Vetera, A. and Dallos, R. (2003) Integrative Practice: Research on Process and Outcomes. In Working Systemically with Families: Formulation, Intervention and Evaluation, p. 59 – 86. Karnac

CHAPTER THREE

Systemic formulation

Formulation in clinical practice

The skills of assessment and formulation have been fundamental in the development of many of the therapeutic professions. For example, from the start clinical psychology nailed its colours to the positivist traditions of science and promised to provide a rigorous and evidence-based approach to clinical work. In the early days of the profession clinical psychologists often worked alongside psychiatrists to provide detailed "objective" assessments, frequently employing standardized tests that shaped clinical formulation. The purpose of the assessments was largely to diagnose with accuracy deficits in functioning with the aim of clarifying their extent and nature. Once established, this was employed to indicate the direction of treatment. For example, a psychologist might assess the extent of impairment in a young child apparently demonstrating learning disability. Based on the assessment particular regimes of interventions might be attempted such as, behavioural programmes to improve the level of independence or communication.

We can propose that formulation is central to any therapeutic

activity. It represents the essential link between theory and practice—how we view difficulties and how we intend to assist people and their families. The two main strands of formulation; assessment and treatment planning are intertwined. Every theoretical model can be seen to contain different ideas about what to look for in assessing a problem and subsequently how to treat it. Many mental health practitioners are encouraged to employ a variety of theoretical and treatment models; for example, combining relatively individual therapeutic approaches with systemic ones. Although many clinicians appear to find their own idiosyncratic ways of attempting such a synthesis, there has been relatively little provided in the way of systematic models to guide this integrative process.

As a consequence of a multi-model based training, therapists are faced with the task of attempting to be both *outside* and *inside* the models that they employ. This poses some difficult dilemmas; for example, an initial decision needs to be made about which model or combination of models should be employed in any given case. However, each model may contain discrete ideas about how to proceed with formulation and connections to other models. Arguably, this is particularly the case for systemic therapy. From *inside* a systemic perspective, it is argued that it offers an integrative model which allows us to include therapeutic work with individuals, and to work with parts of a family, the whole family, and other systems, such as school and work, and so on. However, from the *outside* this position can look like an act of faith or zealous commitment to one approach—systemic therapy. From the *outside*, systemic therapy represents one choice of model and, for example, is seen as having distinct features, such as the emphasis on pattern, meaning, and communication in relationships. This may be seen in contrast to, for example, a CBT approach which emphasizes a person's internal cognitions and representations of their experiences.

We will take a little space in this chapter to discuss these issues by looking relatively briefly at the question of the initial choice of a model. We will then consider how a systemic approach can be seen not as just another approach, but as one that encourages an integrative approach to clinical work.

Let us turn to a clinical example in order to start to explore some of the issues.

Case example:
Charlie—a 15-year-old boy with suicidal and behavioural problems

Charlie was initially referred to the adolescent community service via his GP because he had become very withdrawn, was threatening to self-harm, was at times aggressive towards his mother, was using illegal drugs, was absent from school, and was displaying a variety of apparently psychosomatic symptoms. He came into contact with the Youth Offending Service because, with some friends, he had entered into neighbours' properties through the loft space.

Charlie was an only child living at home with his mother Sarah. His father (Brian) had committed suicide when Charlie was four years old and subsequently his stepfather (Nigel) died of a heart attack while Charlie was alone in the house with him. Charlie was nine years old at the time and it was apparent that both Sarah and Charlie were still upset at this loss. Sarah felt that she had lost control of Charlie and was extremely concerned that he might harm himself and come to a similar fate as his father. She felt unable to cope, appeared quite depressed, and seemed overwhelmed by Charlie's problems and behaviour. Sarah had a relationship with a younger man (Steve) who had been a friend of Nigel's son, Pete. Steve had previously lived with Charlie and Sarah, but Sarah had felt that he was too emotionally dependent and at times was like a second child rather than a father figure to Charlie. As Sarah attempted to develop some separation from Steve, he threatened to kill himself, and eventually engaged in a suicidal gesture by cutting his wrists at her home while she was out.

Sarah's parents lived close by and had become very involved in offering support to Sarah and in attempting to gain some control over Charlie's behaviour. Sarah's brother, Eddie, had his own family and occasionally was in contact with Charlie and Sarah. Charlie stayed with his uncle sometimes and usually "behaved quite well", though more recently he did not want to stay with his uncle. Sarah's parents had taken Charlie to live with them temporarily, to give Sarah some space to recover. However, they initially felt Charlie had a mental illness, perhaps like his father, that needed to be treated. This was later highlighted when, in an initial family assessment,

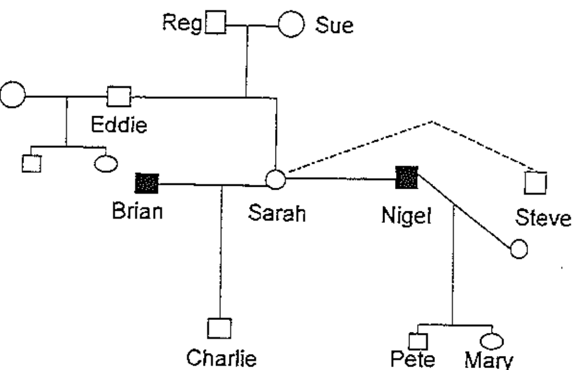

Figure 1.

Sarah's father (Reg) came to the meeting with the results of his searches of the Internet on a variety of psychiatric disorders: schizophrenia, ADHD, and Borderline Personality Disorder, which he felt fitted Charlie's symptoms!

Which model?

Relatively few integrative models have been produced. However, one comprehensive model has been developed by Weerasekera (1996), and this uses as a core axis a division between individual and systemic factors which are then explored in terms of their respective models of aetiology and their treatment implications (Figure 2).

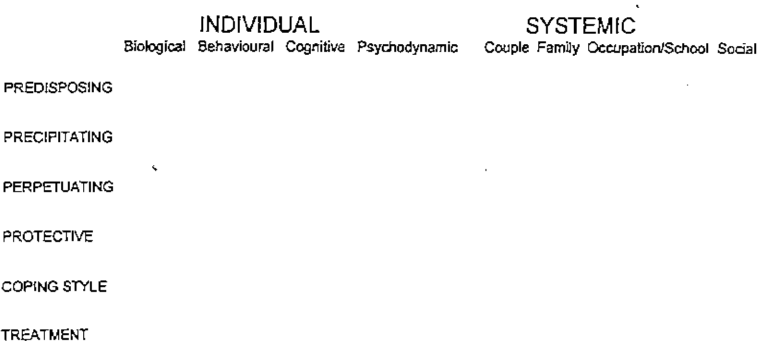

Figure 2. An integrated model of formulation. (From: Weerasekera, 1986.)

Individual versus systemic intervention

So, an initial decision suggested by this model is whether the problem might be approached most effectively from an individual versus a systemic perspective. Key to this initial decision is an assessment of the client's "preferred coping style" and this includes both the therapist's impressions as well as the client's expressed preference for forms of treatment. For example, a person may state that they do not wish their family members to be involved in the treatment of their problem. In practice the decision is far more complex; for example, in work with children it may be difficult for a child to articulate whether he or she wishes to attend with their family. It may also be the case that with many problems there is fairly convincing evidence that a range of relational issues are central, but facing these problems might prematurely raise anxieties and provoke avoidance of family work. There is a considerable tension, therefore, between the extent to which we can fully work collaboratively versus taking some charge or promoting a decision to engage in family therapy.

Weerasekera's (1996) proposed model attempts to deal with this thorny issue in part by focusing on what she calls "coping styles". The initial formulation therefore includes an assessment of the characteristic or preferred ways that the person has of coping with his or her problem. For example, some people express an initial preference to "understand" their difficulties but find it hard to address deeper emotional or relational issues. It is suggested that by accommodating to the person's initial style it is possible to strengthen the therapeutic relationship. However, as work progresses it may be possible that the client is able to risk extending the range of work to other forms of individual work or to systemic work. A thread running through formulation, therefore, is whether the various models are to be employed *simultaneously* or *sequentially*. We may decide, for example, that treatment might helpfully commence by the simultaneous application of a cognitive approach with a young person with anorexia and work with the family system. Alternatively, we may feel that a period of individual work might need to take place before progress with family work is feasible.

Why systemic?

It is possible to identify a number of factors that might suggest that a systemic approach is appropriate:

- there is indication of direct precipitative factors in the family, for example traumatic events such as bereavements, illness, or separations;
- there is clear evidence of relational difficulties within the family and/or between the family and other systems, such as the extended family;
- the client is aware of connections between his or her problems and relational issues in the family.

Returning to the example of Charlie and Sarah above, it was apparent that there was an initial belief that the problem was predominantly Charlie and that some individual work needed to take place. This belief seemed to be shared by Sarah and her parents and it seemed that to avoid this issue would have conflicted with the family's beliefs at that time. However, it also seemed clear that there had been some significant events in this family, such as the suicide by Charlie's father and the death of Nigel. It also seemed that Sarah was in a difficult relationship with Steve, and that the input from her parents to the management of Charlie may have had complex effects, for example, in making it harder for her to exert clear authority over Charlie.

It seemed that a helpful approach might be to start with some individually focused work with Charlie, exploring both medical questions and some of his feelings and beliefs, especially about the losses in his life and how these might be connected to his distress. This approach seemed to fit with Sarah and her parents' beliefs about what needed to happen. However, it also seemed that Sarah, in particular, recognized that there were historical and family issues that were relevant. She also demonstrated a psychologically-minded coping style in that she did see the value of discussing feelings, beliefs, and relationships. However, her parents were initially more concerned with a medical approach, seeking answers to the question of a diagnosis for Charlie. They also had a behavioural orientation, feeling that Charlie needed clear rules and discipline in his life. It was thought, therefore, that some initial therapeutic work focusing on Charlie and some clarification of his psychiatric status was necessary before other work, for example, family therapy, could take place.

Charlie was referred to the Adolescent Community Team. This consists of an integrated service which combines a number of workers who attempt to offer individual assessment and input, some involving home visits along with a systemic service comprising a weekly family therapy clinic. In addition, the service involves supervision of cases within a multi-model perspective. Typically, as in this case, there may be some initial tensions between the direction of work that the family and referrers may think is most appropriate and the beliefs of the team. In this case it was felt early on that family work was indicated and might become the main direction of work. In fact, Charlie seemed to endorse this view since he did not wish to engage in individual work following some initial sessions with the worker. However, the focus of the referral and requests from other agencies, such as the Youth Offending Service, indicated a focus on Charlie rather than the dynamics of the systems in which he was involved.

The politics of formulation

It is tempting to aspire to promote schemes of assessment and formulation that set out clear and detailed guidelines that clinicians might be able to follow. It may be helpful to contemplate developing such maps, not least in that efforts to produce them may reveal the complexity of the task involved. However, we suggest that formulation contains within it the core conceptual, psychological, and philosophical issues relating to therapy. Most fundamentally we are compelled to consider what we believe to be a problem or symptom. Related to this are questions about who is experiencing the problem: the person, the family and/or the community, and so on.

Arguably an important point of contrast between the psychotherapies and psychology on the one hand, and psychiatry on the other hand, is the relative weight given to formulation versus diagnosis. Simply, psychology tends to concern itself more with developing formulations of difficulties than engaging in attempts to diagnose or assign labels to constellations of difficulties. More specifically, psychology and psychotherapy has been closely

concerned with debates about the relative merits of medical versus social models of problems. Taking a medical view assessment is largely about accurately establishing correct diagnoses of conditions. Formulation then follows in a relatively straightforward way, mapping out ways to manage or treat the diagnosed disorders.

Similarly, family therapy has been critical of medical models and instead offers a more social model of the causes and maintenance of problems. Significantly, it has also developed to be increasingly critical of medical and pathologizing processes (Dallos & Draper, 2000; Hoffman, 1993; White & Epston, 1990). Within this framework family therapy offers a critical position in that it endeavours to question the potentially oppressive assumptions that may be made about family members, and even that family members may have been conscripted into holding about themselves:

> I sometimes think that 99% of the suffering that comes in through my door has to do with how devalued people feel by the labels that have been applied to them or the derogatory opinions they hold about themselves. [Hoffman, 1993, p. 79]

In essence this is the cornerstone of the social constructionist (post-modern) position that characterizes the third phase of the family therapy movement. As with the psychotherapies more broadly, this places the clinician working with families in a variety of complex positions regarding formulation:

- as an employee of the state we may feel pressure to offer formulations which contain elements of social control, for example, to enable a child in a family to become "less disruptive" and return to school;
- we may be critical and sensitive in our formulations of patterns of inequalities and oppressions which have shaped the problems in the first place;
- we may be aware of the competing definitions of what and whether there is a "problem"—the individual's view, the family view, differences of opinions within the family, the view of various agencies, such as the police and social services, involved with the family, school, the legal system, cultural systems, and the therapist's professional system.

In effect a primary aspect of formulation is the juggling of these

competing definitions or constructions regarding problems in families. For example, for a clinical psychologist engaged in family therapy there is a need to take account also of the legacy of clinical psychology and the expectations that other professional colleagues hold. Substantially there may be a set of expectations that clinical psychologists are "experts" at assessment and formulation and, more specifically, that they will be able to assess whether an individual in a family "really" has an individual versus a family-based problem.

Again with reference to Charlie, it is possible to see the influence of these wider issues in the work with him and his family. A range of pathologizing processes had come into play. For example, there appeared to be a belief not only in mental illness but also about its heritability, especially seen in the considerable concern expressed that Charlie was like his father. Brian was described as having been a drug user, violent, unstable, and eventually had committed suicide. This concern about mental illness significantly featured in the grandparents' views about Charlie and, to a lesser extent, in Sarah's views. However, it can be seen as part of a much wider discourse regarding the nature of emotional distress. The belief in a medical model was shared not only by family members but also by the family GP, by Charlie's school and, to some extent, the Youth Offending Service. Arguably, Charlie was one of the few people who were actively resisting this definition. When his behaviour became more outwardly directed rather than internally focused, for example, offending behaviour, it is possible that in a way he was trying to state that he was angry rather than mentally ill. An important issue, then, may be the extent to which work with Charlie, including the initial formulation of the problems, takes into account the wider socio-political contexts and attempts to challenge these (Boyle, 1990; Dallos, 1997; Johnstone, 1993).

Systemic formulation

In this section we want to retrace our steps and look at the development of formulation in systemic thinking, and to make some links with other approaches such as functional analysis.

Systemic family therapy contains several features in its orientation to formulation that are sympathetic to the practices of other mental health disciplines. These include the following:

- a holistic approach
- the use of "working hypotheses"
- a multi-dimensional approach
- integration of a variety of theoretical positions—a multi-perspective approach
- a critical and reflective orientation
- evidence-based orientation

In particular, we suggest that systemic theory offered a substantial development in its secondphase in the move from an "outside" and "expert" position to a constructivist view that acknowledged the subjective nature of knowledge and knowing.

Functional analysis and progressive hypothesizing

Increasingly, the level of sophistication and the nature of assessment and formulation has progressed. Many mental health practitioners now would not attempt only an assessment of the individual in terms of his or her abilities and experience but also would look holistically at the various contexts in which the person was immersed. A considerable conceptual development in assessment and formulation has been inspired by behavioural analyses—the ABC model—antecedent–behaviour–consequences. Such an analysis focused on the factors that triggered behaviours/symptoms and the factors that subsequently maintained these. An extension of this form of analysis came to be called "functional analysis". This broadened a strict behavioural analysis to include "internal" events such as thoughts and feelings. For example, a functional analysis might suggest that one factor in the maintenance of aggressive behaviour is that it fosters a feeling of "power and retribution for perceived injustice".

The notion of the "function" of a problem or symptom also played an important role in psychodynamic thinking; for example, that amnesia might be functional in helping a person to avoid unbearable painful traumatic memories. However, "functional analysis" offered some significant developments.

- The function of a symptom was seen as related to secondary gains, such as the rewards that might be derived from the person's social context.

- Functional formulations were phrased in ways which made them subject to exploration and testing—they were refutable.
- By effecting alterations in the functional relationships, change was seen as possible in a relatively rapid way.

Importantly, "functional analysis" stressed both an intra- and interpersonal level of analysis. For example, an analysis of anorexia (Slade, 1982) proposed that the person might gain a perceived benefit by feeling more in control of their lives and proud of their ability to exercise control. In addition they might gain a perceived benefit by both gaining attention from their parents and indirectly offering a protest about the nature of their relationships. This move to an interpersonal analysis was important and offers significant links to systemic thinking.

> As an example, it could be proposed that Charlie's behaviour had been functioning to protect the family from the grief that had been experienced. Two traumatic deaths were very difficult for this family to deal with and the unbearably painful feelings were in a way avoided by the focus on Charlie's behaviour.

Assessment of family structure and process

As we saw in Chapter 1, systemic theory and practice has developed through a number of significant phases. In the first phase, as in early positivist and behaviourally inspired psychology, the emphasis was on making "objective" and "scientific" assessments and formulations. The family was seen as an entity "out there" that could be accurately described and assessed. The purpose, in large part, was to be able to map the nature of the dysfunction and subsequently to develop interventions to correct these. As with clinical psychology a range of standardized tests measuring family function were developed (Circumplex Model—Olson, 2000; McMaster model—Epstein *et al.*, 1993). In short, the aim was to assess dysfunctions of family structure and process. As an example, a family might be seen as having a lack of a clear hierarchy and decision-making capacity in the parental sub-system. Alternatively, they might be seen as caught up in a process whereby

attempts by either parent to take control would be met by the other parent siding with the child. Once the problems were identified, the therapist working within an expert framework, would adopt interventions to alter them (see Chapter 1).

Function of a symptom

A cornerstone of early Milan-team systemic thinking was that symptoms in families served a *function* of stabilizing a family system. In many ways this appeared a counter-intuitive idea, since the established view was that the symptoms were the very thing that was causing the distress and unhappiness in the family. Jackson (1957) was the first to state clearly that a family with serious problems *could be seen as* a rigid or homeostatic system. Examples of this could be seen in accounts of how the removal of a patient from a family into psychiatric services could be followed by another member of the family developing some difficulties *as if* to maintain the status quo of the family dynamics. The classic example came from work with children where it was suggested that, for example, symptoms shown by a child could serve a *function* of distracting attention from the parents' conflicts with each other and thereby stabilizing the marriage. As the child's symptoms grew more intense the definition of the situation as the child having or being the problem would be reinforced. Functional analysis as developed by Slade (1982) put forward the notion of members of a family acting as if they had an investment in keeping the symptomatic member in that role despite overtly stating that they wanted them to change. Part of the functional analysis, therefore, was the extent to which a symptom in one member was meeting the needs of other members of the family and preserving the family *homeostasis*.

Attempted solutions

One of the most enduring and helpful ideas from the first phase is the model of formulation proposed by the Mental Research Institute (MRI) team. This consists of the elegantly simple idea that many problems arise from the failing solutions that are applied to ordinary difficulties; that is, the solution to the problem has become the problem (Figure 3). In this method of formulation the focus is on

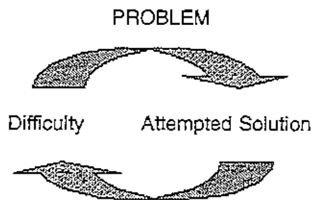

Figure 3. Model of formulation developed by the MRI team.

an identification of what is seen as the problem and how this is linked to difficulties that the family has attempted to overcome. The formulation consists of the following steps.

- Exploration of the problem.
- Deconstruction of the problem—when did it start, who first noticed, what was first noticed.
- Linking the problem to ordinary difficulties.
- Exploration of what was attempted to solve the difficulties.
- Beliefs about the difficulties and what to do about them.
- Discussion/evaluation of what worked/what did not work.
- What decisions were made about whether to persist with the attempted solutions and which solutions to pursue.

As we can see, this model bears a resemblance to functional analysis (ABC) in that attempted solutions in effect represent B behaviours, C consequences are the effects of the attempted solutions, and A antecedents are essentially the difficulties or triggers that set off the attempted solutions. Like functional analysis, this model assumes that there is a recursive cycle in play so that the attempted solutions can serve to construct a vicious cycle whereby there is an escalation of the difficulties.

The second phase of systemic family therapy saw a move towards constructivism. As we have seen, this stressed a view of reality as subjective. Families were no longer seen as "out there" nor the task of the therapy team as being to accurately assess their dysfunctional patterns. It was thought that we could only see a family through our own personal lenses. Consequently our descriptions and formulations were seen as having an "as if" quality—they were propositions rather than truth. As such these

propositions could be more or less useful in guiding our work with a family. The value of our propositions was essentially in terms of the extent to which they facilitated the emergence of change. Instead of assessment and formulation being seen as a one-off scientific activity, it came to be seen as a continual process of developing—testing—and revising formulations. This has much in common with George Kelly's (1955) notion of "man the scientist"—that the essence of science and human experience is similar in that both are engaged in a process of enquiry in which ideas about the world are formed—tested—and revised where necessary (Dallos, 1997; Hoffman, 1998; Procter, 1996).

Progressive hypothesizing

> By hypothesising we refer to the formulation by the therapist of a hypothesis based upon the information he possesses regarding the family that he is interviewing. The hypothesis establishes a starting point for his investigation as well as verification of the validity of that hypothesis based upon scientific methods and skill. If the hypothesis proves false, the therapist must form a second hypothesis based upon the information gathered during the testing of the first. [Selvini-Palazzoli *et al.*, 1980a, p. 4]

The concept of punctuation was incorporated by the Milan team (Selvini-Palazzoli *et al.*, 1978) into the idea of therapy as inevitably progressing through a process of hypothesizing. There could be no objective truth about a family, simply our subjective perceptions as observers. The best we could achieve, therefore, was to formulate hypotheses (hunches) about what was going on that could be more or less helpful in our ways of working. This view broadly encapsulates the pragmatic position of the MRI group in that communication needed to be considered not just in terms of what was intended to be communicated but what its consequences were. Hence, a hypothesis was to be judged in terms not of its ultimate truth or falseness but of how effective it was in facilitating some positive change.

Constructivist approaches have repeatedly drawn attention to the fact that family members may disagree, sometimes violently, about their explanations and narratives. These have been seen as essentially interpersonal disagreements or struggles over the

punctuation of events. More recently, this has been discussed in terms of the competing stories family members hold and which define previous and future events. The analysis of questions about the meaning of a problem, or symptoms, is similar to the processes of deconstruction employed in the analysis of literature and the social sciences. Deconstruction involves taking constructs apart, analysing and tracing their historical origins, examining their inner logic, exploring their contradictions and inconsistencies, exploring the situations that concepts are employed in, and considering what implications there are for action. When we engage in this process with families it is not unusual to find that the conflicts are not so much about disagreements as about different uses of a concept. Deconstruction can be employed as an activity that invites alternative meanings to be considered that by opening up the definition of a concept, can encourage, or at least lay the groundwork for, some mutually acceptable definitions to emerge.

The Milan team argued that the process of developing hypotheses was not only fundamental to the process of formulation but also to the practice of clinical work. They argued that the start of therapy with a family could be an extremely confusing affair and it could be easy for a therapist to feel overwhelmed by the amount of information that a family could present. A hypothesis could help to cut through this potential chaos and help to organize the information into a meaningful and manageable structure. Holding a clear hypothesis can help the therapist actively to engage the family by pursuing issues and asking questions to explore and test the hypothesis. This can serve to offer a direction to the work and help avoid the risk of simply floundering and perhaps unwittingly getting caught up in, or even aggravating, the family's problems. It can also help to reduce the anxiety of the initial contact (which can be considerable for all concerned, not least the therapist). A hypothesis was not to be seen as necessarily true, but as being more or less useful. A core aspect of this was the extent to which the hypothesis was elaborative, that is, it helped to elicit new information. The team went on to note a number of other important aspects of this process:

- explicitly forming and stating our hypotheses can help to reflect on our implicit assumptions which, if left implicit, may get in the way of therapeutic progress;

- articulation of hypotheses can help to reveal differences and agreements within the therapy team which again might impede therapy if left unstated;
- there is less pressure on the therapist to "get it right" which can reduce anxiety, especially in the early stages of therapy;
- as the engagement with the family is less of an "expert" position it may make it easier for the therapist and the team to remain curious and interested as opposed to trying to develop a correct formulation.

In practice there seemed to be times when the Milan team wandered from a constructivist position to making statements about their hypothesis being "correct" or "hitting the nail on the head". There was also a sense that the hypotheses were not always formed in a collaborative way with families.

Exploration of meaning and explanation

Arguably, the work of the Milan team also represented a significant move in that the focus of the hypotheses and formulations was concerned with the construings of the family members. Increasingly the emphasis was on the meanings that family members ascribed to each other's actions. For example, they describe a case of an adolescent boy who was displaying delinquent problems. The boy was living alone with his "attractive" divorced mother. Their first hypothesis was that his behaviour was intended to draw his father back into the family. However, they argued that this was rapidly disproved and it became clear that a more *accurate* hypothesis was that:

> The mother was an attractive and charming woman, and, perhaps after these years of maternal dedication, she had met another man, and perhaps her son was jealous and angry, and was showing this through his behaviour. [Selvini-Palazzoli *et al.*, 1980a, p. 4]

A proposed model of systemic formulation

We want to offer our own synthesis of approaches to formulation in systemic therapy and suggest that this can be summarized in a five-part model.

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

As we have suggested, family therapy has moved through a number of phases and these significantly reflect the nature of the process of formulation. The phases have seen a shift from an emphasis on patterns and processes, on cognitions and finally on language and cultural contexts. These phases are also reflected in the scheme for formulation that has been proposed by Carr (1999):

1. repetitive problem—maintaining behaviours;
2. constraining belief systems and narratives;
3. historical, contextual or constitutional factors.

By the latter he is referring to factors such as family scripts, economic and social support and, importantly, the prevailing cultural values and norms.

Our proposed scheme shares many features of this model but we offer some additional points of focus. In addition, we suggest that it is important to think about assessment and formulation in terms of two interconnected processes: analysis and synthesis:

> *Analysis*: this entails exploration with the family of the nature of their family, each other, and their problems. Though it features in the early session this continues throughout therapy.
> *Synthesis*: this may follow or run alongside the assessment and analysis. It involves starting to integrate the strands of information into preliminary hypotheses or formulations of the problem.

This distinction between analysis and synthesis is consistent with a constructivist view which regards observation and gathering of information as an "active", "selective", and "interpretative" process. In starting to analyse the problem we are inevitably making assumptions and interpretations, for example, about what evidence is relevant, what further material we need, selectively attending to

some factors and less to others. In recognizing this it may be possible to adopt a reflexive stance and be less vulnerable to becoming limited by our implicit assumptions.

1. The problem—deconstruction

The initial starting point from any therapeutic perspective is to explore the "problem/s". This involves a number of related questions:

- how is the problem defined: this includes further questions about whether the problem is framed predominantly as individual or interpersonal;
- how the problem affects relationships;
- how relationships affect the problem;
- for whom is the problem most difficult? Parents, siblings, people outside of the family, etc.;
- life history of the problem, when it started, how it developed, what factors influenced its development.

Exceptions

In the analysis of the problem it is also important to consider not only when and how the problem is seen to function but also to map strengths, and exceptions or "unique outcomes". These are times when the family has been successful in resolving the problems or can draw from other aspects of the wider family network to develop stories of competence, success, and so on:

- recent cases of success in overcoming the problem or when it has been absent;
- distant exceptions;
- exceptions in the wider family network;
- hypothetical exceptions.

Sarah: described the problem as Charlie acting in destructive and, at times, aggressive ways towards her. However, the emphasis was also on her worries, that is, that part of the problem was how anxious she became about Charlie's well-being and in particular her concerns that Charlie might harm himself or ruin his life.

Charlie: appeared largely to deny that he had any problems and could not see what all the fuss was about. In particular he stated that he was staying off school because he did not like it and that he only used drugs to the same extent as other young people his age. He also believed that his mum had a problem in that she worried too much.

Grandparents: saw the problem as essentially residing in Charlie and that he was possibly demonstrating signs of serious mental illness which might lead to his coming to harm. They also saw the problem in terms of the effects it was having on Sarah—that she was depressed, stressed, and becoming physically ill.

Professional systems: Charlie's adolescent worker saw the problem in terms of Charlie's mental health and the potential risk of self-harm. The Youth Offending Team focused on the offending aspects of the problem and had to deal with the consequences of Charlie's actions on the community, especially his neighbours, whose property he had entered with his friends.

Exceptions: Alongside the description of the problems there were instances of actions that were indicative of competencies and health. For example, there were examples of Charlie being kind and considerate to his mother, of his intelligence and creative abilities at school. These were confirmed by the school. There was also an example of Charlie having heroically arrested a man who had threatened staff and stolen goods from a local store.

2. Problem—maintaining patterns and feedback loops

- Structures—exploration of the organization of the family. In particular this is concerned with mapping the family in terms of boundaries, power, and interconnected systems.

  In Charlie's family it is possible that Sarah's power as a parent was somewhat undermined by her parents who, in "helping her out", had also in effect taken over. Similarly, Sarah's relationship with Steve in some ways resembled having another son rather than a parental father figure for Charlie.

- Process and feedback loops—this emphasizes the exploration of repetitive patterns of behaviour based upon feedback loops

between different parts of the system. One pattern that appeared to be present was between Charlie and Sarah:

> Sarah is concerned that Charlie is mentally ill and vulnerable like his father, but at the same time is anxious, stressed, and angry at his behaviour. She therefore monitors Charlie's actions and feelings closely, attempts to confront Charlie but then backs off, tired and tearful.
>
> Charlie feels he is being watched and that he is not trusted, and that he is seen as unstable. He responds in angry ways but also becomes ill, tired, and tearful.

In effect the more Charlie is distrusted the more he appears to act out and the more he acts out the more Sarah distrusts and is worried by his behaviour.

3. Beliefs and explanations

This part of the model invites exploration of the meanings that different family members hold regarding the problems and what should be done about it:

- Family beliefs
- Extra-family beliefs
- Socio-cultural beliefs and discourses
- Family members' perceptions, beliefs

> Connected to the above example, it seemed that a dominant belief was that Charlie has inherited a form of psychiatric illness similar to that of his father. At the same time there were beliefs that Charlie was suffering from delayed grief over the losses that he had experienced. Related to this, his mother, Sarah, appeared to believe that she was at fault for what Charlie had been through. At the same time Sarah also oscillated between feeling angry with Charlie and believing that he was being difficult and did need a firm hand. His grandparents (especially grandfather) seemed to hold these beliefs more extremely, feeling that they needed to offer some discipline but worried that Charlie was seriously ill. They also felt that Sarah was too soft with Charlie, and with people generally, and that Charlie needed a man to sort him out. For her part Sarah, though appreciating the help her parents offered her, also resented that at times they treated her like a child—a feeling that she had harboured for many years prior to the current problems. The grandparents also felt that it was inappropriate for Sarah to be with a young boyfriend who was in competition with Charlie for affection rather than able to offer stability for him.

4. Emotions and attachments

Here, the nature of the emotional dynamics are explored, especially the attachments and emotional dependencies between family members and across the generations.

> It appeared that there had been two traumatic losses in Charlie's family—Charlie's father and stepfather. It also seemed that there had been mixed emotions about his natural father, Brian, who had been unstable and at times violent. Consequently, Charlie's mother, Sarah (and her parents), may have found it difficult to share Charlie's grief at the loss of his father. With these feelings unresolved, the family then experienced a second traumatic loss that probably also affected Nigel's previous family. Consequently, both Charlie and his mother had lost central attachment figures and sources of love and support. In part, this may have shaped the system so that at times there was a role reversal, with Charlie having to look after his mother's emotional needs and her parents stepping in to take charge. This perhaps led to Charlie worrying about his mother and feeling that his mother could not look after him.

5. Contextual factors

At this point resources, history of the problem, environmental factors, extended family, role of professional agencies, and cultural discourses are considered.

> Sarah was a single parent with relatively limited financial resources and her health was deteriorating. The pressures to work and provide for herself and Charlie, along with the worries she had about Charlie, combined to make her feel drained and stressed. She

repeatedly stated that at times she felt so ill that she just could not cope with any problems and stress related to Charlie. She had to withdraw to her bedroom.

There had been a history of traumatic losses in the family and one aspect of this was the loss of a father for Charlie—both his birth father and stepfather, to whom he had been close. The family can also be seen as being in an important transitional phase, with Charlie becoming adult and facing the tasks of developing an adult identity and separation from his mother. It seemed that Charlie and Sarah had been through a lot together and may have found it difficult to negotiate some separation. Charlie's behaviour served to keep his mother highly involved with him and, for example, his absence from school also meant he spent more time at home with his mother. In turn, the involvement of the grandparents seemed to keep Sarah highly connected to her parents. At times she felt this was intrusive, for example, their disapproving attitude and advice about her young boyfriend.

Charlie and his family appeared to be caught up in a classic mad/bad cycle within the various agencies. Charlie had been involved with child mental health services, social services and, on the other hand, with the police and the Youth Offending Service. Between them, the agencies found it hard to decide whether Charlie was "ill" and in need of therapeutic or medical input or criminal and in need of control and sanctions.

One dominant discourse in play was that of "mental illness". Apart from the diagnosis of the problem having the implication that the problems resided in Charlie, there are a connected set of assumptions and beliefs within this discourse:

- Mental illness is hereditary.
- Treatment requires medical methods, such as medication.
- Psychological factors, such as relationships in the family and traumatic events, are marginalized.
- A reflexive position is discouraged, avoiding the need for the other family members to explore their potential roles in the evolution of the problems and, importantly, risking not being able to recognize their own resources and competencies in the face of the problem.

Other less obvious discourses could also be seen to be relevant. For example, Sarah's parents perhaps disapproved of her having a younger man as a partner since this challenged the traditional family pattern of a woman supported by an older man. Moreover, Steve was financially insecure and more likely to be dependent on Sarah than to be a provider. At times this discourse prompted discussions in the therapy team of their own assumptions and prejudices that were not unrelated to the gender of the team members!

Synthesis: a systemic formulation

The above framework may help to direct our attention to the complex web of factors that have shaped and maintained the problem/s. However, it is easy to see that even the brief examples we have offered regarding Charlie and Sarah can quickly come to appear like an overwhelming kaleidoscope of factors. Somehow, this mass of information needs to be combined into a manageable formulation. This requires that we engage in a process of selection of what is seen to be key as opposed to peripheral to our understanding of the problem. In effect, this can be seen as an example of a fundamental psychological process—the construction of a narrative that embraces events, actions, and contexts into a story or "pattern that connects". The Milan team initially referred to this as "hypothesizing" but, as we saw earlier, this was in the sense of seeing a hypothesis as an attempt to construct frameworks of meaning rather than to objectively test the real causes of the problems in a family.

Progressive hypothesizing/formulation

The Milan team (Selvini-Palazzoli *et al.*, 1980b) emphasized that hypotheses should be seen as propositional and changeable. As we continually learn more about the family, we need to be able to revise our hypotheses so that we do not become blinkered by our preferred formulation.

Reflexivity

A systemic approach emphasizes the notion of the "observing"

position and that the therapy system has its own dynamics and beliefs. It is important, for example, to try to be open to how our own family experiences may be colouring how we see a particular family or the actions of some members. Similarly, current life events in the team members will inevitably have a significant effect on our perceptions and formulations.

Collaborative approach to formulation

Systemic formulation has progressed, as has formulation more broadly in the psychotherapies, towards a collaborative, as opposed to an "expert" and outside, approach. Rather than seeing the family as an object about which we formulate, we can see ourselves as entering into a relationship with a family wherein we explore the problem/s and negotiate a shared formulation. This recognizes that it is not a prerogative of family therapists and psychologists but is an essential human activity, albeit the family's formulations may be less formal and shaped by specialist psychological language. If the family has a significantly different formulation to ours it is unlikely that therapy can take place.

Engagement—joining and the therapeutic alliance

The most clearly established common factor that determines how helpful therapy is likely to be is the strength of the therapeutic alliance (Pinsof & Catherall, 1986). A key ingredient of forming a strong therapeutic alliance appears to be that clients and families are able to develop "trust" in the therapist and the team. Related aspects are: (a) family members wish to "feel listened to", (b) that their "views are taken into account"; and (c) that the therapist is experienced as warm and non-critical. This suggests that the therapy system should be "authentic", and for example, not attempt to disguise significant differences in opinions and formulations about the problem/s. In our work, we attempt to discuss our evolving hypotheses with families in order to bring differences of opinion out into the open in an attempt to construct some agreed directions to the work. We should note that many families appear vulnerable and confused about their own formulations and it can be tempting to attempt to "help clarify" things for them. However, this can result in subsequent impasses when the family's core beliefs re-emerge.

Formulations: Charlie and Sarah

We offer some examples of potential systemic formulations of this case. None of these claims to be exhaustive but each attempts to offer a view that fits with the available information. In practice, this means that some features or details may be given more attention than others.

1. Charlie's problems were connected to the experiences of losses in the family. Not only had there been two important deaths of the fathers in the family but there had been mixed emotions about Charlie's birth father, which made it difficult for Charlie and his mother to communicate about their feelings. Sarah had become stressed, and her inability to offer strength and support to Charlie led to his confused behaviours. This drew attention from his mother but escalated as she grew increasingly desperate and hopeless. In turn, Sarah was becoming more concerned, but this alternated with anger and criticism of Charlie's behaviour. Sarah felt anxious about expressing her anger or setting boundaries for Charlie because she was worried that he might be vulnerable, like his father, and harm himself. This can be seen as a feedback loop (Figure 4).

This formulation views both Charlie and Sarah as having problems, and that this is related to an escalating process between them.

A related feedback loop is that Sarah's parents, at the same time as "helping", fuel a process whereby she feels increasingly inadequate as a parent and her parents feel increasingly compelled to intervene in order to "help" her.

2. Sarah is currently involved with a younger man who was a friend of Nigel, Sarah's second husband. This may have the effect of continuing to trigger the unresolved grief surrounding the losses. More specifically, it may be that Charlie's relationship

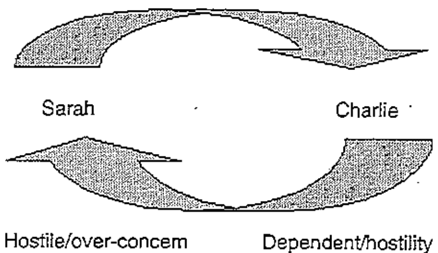

Figure 4. Mutually maintained pattern: Sarah is both angry and concerned, and is alternating between becoming over-involved with Charlie and withdrawing from him. Charlie is angry, but also feels vulnerable and dependent. He alternates between rejecting and being dependent.

with Steve is difficult, that Charlie feels displaced by Steve, and that he has to compete with him for mothering from Sarah. It is also possible that Charlie's relationship with Steve is confusing for Sarah since Steve is nearer to Charlie in his life-cycle, tastes, interests, and so on than Sarah. At times Charlie and Steve may be more like mates. This in turn may make it difficult for Sarah to exert any parental control over Charlie, and to involve Steve in this may be very confusing. As an example of these confusions we can speculate that it would be difficult for Charlie to explain to his friends the composition and nature of his household and his relationship with Steve. Also, Sarah embarked on the relationship with Steve at a time of distress and this set up a pattern of dependency between them. However, as Sarah became less dependent Steve became insecure and also resentful that he had previously looked after Sarah. For her part, Sarah was ambivalent about her relationship with Steve and sought contact with him when she felt vulnerable. Sarah and Steve needed to renegotiate the basis of their relationship but this was difficult because of Charlie's behaviour. This can be viewed as a triangular process (Figure 5).

Related to the triangular process Sarah's parents disapprove of Steve, and their views may impact on Charlie so that he feels confused and caught between his mother, Steve, and his grand-parents (Figure 6).

Arguably, some of the contradictions above are also related to

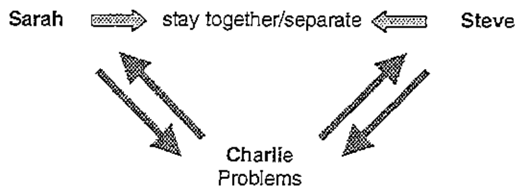

Figure 5. A triangular process. At times Charlie may have been seen as the cause of Sarah and Steve's problems at other times as suffering distress from their difficulties.

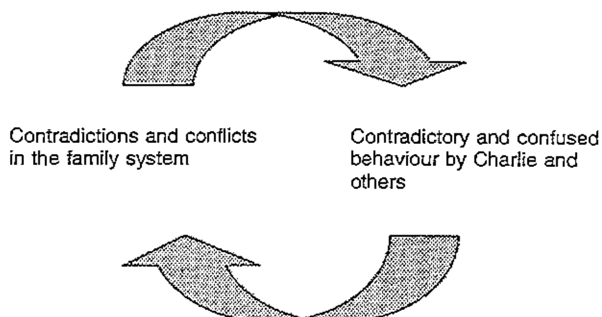

Figure 6. Further effects of conflicting views in the family.

shifting culturally—shared ideas about relationships, especially the role of men and women and family life. Sarah held more "modern" views of family life, as opposed to the more "traditional" views held by her parents. In becoming dependent on her parents she was subject to the influence of discourses that she had resisted in the process of separating from her parents as a young woman.

Reflexive note

1. You may have generated different hypotheses to the above, or emphasized some features more than others. A systemic approach emphasizes that there are no correct formulations. The Milan team encouraged the development of alternative formulations in order to clarify thinking and to facilitate the development of further, more comprehensive, formulations.