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## POSITIVE PRACTICE IN FAMILY THERAPY

Alan Carr  
University College Dublin &  
The Clanwilliam Institute

*Positive practice, a brief integrative approach to consultation with families, is described in this paper. A clear distinction is made between the stages of planning, assessment, therapy, and disengagement. Guidelines for progression from one stage to the next are provided. Frameworks for deciding who to invite to preliminary sessions and methods for planning and organizing lines of inquiry are incorporated into this approach to practice. A three-column model is used to construct formulations. The model allows therapists and clients to map information about the pattern of interaction around the presenting problem, beliefs that constrain family members from altering their roles in these problem-maintaining patterns, and factors that have predisposed family members to hold these beliefs. Positive practice offers methods for evolving new behavioral patterns and belief systems within sessions and for arranging homework tasks for clients between sessions. It also incorporates methods for dealing with resistance, for managing therapeutic crises, for convening individual sessions and broader network meetings, for disengaging from the consultation process, and for recontracting for further episodes of therapy. This evolving approach to practice draws on ideas from many traditions within the family therapy field and takes account of recent research relevant to the practice of family therapy.*

### INTRODUCTION

*"New worlds for old"*  
—James Joyce, *Ulysses*, 1922

Positive practice<sup>1</sup> is an integrative and structured approach to consultation<sup>2</sup> with families and wider networks. Such networks may include professionals from health, education, social services, and related fields. The bulk of this approach to practice was explicitly formulated over a 7-year period in the 1980s and early 1990s while working in a UK National Health Service Child and Family Clinic (Carr, 1995a; Carr, McDonnell, & Owen, 1994). During this period there was a national emphasis on cooperation between health service professionals and their colleagues in social services and education. In addition, many hospitals within the British National Health Service became privately run trusts. These factors created a climate which favored the development of approaches to assessment and intervention that were time limited, that took account of the wider professional network of which the child and therapist were part, which clearly addressed the overlap between the roles of therapist and agent of social control, and which could be evaluated or audited in a relatively objective way.

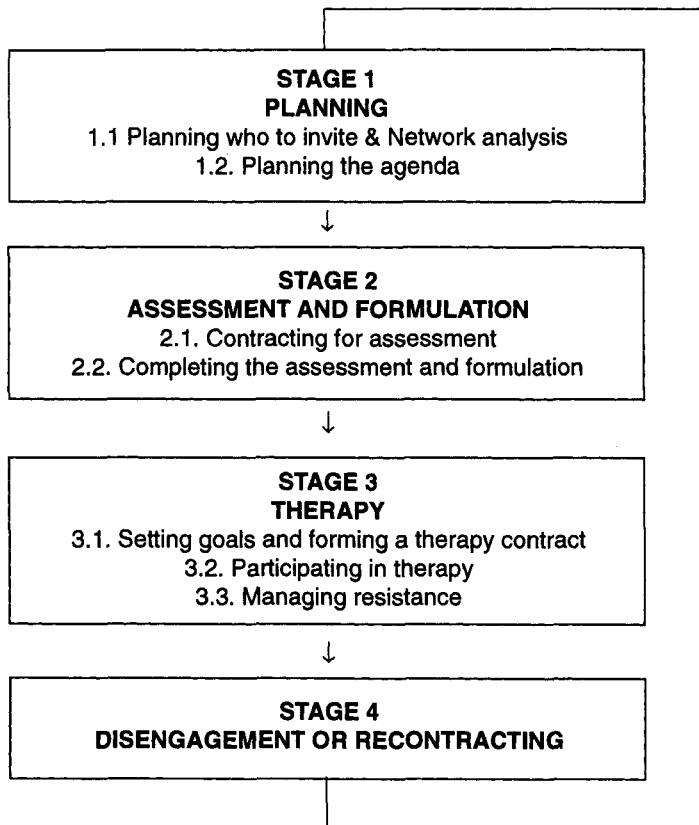
Alan Carr, PhD, Director of the Clinical Psychology Training Programme, Department of Psychology, University College Dublin, Belfield, Dublin 4, Ireland.

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## STAGES OF THE CONSULTATION PROCESS

Positive practice may be viewed as both a developmental and a recursive process. It is a developmental process insofar as it consists of a series of distinct stages which are set out in Figure 1. At each stage key tasks must be completed before progression to the next stage. Failure to complete the tasks of a given stage before progressing to the next stage may jeopardize the consultation process. For example, if a therapist attempts to engage a family in therapy (Stage 3) before a shared understanding of the problem has been formulated (Stage 2), then the therapist and family may become involved in cooperation difficulties and a therapeutic impasse may occur. Positive practice is a recursive process insofar as it is possible to move from the final stage of one episode of consultation to the first stage of the next. For example, the parents of a family who have engaged in an episode of therapy for a child-focused problem may at the end of that episode recontract for a further episode of therapy focusing on marital difficulties.

**Figure 1**  
**Stages of the Consultation Process**



### *Stage 1. Planning*

In the first stage of the consultation process plans are developed in two main areas. First, plans are developed about who to invite to the first session. This plan is based upon

**Figure 2**  
**Framework for Network Analysis**

ROLE	DEFINITION	CONDITIONS UNDER WHICH INVITATION TO FIRST CONSULTATION SHOULD BE OFFERED
Referring agent	The pivotal member of the problem system that connects the therapist, the team, and the agency to the extant problem system	Invite if the reason for referral is unclear or appears to contain some hidden agenda
Agent of Social Control	Representatives of the state, statutorily empowered to intervene in clients' lives without consent for the common good. Social workers, probation officers, and psychiatrists often fill this role	Invite if the reason for referral is unclear or appears to contain some hidden agenda
Customer	Any system member that has an investment in the problem being resolved. There may be more than one customer	Always invite the main customer
Problem Person	The person identified by the referrer or the customer as the individual requiring help	Usually should attend the first session. Only exclude the problem person if he or she is very unwilling to come (e.g., adolescent), or if the customer would find it very difficult to talk about the problem with the problem person present (e.g., infant)
Primary Caregivers	Usually the mother and father, but may be a sibling or foster parents	Always should attend the first session
Legal Guardians	Usually the parents but may be the local authority (represented by a social worker) when children are in care	Always should attend the first session
Change Promoters	Those who have resources to contribute to resolving the presenting problems and who are available to do so	Need not be included in first session but may be included in later sessions
Change Preventers	Those who prevent problem resolution and maintain homeostasis	Need not be included in the first session but may be included in later sessions

an analysis of the network of family members and professionals involved in the case. Second, an agenda for the first session is drawn up. Failure to develop such plans may lead to problems in Stage 2 of the consultation process where the central tasks are assessment and formulation. For example, if the main customer for change is the referring agent and he or she is not invited to the first session due to lack of planning following network analysis, then the task of establishing a contract for assessment may be problematic.

*Planning who to invite and network analysis.* The Barrow family comprised two teenage children, Caroline (14) and Mat (18), and their parents, Dick and Sheila. Caroline Barrow was referred simultaneously by both the educational psychologist, David Trellis, and by Tom Walker, the pediatrician. The former was primarily concerned with Caroline's poor school attendance and the latter with her recurrent abdominal pain for which no organic basis could be found.

From the information contained in the referral letters and from telephone contacts with the referrers it became clear that at least six professionals were involved in the case. The framework set out in Figure 2 was used to make hypotheses about the roles of each of these professionals and each of the members of the Barrow family (Carr, 1990; Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1980). These hypotheses informed our decisions about who to invite to a preliminary consultation session.

The pediatrician and the educational psychologist, the referring agents, did not appear to have hidden agendas and their reasons for referral appeared to be clear. This hypothesis was based on the information in the referring letter and on the good working relationship that had been developed with these two professionals over a period of years. The school nurse, Nurse Boyd, the school doctor, Dr. Reid, and the family doctor, Dr. Wilson, had all been regularly involved in the case and were baffled and somewhat exasperated by the lack of progress but, according to the educational psychologist and pediatrician, prepared to cooperate with a case management plan suggested by our department, which was based in a district general hospital. Our hypothesis was that all three of these professionals were potential change promoters rather than preventers.

The education and welfare officer, Phil Hutchinson, had been involved in the case with the aim of improving Caroline's school attendance. He was potentially an agent of social control since the statutory powers associated with his role allowed him to refer the Barrows to court. In this way the state could intervene in the Barrow family's affairs by prosecuting the parents for failing in their parental duties or removing Caroline from the custody of her parents on the grounds that her needs for care and control were not being met within the family context. However, the educational psychologist assured us that the education and welfare officer would suspend involvement in the case until the Barrows had completed the consultation process at our clinic. I suspected that Mr. and Mrs. Barrow would view the education and welfare officer as a threat and would want to avoid court involvement and therefore accept a preliminary appointment for themselves and their children. However, one of our main concerns was that if the Barrows viewed us as aligned with the education and welfare officer, they would withdraw from treatment because they would see our department's involvement as potentially coercive. We planned to clarify our neutrality early on in the consultation process.

From the pediatrician's letter I suspected that Mrs. Barrow was the main customer. He pointed out that she regularly attended the family doctor with her daughter and was highly concerned about her daughter's abdominal pains and gastric difficulties. It was decided that it would be sufficient to invite Caroline and her parents, along with any other members

of the household, to the first session since this grouping contained the principal customer (the mother), the person with the problem (the daughter), the principal caregivers, and those legally responsible for the problem person (both parents).

*Planning the agenda and hypothesizing.* In positive practice the three-column formulation model, set out in Figure 3, is used to systematize hunches and hypotheses and plan lines of enquiry. In the right-hand column of the three-column formulation model, the suspected pattern of interaction containing the symptom or presenting problem in which the problem person and members of the problem system are caught up is set out. In the left-hand column, factors suspected of predisposing participants in this cycle to persist in this repetitive sequence of interaction are noted. In the central column, suspected beliefs or styles of information processing which mediate the influence of predisposing factors on the

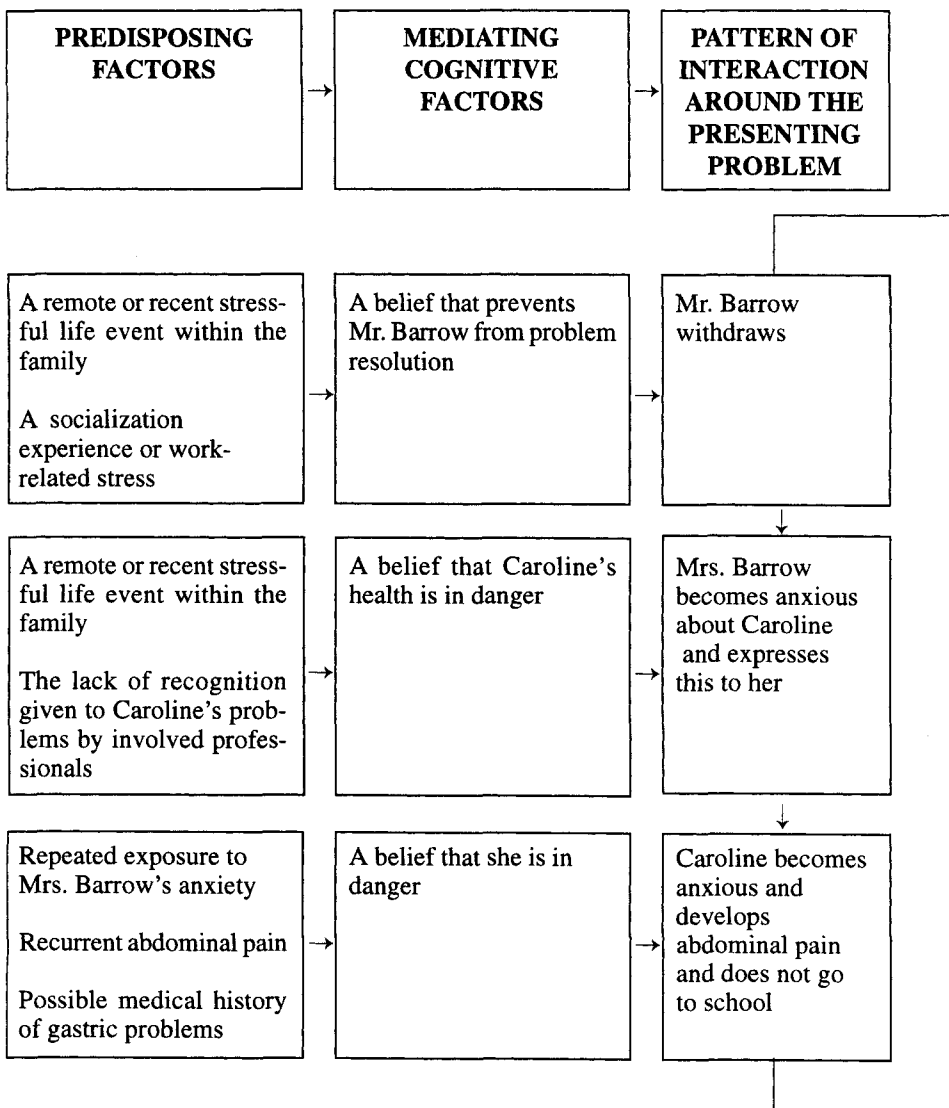
**Figure 3**  
**Three-Column Formulation Model**

PREDISPOSING FACTORS	MEDIATING COGNITIVE FACTORS	PATTERN OF INTERACTION AROUND THE PRESENTING PROBLEM
Remote stressful life events	<b>Beliefs systems</b>	The main problem
Recent stressful life events	Beliefs about problems and solutions relevant to the presenting problem	The pattern of interaction around the main problem
Membership in stressful social systems	Beliefs about parenting and family relationships	The costs and benefits associated with the problem and the pattern
Debilitating somatic states	<b>Styles of information processing</b>	Solution-related behavior that exacerbates the problem
Temperament and personality traits	Attributional style Internal, global, stable attributions for problem behavior	Symmetrical and complementary behavioral patterns
Genetic vulnerabilities	Cognitive distortions Maximizing negatives Minimizing positives	Enmeshed and disengaged behavioral patterns
	Defense mechanisms Splitting & Projection Denial Displacement Reaction formation Rationalization	Triangulation

present cycle of activity are listed.

In the Barrow case, our preliminary hunch was that Caroline and her mother were involved in a relationship characterized by separation anxiety on both of their parts, which manifested itself through Caroline experiencing abdominal pain and through the mother and daughter avoiding separation. This in turn led to school avoidance. We further hypothesized that some set of family or work-based circumstances prevented the father, Dick, from intervening in this anxiety-ridden relationship. Finally, we suspected that the mother and father held beliefs rooted in some remote or recent stressful life events or socialization

**Figure 4**  
**Preliminary Hypothesis for the Barrow Family**



experiences within the family which prevented them from dealing with the separation anxiety problem and Caroline's related abdominal pain and school refusal. There was also the possibility that Caroline had a history of gastric complaints and so was vulnerable to developing abdominal pain (Lask & Fosson, 1989). The anxiety may have been exacerbated by the lack of explicit recognition given to it by virtually all of the involved professionals. A diagram of this preliminary formulation, in three-column format, is presented in Figure 4.

On the basis of this preliminary formulation or hypothesis we planned to inquire about the following issues:

- the cycle of interaction around the problem with a focus on possible triangulation (Colapinto, 1991; Madanes, 1991), costs and benefits of this pattern for family members (Falloon, 1991), and solution-oriented behavior which exacerbated the problem (Segal, 1991);
- family members' beliefs and myths about these types of problems (Byng-Hall, 1988);
- information processing styles of the parents with a hunch that the father may have been denying the severity of the problem and the mother interpreting the problem as particularly dangerous (Beck, 1976; Malan, 1979);
- predisposing factors, including the mother's experiences related to health and illness and the father's involvement in work (Walker, 1985); and
- exceptional circumstances in which the typical problem pattern did not occur (de Shazer, 1985, 1988; White & Epston, 1990).

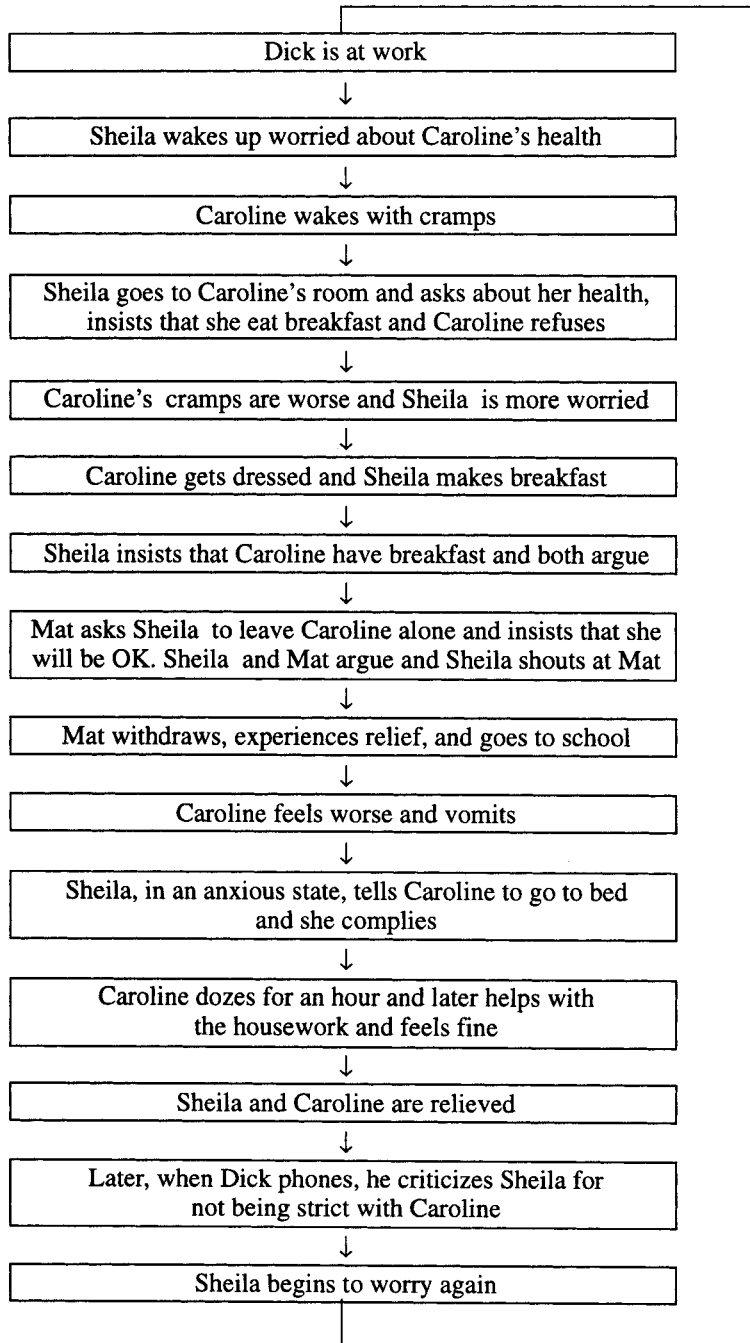
### *Stage 2. Assessment and Formulation*

All four members of the Barrow family attended the first session. The referral process was explained, and each family member's understanding of this was checked before inviting the family members individually to participate in the assessment. All four family members agreed to this. In positive practice, if parents have reservations about the contract for assessment, there is usually confusion about the rationale for referral, and involvement of the referring agent in a rescheduled intake session is advisable. This type of difficulty reflects an incomplete network analysis. When children have reservations about contracting for assessment, they may be invited to observe but not participate in the consultation process until they feel ready to do so. We have found that following a period of observation, most youngsters want their opinions to be heard and agree to an assessment contract.

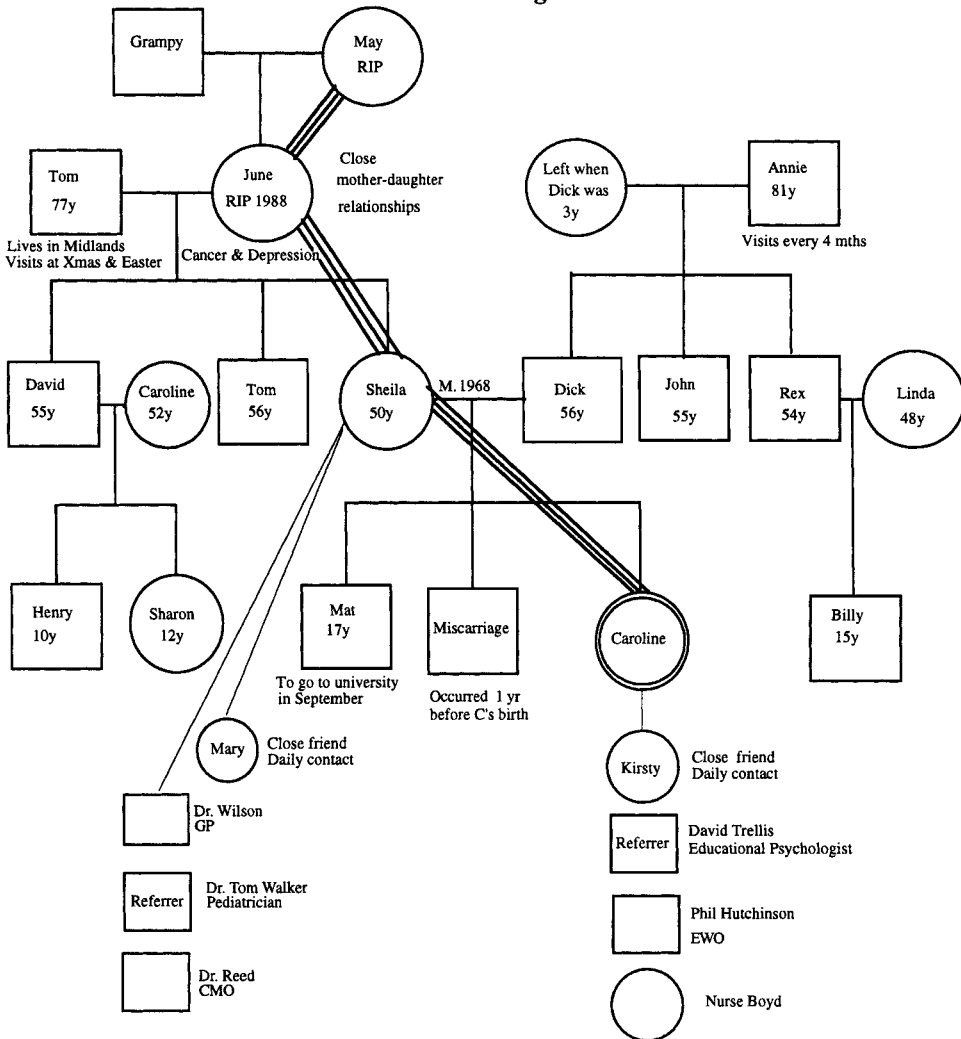
In response to the first line of inquiry about the pattern of interaction around the presenting problem, the description of a typical episode, which had occurred the previous week (see Figure 5) emerged and was put up on the whiteboard in the consultation room. The description of the pattern of interaction was constructed by asking each family member to describe his/her recollection of the sequence of events and integrating these into a single pattern.

This was followed up with inquiries about the beliefs that constrained family members to adopt their roles in this pattern of interaction and predisposing factors that underpinned these beliefs. A family history and genogram were constructed to aid this process. The genogram, which was put on the whiteboard in the consultation room, is presented in Figure 6. Inquiries about exceptional circumstances in which the problem did not occur were also made.

**Figure 5**  
**A Typical Episode Where Caroline Develops Abdominal Pain**  
**and Does Not Go to School**



**Figure 6**  
**The Barrow Genogram**



The following 11 salient points emerged from this 50-minute interview.

1. *Multigenerational history of close mother-daughter relationships.* For four generations the women on Sheila's side of the family had always had close mother-daughter relationships (Friedman, 1991).

2. *Caroline's gastroenteritis.* Caroline had a history of gastroenteritis but was otherwise a healthy teenager with good academic and social skills. When she perceived her mother's anxiety about her health, she feared that she had some undiagnosed illness (Lask & Fosson, 1989).

3. *Sheila's miscarriage.* Sheila had had a miscarriage prior to conceiving Caroline and

so Caroline was a highly valued child.

4. *Grandmother's undiagnosed cancer.* Sheila's mother had died from cancer that had gone undiagnosed a year prior to the onset of Caroline's abdominal pain and school refusal. Sheila felt guilty for not insisting that the physician examine her mother earlier and believed that she might be involved in a similar situation with Caroline, where some important illness was being missed by the involved medical personnel.

5. *Sheila's use of health as a core construct.* Sheila construed Caroline's difficulty as primarily a health problem because in her family of origin, health was a core construct for making sense of the world (Kelly, 1955).

6. *Sheila's cognitive style.* Like her mother, who suffered recurrent depression, Sheila was prone to maximizing the negative and minimizing the positive (Beck, 1976). In this context, she was prone to selectively attending to signs of Caroline's ill-health and to disregarding or minimizing her signs of well-being.

7. *Dick's use of duty and discipline as core constructs.* Dick had grown up in a family in which he took on a paternal role at an early age. He brought up his two brothers after his father had deserted the family when Dick was 3 years old. Duty and discipline were core constructs in the way his family made sense of the world (Kelly, 1955). Illness and other forms of vulnerability were denied or minimized. He therefore interpreted Caroline's predicament as essentially a discipline problem, a failure to do one's duty.

8. *Dick's career path.* Dick desperately wanted to be promoted from his position as a travelling sales representative into a managerial position at head office where he would not have to spend time away from home in the long term. He believed that to attain this promotion he must spend a lot of time away from home in the short term. Hence, his absence from family life.

9. *Caroline's social support network.* For Caroline, Kirsty, her close friend, could neutralize the impact of her mother's anxiety about her (Walker, 1985). She could help Caroline believe that the abdominal pains were only a transient discomfort and could direct Caroline's attention to other issues.

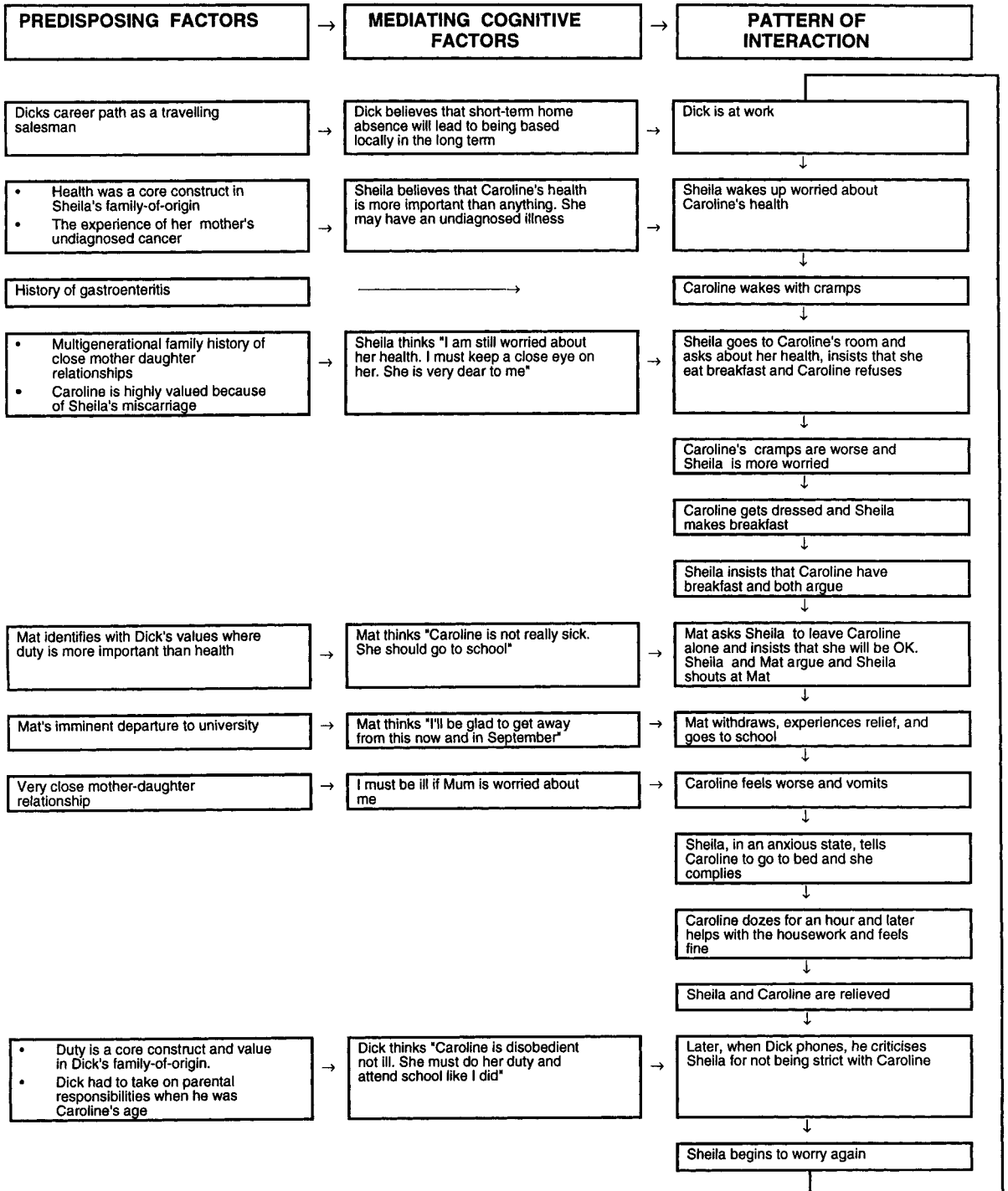
10. *Sheila's social support network.* For Sheila, contact with her friend Mary, the family doctor, or Dick lessened her anxiety about Caroline (Walker, 1985). She felt supported by them and this lessened her belief that she would be responsible for a catastrophe where Caroline's illness would go undiagnosed.

11. *Mat's need to leave home.* Mat identified with his father's worldview and saw the family difficulties as a discipline problem. However, his main concern was finishing school and going to college, so he did not want to become too involved in the struggle between Caroline and Sheila.

*The three-column formulation.* These salient points were integrated with the cycle of interaction around the presenting problem set out in Figure 5 into a three-column formulation. The formulation shows how the specific beliefs of each family member constrain them to act as they do during an episode of the problem. Furthermore, these beliefs are linked to predisposing factors such as stressful life events or early socialization experiences in the family of origin. The formulation is presented in Figure 7. Here is how the formulation was presented and the contract for treatment offered.

*Therapist:* This is a typical episode from the time Sheila wakes up in the morning till Dick calls at night. Now what I've tried to do is guess from all the other things you've said to me what forces you to repeat this dance again and again one week after another for months. That's the question. How is it that this keeps

**Figure 7**  
**A Three-Column Formulation for the Barrow Case**



repeating? I mean . . . that's the mystery.

*Sheila:* Yes. I know . . . She might be . . . But she is . . . she might be very ill.

*Therapist:* (to Sheila). Well Caroline . . . my opinion is . . . she's in a lot of pain nearly every morning. Real pain. Now maybe it doesn't show up on an X-ray but then neither does a headache or a migraine. And we all know that they are real pain. . . . eh . . . Bad pain. You know we all have our Achilles heel. Some people get headaches when they get sick and some people get pains in their joints. But Caroline, we know that your Achilles heel is in your stomach. When you get run down, you get a bad stomach. So where does that leave us? Oh yes . . . I want to point out that I've included Caroline's vulnerability to stomach problems . . . her Achilles heel . . . here on the map of the problem (points to third listed predisposing factor).

*Caroline:* Yes. m . . . hm

*Therapist:* (to Sheila). Well Sheila . . . when you wake up, you go and check on Caroline because you know she gets a bad stomach. My guess is that you don't want the thing that happened with your mum to happen again. And in your family health was a central concern. You said to me that your mum said "Your health is the main thing." So that's the way you think about Caroline. Are you with me so far? (Sheila nods.) The other thing is, you are really close to your daughter so you sense what she feels and she feels what you feel . . . eh . . . what concerns you. That's the way all the mothers and daughters have done things in your family going back four generations as far as I understand it?

*Sheila:* Yes my mother . . . She and I were just like that.

*Therapist:* And she was like that with her mother, you said . . . you said earlier?

*Sheila:* Yes, that's right.

*Therapist:* So I've put those things: the concern with health in your family, the unfortunate situation with your mother's diagnosis, and the special kind of relationships mums and daughters have in your family in here (points to the relevant predisposing factors).

*Sheila:* Yes. I see.

*Therapist:* (to Sheila). These are my best guess at what you say to yourself in these situations . . . sort of simplifications of what you might say. Not exactly what you say . . . but the gist of what you think to yourself privately. Do they hit the spot?

*Sheila:* Well. . . . Yes sometimes I think . . . eh . . . She's getting worse.

*Therapist:* (to Caroline). And I'm guessing that you think to yourself . . . this sort of thing . . . (points to "I must be ill if Mum is worried about me," part of the formulation diagram.)

*Caroline:* Not really . . .

*Therapist:* You don't think that at the front of your mind? But I'm guessing that you see Mum being worried and maybe this is at the back of your mind . . . maybe even in your unconscious . . . I'm not sure . . . but I think so?

*Caroline:* mmm . . .

*Therapist:* (to Dick). You talked about short-term sacrifice for long-term gain. I put that in here (indicates place in formulation). You also talked about the importance of duty in your family when you brought your brothers up and how you see Caroline's school absence as . . . eh . . . not doing what is expected of her. So . . . that is in the map too, just here. When you phone Sheila you say Caroline

must not get away with this . . . . Like she is disobedient . . . and your wife says . . . “But she is sick” . . . That’s the main conflict between you about this whole thing . . . two ways of looking at the same thing . . . I suppose . . . two very different constructions.

*Dick:* Yes, she must do what she is told. If her mother tells her to go to school, she must go.

*Therapist:* You have strong views about this, Dick, so they are included in the map. Now, Mat, I guess you share Dad’s view, so I put that in here (indicates Mat’s position). I also suspect you want to be freed up a bit from this situation to, eh . . . to do what you need to do next . . . in college and that.

*Mat:* Yea . . . that’s it.

*Therapist:* So what this map is saying is . . . your beliefs are tying you all into this circle and your beliefs are rooted in where each of you has come from. Important things that have happened in the past . . . or are going on now outside the family. Can you accept this map as a rough description of the problem you have brought here? Not the truth . . . just a *good enough* map.

*Dick:* Yes. In a nutshell . . . yes . . . you put it in a nutshell there.

*Sheila:* Yes, but she . . . Caroline . . . is ill.

*Therapist:* That is included in the picture, Sheila (points to predisposing factor of gastroenteritis history).

*Caroline:* Can you accept it?

*Sheila:* Yes.

*Therapist:* Well. It follows from this that there are some things that can be done to solve the problem. Would you be interested in hearing about those things now?

*Dick:* Yes. that’s what we’re here for.

*Caroline*

*and Sheila:* Yes.

At this point it was suggested that the objective of further consultations would be to help the parents find a way of developing a plan to work together to help Caroline deal with the pain and return to school, even though they held very different beliefs about the nature of the problem. This broad objective was accepted. However, specific therapeutic goals required some clarification and elaboration since clear, realistic, visualized goals that are fully accepted by all family members are crucial for effective therapy (Carr, 1993). The elimination of Caroline’s pain, regular school attendance, and a cessation of the morning arguments between Sheila and Caroline were the principal goals set by the Barrow family in the second session.

The first session closed with an agreement to a contract for six further sessions. In addition, family members were offered the following intersession tasks. Sheila and Dick were offered the task of discussing the various courses of action that would follow from their different beliefs about the problem and to list the pros and cons associated with each course of action. Caroline was invited to record a pain rating three times a day on a 10-point scale and to note factors that affected the intensity of these ratings. Mat was invited to withdraw from further involvement in the problem altogether.

### *Stage 3. Therapy*

In positive practice, the therapy stage includes goal setting and contracting, participat-

ing in therapy, and the management of resistance. Participation in therapy involves both the completion of tasks within therapy sessions and the completion of tasks between sessions such as those offered to the Barrow family at the end of the first session.

*Tasks between sessions.* The design of a task depends upon its function. With the Barrow family, one of our intentions was to assess fluctuations in Caroline's abdominal pain over the course of a week and factors related to these fluctuations. Hence the pain-monitoring task. A second intention was to assess the flexibility and scope of Dick and Sheila's belief systems about the problem. A third intention was to assess the capacity of the system to reduce enmeshment, so we invited Mat to withdraw from the problem cycle. All three tasks were designed as simply as possible and were based on clear and explicit intentions.

*Focusing on behavior and focusing on beliefs within sessions.* When the central focus of the session is on behavior, the therapist's aim is to coach family members in skills that would allow them to break out of the cycle of interaction around the problem specified in the right-hand column of the three-column formulation. These skills may include those required for effective communication, interpersonal problem solving, child management, or the regulation of internal emotional or sensory states. In the second session with the Barrow family described below, for example, Caroline was coached in pain management skills (Ioannou, 1991).

A progress review at the outset of the second session revealed that Caroline's average pain rating prior to school each morning was 5 on the 10-point scale and lower ratings occurred when Caroline's friend, Kirsty, accompanied Caroline to school or on Mondays and Fridays when Dick, the father, had been around early in the morning or was due to be around in the evening. Caroline had attended school on seven of the nine school days that occurred between the first and second session. Sheila and Dick completed their task of discussing the pros and cons of their respective beliefs about the best way to solve Caroline's problem and agreed that there were serious difficulties with both approaches. Dick's disciplinarian approach would lead to opposition from Sheila, and Sheila's medical approach would lead to opposition from Caroline and Dick. Mat had, as requested, reduced his involvement in the cycle of interaction around the presenting problem and not joined the family at the clinic for the second session.

The central focus for the session was on behavior, specifically, on training Caroline in pain management skills. Caroline was coached in relaxation exercises and helped to use visualization to manage abdominal discomfort (Ioannou, 1991). This training was done in the presence of the parents. Caroline was then invited to practice the exercises alone on a daily basis and to use them to manage the episodes of pain when they recurred. The importance of Caroline taking full responsibility for the management of her pain and learning to control it independently was emphasized. The fact that this would increase the probability that the cycle of interaction in the right-hand column of the three-column formulation would be disrupted was pointed out. The parents accepted this and agreed to refrain from inquiring about Caroline's pain each morning. The father's urge to follow through on some disciplinarian solution and the mother's wish to pursue further medical investigations were identified as factors that might lead them to disrupt Caroline's attempts to use her pain management skills. It was therefore decided to help Dick and Sheila construct a new belief system about the problem and to negotiate a new set of responsibilities concerning its management. The exploration of the parental belief systems was identified as a focus for the next session.

Finally, Caroline agreed to continue the symptom-monitoring task and to ask Kirsty to go to school with her as often as possible since this would distract her from the pain. This

was an exception-amplifying task.

A review at the outset of the third session showed that Caroline's average rating during episodes of pain had been 5 on a 10-point scale during the 2-week interval between sessions. This was the same rating as that reported in the previous session. She had practiced the pain management exercises and used them to good effect on six out of nine school days. The effectiveness of the exercises was enhanced when Kirsty was present and reduced when Caroline became embroiled in arguments with Sheila.

Following the plan to focus on parental beliefs about the problem in this, the third, session, Sheila was invited to articulate the beliefs that underpinned her anxiety about Caroline's health. She said that she was convinced that Caroline suffered from an undiagnosed illness. This belief would not change even if a thorough physical examination revealed nothing abnormal about Caroline's health because Sheila believed that the source of Caroline's pain might not be identified by routine medical investigations. Sheila said that she did not therefore want a second medical opinion. Rather, she wanted certainty and she knew that this was unobtainable, so her anxiety about Caroline's well-being continued to increase. In response to inquiries about his beliefs, Dick said that Caroline's school nonattendance constituted a disobedient and manipulative behavioral pattern requiring a disciplinary response. He was angrier about the problem now than he had ever been.

Following these two extreme framings of the problem, a reframing of Caroline's symptom (which was a simplification of the formulation constructed in the first session) was offered. First, it was reiterated that Caroline was vulnerable to abdominal pains because of her history of gastrointestinal problems. Second, it was highlighted that the stomach pain was exacerbated by anxiety. Third, it was stated that the parental disagreement about the nature of the problem and the appropriate solution was a major source of anxiety for Caroline. This reframing was apparently accepted by Caroline and her parents.

The elaboration of this reframing of the problem and the development of a plan for the parents jointly to support Caroline in her attempts at pain management were the main issues tackled in the latter half of the session. It was agreed after much discussion that Dick would call home every morning and offer Sheila support over the telephone. If Caroline had not left the house by 8:35 a.m., Sheila was to take her to the family doctor's surgery for a checkup. If he gave her a clean bill of health, she was to take her to school and explain to her teacher that she needed a brief period to complete her pain management exercises before joining the class. This session ended on a light note, with all three members of the Barrow family expressing confidence that they could follow through on these tasks, and Caroline agreed to continue to keep her record of pain ratings.

*Resistance, therapeutic dilemmas, and crises.* It is not unusual for cooperation problems or resistance to develop after a period of therapeutic progress. Resistance to co-operating with therapy tasks may occur because of unforeseen circumstances, lack of skill on the clients' part, or lack of commitment to the change process. A discussion of the management of resistance based on these factors is described elsewhere (Carr, 1995b). Our concern here is with resistance which arises when family members believe that the disadvantages of therapeutic change appear to outweigh the disadvantages of the status quo. In such cases, articulating both sides of this therapeutic dilemma may precipitate a crisis. The process of questioning resistance, framing a therapeutic dilemma, and managing the resultant crisis in the Barrow case will now be reviewed.

Four weeks after the third session, Sheila and Caroline attended the clinic without Dick, who was unable to attend because of his work commitments. A progress review revealed

that the problems were worse and the family only partially completed the tasks agreed to in the previous session. Caroline's average pain rating had increased from 5 to 6, and her school attendance had dropped from 4 to 3 days per week. Dick had phoned Sheila each morning for a few days to offer support in managing her concern for Caroline's health but then stopped because it interfered with his work routine. On only one of the four occasions when Caroline's pain led to school nonattendance was the family doctor involved as agreed.

The heart of this fourth session focused on inquiring about the beliefs that underpinned the family's resistance to carrying out the agreed tasks. Caroline and Sheila were asked to speculate on what prevented Dick from following through on making contact each morning with Sheila by phone. Both Caroline and Sheila thought that Dick desperately wanted promotion so that he would not have to spend so much time away from home in the long term. In order to get this promotion, he was reluctant to take time off to call Sheila because it might interfere with his work schedule. When asked what beliefs he might have acquired from his parents that also prevented him from phoning Sheila to offer support, Sheila said that she believed that in Dick's family, talking or negotiating about a problem was seen as a sign of weakness. He may not have phoned because he might not have wanted to appear weak. This process of questioning about layers of beliefs that may underpin resistance is a central part of its management (Pearce, 1994).

Caroline and Sheila were then invited to speculate on possible ways that Dick could offer support to Sheila without compromising his promotion prospects and without believing that he was appearing to be weak. Three options emerged from this discussion. First, that Sheila call Dick early each morning before Dick started work, state her concerns, and request advice. Second, that Sheila agree not to call Dick unless she and Caroline were arguing and then that Sheila ask Dick to act as a sounding board. Third, that Dick take a week's leave of absence from work and take a more active role in helping Caroline get to school and manage her pain. Because Dick had not attended, I wrote to him after the session asking his opinion on the viability of these three courses of action and inquiring if he could offer some alternative option.

Following the exploration of ways around the resistances that were blocking Dick, factors that prevented Caroline and Sheila from following through on the plan to visit the family doctor and enlisting the help of the teacher were explored. On the first morning when the family doctor was visited, he assured Caroline that there was no medical basis for her pain and that it was *all in the mind*. This well-intentioned reassurance led Caroline to feel humiliated, and she resolved not to return to the surgery lest she be humiliated again.

Caroline said that on the mornings when she had severe pain she would like to stay home and do schoolwork there. But if she had to go to school, she did not want the family doctor involved. Sheila objected to this on the grounds that involvement of the family doctor was an important way of ruling out dangerous medical conditions and her failure to take this line of action with her mother had contributed to her mother's premature death. This difference of opinion on the role of the family doctor had led to a number of intense arguments between Sheila and her daughter in the preceding month.

At the end of the session the therapeutic dilemma faced by the Barrows was outlined. Maintaining the status quo entailed the following disadvantages:

1. Caroline continuing to experience pain, school absence, and conflict with Sheila;
2. Sheila continuing to experience anxiety about having a child with an unknown illness;
3. Dick continuing to experience anger about having a disobedient child; and
4. A continuing disharmony between Dick and Sheila due to their unresolved conflict

about the nature of the problem and the most appropriate way to deal with it.

Seeking a solution to the problem, on the other hand, also entailed disadvantages.

1. Dick would have to put more time and effort into his relationships with Sheila and Caroline and this might compromise his promotion prospects, which would, in the long term, lead to him spending more time away from the family.

2. If Dick and Sheila began to try to resolve their conflict about how best to conceptualize the problems and solve them, the process of discussing their conflicting views might lead to an extremely angry argument which would exacerbate the marital disharmony they currently experienced.

3. If Sheila insisted on Caroline visiting the family doctor when she had stomach pains, the conflict between mother and daughter might intensify.

The fact that such dilemmas are sometimes an inevitable part of the change process and that therapeutic progress is unlikely until some way out of such dilemmas can be found was mentioned. In the meantime it was suggested that Sheila and Dick put aside two 30-minute periods to discuss the dilemma before the next appointment in a fortnight.

Ten days after this, the fourth, session, there was a crisis phone call from Dick at 10 a.m. He said that after receiving my letter he decided to take a far more active role in helping Caroline by driving her to school each morning. However, on this particular morning she responded by refusing to get out of the car because of the severity of her pain and refusing to visit the family doctor to have her health assessed because of her fear of humiliation. She bit Dick on the hand when he attempted to force her physically from the car to the school. She then crooned and rocked like a baby on the floor of the car until he drove her home. Dick believed that her condition was a reflection of an exclusively intrapsychic problem which required immediate sedation and hospitalization.

An offer was made to convene a network meeting within 48 hours to which all family members and involved professionals would be invited. A telephone conversation with Caroline confirmed that she was neither a danger to herself nor others and was confident that, if no pressure were put on her to attend either the family doctor or school, there would be no recurrence of conflict between herself and Dick. In light of this information, Dick agreed to postpone any action that would lead to hospitalization and sedation until after the network meeting.

Resistance occurs when the therapist invites the family to change the pattern of interaction around the presenting problem and the beliefs that go with this pattern, but the family respond by maintaining the status quo (Anderson & Stewart, 1983). If the therapist responds by co-constructing with the family a therapeutic dilemma which states the disadvantages of the problem and the disadvantages of taking responsibility to resolve the problem, then a therapeutic crisis such as that described by Dick during the crisis phone call will often occur. When Dick received my letter and considered the three options for action outlined, he selected the third as the most viable. However, in taking on a more active role in helping Caroline, he probably based his actions not on the complex three-column interactional formulation of the family's difficulties but on a simplistic individualistic formulation, that is, that the core problem was one of simple disobedience. He probably construed Caroline as a *bad* girl who needed firm handling and a forcible return to school. When Caroline bit Dick and crooned in response to his treatment of her as a disobedient child, he was extremely distressed and began to doubt his framing of her as *bad*; he also began to doubt the wisdom of the ineffective approach he had taken in returning her to school. In response to the doubt, he probably chose another simplistic individualistic framing of

Caroline's behavior. He chose to see his daughter not as *bad* but as *mad*. As noted in the three-column formulation model in Figure 3, under stress, parents often attribute their children's problem behavior to internal, global stable factors such as *badness* or *madness* (Barton & Alexander, 1981) and in doing so use the defenses of splitting and projection (Malan, 1979) to avoid emotional pain. These cognitive factors may then underpin problem-maintaining patterns of interaction. This was probably what was occurring with Dick in this situation. He probably adopted this style to avoid the emotional pain that he and Sheila would have to endure if they were to negotiate an agreed solution based on the three-column interactional formulation of the problem.

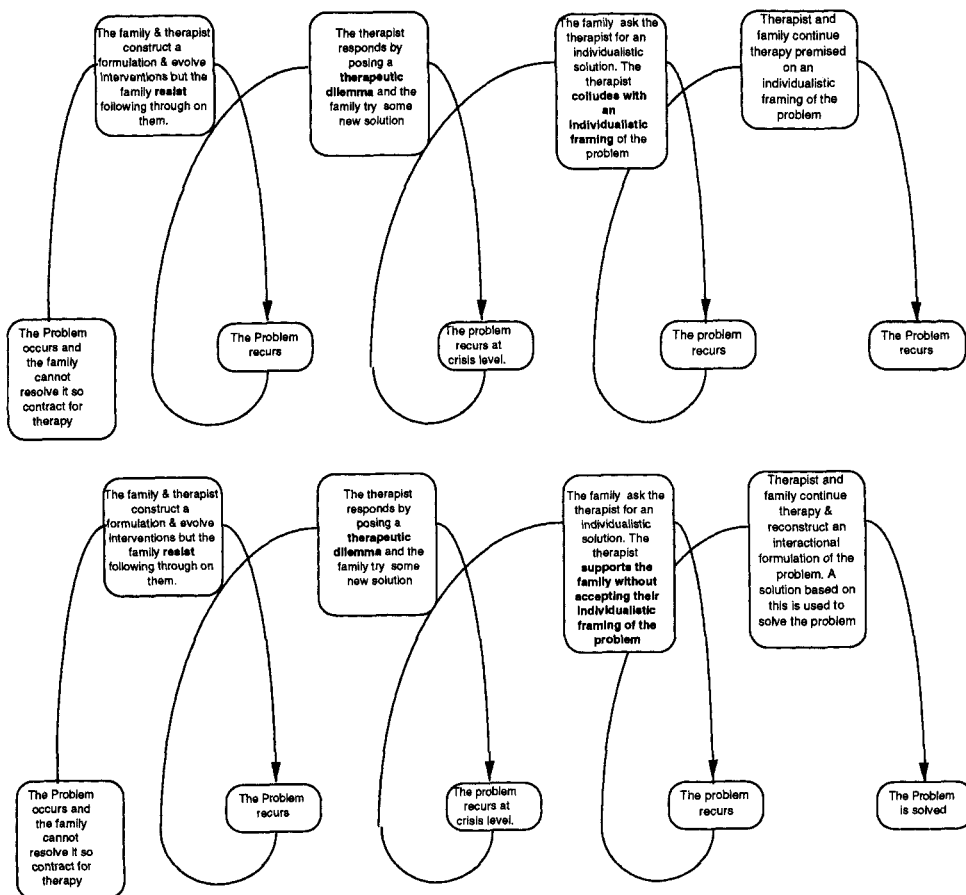
Therapeutic crises often involve some family members doubting the interactional three-column formulation of the problem and redefining the problem simplistically as exclusively an individual difficulty rather than as a complex phenomenon entailing an interactional component, just as Dick did. A central feature of positive practice is to avoid collusion with such attempts to reframe complex problems entailing both individual and interactional difficulties in simplistic, exclusively individualistic terms, while at the same time supporting the family member requesting the individualistic reframing. That is not to say that individual biological predispositions (Simonoff, McGuffin, & Gottesman, 1994) or intrapsychic states and traits (Beck, 1976; Byng-Hall, 1988; Malan, 1979; Rutter, 1987) do not have a valid place in a comprehensive formulation. From Figure 3 it is clear that both of these types of factors are taken into account in positive practice. Rather, the point is that in positive practice, all formulations are complex and entail an interactional component. A map of a therapeutic system responding to a therapeutic dilemma with a crisis to which the therapist responds by colluding with a simplistic individualistic framing of the problem is presented in Figure 8 along with an alternative pattern where the therapist supports the family and helps them to retain allegiance to a complex interactional framing of the problem and its solution. This latter pattern occurred in the Barrow case, following an individual consultation and a network meeting, which are described below.

*Individual consultations and network meetings.* Although a systemic frame of reference is used to conceptualize and formulate problems within positive practice, it is recognized that individual sessions, family sessions, and wider network meetings may be used to achieve specific short- or long-term therapeutic goals entailed by the systemic three-column formulation. With the Barrow case, a network meeting was convened to resolve the therapeutic impasse that had been reached, and this was preceded by an individual session with Caroline to assess risk of self-harm and to clarify her view of her current situation.

Her abdominal pains were becoming worse. She rated them at 8 on a 10-point scale. She was angry at both of her parents for worrying about her excessively and for intruding into her personal space. She worried about her mother, Sheila, and wished that her father, Dick, was more regularly available to support Sheila. Looking to the future, she said that she would go to school and tolerate the abdominal pain if her parents became less intrusive. Her mood was low, but she expressed no suicidal ideation or intention. She said that she would like her views represented in the network meeting which was convened immediately following this individual session. I agreed to act as Caroline's advocate in the meeting but made a distinction (to both Caroline and those who attended the meeting) between the role of advocate and that of convenor of the network meeting. This was done to preserve a position of neutrality within the overall therapeutic system.

The following people attended the network meeting: Dick, Sheila, and Caroline Barrow; the family doctor, Dr. Wilson; the school nurse, Sarah Boyd; the education and wel-

**Figure 8**  
**Maps of Problem-Maintaining and Problem-Resolving Therapeutic Systems**



fare officer, Phil Hutchinson; and the teacher, Ms. Hackett. The pediatrician, Dr. Tom Walker; the school doctor, Dr. Reid; and David Trellis, the educational psychologist, were unable to attend. Incidentally, David Trellis, who referred the case, was no longer involved because he had changed jobs and his post had not been filled since his transfer.

Following introductions, a brief summary of the consultation process was outlined. An agenda for developing a coordinated plan to deal with Caroline's pain and the issue of school attendance was set. Each network member made an initial contribution about their degree of involvement, their views on the overall formulation, and their views about solutions. As the meeting progressed, a consensus emerged that the problem was a complex multifactorial phenomenon rather than a simple unidimensional difficulty. The three-column formulation was presented verbally late in the meeting as an attempt to systematize the many factors involved. A variety of possible solutions were explored and suggested, including taking no action, arranging a behavioral program, offering individual counseling, arranging hospitalization, making a referral for inpatient psychiatric treatment, conducting a

medical re-evaluation, arranging home tuition, pursuing a graded school re-entry program, and so forth. I presented Caroline's position articulated in the individual session. Shortly after this, Caroline, who had said little throughout the meeting, outlined the following plan. She said that she would like to go to school every day. If she felt sick or had stomach aches, she did not want anyone either at home or at school to ask her about it. Then, once in school, she wanted permission to leave class if the pains were so bad that she could not concentrate. She wanted to be able to talk to Ms. Hackett from time to time, but not on an appointment basis. After some discussion, everyone involved agreed to the plan and the Barrows were offered a follow-up appointment for the following week.

#### *Stage 4. Disengagement or Recontracting*

At the end of an episode of consultation, progress toward goals agreed on in the therapy contract is reviewed. When negligible progress has been made within 6 to 10 sessions, it is probably unlikely that further sessions based on this approach to practice will lead to the attainment of therapeutic goals. This type of outcome will occur in about 25%-33% of cases (Carr, 1991; Carr et al., 1994). Referral to some other type of service better suited to clients' needs is appropriate in these circumstances. It is wasteful of both the therapist's and the clients' resources in these cases to become engaged in *more of the same* type of therapy (Segal, 1991). In cases where partial or complete goal attainment occurs, disengagement or recontracting for a further episode of consultation with a different problem focus are the two main options.

An exploration of family members' beliefs about the permanence of change, the conditions under which relapses are likely to occur, and the family's plans for relapse management are important issues to cover during disengagement sessions when significant progress has been made. When family members doubt the permanence of change, factors that would provide evidence for permanence may be explored in the session and methods for tracking these examined. Families may be educated about factors associated with relapse, such as the build up of stressful life events (Marlatt & Gordon, 1985). Specific plans for relapse management may be detailed and clients may be offered the opportunity to recontract for therapy in the event of a relapse. Where families have members with chronic physical or psychological disabilities, possible future lifecycle transition periods when a further episode of consultation may be appropriate should be identified as part of the disengagement process.

In the sixth session Caroline was seen with her parents and indicated that her abdominal pains had intensified for a few days following the network meeting but then abated. Her parents and teachers followed through on the agreed plan, and Caroline said that this made the management of the pain and school attendance tolerable. She then asked to be seen alone and confided that she had begun to construe the abdominal pain as a headache in her stomach made worse by worrying about her mother. She said that she and Sheila had not fought in the mornings and that her relationship with Dick had improved. In the final part of the session, the parents were seen alone and confirmed that they were being mutually supportive.

The atmosphere in the seventh session was celebratory. Caroline said that the pains had stopped completely over the Easter holidays and had not recurred. She had taken up yoga and was enrolled in a modern dance class. Sheila and Dick were planning a spring vacation together in the Lake District. They had not taken a vacation as a couple since their son's birth, 18 years previously.

The heart of the session focused on beliefs about the permanence of the change and on relapse management. All three family members saw the therapeutic gains as permanent

rather than transitory. This, they said, was because they saw the changes in Caroline's stomach pains and school attendance as part of a wider change in the patterns of interaction within the family. They affirmed that the cycle of interaction around the presenting problem had been disrupted by Sheila agreeing not to ask Caroline about her health in the morning, by Dick spontaneously phoning Sheila occasionally to check if she was coping, and by Caroline taking responsibility for managing the pain if it occurred at school. They also noted that Caroline felt more connected to Dick. In the past she had felt threatened by him. It was also apparent to them that Sheila and Dick's relationship was now stronger and more supportive. Finally, they noted that the involvement of the professional network in their family life had virtually ceased and that this allowed them to get on with day-to-day activities as opposed to worrying about the problem.

Caroline left this session early to meet her friends. Dick and Sheila then talked openly about the strain that Dick's work and Sheila's bereavement had placed on their marriage and how they had found it increasingly difficult to talk openly to each other. They noticed that this had begun to change since the network meeting. A follow-up phone call 4 months later confirmed that the gains made had been maintained.

## DISCUSSION

The approach to practice described in this paper looks to Bateson (1973) and the tradition of Milan systemic family therapy for its central clinical framework (Campbell, Draper, & Crutchley, 1991). Aspects of behavioral (Falloon, 1991), structural (Colapinto, 1991), strategic (Madanes, 1991), and Bowenian (Friedman, 1991) models of family therapy have been integrated into this core approach to practice along with elements drawn from the fields of brief therapy (Cade & Hudson-O'Hanlon, 1993), cognitive therapy (Beck, 1976), personal construct psychology (Kelly, 1955), and psychodynamic therapy (e.g., Malan, 1979). The theoretical ideas and therapeutic techniques adopted from these diverse sources have been integrated in positive practice through frameworks designed to aid the conceptualization of the consultation process (Figure 1), network analysis (Figure 2), formulation (Figure 3), task selection (Carr, 1995, p. 95), and the management of resistance (Figure 8). Insofar as positive practice provides these underlying frameworks for guiding integration of theoretical ideas and therapeutic techniques from a variety of schools of individual and family therapy, it is similar to other integrative approaches to family therapy practice (e.g., Breunlin, Schwartz, & MacKune-Karrer, 1992; Pinsof, 1994) and quite distinct from eclectic approaches to the practice of psychotherapy or family therapy which offer no clear rationale for inclusion of new ideas and techniques or selection of specific ideas or techniques under particular circumstances (Breunlin et al., 1992; Carpenter & Treacher, 1993; Dryden, 1992; Lebow, 1987; Norcross & Goldfried, 1992). The approach to practice described in this paper is not intended to represent yet another new school of family therapy. Rather, it is part of the current integrationist trend which is sweeping the fields of psychotherapy and family therapy in both the U.S. (Norcross & Goldfried, 1992; Sprenkle & Bischof, 1994) and the UK (Carpenter & Treacher, 1993; Dryden, 1992).

Because of its emphasis on the socially constructed nature of problem formulations and the choice of usefulness as a criterion for selecting between different formulations of the same problem, positive practice may be viewed as falling within the postmodernist traditions of social-constructionism and neopragmatism (Pearce, 1994). The model as a whole is informed by empirical research on child development, social psychology, psycho-

therapy, and the provision of mental health services. However, in keeping with the postmodernist perspective, it is recognized that such research results are social constructions of communities of scientists and clinicians rather than absolute facts with privileged truth value. A central feature of the approach is that the clinician explores ways of integrating new empirical findings, theoretical insights, and practical procedures into a coherent and unified approach to consultation. Positive practice, therefore, provides a framework for assimilating material and skills acquired by seasoned clinicians through continuing professional development programs. Positive practice also offers a useful first framework for novice clinicians. At University College Dublin, our clinical psychology trainees find that the highly structured unifying framework of positive practice enhances clinical confidence and competence. The confused eclecticism that arises from exposure to multiple models without any unifying framework is avoided.

Although, the approach to practice described in this paper was developed explicitly for use in cases referred for child-focused problems, it may probably be used for a wide variety of cases. Recently, I have been using a version of the model for working with individual adults and couples facing midlife dilemmas.

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## NOTES

<sup>1</sup> *Positive practice* was the term selected to label the approach to practice described in this paper and elsewhere (Carr, 1995) because of the connotations entailed by the adjective *positive* as defined in the *Concise Oxford Dictionary*. In the first instance *positive* means “formally laid down” and in the second instance it means “explicitly laid down.” There is no implication that these connotations do not apply to other approaches to the practice of family therapy.

<sup>2</sup> The term *consultation process* is used throughout the text as a superordinate term to cover the stages of planning, assessment and formulation, therapy, and disengagement and recontracting outlined in Figure 1 and described in detail in the text.