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8 Systemic Family Therapy

Systemic family therapy has evolved across geographical locations since the early 1950s. Clinically, it developed in the context of a number of therapeutic movements, including child guidance clinics, marriage counselling, and sex therapy. Whilst it is theoretically rooted in the interdisciplinary field of systems theory, or cybernetics, systemic family therapy has prided itself upon its development from practice to theory. It has also been open to influence from a heterogeneous range of other psychotherapeutic approaches and wider intellectual currents. Distinct phases of development are often identified, within which more specific schools have emerged, frequently connected with specific practitioners or clinics. These are outlined in detail elsewhere (e.g., Dallos & Draper, 2010). We present a brief overview of some of these schools before focusing on an integration of enduring systemic ideas that characterises contemporary systemic practice, especially in the UK (Vetere & Dallos, 2003). We use ‘systemic family therapy’, ‘family therapy’, and ‘systemic practice’ interchangeably to refer to therapeutic practice based upon systemic principles; other therapies delivered to family groups based upon different theoretical principles (for example behavioural family therapy; Falloon, 1988) are not discussed here.

Key systemic approaches include:

- *Structural family therapy*, largely developed by Salvador Minuchin (e.g., 1974) and colleagues in New York in the late 1950s and 1960s.
- *Strategic family therapy*, developed initially during the late 1960s and 1970s at the Mental Research Institute (MRI) in Palo Alto, California. Key figures included Don Jackson, John Weakland, and Paul Watzlawick (e.g., Watzlawick, Weakland, & Fisch, 1974). Strategic approaches were further developed during the late 1970s and 1980s in Milan by a group including Mara Selvini Palazzoli, Luigi Boscolo, Gianfranco Cecchin, and Guiliana Prata (e.g., Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1980). Later, the group divided and ‘post-Milan’ approaches were developed (e.g., Cecchin, 1987).
- *Social constructionist approaches* began to influence systemic therapy from the late 1980s onwards. This influence is particularly evident in narrative therapy, developed in the 1990s by Michael White from Australia and David Epston from New Zealand.
- *Solution Focused Brief Therapy* also sits within systemic approaches. It was developed during the 1980s by Steve de Shazer, Insoo Kim Berg, and colleagues in the Milwaukee Brief Family Therapy Centre.

8.1 The Central Tenets of Systemic Family Therapy

8.1.1 Systems Theory

The interdisciplinary study of systems theory (Von Bertalanffy, 1950) underpins family therapy. It is this theoretical framework, alongside an emphasis upon working with several people at once, that distinguishes family therapy from other therapeutic approaches. Systems theory assumes that the behaviour of a system can only be understood by considering the individual characteristics of elements within the system, *and* the relationship between these elements. Families are ‘systems’ of people, which in turn relate to wider social systems. As individual experience is seen as fundamentally interpersonal, rather than intrapersonal (Vetere & Dallos, 2003), psychological distress is viewed as being intimately bound up with relationships (Dallos & Draper, 2010). Any particular ‘problem’ is not seen as a problem *per se*, but part of a larger process involving many other people, behaviours, and meanings (Campbell, Coldicott, & Kinsella, 1994). This contrasts with many psychotherapeutic approaches which focus primarily on the individual’s intrapsychic experience. That said, intrapersonal experience is not denied: Minuchin (1974) suggested that the structural family therapist could be compared to a technician with a zoom lens, who could zoom in to study the individual’s intrapsychic experience but could also observe with a broader focus on the system.

Several fundamental cybernetic ideas have endured throughout the history of systemic family therapy. There is an interest in how different members of a family *communicate* with each other: what and how things are expressed, and what goes unexpressed. Communication is the principal means by which different members of a system relate to each other and therefore a key area for intervention. Systemic family therapists are also reliably interested in the *(in)stability* of systems. ‘Stuckness’ or change are as likely to be the product of the flow of communication or information between parts of a system as of the intrinsic properties of any one person or part (Selvini Palazzoli et al., 1980). Finally, because specific behaviours and experiences are viewed as the collective achievement of many parts of a system, causation is considered to be *circular* rather than linear. This means that a cause cannot be traced backwards in a linear or reductionist fashion to an original source, meaning that any solutions to an apparent problem do not need to tackle the problem ‘at source’, but can be found in many places in a system; successful change is therefore achieved through the spiralling effects of feedback throughout the system (Penn, 1982). Families and therapists often seek the satisfaction and certainty of a linear explanation for problems, but this carries the risk of closing down opportunities for change that lie in unexpected places (Cecchin, 1987).

8.1.2 The stance of the therapist

A key feature of family therapy, especially in the function and purpose of formulation, is the emphasis on the therapist's use of 'self', and awareness of the stances they might take within sessions. It should be noted that there is little persuasive evidence for the relationship between this and the outcome of therapy (Horne, 1999), but it is generally accepted that the therapist should adopt a 'not-knowing' position and avoid imposing 'expert' therapeutic values (Amundson, Stewart, & Valentine, 1993).

This "not knowing" stance is usually considered necessary but not sufficient: the therapist may change stance depending on whether they wish to 'elicit' ideas and theories about the problem; 'probe' and offer new ideas or descriptions; 'contextualise' to make connections between a behaviour or idea and overall patterns in the system; 'match' to reflect back and empathise; or 'amplify' a particular idea, affect, theme, or behavioural sequence (Real, 1990). These stances are not exhaustive, but offer an illustration of how the therapist may shift their intentions and actions. The therapist should also be sensitive to their own experience as a potential tool that can further the therapeutic process (Rober, 2011). This has important implications for formulation: the therapist is not the fount of expert knowledge in which the solution will be found. Instead, they are a catalyst for change, using hypotheses to initiate and encourage change within a system.

8.1.3 Formulation Within Family Therapy

'Formulation' is not a term used in early family therapy literature, but has become more commonplace, perhaps particularly where clinical psychologists are also family therapists (e.g., Dallos & Draper, 2010). However, the processes of 'formulation' can be seen throughout the literature, as therapists drew connections between assessment information and systems theory to develop an understanding of problems and to devise an appropriate intervention. A seminal paper (Selvini Palazzoli et al., 1980) introduced three guidelines for family therapists, including 'hypothesising', which translates to what might be considered formulation. The Milan school were not concerned principally with the truth value of a hypothesis; rather, they were interested in a hypothesis' capacity to stimulate change in a system – it should offer the starting point for further investigation and should help the therapist to construct circular questions.

One legacy of the Milan approach is the caution provided to family therapists against 'marrying' our own hypotheses, at which point they cease to be helpful (Cecchin, 1987). Instead, they should revise their hypotheses in light of feedback from the family, and there is some evidence that therapists' reformulation of events and behaviours are an important component of therapy, in that they open up new possibilities for action and experiences (Sundet, 2011). The family therapist should never

reach their final destination of complete understanding of their clients, as the not-yet-said is infinite (Rober, 1999).

Unlike some other approaches, family therapy does not have a range of pre-determined, problem-specific formulation models, although each of the schools offers specific ideas for formulating and intervening. There are no clear and detailed guidelines for family therapists to follow (Dallos & Draper, 2010), but rather a number of ‘reference points’ that might guide hypotheses (Boscolo & Bertrando, 1996). These are grounded in relevant theory, including ideas about attachment, power, and gender. Ideas about transitions in family boundaries (e.g., Wood & Talmon, 1983) and attachments (e.g., Byng-Hall, 2008) also offer frameworks for thinking about why difficulties arise within families.

8.1.4 Theories About ‘Problems’

While all systemic approaches share the quite abstract principles described above, they vary significantly in the more concrete or mid-level concepts that they use to hypothesise why problems emerge within systems and how change might happen. These include behavioural patterns, belief systems, or emotional patterns within the family system, and the relationship between the family and wider cultural and political contexts (Vetere & Dallos, 2003). Systemic family therapists therefore draw upon a rich and diverse range of ideas, change might take place at a number of inter-related levels, and the formulation may well depend on the level of change that the therapist and family are working to create.

8.1.5 Structural Concepts

Structural perspectives focus on the organisation of family, including hierarchies and subsystems within the family, boundaries, rules, members’ roles, and transactional patterns (Vetere, 2001). Family ‘function’ or ‘dysfunction’ would be determined according to how well or otherwise the family structure serves the developmental needs of the family members, and ‘symptomatic behaviour’ would be viewed as relating to some form of dysfunctional organisation (Colapinto, 1988). However, it is also assumed that the family has the competence to draw on inter- and intra-personal resources to bring about change, supported by the therapist (Vetere, 2001). The aim of therapy from a structural perspective is therefore to change the organisation of boundaries and related closeness or distance between family members and subsystems, in order to change each individual member’s experience (Minuchin, 1974). The therapist aims to achieve this by supporting what is going well in the family, and joining family members to create changes in structures that are sustainable by challenging symptomatic behaviour, family structure, and/or family belief systems (Vetere, 2001).

8.1.6 Strategic Concepts

Strategic family therapy is so called because the therapist designs strategies in order to create change (Rosen, 2003). Within this approach, people are seen as inherently 'strategic' in attempting to influence each other, and problems are viewed as being embedded in repetitive interactional patterns (Dallos & Draper, 2010). Problems may be formulated as having a function within the system, such as maintaining system stability, and within therapy the therapist may 'reframe' the problem in terms of considering what function a particular problem might serve for members of the family.

An enduring strategic idea is that families may attempt to solve problems, but that repeatedly used ineffective solutions maintain problems, or give rise to new problems. When families present for help, it is often the ineffective solution, rather than the original problem, that is causing most difficulty. The aim of strategic approaches is to create behavioural change by disrupting unhelpful interactional patterns that inadvertently function to maintain the problem. The therapist contributes to the change process by encouraging experimentation to creatively solve challenges in novel ways, as well as encouraging what might be usually discouraged within the family, and emphasising and encouraging the clients' competence (Keim, 2012). The therapist might use a broad range of strategies and techniques designed to influence the specific family system. A range of example interventions are offered by Smith, Ruzgyte, and Spinks (2011).

8.1.7 Social Constructionist Concepts

The influence of social constructionism gave rise to even greater emphasis within family therapy on the role of language and multiple layers of context in creating and maintaining psychological distress. This emphasis owes a particular debt to the social constructionist argument that language, to a significant degree, constrains what can be thought and communicated about difficulties, and acts to help constitute subjective experience. Change within therapy was therefore seen to be brought about by the evolution of new meaning through dialogue (Anderson & Goolishian, 1988). The 'story' metaphor has had particular influence. This suggests that the 'problem saturated' stories that families frequently carry about their difficulties, whilst appearing to be convincing explanations, also serve to obscure possibilities for change. Therapists are concerned with assisting families to author alternative accounts of their lives that open up possibilities for change in action and experience.

8.2 Moving Towards Integration of Systemic Approaches to Formulation

In our formulation we draw upon an integrated model of systemic formulation first proposed by Vetere and Dallos (2003) and since discussed by Dallos and Draper (2010), and Dallos and Stedmon (2014). It proposes that assessment and formulation are two, interconnected processes referred to as ‘analysis’ and ‘synthesis’. Analysis refers to the exploration of the nature of the family and their problems, while synthesis refers to ‘starting to integrate the strands of information in preliminary hypotheses or formulations of the problem’ (Vetere & Dallos, 2003, p. 75). The model attempts to reflect the differing emphasis placed by different phases of family therapy on patterns and processes, cognitions, language, and cultural contexts, and draw these together into one model, with five parts:

1. The problem – deconstruction
2. Problem-maintaining patterns and feedback loops
3. Beliefs and explanations
4. Emotions and attachments
5. Contextual factors

Our experience of using this model within clinical practice has highlighted its strengths but also potential challenges. Its breadth can be advantageous, in allowing consideration of a range of relevant factors drawn from the different schools of systemic family therapy. However, the model also throws open a challenge to the clinician in terms of where and how to focus within any of the five areas. There is no suggestion that the five parts of the model are intended to be considered sequentially, and in practice, there is often significant overlap between the five areas.

8.3 Empirical Evidence of Effectiveness

Family therapy has traditionally had an uncomfortable relationship with the decontextualized empiricism that characterizes much psychotherapy outcomes research. Arguably, research into therapies that focus on one individual offers clearer measurable outcomes than therapy with a relational focus. Not only might therapists and service commissioners have different views on outcomes, but different members of the same family may also have disparate views on what constitutes both the problem and the desired outcomes (Chenail *et al.*, 2011, cited Chenail, 2013). There are also challenges regarding what constitutes a measurable outcome, and how to capture therapeutic change that takes place during and outside therapy sessions, and both within and between individuals (Heatherington, Friedlander, & Greenberg, 2005).

Nevertheless, as the political climate of service provision has changed, there has been exponential growth in research during the past three decades (Sprenkle, 2012) and increasing interest in practitioners conducting research (e.g., Williams, Patterson, & Edwards, 2014). There is now evidence that family therapy can be effective for a wide range of difficulties across the life span (Stratton, 2005), although there remain significant gaps in empirical evidence for widely used approaches, including narrative therapy (Heatherington et al., 2005). Qualitative evidence has also begun emerging regarding families' experiences of therapy (e.g., Chenail et al., 2012). The evidence for one particular type of family therapy over another remains equivocal. Why family therapy works, or when and under what circumstances, remains "shrouded in mystery", and there is little to refute the hypothesis that family therapy works because of common mechanisms of change across all approaches (Sprenkle, 2012, p. 25). These common factors include conceptualising difficulties in relational terms, working to disrupt dysfunctional relational patterns, expanding the direct treatment system, and expanding the therapeutic alliance (Sprenkle, Davis, & Lebow, 2009), and support an argument for the integrated approach outlined above. It is also important that research evidence in isolation does not determine clinical decisions made by therapists, who should integrate the evidence-base with the culture, values, and preferences of clients, and their own clinical expertise, in order to deliver competent therapy (Chenail, 2013).

8.4 Critique

In a certain sense, systemic family therapy has been its own strongest critic. One reason for the fractured evolution of this approach is the willingness of practitioners to criticise their particular school, and draw upon a range of ideas to inform these criticisms. Implicit assumptions about 'normal families' underpinning earlier structural approaches, ethical concerns that a therapist might seek to be 'neutral' when particular family members may be oppressing or abusing other family members, and other aspects of family therapy have been critically and rightfully scrutinised (Dallos & Draper, 2010). However, many of the attributes of systemic family therapy described above might be considered potentially problematic, either as a basis for formulation, or more widely as a school of psychotherapy demanding a significant place within psychological healthcare. The emphasis upon the inter-personal certainly appears to have resulted in an under-theorisation of intra-psychic phenomena, and the lack of models to explain the aetiology and development of specific problems, whilst consistent with a systemic epistemology, means family therapists must work from broad principles rather than a precise 'recipe'. This perhaps compares unfavourably with the testability and consistency offered by increasingly prescriptive cognitive-behavioural approaches to formulation and therapy, and potentially carries the risk that

family therapy constructs and interventions can be used by some clinicians in an ineffective or theoretically contradictory manner.

Clinical work with multiple persons and teams of therapists may also be alien to clients expecting an individual approach, and the use of teams of therapists might be considered costly by service commissioners. However, research examining the costs of such approaches at the two-year follow-up stage suggests that family therapy is no more costly, and may be substantially less costly, than other therapies (Stratton, 2011).

8.5 Formulation in Action

Below, we illustrate the process of formulation in three stages. First we consider our initial responses to the case. Second, we describe an ‘analysis’ of some potential systemic hypotheses following the five areas described above. Finally, we present a distilled ‘synthesis’ of these ideas.

In keeping with the use of self and reflexivity in family therapy, we gave thought to the information that appeared most salient to each of us individually, considered our initial positions in relation to different members of the family, and how these might create ‘blind spots’ or potential biases during formulation and therapy. Anna’s initial thoughts were as follows:

I was struck by the apparent lack of affirmation Molly received from her parents, in contrast to my own experiences as a daughter. Molly’s wish to make her parents proud because of their emphasis on success was in common with my own wish to make my parents proud through achievement. However, I was fortunate to draw on emotional and practical resources from my parents. Initially, I found it difficult not to align myself with Molly ‘against’ her parents for expecting her to succeed, but seeming to ‘fail’ to provide the foundations from which she could achieve. I would need to remain cognisant of this within sessions in order not to privilege her perspective over that of her parents. I also have strong feelings against the medicalisation of distress; I was conscious that I felt angry that it seemed the systems around Molly may be more willing to frame her as ‘histrionic’ or ‘ill’, rather than consider how sexual abuse or familial and social circumstances may have contributed to her distress.

Mike’s initial thoughts were as follows:

I was curious about when (if ever) relationship difficulties had not been such a significant part of Molly’s life. On first reading the case summary, a ‘problem saturated’ story of Molly’s life seems unavoidable. Her descriptions of relationship difficulties and disappointments at various stages of her life make this appear to be a long-standing and continuous problem. Her experience of being sexually abused and the lack of a supportive response to this might well account for some of these difficulties. However, this story might risk neglecting important contextual aspects of each significant relationship experience, although I’m aware that this response might constitute ‘wishful thinking’ on my part, and inquiring after ‘exceptions’ to troubling experiences must never be allowed to be construed as a lack of appreciation of the seriousness of a person’s dif-

difficulties. I was also concerned with Molly's apparent reluctance to discuss her experience of sexual abuse. There might be any number of potential hypotheses to explain this reluctance, but I would be interested in how we might talk about 'talking about the abuse', in order that any discussion of such a potentially significant experience does not compound the apparent harm of the lack of response to the abuse when it occurred.

To best illustrate the process of formulation in systemic practice, we begin by sharing our development of many potential systemic hypotheses. The information most pertinent to the formulation is that which gives insight into the relationships between Molly and her family/social systems, both past and present. In many respects, information about presenting 'problems', such as eating and sleeping patterns, would be less pertinent to us, as these would be seen as a manifestation of relational difficulties. However, they must not be dismissed, as they may be viewed as 'the problem' by Molly and connect to her goal to 'get better'. Changes in these reported difficulties may also provide an opportunity to measure change.

8.5.1 Deconstruction of the Problem

We agreed to prioritise the deconstruction of the problem. This would include consideration of how different members of the family define the problem, how the problem affects relationships and vice versa, for whom the problem is most difficult, the life history of the problem, and exceptions to the problem (Vetere & Dallos, 2003). At this point, we only have information from Molly, which would be a significant limitation. We would want to seek information from family members by inviting them to a family session.

On the whole, Molly frames the problem and the onus for change as located within her, e.g., referring to needing help to "sort (herself) out". There are many indications of her perceived personal failings, such as being unattractive, under-achieving, unable to fit in, and unable to meet the sexual needs of potential partners. Even where problems have arisen in the context of other people behaving in particular ways towards her, Molly frequently frames the problem as her reaction to them. Similarly, family members appear to locate the problem within Molly, viewing her as "overly emotional". To us, the interpersonal nature of Molly's difficulties seems evident throughout her history and current concerns, and our first hypothesis is that the array of difficulties Molly describes over time are signs of a struggle to 'fit in' with her family and wider social system. Moving towards a more systemic deconstruction of the problem may be a challenge, as we would be starting at a very different position to Molly and members of her system. This also highlights some of the inherent tensions within contemporary family therapy, as our fundamental hypothesis that the problem is relational may be seen to contradict the adoption of a 'not knowing position'. As family therapy values and allows for multiple perspectives to be heard,

we would not seek to dismiss individualised conceptualisations of Molly's difficulties, but to open up the possibility that Molly's difficulties may be *both* located in her (through their construction within the language of the system) *and* relational in their origin and maintenance.

There do appear to be some exceptions to Molly's difficulties, including: success at school; forming relationships (both with men and colleagues); gaining employment; initially enjoying living independently in her flat and being motivated; and some positive relationships with staff during her inpatient stay. Further, some of the problematic processes identified below might very well be intended to solve other problems. Any such exceptions or good intentions might be drawn upon in both the development of hypotheses and during interventions, but remain undeveloped and relatively untouched at the stage of assessment.

8.5.2 Problem-maintaining Patterns and Feedback Loops

Here, we would be interested in considering the structures of the family and any repetitive behavioural patterns based on feedback loops within the system (Vetere & Dallos, 2003). Drawing on structural family theory, it could be suggested that the boundaries between family members seem to be rigid to the point of disconnection (Minuchin, 1974), and have led to a perceived lack of emotional connectedness between family members. However, in light of Anna's aforementioned reflections, it would be important to understand the boundaries of the family from the perspective of each of its members, rather than imposing the therapist's own, potentially biased, perspective.

We would not argue that the kind of family structure described by Molly is always problematic, but that in some circumstances there is a poor fit. In Molly's case, this structure might have significantly reduced the family's ability to respond to her experience of sexual abuse in a constructive fashion. Indeed, Molly herself reported feeling constrained from disclosing the abuse, and her family appear not to have been alert to any changes in emotion or behaviour that Molly most likely experienced after the abuse.

The family organisation may have compounded these difficulties later. The transition out of the family home to university was difficult for Molly. Transitions such as a child leaving home are often stressful for the system, and the family will sometimes respond by clinging to old roles and patterns (Wood & Talmon, 1983). In addition, there is evidence that parent-daughter boundaries are connected to young adult females' development of an independent identity (Fullinwider-Bush & Jacobvitz, 1993). Molly attempted to follow a 'normative' path of going to university, but "failed" to take this step towards autonomy, relative to both the family norms and expectations (achieved by her sister), and broader social norms. It may be that this context perpetuated the organisational family pattern of Molly being identified as "overly emotional" by other family members.

The primary feedback loop we would be interested in focusing on relates to Molly's expression of emotion and need for closeness, and the apparent consequential rejection by others, which may lead to an escalation in both distress and rejection. An alternative is for Molly to suppress the expression of her emotional needs, but this may lead to other manifestations of distress. We also considered a feedback loop in which Molly aims to please others but has never quite succeeded or 'failed enough'; her successes have not been sufficient to achieve the kind of recognition she seeks from her parents (in particular), but neither has she failed sufficiently to prompt experimentation with other goals or life plans.

Two other possible feedback loops were identified that might be of relevance, but which will not be the key focus of the present formulation. The first related to Molly's difficulties having sexual relationships, leading her to avoid intimacy. This in turn may lead others to view her as not seeking intimacy, thus maintaining the difficulty by reducing opportunities to develop sexual relationships. The second related to Molly withholding information about being sexually abused from her family through fear of 'wrecking the family'. The family is therefore denied the possibility to respond in any way, maintaining Molly's fear and anticipation of a catastrophic response, and potentially facilitating further withholding of information.

8.5.3 Beliefs and Explanations

We would also explore different levels of beliefs about the problem and what should be done about it, including family members' perceptions, and socio-cultural beliefs and discourses from outside of the family (Vetere & Dallos, 2003). There appears to be congruence between Molly's belief that she is not coping, and the family belief that she is 'over emotional'. These beliefs might also link with discourses in mental health services about individuals who may be discussed as having a 'personality disorder'. The interaction between these beliefs at different levels may contribute to a dominant story that the problem is located within Molly, and is related to her personal failings, rather than having a relational aetiology. It is striking that these explanations do not draw upon Molly's experience of sexual abuse and the lack of a protective response to this. Further, these explanations do not really account for exceptions when Molly has been able to function well and relate to others.

8.5.4 Emotions and Attachments

In deconstructing the problem, we were particularly drawn to the hypothesis that expressions of emotion were discouraged within the family and that Molly's emotional expression led her to be viewed as "overly emotional". This is a pattern that appears to have occurred in Molly's other relationships, and in the initial response

she received from mental health services. Molly's expression of emotion might be helpfully understood as an attachment behaviour with an *intended* function of securing relational safety and closeness, but an *actual* effect of troubling her relationships and triggering further distress.

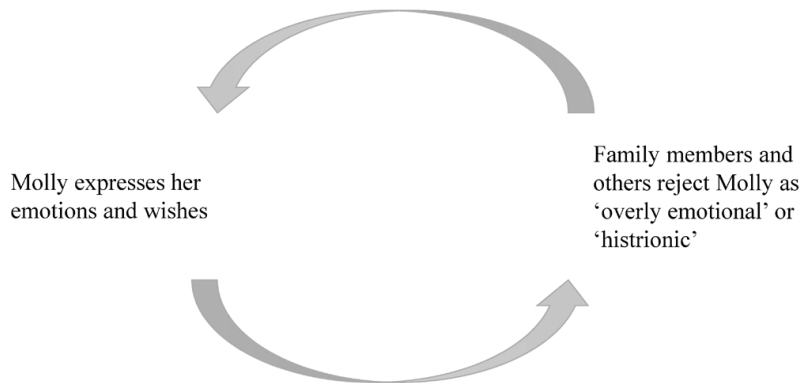
8.5.5 Contextual Factors

These factors relate to resources, the history of the problem, environmental factors, extended family, role of professional agencies, and cultural discourses (Vetere & Dallos, 2003). These have largely been addressed in the previous sections of the model so will not be considered further here.

8.5.6 Initial Formulation

The analysis above using the integrated framework helped us to consider a range of systemic ideas and theories that may be relevant to developing a formulation of Molly and her difficulties. However, it already appears “like an overwhelming kaleidoscope of factors” that need to be synthesised into a manageable formulation (Vetere & Dallos, 2003, p. 81). In reality, we would not be sharing hypotheses with the family based only on information from one family member. Instead, we would work from a position of curiosity with the family to develop and revise hypotheses that may be useful in introducing potential for change. Hypotheses would be shared with the family soon after they came to mind, to lead to the family discussing the idea (Byng-Hall, 2008) and to facilitate opportunities to respond to their feedback in line with the principle of circularity (Selvini Palazzoli et al., 1980).

Molly's identity is dominated by beliefs or a dominant ‘story’ that she falls short of her own and other people's standards and expectations, both in terms of relationships and achievements. These beliefs seem to have developed through early experiences of family relationships and continue to affect her relationships with others within and outside of the family. Molly is more open about expressing her emotional needs than her parents. Molly's mother in particular seems to focus on achievements rather than emotions in her interactions with Molly, perhaps because she was keen for her daughter to be ‘successful’. The problem maintaining feedback loop below outlines the relationship between Molly's emotional expression and her family's view of her:



The problem may escalate as Molly experiences increased distress in response to rejection, or expresses her emotional needs in other ways (including some of the behaviours she sees as problematic), which may in turn lead to further actual or anticipated rejection. Molly's experience of sexual abuse, and her fear of rejection if this is disclosed, may also contribute to this problem-maintaining feedback loop.

However, it is important to note that the formulation remains tentative and could change significantly when different perspectives from other family members are put forward.

8.5.7 Intervention Objectives

The objective of the therapy would be to achieve positive change for Molly in the areas that she has identified. However, in keeping with the wide range of options available for change within systemic practice, the 'specific' mechanisms of change are potentially still broad – creating change in any of the behavioural patterns, belief systems, or emotional patterns within the family system and in the relationship between the family and wider cultural and political contexts (Vetere & Dallos, 2003). Given the complexity of even small social systems, how change unfolds must be regarded as uncertain. Rather than prescribing precise targets for change, formulation in systemic practice suggests areas for therapists to focus upon. Skilfully done, these therapeutic efforts will incite changes in patterns of communication, belief, and behaviour in the areas of most concern to the family.

Ultimately, Molly and her family must determine whether the objective of achieving positive change has been met. In systemic practice families are frequently invited to comment on whether any progress is being made. 'Scaling questions' are a well-known technique of monitoring progress towards problem resolution, using a ten-point scale (Berg & de Shazer, 1993). To aid the measurement of change, we could also use a well-established contemporary measure of family functioning and change, such as the SCORE-15 – derived from the original SCORE-40 (Stratton, Bland, Janes, & Lask, 2010, see aft.org.uk/view/score.html).

8.5.8 Intervention Plan

In keeping with a systemic approach, here we identify our starting point for therapy and likely approach to the work. Anything more specific would assume that our ideas and practice would not change across the therapy, which is certainly not the case.

A systemic intervention would most likely face two initial challenges: firstly, joining with the family to promote a family level solution to something that is perceived to be an individual's problem; and secondly, beginning the work with a systemic hypothesis that challenges key family beliefs. Our starting point would be to invite the whole family into a therapy session, if they were willing, in order to focus on the relational aspects of Molly's difficulties. As therapists, we would aim to create a secure therapeutic base for the family; the initial session may last an hour and a half or more, to "allow time for difficult issues to emerge with some intensity and have some chance of being addressed" (Byng-Hall, 2008, p. 138). Molly would also need to be given individual time, apart from her family, to consider how and when her experience of abuse may, or may not, be discussed.

A range of question types would be used within sessions to facilitate 'interventive interviewing' (Tomm, 1988) – a style of asking therapeutic questions that potentially fosters change in a system. Lineal questions would be used first in order to establish the definition of the problems from the perspective of each family member. Circular questions would then be used more frequently to compel the family to experience the circularity of their family system, to shift away from more linear stances, leading to increased perceived membership of the problem (Penn, 1982). This would open up the possibility for new stories to develop within the family system based on familial patterns rather than "truths" and facts (Cecchin, 1987). We would also be interested in identifying patterns or scripts within the family that highlight how family roles have developed (Byng-Hall, 2008), and may use genograms of wider family relationships to reveal broader patterns (McGoldrick, Gerson, & Petry, 2008).

If within-session exploration supported the initial formulation outlined above, the aim of therapy would be to disrupt these patterns by focusing on both how Molly expresses her emotional needs, and how others respond to her. In addition to the above, we might make use of strategic questions, which are designed to influence the client or family in a specific way, in this case by reducing the likelihood of them continuing along the same problematic path (Tomm, 1988). Reflexive questions would also be used to encourage the family to generate their own connections and solutions in their own manner and time (Tomm, 1988). By generating alternative ways of behaving, and fostering alternative beliefs about the behaviour within the family system, we would be optimistic that beneficial therapeutic change would be forthcoming. However, if change within the system was difficult to enact, we would revisit our hypotheses and formulation in order to identify any crucial information we may have missed, and reflect on any assumptions that were made that may have been erroneous or that led to a less effective way of working with this particular family system.

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8.6 Systemic Family Therapy Formulation: Critical Commentary

“The map is not the territory” warned Alfred Korzybski more than 80 years ago, and the metaphor of the map helps to portray some of the issues involved in critically reviewing a case formulation developed from a theoretical framework different to one’s own. Just as a topographical and a geological map will show different features of the same terrain, so the different observational perspectives entailed by the various therapeutic orientations afford different representations of the same clinical phenomena. Some discrepancies are simply a matter of nomenclature, allowing for straight translations between alternative formulations; others represent different emphases in observation. We can compare divergent maps and even enter into their particular viewpoints if they share sufficient common characteristics. By contrast, we would have difficulties recognising a territory represented by aboriginal songlines, and our pets presumably have precise olfactory maps of our homes to which we have as little access as they have to our carefully drawn floor plans. What allows us as psychologists to mediate between our varying therapeutic perspectives are common clinical observations, which – although constrained by our interpretative scaffolds – are relatively constant, and our shared commitment to paying attention to evidence, both from the narrower clinical and the broader psychology sources, even though we may argue about what should count as legitimate evidence.

Regarding this latter point, we think that the authors of this chapter could have been bolder in arguing not only for the possibility, but indeed for the necessity of using multiple sources of evidence. While systemic approaches and ISTDP share misgivings about the ‘decontextualized relationship that characterises much psychotherapy outcome research’, there are serviceable alternatives. Contemporary ISTDP researchers make extensive use of single case study designs for investigating both outcome and process. With this in mind, there is no good reason why the processes and contexts characterising successful systemic family therapy should remain “shrouded in mystery”. An allegiance to maintaining openness to multiple explanations and scepticism towards assertions of ‘the truth’ should not lead us to give up on the search for truths, partial though they may be.

Using the therapist’s own experience as a potential source of information is an idea that appears to be shared by psychodynamic and systemic practitioners, be that in order to ‘further the therapeutic process’ as suggested in this chapter, or to gain better understanding, both cognitively and emotionally. To record the authors’ differential initial reactions to the clinical material is a promising start, but we wonder whether it has been made the most of here. There is a clear contrast between Anna’s emotional – and in part visceral – reaction to the material, based on her personal history and early experience as well as on her current values, and Mike’s more cognitive response, driven by intellectual curiosity but tempered by caveats about potential

biases. It may be that these are gendered reactions or that they are simply representative of two of the repertoires at the therapist's disposal – feeling and thinking. It is plausible, however, that they might pick up a tension within Molly, between her emotional needs and her wish to please by intellectual achievement, as later alluded to in the description of the 'primary feedback loop'. Such an intrapsychic experience would of course be played out in, and reciprocally strengthened by, its interpersonal parallels. To explore this possibility further, we wish that the authors had drawn on the two other repertoires available to them – acting and relating. It would have been good to have had access to the dialogue between them, exploring their different reactions rather than filing them away as potential sources of trouble. Having two (or more) people interacting in responding to the same material is a valuable resource between co-therapists or in a reflective team; it might have equally helped to deepen the reader's access to the systemic formulations. This could have also led us into a discussion of intersubjectivity (to what extent the drawing of the map *creates* the territory), which should be a particular strength of the systemic approach and an area that other viewpoints could learn from. Though an area of debate among psychodynamic therapists, it is not usually addressed within the literature on ISTDP.

Most notably, we were struck by the relative neglect of specific emotions in the formulations. It is not clear whether in systemic approaches emotions would be seen purely as epiphenomena, as in behavioural theory, or regarded as central, as they would be in process-experiential and psychodynamic approaches. 'Emotions and attachments' had been listed as one of the five areas that an integrated model of systemic formulation would need to pay attention to, but it appears that they are not an important component in this chapter, maybe mirroring Molly's family and their attitudes towards emotional expressiveness. 'Distress' is a rather imprecise description for a reaction that may encompass anger, sadness, disgust, shame, guilt, humiliation, and fear, among others. One might argue that such feelings are intrapsychic experiences and therefore outside the purview of an interactional perspective; however, such a position would overlook the concept of emotions being reciprocally determined, either in a symmetrical or complementary fashion, as first postulated by interpersonal theorists.

Finally, we would want to acknowledge the broad areas of overlap between our outlook and the systemic perspective. Critical reviews invite the 'narcissism of small differences' that often characterises the exchanges between the different therapeutic tribes. Research evidence tells us that theoretical orientation has a negligible influence on outcome variance, but as clinicians we need the containment that a coherent perspective affords us when faced with the uncertainties and challenges of our daily practice. We hope the dialogue in this chapter and this book helps all of us to broaden our repertoires – emotional, relational, cognitive, and behavioural – when we engage in psychological therapies.

Anna Tickle & Michael Rennoldson

8.7 Author Response

We would like to signal our agreement with the key sentiment of the critique; that we have far more in common than apart.

When focussing upon our differences, the ISTDP authors have identified in our formulation an absence that is arguably seen across much, though not all, systemic thought and practice – namely a lack of a precise classification of emotion. One potential response that we might adopt as systemic practitioners is to make greater efforts to incorporate interpersonal theories of emotion, such as attachment theory or ideas from the psychodynamic tradition. However, we are drawn to a different response that reflects another point of difference identified in the critique. Many contemporary systemic practitioners do believe that the map ‘creates’ the territory. That is to say, the ideas and words we use to name and interpret experience become constitutive of that experience. From this flows a reluctance to name or specify emotion at the level of detail promoted within ISTDP at the stage of formulation. Rather, we might invite Molly and other family members to ‘name’ these experiences for themselves. Differences identified between family members in conceptualising emotional experiences would be seen not as problematic, but as a potential resource for therapeutic change. At this stage in the formulation, the feedback loop that offers a general interactional pattern relating to emotional expression could be a starting point from which to identify situations or examples in which specific emotions could be named and discussed.

The critique also encouraged greater use of research to investigate both outcome and process. There is undoubtedly a need for systemic practice to develop a much more substantial body of process and outcome research. However, finding a form of credible and purposeful research that remains consistent with an interest in multiple perspectives and a model of circular causation is a challenge.

We also agree that it would have been useful for us to present some of the dialogue between us about our initial responses to the material, although our rationale for this would be different to that suggested. The critique saw it as plausible that our two different reactions – one more ‘emotional’, the other more ‘cognitive’ – might represent a tension within Molly. From our perspective, the different reactions would not be seen to reflect the internal state(s) of the client, but instead to reflect the ‘use of self’ encouraged within systemic therapy. Observing intersubjectivity in action could have given insight into how multiple perspectives might shape a systemic formulation, including potential benefits of different therapists’ world views compensating for each other’s ‘blind spots’. Equally, it could raise some questions about the interactional patterns and issues between team members, such as whether some are seen to hold more power and influence than others and potential reasons for this.

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