without us identifying the referring social worker as the customer and inviting them to bring the family to the first meeting. Furthermore, many families show marked improvement following assessment only. That is, once they develop a shared three-column systemic understanding of their difficulties and exceptional situations where their problems were expected to occur but did, they spontaneously avoid problematic interactions and engage in exceptional non-problematic interactions instead. Finally, some families come to therapy with one problem, such as parenting difficulties and when this is resolved, request therapy for adult-focused concerns. To address these various challenges, the process of therapy is conceptualized as a developmental stage-wise process.

The framework set out in Fig. 11.3 outlines the stages of therapy from the initial receiving of a referral letter to the point where the case is closed. The first stage is

Table 11.3 Intervention

Contexts	Narratives & beliefs	Behaviour patterns
Addressing constitutional factors • Psychoeducation about condition • Facilitate adherence to medication regime • Refer for medical consultation • Arrange placement appropriate for person with constitutional vulnerability (e.g. intellectual disability) **Addressing contextual issues** • Network meetings • Child-protection interagency meetings • Home-school liaison meetings • Advocacy • Changing roles • Building support • Rituals for mourning losses • Exploring secrets **Addressing family of origin issues** • Facilitate exploration of transgenerational patterns, scripts myths and relationship habits • Facilitate re-experiencing, expressing and integrating emotions from family of origin experiences which underpin destructive relationship habits • Coach clients to reconnect with cut-off parental figures	**Reframing problems** • Frame problems in interactional terms • Frame problems in solvable terms • Frame intentions in positive terms **Pinpointing strengths** • Find unnamed obvious strengths • Attribute them to clients as defining characteristics **Relabelling** • Find negatively labelled behaviours • Relable them in positive non-blaming terms **Presenting multiple perspectives** • Split messages • Reflecting team practice **Externalizing problems and building on exceptions** • Separate the problem from the person • Identify and amplify exceptions including pre-therapy improvements • Involve network members • Link the current life exceptions to the past and future • Build a new positive narrative based on the series of exceptions **Addressing ambivalence** • Explore ambivalent narratives about the pros and cons of change and maintaining the status quo • Explore narratives about catastrophes associates with change • Explore narratives about powerlessness and change	**Creating a therapeutic context** • Contract • Lay ground rules • Facilitate turn taking • Manage time and space **Changing behaviour patterns in sessions** • Facilitate enactment • Coach new behaviours • Unbalance system • Mark boundaries **Facilitating expression of unmet attachment needs** • Distinguish primary (vulnerable/adaptive) emotions from secondary (hard/maladaptive) emotions • Facilitate intense expression and reception of primary emotions and attachment needs **Changing rates of positive and negative behaviour in couples** • Facilitate behaviour exchange • Build acceptance **Changing rates of positive and negative behaviour in parent-child interactions** • Schedule special time • Introduce reward systems • Coach behaviour control skills **Problem-solving and communication skills training** • Communication skills training • Problem-solving skills training **Tasks to change behaviour patterns between sessions** • Symptom monitoring • Restraint • Managing graded challenges • Practicing symptoms • Self-regulation

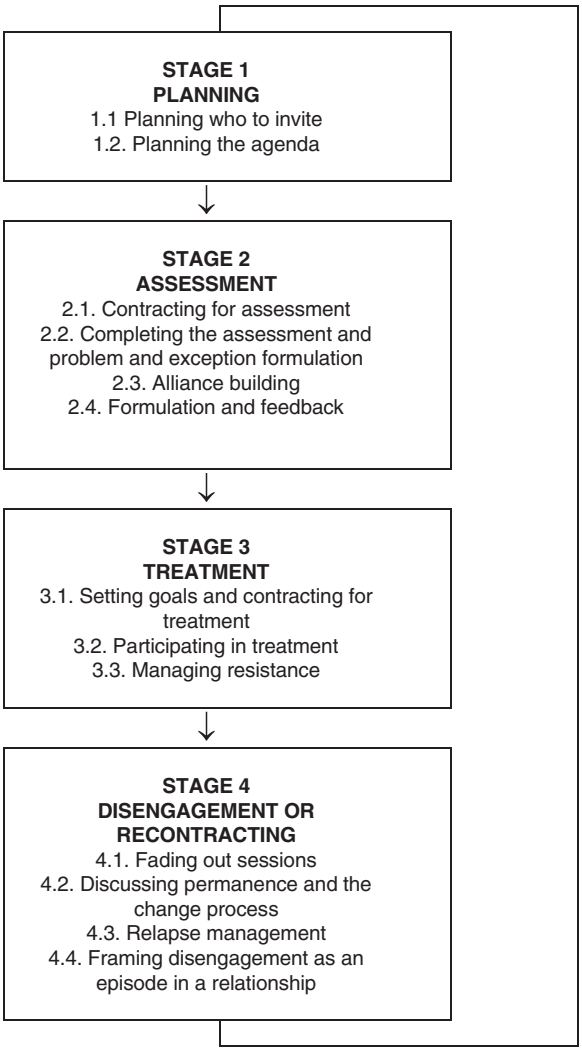

Fig. 11.3 Therapy stages

concerned with planning, the second with engagement and assessment, the third with treatment and the fourth with disengagement or recontracting for further intervention. At each stage, key tasks must be completed before progression to the next stage occurs. Failure to complete the tasks of a given stage in sequence or skipping a stage may jeopardize the consultation process. For example, attempting to conduct an assessment without first contracting for assessment may lead to co-operation difficulties if the couple find the assessment procedures arduous or threatening. Failure to complete the assessment before treatment compromises decision making about goal setting and selecting specific therapy strategies. Therapy is a recursive process insofar as it is possible to move from the final stage of one episode to the first stage of the next. In the remainder of the chapter, the use of the model in routine clinical practice is illustrated with a case study.

11.2 Case Example

Tom and Sue, a white, working class couple in their mid-20s, were referred by a social worker for therapy at a psychology clinic in a UK market town. In the referral letter, the social worker indicated that the couple had multiple problems. Tom had an explosive temper, which was frightening for Sue and her two children. Sue, who had a history of panic attacks, had developed a constricted lifestyle because of fears of having panic attacks outside the home. The couple argued constantly. Although no violence had occurred, the potential for violence led to the referral. The case was referred to social services by a health visitor who became concerned for the welfare of the couple's children, Maeve (4 years) and Mike (1 year), when conducting a routine developmental assessment with Mike around the time of his first birthday. The social worker met with a frosty reception when she visited the couple at their home. They initially insisted that everything was OK and that no family evaluation and support was required. The social worker explained that she had a statutory obligation to evaluate the capacity of parents to provide a safe home environment for the children. In the conversation that followed, the social worker concluded that the couple frequently argued about how best to care for the children. These arguments often escalated towards violence and rarely led to shared decisions. The social worker, therefore, referred the couple for systemic therapy to address the conflict between them, since this was interfering with their capacity to co-operatively meet their children's needs.

11.2.1 Assessment Contracting

From the referral letter, it was apparent that the social worker was the main customer, and the couple were probably ambivalent about attending therapy. Therefore, invitations to the first session were sent to the referring social worker and the couple, with a request that the social worker arrange transportation for the couple to attend the clinic. In the intake meeting, the couple expressed their ambivalence about attending therapy, but the social worker pointed out that if the couple decided not to attend therapy, then their children's names would be placed on an at-risk register held at her department. In light of this information, the couple agreed to attend two sessions during which an assessment would be conducted. If that indicated that they were suitable for therapy a further contract for 10 sessions of therapy would be offered.

11.2.2 Problem Formulation

In developing a problem formulation, diagrammed in Fig. 11.1, we asked Tom and Sue to describe conflictual episodes, detailing how they began, what happened during them, how they concluded and how the next episode started. We asked them about their behaviour, feelings, beliefs and family-of-origin experiences where they

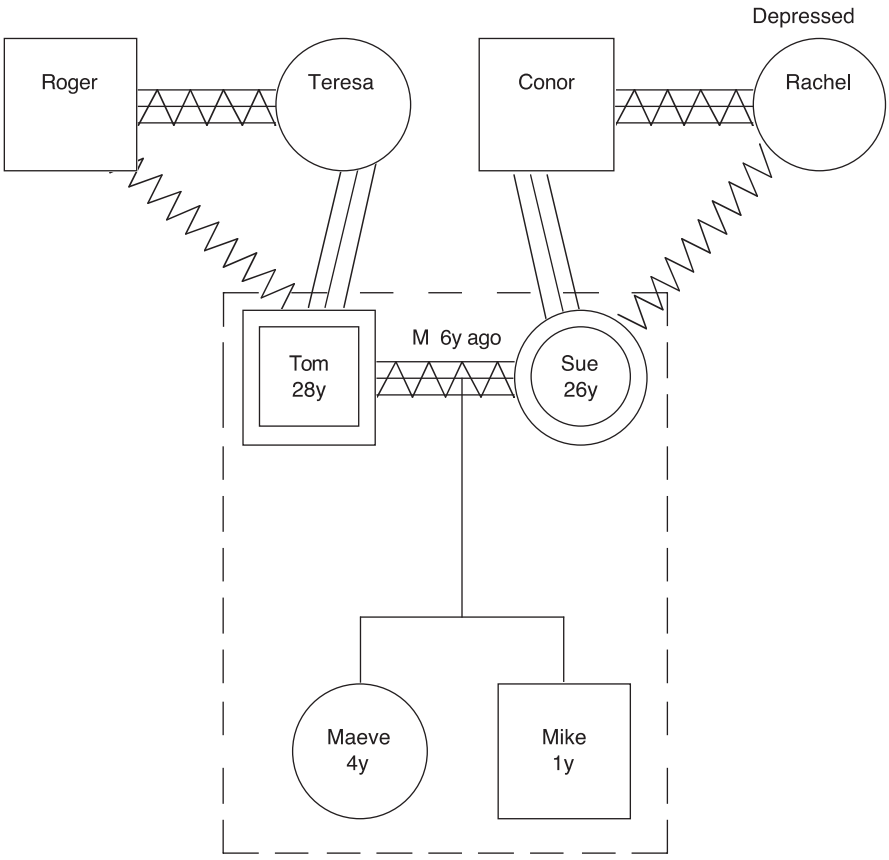

Fig. 11.4 Tom and Sue's genogram

may have learned to respond to each other in the ways that they did during these episodes. A genogram, given in Fig. 11.4, was drawn to clarify family-of-origin relationships. We also observed the family during enactments in which we invited the parents to reach an agreement on how best to schedule regular periods of positive family interaction. The children were present in one of these enactments.

It became clear that Tom's aggression was commonly expressed when Sue had difficulty being attuned to her children's needs and responsive to these in an effective way. Underlying this, Sue had a belief that she was not a good mother and could not meet her children's needs. This belief had its roots in her family-of-origin experiences. She had a longstanding conflictual relationship with her mother, who did not meet her needs responsively, and so lacked a role model for being a responsive parent.

Tom's demands that Sue meet his needs, rather than those of the children, were expressed aggressively, because typically he was angry for having postponed asking Sue to prioritize his needs over those of the children, believing that Sue would inevitably reject or neglect him. These beliefs had their roots in Tom's family-of-origin experiences where his parents had a stormy conflictual relationship.

Sue's difficulty in meeting Tom's needs arose from a feeling of being overwhelmed, by the demands of the children and of Tom. She believed that the demands of the children and Tom were more than she could cope with. This belief in her helplessness arose in part from having grown up in a family where her mother suffered from depression, and frequently expressed beliefs about her own helplessness.

In response to Sue not meeting his needs, Tom, feeling hurt and angry, criticized Sue and escalated his aggressive demands. He behaved as he did during problematic episodes because he believed that Sue was being purposefully uncooperative to punish him, and that it was unfair that she didn't cherish him, because he was devoted to her. Another aspect of his personal narrative was the belief that others, including Sue, were trying to take advantage of him. He had learned this when he was young by observing his father. Tom had a conflictual relationship with his father, who treated his mother as Tom treated Sue.

During conflictual episodes, Sue would initially fight back against Tom's escalating demands, feeling both angry and anxious. Eventually, she would withdraw into anxious silence or, following stressful exchanges, have a panic attack. Sue believed that arguments between couples were competitive exchanges that were won or lost. She believed that she could never beat Tom in an argument and this is why she gave in to him each time, a process that reinforced her beliefs in her own lack of power to influence Tom. Also, when she became distressed she believed that her increased physiological arousal was a sign that she was about to have a heart attack, a belief that often preceded her panic attacks. Sue had learned this way of thinking as a child from her mother who often expressed these types of catastrophic views.

Conflictual episodes would typically conclude with both Tom and Sue withdrawing from each other. Tom would feel hurt and angry at Sue. He would also feel guilty for feeling angry because he did not want to hurt the Sue, whom he loved. Sue would feel anxious that Tom might criticize her again, because in their relationship she saw herself as a helpless victim. She also felt sad to lose support from Tom, whom she loved. The couple would then not be on speaking terms for a few days. Gradually they would have increasingly more contact until the next conflictual episode occurred.

11.2.3 Exception Formulation

In contrast to the problem formulation, a three-column formulation of exceptional episodes in which the problem was expected to occur but did not is given in Fig. 11.2. This formulation of exceptional episodes was based on interviews and observations of family interaction mentioned in the previous section. During exceptional episodes, Tom helped rather than criticized Sue when she was having difficulty with the children. In response, she smiled at him and good feelings between them followed. Tom had learned from his mother that 'a little kindness goes a long way' and it was this story that underpinned his generous behaviour. Tom's mother was well

disposed towards the children. Both she and her husband valued them highly, since they were their first grandchildren. Sue had learned that 'one good turn deserves another' from her dad with whom she had a good relationship and this story underpinned her good feelings when Tom was kind to her. Both Sue's father and mother valued the children highly, since they were their first grandchildren.

11.2.4 Treatment Contracting

On the basis of the assessment and the problem and exception formulations, the couple were offered and accepted a contract for 10 sessions of therapy. Their acceptance of the therapy contract was partially due to the strong therapeutic alliance that developed during the assessment sessions. In the treatment manual it is noted that all other features of this approach to systemic practice should always be subordinated to efforts to build a strong working alliance, since without it, research consistently shows that clients drop out of assessment and therapy or fail to make progress. The overall goals for therapy agreed between the couple, the referring social worker and the therapist were to help the couple reduce the level of conflict in their home and increase the safety of the children's parenting environment. The children attended five of the 10 sessions.

11.2.5 Therapy

The following interventions were used in 10 sessions of therapy:

Interactional reframing
Externalizing the problem
Pinpointing strengths
Building on exceptions
Tom's challenge: Self-regulation
Sue's challenge: Being courageous
Managing resistance
Parenting
Building support
Disengagement
Relapse management

The interventions were implemented (broadly speaking) in the order listed, although the therapy was by no means as neat and packaged as it appears in the following description. The selection and implementation of the interventions were informed by the problem and exception formulations in Figs. 11.1 and 11.2, the treatment manual, and also the therapist's creativity, flexibility and clinical judgement in matching interventions to clients' needs.

Interactional Reframing

In the early sessions of therapy, the problem formulation was revisited repeatedly. The couple's difficulties were reframed as an interactional problem rather than as a reflection of personal psychological or moral deficits. There was a gradual moving away from the dominant narrative that each of them suffered from individual psychological problems. This narrative, couched in deficit discourse entailed the view that the main problem was either Sue's 'bad nerves' or Tom's 'short fuse'. As therapy progressed the couple came to understand the family's difficulties as the problematic interaction pattern described in Fig. 11.1, in which a central concern was how to co-operatively respond to the children's needs.

Externalizing the Problem

In the early sessions of therapy, the couple's difficulties were externalized and framed as peripheral to the core of their essentially positive relationship. They were invited to name their problem in a metaphorical way, and in response they began to talk about their problematic episodes, mapped out in Fig. 11.1, as 'the North Wind that blew through their house'. They began to monitor the occurrence of problematic episodes and to withdraw from these if they spotted themselves contributing to them. They referred to this as 'closing the shutters to keep the North Wind out of their house'.

Pinpointing Strengths

Reframing the problem in interactional rather than individual terms, externalizing the problem, naming it in a metaphorical way, and adopting joint ways of combating the problem offered many opportunities to highlight Tom and Sue's personal strengths (e.g., thoughtfulness, courage, persistence) and strengths that characterized their family relationships (e.g., loyalty, warmth, sensitivity, steadfastness). Through naming these strengths, Tom and Sue began to develop a more optimistic narrative about their relationship, and a more positive view of themselves as parents.

Building on Exceptions

The therapy also involved revisiting the exception formulation in Fig. 11.2. The couple were repeatedly invited over the course of therapy to remember and recount, in emotive detail, many exceptional episodes in which the problem might be expected to occur, but did not. Invitations to give accounts of such episodes initially focused on the pattern of interaction, then the underlying personal narratives, and then finally the constitutional, historical and contextual factors that underpinned the positive personal narratives. The similarities between these exceptional positive

episodes and other similar past episodes were explored. The couple were also invited to consider what the occurrence of these episodes said about them as a family and how they expected such episodes to recur in the future. Through this process, the couple developed a narrative about their relationship and their family marked by kindness, concern, sensitivity, warmth, closeness, understanding, compassion and many other positive qualities, which they recognized, had always been there and would probably persist into the future. In this way, an optimistic narrative about their family was developed.

Tom's Challenge: Self-regulation

A third aspect of the therapy focused on helping Tom to define himself as a man who was engaged in learning to identify and express his attachment needs in a direct way. He came to talk about himself as a man who was learning to sooth his own sense of panic or anger when he feared his attachment needs would not be met by Sue immediately. In developing this new narrative about the sort of man he was, Tom gradually gave up the story that Sue was to blame for his aggression. He adopted a more optimistic narrative about himself as a man in charge of his own feelings and responsible for his own behaviour. Some skills training was offered to Tom to help him identify and state his needs, and to monitor and contain rising frustration if his needs were not met.

Sue's Challenge: Being Courageous

A further aspect of the therapy focused on helping Sue to define herself as a courageous woman who was learning to accept that a racing pulse and sweaty palms were signals to relax, not panic. To help her revise her personal narrative, Sue was invited to set herself challenges in which she made her pulse race and her palms sweat, and then deal with these challenges by using relaxation skills and support from her partner. She and Tom planned and completed a series of graded challenges. Earlier challenges involved containing and soothing Sue's increased physiological arousal in the therapy sessions. In later challenges, the couple travelled away from the house for gradually increasing distances, until eventually they both went on a date in the city. This was a major achievement for the couple. It consolidated Sue's optimistic story about herself as a courageous woman who was increasingly ready to take on greater challenges in her life.

Managing Resistance

Progress in therapy was intertwined with periods of slow movement, and ambivalence about change. Managing resistance was the main therapeutic activity during these periods. Indeed, as part of the contracting process, we explained to Tom and

Sue that ambivalence about change and resistance to it were an inevitable part of therapy and to be welcomed, since they are an indicator that the therapy is working and change is really happening. Resistance showed itself in many ways. Below, two examples will be mentioned.

While Tom was moving towards defining himself as a man who was engaged in learning to identify and express his attachment needs in a direct way rather than blame Sue for his aggression, progress was not straightforward. He would occasionally doubt that the benefits of defining himself in this new way outweighed the costs of giving up the view that Sue, and not he, was responsible for his aggressive and violent outbursts. When this occurred, we invited Tom to address his personal dilemma about the costs of maintaining the status quo and the costs of changing his situation. He came to see that if he maintained the status quo he could preserve a story about himself as a good man provoked to violence by Sue, but he would have to give up any hope of a truly intimate and loving relationship with her and the two children. This, we suggested was because Sue could not be fully intimate with a man who attacked and blamed her for things that she had not done.

Similarly, progress was far from straightforward when Sue was learning to define herself as a courageous woman. She would occasionally doubt that the benefits of defining herself in this new way outweighed the costs of giving up the view that she was a helpless victim who could justifiably remain cocooned at home forever. When this occurred, we invited Sue to address her personal dilemma about the costs of maintaining the status quo and the costs of changing her situation. She came to see that if she maintained the status quo she could avoid the terror of facing her fear, but she would have to give up any hope of defining herself as a powerful woman in her own right, a competent role model for her daughter, and an equal partner for Tom.

For both Tom and Sue, the theme of abandonment underpinned the catastrophic narrative that fuelled their ambivalence about change. Tom's personal narrative was that if he accepted full responsibility for his anger and violence, then this meant that he was not a good man, and so Sue would have to leave him. Sue's personal story was that as long as she was a helpless terrified victim, Tom would remain to protect her, but if she showed signs of sustained courage and strength, he would leave her to fend for herself. To address these catastrophic narratives, Sue and Tom were invited to explore alternative more optimistic narratives of the future in which Tom could allow himself to be forgiven and accepted by Sue and Sue could allow herself to be on an equal footing with Tom (rather than in a one-down position). The pessimistic narrative of abandonment and the related ambivalence about change receded over the course of therapy as Tom and Sue's more optimistic story about their lives came to the fore.

Parentings

Therapy also focused on inviting the couple to explore their story about themselves as good-enough parents. Parenting issues were addressed in all sessions, but were the central focus of four sessions in particular. Invitations were offered to them to

describe ways in which they successfully met their children's needs for safety, security, nurturance, control, intellectual stimulation and age-appropriate responsibilities. Through describing many examples of good-enough parenting and enacting these within conjoint family sessions, Tom and Sue developed a story about themselves as competent, but not perfect parents. This optimistic parenting narrative, led them to ask us for expert advice on parenting skills so that they could improve the way they managed the challenges of child-rearing. It was into this context that behavioural parenting skills training was offered. This covered all the usual skills to enhance parent-child interactions, increase positive behaviours and extinguish aggressive and destructive behaviours. The couple incorporated these skills into their own parenting styles and into their own story about themselves as good-enough parents. This skills training involved direct coaching during conjoint family sessions. During these sessions Maeve (aged 4) began to describe herself as more 'grown up', as viewing her father as a 'gentle daddy' rather than a 'cross daddy' and her mother as 'more fun'.

Building Support

The couple were invited in the middle and later stages of therapy to strengthen their ties with their families of origin. This was not an easy invitation for the couple to accept. Over the years both couples had become increasingly distant from their parents because in each of their families they felt triangulated. This is illustrated in the genogram in Fig. 11.4. During her teens, Sue had gradually become a confidant for her father and was estranged from her depressed mother. Tom, in contrast, had become a confidant for his mother and had frequent conflicts with his father. In both Tom and Sue's families of origin their parents were locked into rigid, close, conflictual patterns of marital interaction. Despite all this, as Tom and Sue's narrative about their own relationship became more hopeful, they became more understanding of their parents' difficulties and were prepared to visit their families of origin more frequently. They let their parents know that they had come through difficult times, but were now hopeful that there were better times ahead, and that they were strong enough to build a good family. This admission of vulnerability and declaration of hope strengthened ties between Tom and Sue and their families of origin. Also, the grandparents, Roger and Teresa, and Conor and Rachel, welcomed the opportunity to spend time with their grandchildren, Maeve and Mike. This created a context within which they could be more supportive of Tom and Sue.

Disengagement

The first 6 sessions were held at weekly or fortnightly intervals. As the family began to make progress, the final 4 sessions were spaced at three to five weekly intervals. Much of the therapy in the last three sessions focused on helping the couple make sense of the change process, develop relapse management plans and understand the process of disengagement as the conclusion of an episode in an ongoing

relationship with the clinic rather than the end of the therapeutic relationship. Tom and Sue were invited to forecast the types of stressful situations in which relapses might occur, their probable negative reactions to relapses, and the ways in which they could use the strengths they had discovered in therapy to deal with these relapses.

After 10 sessions a review conducted with the referring social worker indicated that the family was doing much better. The social services department decided that frequent monitoring of the family was no longer necessary. At the review, the following specific treatment gains were noted. In the social worker's view, the conflict between the couple no longer placed the children at risk. The frequency of episodes of conflict between Sue and Tom had reduced from five to one per week and the couple was confident that these arguments would never become violent. Both children were healthy, well-adjusted and were being well cared for. There were marked improvements in Tom's anger management and Sue's panic disorder with agoraphobia. The couple said their marital satisfaction improved. Supportive links with each of their families of origin were strengthened. In short, the therapy goals had been attained.

Relapse Management

A relapse occurred a couple of years later at a time when Sue began working outside the home for the first time since the birth of the first child. After two sessions in which the couple explored ways that they could use their strengths to jointly manage the new challenges in their lives, the frequency of the couple's unproductive arguments reduced again.

Therapist Dilemmas

There were three dilemmas central to the therapists' experience in this case. First, there was the issue of customerhood. Clearly, the main customer initially was the referring social worker, not the family. We addressed this issue by conducting a careful network analysis and inviting the social worker to bring the family to the contracting session and explain the implications of accepting or rejecting an offer of therapy. Second, in this case, there was a statutory requirement to monitor the risk that the parents posed to the children's welfare, and the conflicting requirement for the parents to engage in a trusting therapeutic relationship to reduce this risk. We addressed this dilemma by agreeing that the referring social worker would adopt the statutory risk-monitoring role, and the therapist would adopt an exclusively therapeutic role. A third issue, in this case, was making space for both the narratives of the children and those of the parents. The needs and welfare of the children Maeve and Mike, both of whom were under 5 years were paramount in this case. But the parents, Tom and Sue, were also 'needy clients' with limited personal coping resources. Throughout the therapy, we were mindful of balancing the needs of the

children and the needs of the parents. This was challenging because Tom and Sue's stories were well articulated, but specific steps had to be taken to make the implicit narratives of Maeve and Mike more salient. We did this during the assessment sessions through facilitating enactments and commenting on episodes in which the parents made good-enough or ineffective attempts to be attuned to the children's needs and co-operatively meet these. Throughout the ten sessions of therapy, parenting issues were addressed, and parent training was a central focus of 4 sessions. Our approach to parent training involved helping Tom and Sue become attuned to the needs of Maeve and Mike, and in doing so to be able to listen to their implicit or unarticulated narratives. In this sense, Maeve and Mike's narratives were central to the success of this episode of therapy. The therapy as a whole was very demanding and the management of the dilemmas mentioned in this section was addressed in peer supervision, with reference to the manual.

11.3 Summary

In the integrative model of systemic therapy summarized in this chapter and detailed in the treatment manual, therapy is conceptualized as a developmental and recursive process involving the stages of planning, assessment, treatment and disengagement or recontracting, as shown in Fig. 11.3. Specific tasks must be completed at each stage before progressing to the next. For any problem, an initial hypothesis and later formulation may be constructed, informed by Table 11.1 and illustrated by the example in Fig. 11.1. In the initial hypothesis and later problem-formulation the behaviour pattern (and related feelings) which maintains the problem are specified; the constraining narratives and beliefs which underpin the family members' roles in this pattern are outlined; and the broader contextual factors that predispose family members to become involved in these narratives and behaviour patterns are given. In addition, a similar three-column formulation may be constructed to explain exceptional episodes in which problems might be expected to occur but did not happen. This is informed by Table 11.2 and illustrated by the example in Fig. 11.2. These three-column formulation models provide a template for guiding the assessment of problems and strengths and for planning systemic therapy. Therapeutic interventions, listed in Table 11.3, may be classified in terms of the specific domains they target within three-column problem and exception formulations, with some interventions targeting behaviour change, some targeting narratives and beliefs, and others focusing on contextual risk and protective factors. In any specific case, the selection and implementation of interventions are informed by problem and exception formulations for that case. However, therapists must also exercise considerable creativity, flexibility and clinical judgement in matching interventions to clients' needs in any particular case.

References

Carr, A. (1989). Countertransference to families where child abuse has occurred. *Journal of Family Therapy, 11*(1), 87–97. https://doi.org/10.1046/j.1989.00335.x

Carr, A. (1990a). Failure in family therapy: A catalogue of engagement mistakes. *Journal of Family Therapy, 12*(4), 371–386. https://doi.org/10.1046/j.1990.00403.x

Carr, A. (1990b). A formulation model for use in family therapy. *Australian and New Zealand Journal of Family Therapy, 11*(2), 85–92. https://doi.org/10.1002/j.1467-8438.1990.tb00798.x

Carr, A. (1990c). Giving directives effectively: The implications of research on compliance with doctor's orders for family therapy. *Human Systems: Journal of Systemic Consultation and Management, 1*, 115–127.

Carr, A. (1993). Systemic consultation and goal setting. *Human Systems: The Journal of Systemic Consultation and Management, 4*, 49–59.

Carr, A. (1994a). Positive practice: A structured integrative approach to family therapy. *Journal of the Irish Association of Counselling and Therapy, 1*(31), 48–61.

Carr, A. (1994b). Involving children in family therapy and systemic consultation. *Journal of Family Psychotherapy, 5*(1), 41–59. https://doi.org/10.1300/j085V05N01_03

Carr, A. (1995a). *Positive practice: A step-by-step approach to family therapy*. Harwood.

Carr, A. (1995b). Resistance, dilemmas and crises in family therapy: A framework for positive practice. *Journal of Family Psychotherapy, 6*(4), 29–42. https://doi.org/10.1300/j085V06N04_03

Carr, A. (1996). A structured approach to disengagement in family therapy with child-focused problems. *Contemporary Family Therapy: An International Journal, 18*(4), 471–487. https://doi.org/10.1007/BF02195711

Carr, A. (1997a). Positive practice in family therapy. *Journal of Marital and Family Therapy, 23*(3), 271–293. https://doi.org/10.1111/j.1752-0606.1997.tb01036.x

Carr, A. (1997b). Development of positive practice. *Feedback, 7*(2), 23–29.

Carr, A. (1997c). Three stages in the development of an integrative approach to working with families. *Éisteacht: Journal of the Irish Association of Counselling and Therapy, 1*(40), 9–15.

Carr, A. (1999). Positief behandelen in gezinstherapie. *Gezins Therapie, 10*(1), 30–60.

Carr, A. (2000a). Evidence-based practice in family therapy and systemic consultation. II. adult-focused problems. *Journal of Family Therapy, 22*(3), 273–295. https://doi.org/10.1111/1467-6427.00152

Carr, A. (2000b). Evidence-based practice in family therapy and systemic consultation: I: Child-focused problems. *Journal of Family Therapy, 22*(1), 29–60. https://doi.org/10.1111/1467-6427.00137

Carr, A. (2000c). *Family therapy: Concepts, process and practice*. Wiley.

Carr, A. (2002). Compendium of practices for including children in family sessions. In L. D. Miller (Ed.), *Integrating school and family counselling: Practical solutions* (pp. 73–87). American Counselling Association.

Carr, A. (2005). Narratives of hope. In A. Vetere, E. Dowling, & E. (Eds.), *Narrative therapies with children and their families: A practitioner's guide to concepts and approaches* (pp. 268–282). Routledge.

Carr, A. (2006). *Family therapy: Concepts, process and practice* (2nd ed.). Wiley.

Carr, A. (2007). Family therapy training on a clinical psychology programme. *Journal of Family Therapy, 29*(4), 326–329. https://doi.org/10.1111/j.1467-6427.2007.00394.x

Carr, A. (2009a). The effectiveness of family therapy and systemic interventions for child-focused problems. *Journal of Family Therapy, 31*(1), 3–45. https://doi.org/10.1111/j.1467-6427.2008.00451.x

Carr, A. (2009b). The effectiveness of family therapy and systemic interventions for adult-focused problems. *Journal of Family Therapy, 31*(1), 46–74. https://doi.org/10.1111/j.1467-6427.2008.00452.x

Carr, A. (2012). *Family therapy: Concepts, process and practice* (3rd ed.). Wiley.

Carr, A. (2014a). The evidence base for family therapy and systemic interventions for child-focused problems. *Journal of Family Therapy, 36*(2), 107–157. https://doi.org/10.1111/1467-6427.12032
Carr, A. (2014b). The evidence base for couple therapy, family therapy and systemic interventions for adult-focused problems. *Journal of Family Therapy, 36*(2), 158–194. https://doi.org/10.1111/1467-6427.12033
Carr, A. (2016). How and why do family and systemic therapies work? Keynote address to AAFT, Melbourne, 2015. *Australian and New Zealand Journal of Family Therapy, 37*(1), 37–55. https://doi.org/10.1002/anzf.1135
Carr, A. (2017). Narratives of hope. In A. Vetere & E. Dowling (Eds.), *Narrative therapies with children and their families: A practitioners guide to concepts and approaches* (2nd ed., pp. 289–312). Routledge.
Carr, A. (2018). Couple therapy, family therapy and systemic interventions for adult-focused problems: The current evidence base. *Journal of Family Therapy*. https://doi.org/10.1111/1467-6427.12225
Carr, A. (2019). Family therapy and systemic interventions for child-focused problems: The current evidence base. *Journal of Family Therapy, 41*(2), 153–213. https://doi.org/10.1111/1467-6427.12226
Carr, A., & McNulty, M. (2006). Chapter 5. Systemic couples therapy. In A. Carr & M. McNulty (Eds.), *Handbook of adult clinical psychology: An evidence based practice approach* (pp. 157–219). Brunner-Routledge.
Carr, A., & McNulty, M. (2016). Chapter 6. Systemic couple therapy. In A. Carr & M. McNulty (Eds.), *Handbook of adult clinical psychology: An evidence based practice approach* (2nd ed., pp. 161–205). Routledge.
Gurman, A. (Ed.). (2008). *Clinical handbook of couple therapy* (4th ed.). Guilford.
Gurman, A., & Jacobson, N. (Eds.). (2002). *Clinical handbook of couple therapy* (3rd ed.). Guilford.
Gurman, A., & Kniskern, D. (Eds.). (1981). *Handbook of family therapy*. Brunner/Mazel.
Gurman, A., & Kniskern, D. (Eds.). (1991). *Handbook of family therapy* (Vol. II). Brunner Mazel.
Gurman, A., Lebow, J., & Snyder, D. (Eds.). (2015). *Clinical handbook of couple therapy* (5th ed.). Guilford.
Jacobson, N., & Gurman, A. (Eds.). (1986). *Clinical handbook of marital therapy*. Guilford.
Jacobson, N., & Gurman, A. (Eds.). (1995). *Clinical handbook of couple therapy* (2nd ed.). Guilford.
Sexton, T., & Lebow, J. (Eds.). (2016). *Handbook of family therapy* (4th ed.). Brunner-Routledge.
Sexton, T., Weeks, G., & Robbins, M. (Eds.). (2003). *Handbook of family therapy* (3rd ed.). Brunner-Routledge.

Alan Carr, PhD. Professor of Clinical Psychology and Founding Director of the Doctoral Programme in Clinical Psychology at University College Dublin. Couple and family therapist at Clanwilliam Institute, Dublin. He has practiced in Canada, the UK and Ireland. He has written over 20 books and 500 papers and presentations in the fields of clinical psychology, family therapy and positive psychology. His work has been translated into a number of languages including Portuguese, Polish, Korean and Chinese. E. alan.carr@ucd.ie