Chapter 8
Systemic Approaches to Therapy Manuals: Family Situation Mapping and Systemic-Relational Assessment of Treatment for Families, Couples and Individuals

Francesco Colacicco

8.1 Introduction

La Mappa del Terapeuta (The Therapist's Map), published in 2013 by Scione Editore (Rome), is a psychotherapy manual which can be adopted across different clinical contexts (psychotherapy centers and services) and for therapist training. This book is widely used by the *Istituto Dedalus* and other schools belonging to the *Centro Studi di Terapia Familiare e Relazionale di Roma* (Family and Relational Therapy Study Center in Rome) where it is adopted by trainee therapists specializing in family and relational psychotherapy when working under indirect supervision.

The manual provides a model for the assessment of therapy work with families, couples, and individuals, for data collection to facilitate therapists in collecting and organizing patient information which can be added to the patients' medical record. These forms enable the therapist to define the context for treatment and to follow its progress over time; they also enable the institution within which the therapist works to collect patient data and to assess interventions through a follow-up. Furthermore, the use of this manual can allow therapists, and the structures they work in, to conduct research projects and assess the effectiveness of the services provided.

Director of the *Istituto Dedalus*, post-graduate training school of specialization in psychotherapy recognized in Italy by the Ministry of Education, University and Research; and teacher within the *Centro Studi di Terapia Familiare e Relazionale di Roma*

F. Colacicco (✉)
Istituto Dedalus - Centro Studi di Terapia Familiare e Relazionale, Rome, Italy
e-mail: f.colacicco53@gmail.com

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_8

8.2 The Manual

"Many clinicians, psychotherapists and researchers have observed identical psychological phenomena; they labelled them in different ways, used them to construct a theory, and then added the fateful 'therefore' which led to the construction of an interpretative model of facts and - at times - to a psychotherapeutic approach. The consequences of this were a poor integration of ideas and a lot of confusion" (Cancrini & Harrison, 1983, *La trappola della follia*, pp. 121, La Nuova Italia Scientifica, Roma).

Many efforts at integrating and synthesizing different approaches have crashed against the barrier set by observer encoding and assessment. Much in the same way in which the psychoanalyst – fascinated by the complexity of his patient's inner world – could not see the system of family relationships in which the patient was immersed, so the family therapist, in turn, fascinated by family games, by the family dance, overlooked the fact that the family script is written by both subjective and group "internal parts," by the copy processes used and the attachment styles learned through the construction of bonds. There have been several developments in this field, and we are beginning to see some initial integrations and synthesis of approaches. Given that the object is determined by the interested observer's chosen focus and the background is therefore the context – or the frame – in which the object is inserted, we must be aware that the key or lens through which we "read" a situation will establish relationships and highlight some aspects instead of others. A therapeutic skill lies "in this reorganization, correlation, reformulation of data experience," and it does not thrive within a rigid therapeutic *schema*. The therapist's behavior should reflect the belief that it is possible – as it is in the classic illustration referred to by Gestalt therapists – to see both the young woman and the old woman, shifting focus between the inside figure and the outside figure. He should seek the double image of the self that the image always provides, a different organization of the relationship between the figure and its background.

Hence the idea led to this book, a psychotherapy manual. I collected from my working and teaching experiences and all my papers and notes to build a *map*, which is – naturally – a partial and approximated map to aid the therapist. It is a map which I offer to my students and which I keep on the desk during case supervisions. As family therapists know too well, the map itself does not represent the territory but rather a guide to cross it, to help, at every turn, identify the destinations to be reached and which path to follow. It can help the therapist have a firm grasp on the helm when the waters are stormy and to look for the right landing places. It is a guide to the construction of therapy, to the therapy process: it can help formulate hypotheses, define objectives, and gather results. I have used it, found it useful, and wanted to share it through *La Mappa del Terapeuta*.

8.2.1 Part One

The manual is divided into three parts. The first part focuses on *psychotherapy* and *psychopathology*.

I begin by emphasizing the importance of how psychopathological processes can inform psychotherapeutic treatment, underscoring that disorder assessment should not be based solely on the observation of symptomatic behaviors but must also take into account the type of personality structures encountered and the level acquired by the patient's defensive organizations and the subject's interaction both with his or her family and environment.

Family therapists know that a family does not become dysfunctional within a single generation (Bowen & Kerr, 1990); therefore – from the very first diagnosis – the clinician's attention should not focus exclusively on the presence of mental disorders. The great diversity of clinical cases is determined by many factors: by age and stage of the life cycle; by the effects of combined subjective needs; by defense mechanisms; by physical limits and possibilities; by the environment's reaction; and by the structural characteristics of personality disorders, not intended as a specific form of characteropathy but as a group of homogeneous character and personality disorders as seen from the perspective of cognitive and defensive structures.

Therefore patient care should not provide symptom-focused therapy (centered exclusively on symptom remission) but should focus on the symptom's function (on the function of disorders and problematic behaviors), looking for connections between a subject's personal and family history and the initial onset and further development of mental and behavioral disorders. The therapist must *plan* the intervention, putting together information regarding the patient's life cycle phase and the *subjective emergency* experienced by the patient. To this purpose, the ability to recognize the psychopathological processes acted by the patient is vital.

Furthermore, it is a known fact that countertransference is a common element shared by different forms of psychotherapeutic intervention: similar mechanisms are also activated when therapists work with a group rather than with a single patient. As it is true that the family will represent its myth to the therapist, it is also true that therapists will do the same, representing their own family myth: therapy is a setting in which two family myths meet and interlace. Family therapists can, therefore, use their perception of themselves as an object of transference to understand what is happening during family therapy, being however well aware of the complexity of the situation and of the developing emotional reactions towards the different parts and not just towards the family system as a whole. One of the risks when working with families is that the family could become enmeshed into the therapist's psychological economy and he or she could become dependent on it. To counteract the therapist's tendency towards fusion, it is advisable to structure the setting by providing a co-therapist, when possible, and a supervisor, always.

The first part of the manual devotes special attention to personality disorders. The diagnosis of borderline personality disorder has changed over time according to the different clinical paradigms that have dominated psychiatry, from the psychoanalytic paradigm to the medical and pharmacological one to the dominant one today which is that of specificity and specialization, both in terms of etiology and treatment.

Situations of distress generated by borderline functioning are far more common than those caused by neuroses and psychoses, and the various authors who have

explored this topic over the years can be divided into two groups: those who emphasize "conflict" and those who focus on a "deficit," not considering that the different assessments were probably related to studies targeting different populations. From the etiological point of view, it is self-evident that factors of pathology are related to intrapsychic, environmental, and relational aspects as well as to the interaction of these aspects.

Patients who are diagnosed with BPD according to a language shared by psychiatrists, psychologists, and psychotherapists (in other words shared by those healthcare providers who are faced with the challenge of working with unmanageable patients) actually belong to three different categories: while only some of them manifest psychotic structures, others display an overlap between compulsive and self-aggressive behaviors and deeper mood disorders without however meeting the criteria for a psychotic description; in other words they only send signals of psychiatric distress (these situations will revert to normality if treated appropriately and promptly). Lorna Smith Benjamin authored a priceless contribution to the study of personality disorders and their treatment, and we refer extensively to her approach in this manual (Benjamin, 1996, 2003, 2018).

Patients with personality disorders are highly treatment-resistant and tend to react more to their internalized key figures than to the people they interact with in the here and now. Therapy success is therefore possible if and when the patient is freed from the expectations and hopes linked to these internalizations. We must keep in mind that even when treating adult patients, those patients are, ultimately, the injured children who still cry inside them, and it is these injured children that we must reach out to through our therapeutic work (Cancrini, 2012, 2017).

8.2.2 Part Two

The second part of the Manual focuses on *the growth of children*.

After summarizing the transformations undergone by the family system and after having defined its new functions, we identify the main family styles and risk factors as these are characteristic of multiproblematic families. Subsequently the close link between early experiences and some emotional and relational disorders during adulthood is highlighted. These disorders seem to be modeled through childhood experiences and – in turn – influence the articulation of subsequent experiences. This has been confirmed not only via the extensive research on the subject but also by clinical observation which highlights the frequency with which early negative experiences are associated to specific psychological problems in adolescence and adulthood.

Because of environmental and family continuity across the years, early childhood experiences and later events in adulthood are rarely independent of each other. For example, children raised in a high-conflict family environment, who – for extensive periods of time – are neglected or subjected to/witnesses of physical or sexual abuse, almost inevitably acquire behavioral patterns which are then exported to other environments (such as school). Thus their own behavior generates situations in which contexts external to the family – contexts which could potentially be

beneficial to the subject and somewhat compensate the negative experience – cannot fully yield the benefits and compensatory values which they could provide. The idea that negative experiences have a lasting effect is linked to experiential continuity, i.e., the fact that other educational contexts or other relational resources end up being characterized by the persistence of the negative experiences. We can state that negative experiences and losses that occur during childhood do not necessarily determine the development of a personality disorder if these experiences are followed by authentic positive experiences.

This section of the manual ends with a focus on the challenges couples face when carrying out their own developmental tasks and the impact that these have on their children.

Families have changed over the years, and they must face many different distressing and difficult situations not to mention many developmental and critical steps (Scabini, 1995). Therapy should be progressively aimed at working on the difficulties in the relationships between the adult pair and between adults and their children; it should focus on preventing situations of distress and on supporting families as they face contingent difficulties. The issue at hand often requires activating parenting skills; building a place where family members can be heard; eliciting their requests for help; accepting the explicit requests made by members in distress; and recognizing forms of hidden distress which have not been voiced or defined yet. Systemic therapists often work with families which have a transitory structure: the definition of the system to be treated in these situations is not simple, it is never initially predetermined, but it develops during treatment. At times the difficulty and the impossibility of working with the entire family system lead to working with single individuals.

Often the couple represents the "thread" which therapy must "pull to loosen the tangle of family suffering." The transformation of the family system (Colacicco, 2003; Malagoli Togliatti & Rocchietta Tofani, 1987; Scabini, 1995), the dissolution of a typical family organization into different family realities, the constitution of multiple family groups, the revealing of new family situations, and the to-and-fro motions which different families build around the couple make this the hub around which the network of bonds – the web of relationships which we are a part of – revolve, enveloping itself on it. We have observed the increasing frequency of family therapists who, after having screened the entire family system, attempt to work directly with the marital couple, as well as psychodynamic therapists who – following an individual case assessment – recommend couples therapy. Whether psychotherapy begins with the family or whether it is centered initially on the individual, it seems to naturally lead to working with the couple.

8.2.3 Part Three

The third part of the manual, based on the concepts described above, focuses on *therapy with the individual, with couples, and with families*. In this third part, I refer to some case studies to exemplify the technical aspects of recommended therapist interventions.

Today it is a well-established fact that systemic-relational interventions are no longer aimed solely at the traditional family but can be adopted when working with families, couples, and individuals. As far as individual treatment is concerned, it must be stated that – despite the fact that family therapy was originally conceived in opposition to individual therapy – currently this controversy seems to have been largely overcome. While a few years ago family therapy was recommended by systemic therapists as the *panacea* for all ills, so much so that patients were almost automatically referred to family treatment, the current trend has changed; today the patient is assessed on several comparable parameters (age, personal traits, age at onset of symptoms, chronicity, configuration of the family system, life cycle phase, etc.) before defining a specific referral.

On the other hand, individual therapy is perfectly compatible within the systemic-relational model (Boscolo & Bertrando, 1996; Canevaro et al., 2008; Colacicco, 2001, 2007, 2017; Loriedo et al., 1989; Selvini Palazzoli & Viaro, 1989), even from a theoretical standpoint, given that treatment focuses on the interactions between systems, even if they are very specific systems such as the individual subject. Today individual treatment falls within the area of intervention of the systemic-relational therapist. It is for these reasons that I believe it is more accurate to talk about *an interpersonal and relational approach* (Colacicco, 2017) rather than of "family therapy" given that the latter term can be reductive and partial.

Moreover, since in our society the subsystem that performs parental functions is usually the marital couple, it follows that the characteristics of the parental role and the type and quality of family life will be determined by the childhood experiences of the parents and by the marital relationship that is structured by the couple.

Given that perception and social learning which occur during childhood are encoded in a person's memory and are subsequently "copied" into their adult relationships and given that adult behavior is determined as much by destructive as it is by constructive experiences, the potentially beneficial impact of therapy is self-evident because of the enormous potential of psychotherapeutic work contained here.

On these grounds it is increasingly clear that therapy must work with *the family inside the patients' mind* and must work more with the representation of the family in the head rather than the real present-day family. In fact, especially when working with adult patients, inviting the family to participate in therapy can be counterproductive[1], and more often than not, based on our clinical experience, it is not possible to arrange family meetings.[2] So, with increasing frequency, family therapists find

[1] The young adult in the organization phase, with neurotic area disorders, can be treated individually or in pairs, if his ability to build bonds outside the family allows him to carry out a job that looks forward instead of a job aimed backwards, towards the family of origin. The situation is different when the disorder occurs in other phases of the family life cycle, when the symptoms are at the service of family homeostasis. In all these cases, the first choice intervention is with the family (Cancrini L. & La Rosa C. 1991, *Il vaso di pandora*, pp. 132–133, Carocci editore, Roma).

[2] The delimitation of the system to be treated is particularly difficult with multiproblematic families. In these situations, the therapist is immediately confronted with the difficulty of summoning the whole family, for his tendency to come or not to come to therapy for instrumental and functional reasons with internal logic. Hence the inopportunity is to often convene the entire family and

themselves alone in the room with their patient, and which task is more congenial than working with the family in the patients' mind? In this setting family therapists can do their best work knowing well which techniques can be used to help the patient rebuild his or her story, knowing the how-to and where to go.

The systemic approach can be effectively applied and integrated with Lorna Smith Benjamin's *Interpersonal Reconstructive Therapy*. The latter approach is now an integral part of our training, and it is extensively and successfully implemented in the individual treatment of our patients (Colacicco, 2014). We often refer to this approach in our manual, and to exemplify its use, we have included in the manual the script of a role-play session conducted by Dr. Benjamin with a trainee therapist and the script of a session I held with another trainee therapist in which I used the *diagram of well-being*.[3]

Regarding couple therapy, the clinical experience shared by several couples' therapists leads us to assert that there is usually a unique pattern which characterizes the couple's relational system: the psychic root of the original and spontaneous attraction which originally bound the partners (Caillé, 1990; Caillé & Rey, 1998, 2005; Elkaim, 1992). Couple's relationships cannot be understood only in terms of *the object relation* of a *single subject*; rather it presupposes the organization of reciprocal attractions which originate the birth of an "us". Unconscious collusion is a general phenomenon, present in all couples and found at all unconscious libidinal levels. It is the product of the combination between the shared general problem and the two different, complementary and opposite ways of dealing with it.

Our interest in this aspect is not merely diagnostic since it also holds important indications for treatment: identifying a problem in one of the two partners allows us to infer its presence in the other partner as well, even if it is expressed in opposite and complementary ways. It is on this core theme that therapy interventions should focus on the psychic interlacing which the couple weaves around the theme it has "chosen," on the study of the couple's affective dynamics, and on the use that the two partners make of the mutual bond.

This part of the manual summarizes the main technical aspects of couple's interventions, illustrating different case studies and the related therapy processes. There are extensive references to the contributions made by the most important couple therapists.

---

to choose to see individual members individually (Cancrini L. 1994, *W Palermo viva. Storia di un progetto per la prevenzione delle tossicodipendenze*, pp. 112–113, la Nuova Italia Scientifica, Roma).

[3] This diagram is a new and useful technique which can help the systemic-relational therapist on many levels: it enables the patient to narrate his or her personal, marital, or family history, highlighting the dysfunctional aspects, while using an alternative channel to that of the spoken word, with all the pros that can be derived from using an analogue technique. This allows patients to activate new learning processes, become aware of new questions and emotions which they experience in other contexts or which could be highlighted if freed from the rigidity of their scripts, rigidity which does not belong to a "linear" dimension but rather to a dimension which is "relational and circular."

Chapter 9 of the manual focuses on the systemic assessment and setting of therapy work with families and presents a map of family situations. This section is the core of the manual.

In 2005 a team working at the *Unità Operativa Dipartimentale di Psicoterapia della Sapienza, Università di Roma* (Department of Psychotherapy of *La Sapienza* University of Rome) began a research project on the assessment of psychotherapeutic treatment of families, couples, and individuals.

The research team devised a data collection form, in the form of a questionnaire, which was submitted to therapists to collect data on their work, analyzing individual case studies and keeping in mind that – when organizing their intervention – the systemic-relational therapists always collect data regarding which life cycle phase which the family is currently going through. For the systemic-relational assessment of family situations, a series of tables have been developed by matching life cycle phase, the specificities of the situation and the subjective emergencies, modifying and integrating the tables created by Luigi Cancrini (Cancrini, 1987; Cancrini & La Rosa, 1991), from which I drew the inspiration.

While this map covers all the main transitions of life, it does not claim to describe the entire "territory" of the different life situations. It does aim at providing the therapist with a possible pathway within which to move to be able to explore it.

For the systemic and relational assessment of family situations, a series of tables have been developed, combining the phases of the life cycle, the specificities of the situation treated, and the subjective emergencies raised by patients. The phases of the life cycle have been summarized as follows: young adult without ties in the organization phase; adult/young adult without ties and/or with unstructured emotional ties; emerging couple, couple with no children, with young children, with preteen and teen children, and with adult children; retirement; and old age. For each phase there is a corresponding table (which is in turn correlated with all the others) that cross-references the data of the different specific situations with those of the subjective emergencies raised, at the various levels (individual, family, couple, parenting, children, the elderly).

Following is an extract of our *map*, specifically the tables relating to the *launching* phase (children leaving home) and regarding the situations generated during this phase: the symptomatic emergencies generated by children leaving home (Table 8.1) and the parents' problems in releasing the children (Table 8.2).

The sample on which, in 2006, the final version of the data collection form[4] for the assessment of treatment with families, couples, and individuals was defined consisted of families, couples, and individuals which were being treated in three different structures: a public one, *Unità Operativa Dipartimentale di Psicoterapia* (a local public health service where patients pay a minimal for treatment); a private one, the *Istituto Dedalus* which is a psychotherapy specialization school where patients are seen in private practice; and a third institute, the *Centro di Terapia*

[4] The first version of the form was conceived and tested in 2004 at the Unità Operativa Dipartimentale di Psicoterapia of the "La Sapienza" University in Rome.

Table 8.1 Analysis of possible combinations between life cycle phase, situation experienced, and subjective emergencies caused by children leaving home

Life cycle phase	Situation	Subjective emergency
Adult children: Children are adults and begin to detach (leaving-home phase). The system accepts the increasing number of in-and-out movements. Newfound interest in the marital subsystem, development of equal relationships between parents and adult children, redefinition of relationships to include grandchildren and in-laws	**If solved,** the actual focus shifts towards growth-related goals and further differentiation. If the *individuation process is so uncertain that it entirely prevents leaving home or only allows an attempt to do so while never fulfilling this step:* **1. Leaving home is impossible**: children who have manifested difficulties during the identification phase begin to shutdown any chance they might have of leaving home, long before the moment in which this would normally take place. **2. Leaving home is unacceptable**: the family cannot cope with the emotional emancipation of a child. ***The leaving-home phase may also be:*** **3. Difficult or problematic**: the child has effectively left the house but faces challenges in reconciling the demands of the family with those of external reality; however, the actual focus is still towards growth objectives and further differentiation. **4. Apparent**: leaving home can be incomplete and partial with unexpected returns and severe personal limitations. **5. Compromised**: leaving home can only happen if the child takes on a family-mandated project	**Child level:** **Personality disorder**[a]: intense unstable personal relationships, self-destructiveness, chronic dysphoria (anger or boredom), transient episodes with psychotic manifestations or cognitive impairment, impulsiveness, identity disorders, poor social adaptation, constant strained efforts to avoid abandonment (real or imaginary), although these patients are not psychotic they display psychotic mechanisms. **1.** Functions occasionally **2.** "Low threshold" functioning (subject is easily triggered) **3.** Pervasive functioning (almost constant and without context distinctions) ***If leaving home is impossible there can also be:*** **4. "Developmental" forms of dissociative syndrome**: "true" schizophrenia according to authors who defend the need to distinguish between two types of dissociative disease. ***If release is unacceptable:*** **5. Psychotic breakdown in the form of psychosis or "acute schizophrenia"** (delusional *bouffée*, aigue of French psychiatrists). **6. Depressive breakdown or manic episode**, compensation, and chronicization of the same through **drug addiction.** **7. Severe psychosomatic disorders and psychogenic eating disorders**

[a]Different personality disorders can coexist within the same subject. According to Kernberg there is a borderline organization of basic personalities which can be found in different syndromes and in normal people when these are experiencing high stress levels. According to some clinical studies, this disorder can last a few years (five or so); then it calms down for a period and can return at a later age, when the children leave the home

Table 8.2 Analysis of possible correspondences between life cycle phase, situation experienced, and subjective emergencies raised by parents with children

Situation	Subjective and interpersonal emergencies	
If the ***individuation process is so uncertain as to allow only an attempt to leave home, or prevents it entirely:*** **1.Leaving home is impossible**: children who have manifested difficulties during the identification phase begin to shutdown any chance they might have of leaving home, long before the moment in which this would normally take place. **2. Leaving home is unacceptable**: the family cannot cope with the emotional emancipation of a child. ***The leaving-home phase may also be:*** **3. Difficult or problematic**: the child has effectively left the house but faces challenges in reconciling the demands of the family with those of external reality; however, the actual focus is still towards growth objectives and further differentiation. **4. Apparent**: leaving home can be incomplete and partial with unexpected returns and severe personal limitations. **5. Compromised**: leaving home can only happen if the child takes on a family-mandated project	**Parent experiences:** **1.** Free-floating anxiety or related to specific situations, which can evolve into a current neurosis. **2.** Reconversion hysteria or anguish. **3.** Simple forms of *vaginismus, impotentia consundi*, *eiaculatio praecox*. **4.** Different psychosomatic disorders. **5.** Trauma-induced depression (neurosis) (possibly alcoholism or type A drug addiction, trauma-induced anorexia). ***If parents cannot go through the leaving-home phase:*** **6.** Psychotic breakdown if leaving has not occurred. *or* **7.** Depressive (or manic) crisis if the leaving phase is incomplete. **8.** Possibly alcoholism or type B and C substance addiction, transitional anorexia and/or bulimia. **Personality disorder**: intense and unstable personal relationships, self-destructiveness, chronic dysphoria (anger or boredom), fleeting episodes of psychotic displays or cognitive impairment, impulsiveness, identity disorders, poor social functioning, constant efforts to avoid abandonment (real or imaginary), although these patients are not psychotic, they exhibit psychotic mechanisms. **9.** Occasional functionality **10.** "Low threshold" functionality (is easily triggered) **11.**Pervasive functionality (almost constant and without context distinctions)	**Couple experiences:** **1.** Conflict in the couple: brief and violent fights or continuous and explicit contrasts, with or without threats of separation. **2.** Behaviors which signal a break in the marital pair or in the workplace: crisis of the couple with conspicuous betrayals and/or separations or divorces. **3.** Different problems and difficulties in the area of sexuality, including recidivous or previously emerged issues. **4.** Modulation of marital conflict through the involvement of children (triangulations) **5.** Sudden professional crisis at work or search for new working conditions

Familiare of Lecce, which is subsidized by the local health authorities and therefore provides free treatment. Analyzing the data collected over a period of 3 years and relating to 150 case studies, we were able to reconstruct the main intervention models used by family therapist in these structures. This allowed me to summarize, in the manual, which systems the therapist intervenes on and how, who is called in for the sessions, and which interventions are made.

A) When

Children are small and must be accepted as new members of the system, when the parental subsystem is formed, the marital subsystem is re-established, relations with the trigenerational family are reformulated, and the roles of parents and grandparents are re-negotiated.
And the children present that series of disorders which are typical of early detection, problems in school, psychosomatic, and eating disorders or disorders of a psychotic type which are identified in secondary detection.
The family therapist's goal is to recreate conditions that foster the child's growth. He or she immediately calls in the sub-system in which the difficulty arose and works on the situation. Interventions are rapid and symptom-focused. The therapist seeks to leverage the awareness of the child's caregivers so that the child is not left behind, to encourage the development of socialization initiatives and to create a feeling of "team" collaboration among the adults. Parental competence is never questioned.

B) When

Children are teenagers, some have left school, others work, and others still don't; boundaries must become more flexible to allow for the independence of the children (relationships between parents and children shift and adjust to allow the adolescent to enter and exit the system); interests and relationships are newly discussed within the marital subsystem.
And children display disruptive behaviors which create a break from family and or school, difficult social relations, psychosomatic problems, eating disorders, or drug problems.
The therapist initially carries out separate interviews with the parents and with the adolescent and later builds a more flexible setting (sessions with the parents, the adolescent, the whole family); the therapist focuses on the system of alliances, trying to avoid falling into the trap of expressing compassion or solidarity for the younger patient or siding with the parents and assuming "normalizing" positions.

C) When

Children are adults and detach, the family system must accept an increasing number of movements in and out of the family; new interests are discovered within the marital subsystem, and new peer relations are established between parents and adult children. Relationships are redefined to include new partners, in-laws, and grandchildren.
And *the young adults express personality disorders, dissociative syndromes, severe psychosomatic disorders, depressive or psychotic breaks, or substance abuse*.
Therapist intervention is focused on involving the entire family, enrolling parental collaboration during crisis interventions; interventions are characterized by a strong insistence. The therapist must think in systemic terms and

make use of a syntaxis of the second type[5] implementing counter-paradoxical interventions.

In the second part of the chapter, the data collection form for the assessment of family, couples, and individual treatment is presented.

It is divided into six sections:

- The first section collects data regarding therapy setting (treatment procedure, referral, patient request, patient/couple/family socioeconomic data).
- The data collected in the second section concerns the assessment of psychopathology in all symptom-presenting subjects (using the DSM as a reference).
- The third section structures therapy intervention based on the systemic-relational assessment (connecting phase of the life cycle, type of situation, and subjective emergency). This assessment also aims at answering questions such as "When did the patients seek treatment" and "When did the problems first arise."
- The fourth section collects data regarding the implemented intervention. The focus here is on the treated system, on previous therapies, and on other structures or institutes involved. Data is collected regarding past hospitalizations, suicide attempts, prescribed medications, and the "incurred cost" which all this had on the subjects' lives before therapy. Lastly the focus shifts onto the therapist, requesting him or her to define the adopted treatment rationale and specifying which treatment approach was implemented, which goals were defined and which techniques were used to pursue them. Subsequently different aspects of the described therapy are analyzed including setting, history of previous treatments, and liaison with other structures involved in the treatment process and treatment effects. Treatment is described using a range of intervention characteristics describing the therapist's approach, his or her rationale, techniques, and tools adopted. These categories refer to a treatment plan designed for couples, families, and all those individuals who agree that all human systems can be effectively treated using the systemic-relational approach.
- The fifth section of data collected helps the therapist analyze his/her countertransference ((Cancrini, 1997, 1999; Colacicco, 2001; Eiguer, 1983; Fissi, 1986; Fruggeri, 1992; Nicolò, 1983; Shapiro, 1983) following three different paths. Because there is always a specific connection between impasse in treatment and

[5] In his book *Psicoterapia, grammatica e sintassi*, Luigi Cancrini analyzes the basic common rules of different therapy approaches and develops a two-level analysis: syntax – which concerns intervention guidelines and objectives – and grammar, which instead concerns the practical ways in which sessions are managed. Drawing on this analogy between therapy and language, Cancrini proposes a verbal scheme of therapy construction shared by all psychotherapists, identifying two possible outcomes of the therapy process: after having understood and expressed the significance of the symptoms, the reasons of all parties involved and having sympathized with the (designated) patient, the therapist can then choose to push the patient (or family) to change or to respect the deep motivations of the symptom (either because they are important or because they are too strong). Assuming this second position (syntax of the second type), the therapist applies a new logic and assumes a new position (no longer pushing the patient to change as is usually expected in treatment), implementing indirect and counter-paradoxical interventions (Cancrini L. 1987).

the therapist's countertransferral fixation (especially when the therapist works alone), we decided to analyze this aspect as well when assessing treatment. This is also why we ask therapists to compile a specifically designed table for all those situations in which they felt strongly emotionally involved.

- The last section collects data regarding follow-up sessions. The forms here are different for the different systems treated (family, couple, individual). Data on "incurred costs" is once again collected, this time posttreatment.

This form is part of the patients' case formulation and is necessary to collect and systematically organize the data collected by the therapist. It helps the therapist to both structure the therapy interventions and monitor their progress. This data collection form also enables the structure within which the therapist works to collect data on its users and to assess therapist interventions.

Two chapters follow, 10 and 11: *The territory, notes from my travels* and *Effectiveness of psychotherapy*.

In the former I illustrate some case studies to convey the sense of what happens inside the therapy setting, without the expectation of "showing exactly how it is done," rather to sketch out a rudimentary map of the territory. These are therapy narratives, reconstructions of therapeutic processes which tie the therapist and his/her patients, and in which the topics chosen only function as an example. Substance abuse, mental health problems, mothers with difficult children, anorexia, separated couples under court supervision, children's requests for help, etc. are all problems which patients bring into the therapy room: different situations which present a variety of different symptoms and which relate to different phases of the life cycle.

In the final chapter, I tried to underscore the importance of assessing therapeutic work. Therapy effectiveness is an extremely relevant and current topic. We are constantly pressured by the national health service to provide evidence of the effectiveness and cost of our work, pressured to measure and assess the quality of our work, yet it is only recently that therapists have begun to consider how to effectively measure the impact of their interventions through research studies (Colacicco, 2005). In this concluding chapter of the manual, I summarize the main criteria used to assess therapy effectiveness, referring to other authors who have extensively researched the subject, and I quote a few studies specifically designed to assess the long-term effectiveness of therapy on family systems.

8.3 Dissemination and Study of the Manual

In writing this manual, I made a conscious effort of integration and synthesis in an attempt to overcome that "observer assessment encoding" barrier which hinders our work as systemic therapists. It has been an effort aimed mostly at "searching for a different organization of the relationship between the figure and its background."

Since its publication, this manual and its data collection form have been widely adopted. One of the most convincing examples of its utility is provided by a research conducted by the *Centro Psicoterapeutico Familiare per le Dipendenze della ASL di Lecce* (Family Psychotherapeutic Center for Addictions, national health services, of Lecce) and by the Istituto Dedalus. A total of 136 case studies were analyzed, all treated by a team of 6 expert therapists who worked in pairs. Therapies were designed for single individuals, couples, and families; the patient sample mostly reported anxiety disorders or mood disorders (depression). Almost all cases presented a diagnosis on Axis I paired with a personality disorder on Axis II. Subjective emergencies and the subsequent request for treatment were experienced mostly by young adults with no significant pair-bond, either still in the organizing phase or with very weak emotional ties.

A large part of the case studies experienced distress during the family life phase with adolescent and preadolescent children. Treatments prescribed in these cases were mostly structural and involved families, couples, and single individuals, outlining a different profile for each system that was being analyzed.

The report's conclusions read "… the results suggest that the team working at the *Centro Psicoterapeutico Familiare per le Dipendenze* is capable of welcoming and responding promptly to a variety of situations of distress, providing focused and functional interventions. The *Centro* provides good quality psychotherapeutic treatment to the territory. Specifically, the results yielded by the follow-up show an improvement in patient psychological well-being which seems to have a significant effect even on the "incurred costs." Intercepting suffering and distress and providing structured interventions seem first and foremost to prevent a degeneration of the situation and to significantly and effectively help families, couples, and individuals to overcome specific problems related to their phase of the life cycle. Furthermore providing therapy treatment seems to have been beneficial to the general community,[6] lightening the load shouldered by other public services and reducing the number of absences from work.

Lastly, these research results suggest the efficacy of a multilevel assessment which enables therapists to go beyond the standard diagnosis, favoring the structuring and development of a therapy process. Further work is necessary to refine and gain mastery of these research tools in order to allow therapists to better their understanding of clinical situations and work towards the constant improvement of their clinical practice (Colacicco et al., 2014).

[6] The usefulness and effectiveness of psychotherapeutic interventions with the observed patients emerge from the follow-up forms. The results recorded by the data collection form were submitted to the institutes' administration for the assessment and planning of services for the local territory.

8.4 Conclusions

La Mappa del Terapeuta is a manual through which I have tried to summarize, with clarity and simplicity, the experience I have gained during my last 40 years, experimenting myself and everything that I have learned working with individuals, couples, and families.

"In the footsteps of Milton Erickson and his monumental work (Haley, 1985). Within a training path based on systemic work with families and which then came to consider the possibility, in some situations, of a work centered on the person" (Cancrini, 2013, *Presentazione*, in Colacicco F., *La mappa del terapeuta*, Scione Editore, pp. 9, Roma). Other systemic therapists (Boscolo & Bertrando, 1996) have faced the issue of varying their methods of intervention when deciding to work alone with a patient. In the manual I express my thoughts on this point, I illustrate my approach, and I give some indications of intervention, trying to integrate the *systemic* with the *relational* and the *interpersonal*. It is a book that aims to train students who are starting with the difficult work of the psychotherapist.

The history of psychotherapy is made up of conceptual and personal quarrels, which have given rise to an incredible number of schisms and schools. The attempt to fly a little higher, above sectarianism and mutual disqualifications, in search of what should be saved as useful for the work we have all chosen to do, has always been for me, as for Luigi Cancrini and many other psychotherapists of the Center for Family and Relational Therapy Studies, the founding element of a serious training of students, trying to offer them a wide repertoire of information and experiences that allow them to use an intelligent, reasonable, and especially useful eclecticism (for them and their patients), making them capable of modulating their interventions according to settings variation, and teaching them to work with individuals, couples, and families.

Acknowledgements There are many people I would like to thank for the work which has led to the creation and implementation of this data collection form, first and foremost my students and colleagues (Fulvia Adragna, Gabriella Maria Bianco, Federico Bussoletti, Serena Cesi, Claudia Colamedici, Patrizia Costante, Silvia Curiale, Tania Di Giuseppe, Angela Falvo, Giusy Granata, Dora Monaco, Teresa Pomponi, Anna Rosa Prete, Adriana Romano, Sandra Stefanelli, Alessia Supino, and Claudio Tramentozzi, Rosangela Vaglio). Special thanks go to Francesca Martini, who worked by my side in both developing the form and coordinating the entire research project.

References

Benjamin, L. S. (1996). *Interpersonal diagnosis and treatment of personality disorders*. The Guilford Press.

Benjamin, L. S. (2003). *Interpersonal reconstructive therapy*. The Guilford Press.

Benjamin, L. S. (2018). *Interpersonal reconstructive therapy for anger, anxiety, and depression. It's about broken hearts, not broken brains*. American Psychological Association, Washington.

Boscolo, L., & Bertrando, P. (1996). *Terapia sistemica individuale*. Cortina Editore.
Bowen, M., & Kerr, M. E. (1990). *La valutazione della famiglia*. Astrolabio.
Caillé, P. (1990). *Il rapporto famiglia terapeuta. Lettura sistemica di una interazione*. La Nuova Italia Scientifica.
Caillé, P., & Rey, Y. (1998). *C'era una volta. Il metodo narrative in terapia sistemica*. Franco Angeli.
Caillé, P., & Rey, Y. (2005). *Gli oggetti fluttuanti. Metodi di interviste sistemiche*. Armando Editore.
Caillé, P. (2015). Viaggio nella sistemica. In *Il terapeuta, le domande di aiuto, la formazione*. Alpes.
Cancrini, L. (1987). *Psicoterapia, grammatica e sintassi*. La Nuova Italia Scientifica.
Cancrini, L., & La Rosa, C. (1991). *Il vaso di pandora*. Carocci editore.
Cancrini, L. (1997). *Lezioni di psicopatologia*. Bollati Boringhieri.
Cancrini, L. (1999). *La luna nel pozzo. Famiglie, comunità terapeutiche, controtransfert e decorso della schizofrenia*. Cortina Editore.
Cancrini, L. (2012). *La cura delle infanzie infelici. Viaggio nell'origine dell'oceano borderline*. Raffaello Cortina Editore.
Cancrini, L. (2017). *Asccoltare i bambini. Psicoterapia delle infanzie negate*. Raffaello Cortina Editore.
Cancrini, M. G., & Harrison, L. (1983). *La trappola della follia*. La Nuova Italia Scientifica.
Canevaro, A., Selvini, M., Lifranchi, F., Peveri, L. (2008). *Terapia familiar sistemica col coinvolgimento dei familiari significativi*, Psicobiettivo, 1/2008, anno XXVIII, (pp. 143–166), Franco Angeli.
Colacicco, F. (2001). *Oltre il muro delle resistenze: importanza dei processi psicopatologici nell'informare il trattamento psicoterapico*, Ecologia dellamente, N.24, 2/2001. Il Pensiero Scientifico Editore.
Colacicco, F. (2003). *Alla ricerca dell'intreccio psichico della coppia*, Ecologia della mente, 1/2003. Il Pensiero Scientifico Editore.
Colacicco, F. (2005). *In tema dell'efficacia delle psicoterapie, con particolare riguardo alla terapia familiare e al suo insegnamento*, Ecologia della mente, 1/2005. Il Pensiero Scientifico Editore.
Colacicco, F. (2007). *La ruota che stride. Meccanismi di difesa e trattamento psicoterapeutico*, Ecologia della mente, 2/2006. Ecologia della mente.
Colacicco, F., Martini, F., Bianco, G. M., Prete, A. R., Romano, A., Vaglio, R. (2014). *La valutazione del trattamento psicoterapico con le famiglie, le coppie, gli individui*, Ecologia della mente, Vol. 37/2014. Il PensieroScientifico Editore.
Colacicco, F. (2013). *La mappa del terapeuta*. Scione Editore.
Colacicco, F. (2014). *Ogni psicopatologia è un dono d'amore*. Scione Editore.
Colacicco, F. (2017). *Il giocatore di scacchi. Una metafora per le relazioni interpersonali*. Alpes.
Eiguer, A. (1983). *La terapia familiare come processo transferenziale: Transfert, contro- transfert e neuropsicosi da transfert*, Terapia FAmiliare, 14, (pp. 65–86), I.T.R.
Elkaim, M. (1992). *Se mi ami non amarmi*. Bollati Boringhieri.
Fissi, S. (1986). *Legittimità e delimitazione del concetto di controtransfert in terapia familiare*, in Terapia Familiare, (p. 21), I.T.R.
Fruggeri, L. (1992). *Le emozioni del terapista*, Psicobiettivo, 3, (pp. 23–34), Franco Angeli.
Haley, J. (1985). *Conversation with Milton H. Erickson, M.D.* (Vol. I, II, III). Triangle Press/ W.W. Norton & Co..
Loriedo, C., Angiolari, C., & De Francisci, A. (1989). *La terapia individuale sistemica*, Terapia Familiare, 31, (pp. 13–25), I.T.F.
Malagoli Togliatti, M., & Rocchietta Tofani, L. (1987). *Famiglie multiproblematiche. Dall'analisi all'intervento su un sistema complesso*. La Nuova Italia Scientifica.
Nicolò, A. M. (1983). *Sull'uso del contro-transfert in terapia familiare: spunti per una discussione*. Terapia Familiare, 13, (pp. 97–100), I.T.F.

Scabini, E. (1995). *Psicologia sociale della famiglia. Sviluppo dei legami e trasformazioni sociali*. Bollati Boringhieri.
Selvini Palazzoli, M. & Viaro, M. (1989). *Il processo anoressico nella famiglia: un modello a sei stadi a guida del trattamento individuale*, Terapia Familiare, 30, (pp. 5–19), I.T.F.
Shapiro, R. J. (1983). *Il controtransfert in terapia familiare*, Terapia Familiare, 13, (pp. 91–96), I.T.F.