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## **A FORMULATION MODEL FOR USE IN FAMILY THERAPY**

### **ABSTRACT**

A model for simplifying complex information about a given presenting problem and integrating it into a formulation is described in this paper. The model contains three columns. In the right hand column, the cycle of interaction containing the symptom or presenting problem in which the identified patient and members of the network are caught up, is set out. In the left hand column, factors which predispose participants in this cycle to persist in this repetitive sequence of interactions are noted. In the central column (where pertinent) cognitive factors which mediate the influence of predisposing factors upon the present cycle of activity are listed. A sample formulation is first given to demonstrate the way in which the model may be used to simplify and integrate information. The implications of the model, from a clinical perspective, for assessment, treatment planning and the management of resistance, are then illustrated with a detailed case example.

### **INTRODUCTION**

A distinction is made by family therapists between circular and linear explanations (McGuirk, Friedlander & Blocher, 1987). Circular explanations highlight the way in which a family network's attempt to solve an index patient's problem can be viewed as a recursive pattern of social interaction which perpetuates the patient's difficulties. Linear explanations, in contrast, identify discrete historical events as causes of the patient's symptoms. Such factors may be physiological, intrapsychic, interpersonal or societal.

The formulation model set out in this paper represents a way of integrating circular and linear styles of explanation. It is based on the notion that people with behavioural problems and members of their social networks become embroiled in vicious cycles of problems and inappropriate solutions. Such cycles of interaction maintain presenting problems. Participants fail to break out of such cycles because certain personal or historical factors inhibit them from altering their roles in these stereotyped patterns of interaction.

The model was developed within a framework which reflects an integration of structural/strategic (Aponte & van Deusen, 1981; Stanton, 1981a, 1981b) and functional/behavioural (Barton & Alexander, 1981; Patterson & Chamberlain, 1988) approaches to

family therapy. This framework takes account of the structure and development of the family over the course of the life cycle; the social network in which the family is embedded; extrafamilial stress; learning processes and symptom development; belief systems and styles of information processing in determining interpersonal behaviour within the family network; and risk factor research in developmental and adult psychopathology. Within this integrated framework, assessment and treatment are conceptualised as distinct stages. The goal of the assessment stage is to develop a clear formulation of each of the presenting problems. On the basis of these formulations a unique set of strategies is developed in each case for solving each of the presenting problems. These strategies are implemented during the treatment phase.

The problem formulation model described in this paper offers a way of simplifying complex information and integrating it in a clinically meaningful way. It allows the clinician to avoid information overload while maintaining a relatively comprehensive conceptualisation of a given presenting problem. The model dictates a clear set of information gathering tasks. The symptom must be clearly defined and the pattern of social interaction which surrounds it must be determined. Factors which predispose participants in this pattern to maintain their roles must be clarified and the cognitive factors which mediate these predisposing factors must be assessed.

The circular aspect of formulations based on this model will identify network members involved in problem maintenance. This information may be used to decide which network members must be contacted or invited to further assessment or therapy sessions. The circular aspect of this type of formulation will also contain information on ineffective solutions which members of the patient's network have tried, and those aspects of these solutions which maintain the presenting problem.

**Table 10.1. Three Column Formulation Model**

Predisposing Factors	Mediating cognitive factors	Cycle of interaction surrounding symptom
<ul style="list-style-type: none"> <li>• Remote &amp; recent stressful life events</li> <li>• Membership of stressful social systems</li> <li>• Debilitating somatic states</li> <li>• Genetically based vulnerabilities</li> </ul>	<ul style="list-style-type: none"> <li>• Maladaptive belief systems</li> <li>• Maladaptive styles of information processing</li> </ul>	<ul style="list-style-type: none"> <li>• Symptom &amp; related behaviour &amp; feelings of identified patient</li> <li>• Actions and feelings of others which precede and follow the symptom</li> </ul>

**NOTE:** Predisposing and mediating factors, when present, should be specified for each action of each member in the cycle of interaction surrounding the symptom.

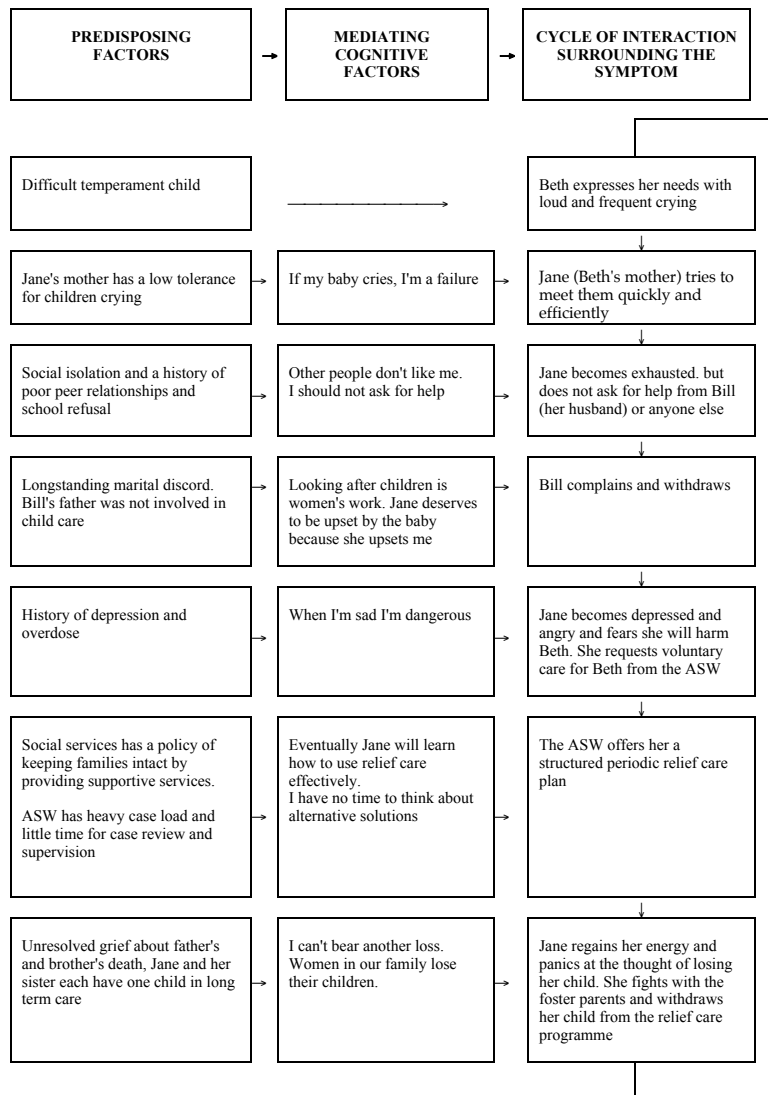
This information will have implications for treatment tactics to avoid, and those worth pursuing so as to break the cycle of social interaction in which the symptom is embedded.

The linear aspects of formulations, based on the model described below, point to factors which impede interventions aimed at directly disrupting the cycle of interaction surrounding the symptom. That is, linear aspects of a formulation following this model define sources of resistance (Anderson & Stewart, 1983). They may also suggest ways of mastering this resistance.

**FORMULATION MODEL**

The Three Column Model for Case Formulation is presented in Table 10.1. In this section the model will be described and illustrated with a sample formulation which is presented in Table 10.2.

**Table 10. 2. Case formulation for Beth, a persistently tearful child whose family had been involved in a relief care programme which has broken down**



### **Cycle of Interaction Surrounding the Symptom**

The right hand column is reserved for a sequential description of how members of the index patient's social network behave and feel before and after an episode of problem behaviour. Such descriptions make specific reference to events which trigger problem behaviour, how the identified patient is treated while the problem behaviour or symptom is exhibited, how members of the network try to deal with the problem, the outcome of such attempted solutions for the identified patient, the network's response to the outcome and how time is spent by members of the network and the identified patient before the next triggering event occurs and the cycle repeats again.

In the example presented in Table 10.2, the referral letter stated that Beth's persistent crying and broken sleep were the main presenting problems. The cycle in which Jane (the mother), Beth (the child), Bill (the husband) and the Area Social Worker were caught up is described in the right hand column. An interview with the Area Social Worker (ASW) and Mary revealed the triggering factor (Beth's illness) and the ineffectual solution (a relief care programme, which had broken down in the way outlined in Table 10.2 on three occasions).

### **Predisposing Factors**

In the left hand column of the model, factors which predispose participants to maintain their roles in the cycle of social interaction which surrounds the symptom are specified. Such factors fall into five subcategories. Remote or recent stressful life events constitute the first subcategory of predisposing factors. Poor maternal bonding, early multiplacement experiences or a personal history of neglect or abuse are examples of remote stressful life events (Wolkind & Rutter, 1985). Financial difficulties or changes in family composition are common recent stressful life events (McCubbin et al., 1982). Involvement in other social systems which make excessive demands on the individual, such as the school or workplace, are included in the second subcategory (Walker, 1985). Relevant temperamental characteristics or personality traits are included in the third subcategory (Rutter, 1987). Debilitating somatic states such as hemiplegia or obesity are contained in the fourth subcategory. The final subcategory includes functional vulnerabilities which have a genetic basis, such as those which have been documented for certain types of learning disabilities and certain psychoses (McGuffin & Gottesman, 1985).

In the left hand column of Table 10.2 factors which predisposed Jane, Beth, Bill and the Area Social Worker to become involved in the cycle outlined in the right hand column of the table are presented. For example, Jane's mother had a low tolerance for children crying. This predisposed Jane to respond quickly to Beth's crying.

### **Mediating Cognitive Factors**

The impact of certain predisposing factors, for example prior stressful life events, on the behaviour of participants in the cycle of interaction surrounding the symptom, may be mediated by cognitive factors. Two categories of such cognitive factors are belief systems and styles of information processing. The defence mechanisms described by psychodynamic therapists (Ursano & Hales, 1986), distortions described by cognitive therapists (Beck, 1976) and the various attributional processes described by functional family therapists (Barton & Alexander, 1981) are examples of styles of information processing.

Belief systems comprising entrenched assumptions, attitudes and expectations which individuals hold about themselves and others which have implications for problem maintenance have been presented by therapists of many orientations, e.g. Beck, 1976; Laing, 1970; Byng-Hall, 1988.

The contents of the central column of Table 10.2 are cognitive factors which mediated the effects of predisposing factors in the left hand column on the behaviour described in the right hand column of the Table. For example, Jane's history of depression and overdosing led to her developing the belief, 'When I'm sad, I'm dangerous'. This belief led to her fear of harming Beth, and to her request for relief care for the child.

### **CASE EXAMPLE**

In this section a more detailed case example will be presented to illustrate how the formulation model outlined above may be used to guide the collection, simplification and integration of information about a presenting problem. The implications of the formulation for treatment planning and the management of resistance will also be described.

**Circumstances of Referral.** The Doyle family which comprised Mr and Mrs Doyle, Sammy (10 years) and Sharleen (14 years) were referred by the G.P. Sharleen's longstanding conduct problems had recently reached a head when she threatened to stab her mother with a bread knife. Beyond this, little information was given in the referral letter other than the fact that Mr and Mrs Doyle were 'desperate for help'.

**Initial Interview.** All four members of the nuclear family attended the initial interview. Once a contract for family assessment had been established the main goal for the first session was to complete the right hand column of the formulation model. Most of the information gathering questions focused on the sequence of social

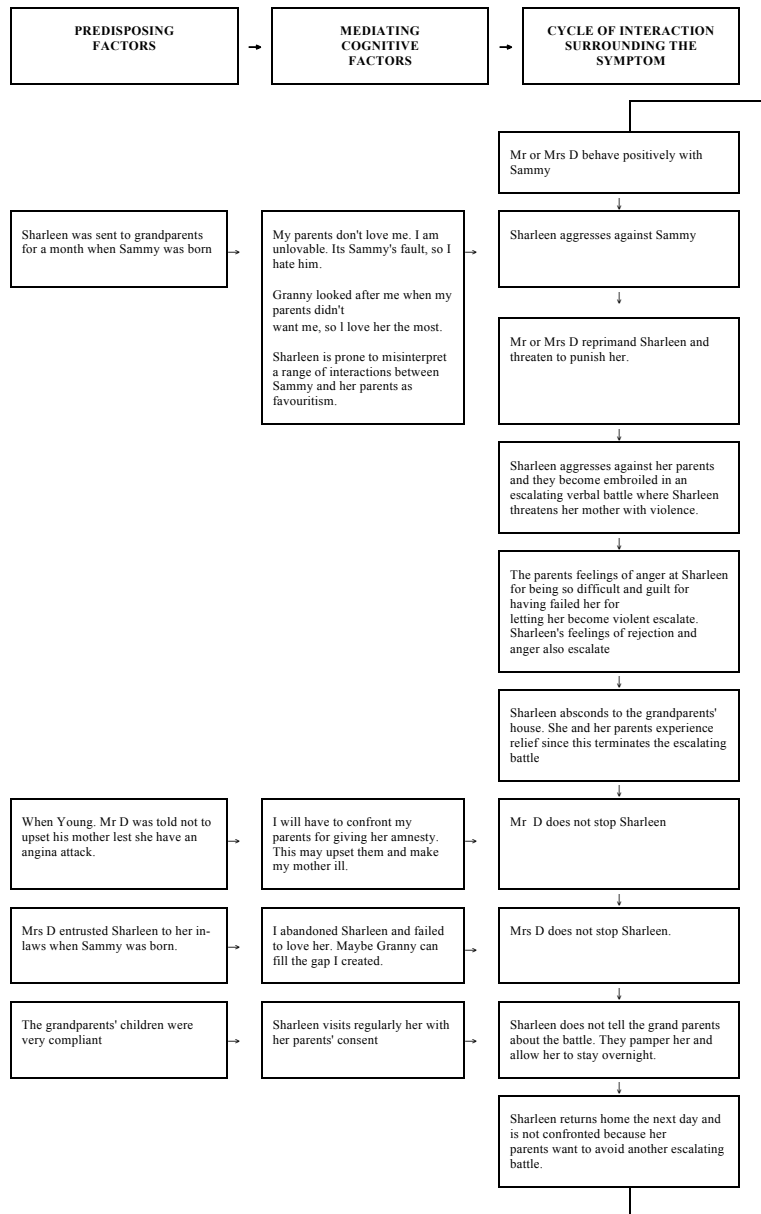
interaction in which the problem behaviour, i.e. Sharleen's conduct problems, was embedded. Both direct and circular questions were used (Selvini-Palazzoli et al., 1980a) to obtain a specific description of Sharleen's problem behaviour and a blow by blow account of the interactions which preceded and followed this behaviour. The family were also asked about their explanations of the problem, their previous attempts to solve the problem which arose from these explanations and the effects of these attempts on the problem itself.

By the end of the first session the following sequence had been revealed:

1. Sharleen fights with her brother.
  2. Her parents reprimand her and threaten to punish her.
  3. She fights with them and these fights often involve an escalation from verbal abuse to physical struggles. These altercations lead to Sharleen feeling angry and rejected. Mr and Mrs D feel angry and guilty.
  4. Sharleen absconds to the grandparents' house and the parents do not wholeheartedly try to stop her. She and her parents feel relief because this provides an escape from the escalating battle for all concerned. They are all likely to repeat this pattern again because they experience the relief as reinforcing.
  5. Sharleen does not tell her grandparents about the fight and they pamper her. She experiences this as reinforcing and so is more likely to do it again.
  6. She returns home the next day and is not confronted because her parents want to avoid another escalating battle.
  7. The cycle repeats when Sharleen and her brother fight again.
- Sequences such as this may suggest whom to invite to the next session, in-session activity and inter-session interventions such as homework prescriptions.

In this example, given the critical position of the grandparents in the sequence, I asked Mr and Mrs D to invite them to the next session. The parents said it would be impossible for them to come. Since time had run out, the most immediate way of assessing this resistance was through a homework assignment. I asked Mr and Mrs Doyle to consider the implications of looking for help from grandmother in solving Sharleen's problems. A task was also given to Sharleen. She was asked to note her thoughts in those situations involving her brother which led to altercations between herself and her parents. Consent was obtained to contact Sharleen's school teacher, a social worker and a clinical psychologist with whom the family had previous contact.

**Table 10.3. Case formulation for The D family and Sharleen, a girl who threatened to stab her mother**



**Contact with Involved Professionals.** The primary reason for contacting involved professionals was to determine if they were currently involved in the cycle of interaction surrounding the symptom or if they had been in the past. If they were currently involved, then their role had to be determined. If they had been involved, the impact of their interventions on the cycle of interaction surrounding the symptom needed to be evaluated. Written reports were obtained from the Area Social Worker and the Clinical Psychologist. Sharleen's teacher was contacted by phone. The teacher and Area Social Worker confirmed that Sharleen's conduct problems were confined to the home. Her achievement, attendance and peer relations at school were broadly within normal limits and she had no record of police cautions or convictions. Previous referrals to the Area Social Worker and a psychologist had been made by the GP when Sharleen was aged 11 and 13 years respectively. Social Services had enrolled her in a summer activities programme and counselled the parents on the management of adolescents. The social worker saw Sharleen as a normal girl and the parents' inexperience in managing adolescents as the core problem. The psychologist had implemented a behavioural parent training programme. He saw Sharleen as a highly impulsive girl who would be difficult for any parent to manage and this was compounded by the parents' inconsistent management of her. Neither of these two previous interventions had led to more than a brief improvement in the girl's behaviour. In each instance the family dropped out of treatment after two to three sessions. From these reports I concluded that Sharleen's problems did not involve members of the community or the school, and were essentially family based. Sharleen had the capacity to behave within normal limits for extended periods of time outside the family context. I also deduced that the final formulation did not have to include other professionals in the cycle of interaction surrounding the symptom, although this is often not the case (Selvini Palazzoli et al., 1980b). Finally, I surmised that explanations of the Doyles' problems which excluded Sammy and the grandparents would probably lead to ineffective interventions.

**Second Family Interview.** A number of goals were set for the second phase of the assessment. These goals were dictated in part by the information already available on the Doyle family and in part by the formulation model. The first was to secure an interview with the grandparents so as to obtain their view of the symptom and the interactions surrounding it. The second was to identify those factors which predisposed the members of the Doyle family to become stuck in this cycle of interaction. The third was to uncover those cognitive factors which mediated the effects of the predisposing factors.

At the beginning of the next session, which was attended by

the nuclear family only, the homework tasks were reviewed. Mr and Mrs Doyle said that they could not involve the grandparents in solving the nuclear family's problems since the grandparents might feel blamed for wrongfully giving amnesty to Sharleen and they would find this stressful. The grandparents could not be exposed to stress because of their ill health. Sharleen said that she realised now that her infractions of house rules usually followed incidents where she saw her parents favouring Sammy over her. These answers which the homework assignments provided, uncovered the rudiments of the belief systems which were locking Mr and Mrs Doyle and Sharleen into their roles in the interaction pattern surrounding the symptom.

A developmental history was taken for each family member to determine the predisposing factors which underpinned these belief systems and to provide clues as to how the belief systems might be elaborated. The following significant information emerged. Mr Doyle was always told as a child not to upset his mother (Sharleen's grandmother) lest she have an angina attack. As a result he developed an unrealistic view of his parents' vulnerability and a primitive fear of killing them should he confront them about their behaviour towards Sharleen. Mrs Doyle said that she sent Sharleen to stay with the paternal grandparents for a month when Sammy was born. Since then she has felt guilty for abandoning her daughter. Mrs Doyle said sometimes she believes that Sharleen's jealousy of Sammy and her conduct problems are justified since she has failed to nurture her daughter adequately. This belief prevents her from stopping Sharleen absconding to grandmother's when she has misbehaved, since grandmother may provide the nurturance which she believes she has failed to give.

At the end of the session I said that the assessment could not continue without having a meeting with the grandparents. I assured Mr Doyle that such a session would be terminated if it became too stressful and that the children need not attend so that heated arguments could be avoided. Mr Doyle agreed to this arrangement. An individual session was also scheduled for Sharleen to obtain her view of the separation which occurred at Sammy's birth.

**Interview with the Grandparents.** Mr and Mrs Doyle and Mr Doyle's parents attended this meeting. I explained how the referral had occurred, the cycle of interaction surrounding the symptom and the predisposing factors and related belief systems which ensnared the Mr and Mrs Doyle in this pattern. I said that their comments on the partially completed formulation were essential if I were to develop an accurate understanding of the whole situation, as a basis for offering the Doyles sound professional advice on how to manage Sharleen's escalating violence.

The grandparents were shocked by the fact that they had never been told that Sharleen's visits to them were always to escape parental sanctions. As for their ill health, they confessed to Mr Doyle that grandmother's angina was a ruse they had used when he was a child to keep him in check so that they would not have to smack him. The fact that he and his siblings had been so compliant as children (in response to the threats about angina), made it difficult for the grandparents to appreciate the extent of their granddaughter's conduct problems.

This information suggested that the grandparents' role in the cycle of interaction surrounding the symptom was being maintained by their ignorance of Sharleen's conduct problems and by their son's reluctance to upset them. The grandparents agreed to participate in further sessions if necessary.

**Individual Interview with the Identified Patient.** Sharleen said that when Sammy was born she felt that he took her place as the centre of her mother's attention. Since then her feeling that she is unloved by her parents and unlovable by all but her grandmother has grown. She disclosed that she continually felt irritable and angry in Sammy's presence, especially when only her mother is present. It was these feelings, she said, which fuelled her aggression towards Sammy and her defiance of her parents. In this way, Sharleen clarified how her beliefs about herself in relationship to her parents, link a predisposing event to her current role in the cycle of interaction surrounding her conduct problems.

#### **Formulation.**

A diagrammatic formulation for this case is set out in Table 10.3. It conforms to the model set out in Table 10.1. What follows is a narrative statement of this formulation.

**Cycle of Interaction Surrounding the Symptom.** When Sharleen believed that her parents' behaviour meant that they favoured Sammy over her, she became jealous and was aggressive towards him. Her parents reprimanded her and threatened to sanction her aggressive behaviour, for example by stopping her pocket money. After a shouting match between the parents and the daughter, Sharleen would abscond to the grandparents' house. (These shouting matches periodically escalated to a level where physical violence was threatened, as in the incident with the bread knife which led to the referral). Both Sharleen and her parents were relieved by the immediate experience of separation and so they were likely as a group to repeat this action. The daughter was pampered by her grandmother during the visits and so was likely to seek amnesty there again. When Sharleen returned home after the visits, she was not confronted because Mr and Mrs Doyle wanted to avoid a recurrence of this aversive process. The cycle was

repeated the next time the parents' behaviour confirmed Sharleen's belief that her parents favoured Sammy over her.

**Predisposing and Mediating Factors.** The family were locked into this cycle of interaction by certain beliefs which in turn had their roots in prior events. Sharleen, a first born child, was jealous of Sammy who usurped her position next to mother when she was four years old and he was born. At that time Sharleen was sent to spend a month with her grandparents. At the time of the assessment she doubted her own self-worth and her parents' love for her. She blamed her parents' apparent rejection of her on Sammy. Hence her readiness to aggress against him. She saw her grandparents as the only people who truly love her. Hence her choice of their house as a place of amnesty. Mr Doyle was reluctant for himself or his wife to confront his own parents because he believed, erroneously, that they were both in poor health did not want to upset them. His view of them as vulnerable derived from his childhood when he was warned, spuriously, never to upset his mother lest she have an angina attack. Mrs Doyle was reluctant for herself or her husband to physically restrain Sharleen when she tried to leave the house. She felt that she had failed her daughter and secretly believed that they may provide Sharleen with the love that she has failed to give.

The grandparents were unaware of their role as amnesty providers for Sharleen, hence their acceptance of the status quo.

**Treatment Plan.** The goals of treatment in this case were to alter the behaviour of each participant in the cycle of interaction described in the right hand column of Table 10.3 and thereby reduce the frequency of Sharleen's conduct problems. The formulation suggested both direct structural (Minuchin, 1981) and indirect or paradoxical (Stanton, 1981a) treatment programmes. It also contraindicated certain treatment strategies and offered an explanation of previous treatment failures.

**Structural Treatment Programme.** With this approach Sharleen and her brother could be helped to avoid jealous interchanges by substituting negotiation for accusation. This in turn would reduce the number of altercations between Sharleen and her parents and the concomitant need for limit setting. As a preliminary step to this, Sharleen's resistance to negotiating with her brother would have to be addressed by helping her to feel as valued by her mother as she believes him to be. Towards this end, Mrs Doyle and Sharleen could be instructed to schedule regular periods of exclusive time together (which would not be contingent upon Sharleen's good behaviour), during which they could carry out activities which promote positive feelings.

The second element of a structural programme would involve helping the parents and grandparents to work cooperatively in setting

limits for Sharleen so that if she were to leave her parents' house, she would not receive amnesty at her grandparents. Mr Doyle's belief about the grandparents' vulnerability, one of the major sources of resistance to such a cooperative venture, had been neutralised during the assessment. However, Mrs Doyle would have to be convinced that she could meet her daughter's need for nurturance if she were to block Sharleen's escape to the grandparents' house. Appreciative feedback from Sharleen, about the exclusive time mother and daughter were to spend together, would be one way to help Mrs Doyle see herself as capable of meeting her daughter's need for nurturance and so reduce Mrs Doyle's resistance to a cooperative limit setting programme with the grandparents.

**Paradoxical Treatment Programme.** The structural programme described above would aim to solve the presenting problem by directly coaching the family to alter their behaviour so that it no longer maintained the presenting problem. An alternative indirect or paradoxical approach would involve describing the cycle of interaction surrounding the problem to the entire family, underlining the positive function of each participant's role in this cycle, and cautioning the family against change lest these positive functions be lost. The cognitive factors in the central column of Table 10.3 provide clues as to what themes might plausibly be used in connoting the behaviour of family members positively. In the D family the following themes were suggested by the cognitive factors set out in the central column of Table 10.3: (a) Sammy was favoured over Sharleen by the parents; (b) Mr Doyle feared for the grandparents' well-being; (c) Mrs Doyle felt grandmother could meet Sharleen's nurturance needs better than she could. These themes suggested the following positive connotations for the behaviour of the family members involved in the cycle of interaction surrounding the symptom.

Mr Doyle's reluctance to contact the grandparents in the past was an expression of his concern for their well-being. Mrs Doyle's reluctance to block Sharleen's escape was a self-sacrificing recognition that Grandmother could meet her daughter's need for warmth better than she could. Sharleen's conduct problems and visits to grandmother were a way of allowing her parents to have exclusive time with Sammy whom they preferred to her, without having to take on the guilt associated with excluding her. Sammy's involvement in the fights with Sharleen and the grandparents' acceptance of her visits also resulted from a recognition that Mr and Mrs Doyle need to be able to spend exclusive time with Sammy without feeling guilt for rejecting Sharleen.

A paradoxical treatment approach would involve the presentation of this positively connoted description of family functioning along with a caution against change. The aim of such an

approach would be to alter the family's understanding of the intentions underpinning their roles in the cycle of interaction surrounding the symptom and the function of these roles. Such a new understanding could result in their finding new ways to fulfil the functions associated with these roles which maintain Sharleen's problem behaviour. In this way the cycle of interaction surrounding the symptom would be disrupted.

**Contraindicated Treatment Programmes.** From the formulation it was predicted that a short or long term residential placement option (e.g. boarding school, relief care, placement of Sharleen with the grandparents, or hospitalisation) would exacerbate the problem by increasing Sharleen's belief that she was not valued by her parents. It would also increase Mrs Doyle's sense of guilt associated with her view that she had failed to nurture her daughter sufficiently. Individual therapy without concurrent family work was also contraindicated in this case (in my view), since it might foster within the family, an image of Sharleen as entirely responsible for the problem. Two previous, essentially educative interventions involving the parents only, were unsuccessful. In the light of the formulation set out in Table 10.3, this was not surprising since such interventions failed to account for the roles of the children and grandparents as active figures in the cycle of interaction in which the problem behaviour was embedded. Furthermore, as educative interventions they failed to take account of the parental resistances (suggested by the cognitive factors listed in the middle column of Table 10.3) to putting the acquired knowledge and skills into practice. Following the assessment sessions which have been described in this paper, the family were successfully treated with the structural treatment programme outlined, in a course of four therapeutic sessions.

## **DISCUSSION**

The formulation model described above was developed as one of a series of clinician's tools (Carr, 1986) and as a device for use in therapist training (Carr, 1987). In formulations based upon this model, all elements which are not contained in the current cycle of interaction are compartmentalised into the linear categories of predisposing and cognitive factors. From a theoretical viewpoint this is a vast oversimplification of extant evidence (e.g. Breunlin & Schwartz, 1986; Cooklin, 1982; Dell, 1986). However, the clinical advantages of this simplification process have been enumerated in the introduction and illustrated with case material.

At the recent NIMH/Family Process conference there was a growing consensus among researchers working from behavioural/functional (e.g. Alexander, 1988) and structural/strategic

(e.g. Stanton, 1981b) positions that distinct stages could be identified in effective family intervention (Wynne, 1988, page 260). It was recognised that the direct problem solving phase of therapy which focuses on breaking the cycle of interaction which surrounds the presenting problem, must often be preceded by a phase of therapy which targets the types of factors which fall into the linear categories of the formulation model described in this paper, e.g. work problems, negative attributions, etc. White (1986), arguing from a Batesonian perspective, has made a similar point. Families fail to break out of cybernetic cycles of problems and ineffective solutions because they are 'restrained' from discovering alternative solutions by certain beliefs or assumptions. White shows how the therapist may loosen these restraints through the use of certain therapeutic tactics grounded in Bateson's notion of 'double description'. These tactics help the family discover new and alternative ways of viewing their difficulties and consequently a way of breaking the cycle of interaction surrounding the presenting problem. The 'restraints' to which White refers are those cognitive factors which fall into the central column of the formulation model described in this paper.

The model also provides a bridge between individual and family based treatment modalities. Linear aspects of the hypothesis may sometimes suggest areas that might fruitfully be dealt with in individual therapy (e.g. Wachtel & Wachtel, 1986) or constitutional vulnerabilities that might usefully be treated pharmacologically (e.g. Falloon, 1985).

The model provides a way for incorporating (linear) research findings on individual risk factors into circular/systemic hypotheses. This is particularly useful in statutory work with child abuse cases (Gawlinski et al., 1988), or in cases where the identified patient is a suicidal adult (Hawton, 1987).

As the first example illustrated, this model of problem formulation allows the role of professionals (including the formulator) in the cycle of interaction surrounding the problem to be specified.

Finally, as research (Patterson & Chamberlain, 1988; Barton & Alexander, 1981) work has shown, a formulation model such as the one described here provides a useful template for asking clinically meaningful research questions, e.g. What types of cycles of interaction evolve around particular types of presenting problems? What types of factors prevent the index patient and members of the network from breaking out of these recursive patterns of social interaction which maintain the symptom?

## REFERENCES

- Alexander, J. (1988). Phases of family therapy process: A framework for clinicians and researchers. In L. Wynne (ed.), *The State of the Art in Family Therapy Research*. New York: Family Process.
- Anderson, C. & Stewart, S. (1988). *Mastering Resistance*. New York: Guilford.
- Aponte, H. & VanDeusen, J. (1981). Structural family therapy. In A. Gurman & D. Kniskern, (eds.), *Handbook of Family Therapy*. New York: Brunner/Mazel.
- Barton, C. & Alexander, J. (1981). Functional Family Therapy. In A. Gurman & D. Kniskern, (eds.), *Handbook of Family Therapy*. New York: Brunner/Mazel.
- Beck, A. (1976). *Cognitive Therapy and Emotional Disorders*. New York: Meridian.
- Breunlin, D. & Schwartz, R. (1986). Sequences: Toward a common denominator of family therapy. *Family Process*, 25, 67-87.
- Byng-Hall, J. (1988). Scripts and legends in family therapy, *Family Process*, 27, 167-179.
- Carr, A. (1986). Three techniques for the solo family therapist. *Journal of Family Therapy*, 8, 373-382.
- Carr, A. (1987). *Constructing Hypotheses to Guide Systems interventions*. National Conference of the Association for Family Therapy, York, UK
- Cooklin, A., 1982. Change in here and now systems vs systems over time. In A. Bentovim, G. Barnes & A. Cooklin (eds.), *Family Therapy: Complementary Frameworks of Theory and Practice (Volume 1)*. London: Academic Press.
- Dell, P. (1986). In defence of lineal causality. *Family Process*, 25, 513-528
- Falloon, I. (1985). *Family Management of Schizophrenia*. Baltimore: Johns Hopkins University Press.
- Gawlinski, G., Carr, A., Irving, N. & McDonnell, D. (1988). Thurlow House Assessment Programme for Families with Physically Abused Children. *Practice*, 2, 208-220.
- Hawton, K. (1987). Assessment of suicide risk. *British Journal of Psychiatry*, 150, 145-153.
- Laing, R.D. (1970). *Knots*. Middlesex: Penguin.
- McCubbin, H., Patterson, J. & Wilson, L. (1982). Family Inventory of Life Events and Changes. In D. Olson et al. (eds.), *Family Inventories*. University of Minnesota, MN: Family Social Science Departmental Press.
- McGuffin, P. & Gottesman, I. (1985). Genetic influences on normal and abnormal development. In M. Rutter & L. Hersov (eds.), *Child and Adolescent Psychiatry* (2nd. ed.). Oxford: Blackwell.
- McGurk, J., Friedlander, M. & Blocher, D.H., (1987). Systemic and nonsystemic diagnostic processes: An empirical comparison. *Journal of Marital and Family Therapy*, 13, 69-76.
- Minuchin, S. & Fishman, C. (1981). *Family Therapy Techniques*. Cambridge MA: Harvard University Press.
- Patterson, G. & Chamberlain, P. (1988). Treatment Process: A problem at three levels. In L.C.Wynn (ed.), *The State of the Art in Family Therapy Research*. New York: Family Process.
- Rutter, M. (1987). Temperament, personality and personality disorder. *British*

- Journal of Psychiatry*, 150, 443-458.
- Selvini-Palazzoli, M., Boscolo, L., Cecchin, G. & Prata, G., (1980a). Hypothesizing - circularity - neutrality: Three guidelines for the conductor of the session. *Family Process*, 19, 3-12.
- Selvini-Palazzoli, M., Boscolo, L., Cecchin, G., & Prata, G. (1980b). The problem of the referring person. *Journal of Marital and Family Therapy*, 6, 3-9.
- Stanton, D. (1981a). Strategic approaches to family therapy. In A. Gurman & D. Kniskern (eds.), *Handbook of Family Therapy*. New York: Brunner/Mazel.
- Stanton, D. (1981). An integrated structural/strategic approach to family therapy. *Journal of Marital and Family Therapy*, 7, 427-439.
- Ursano, R. & Hales, R. (1986). A review of brief individual psychotherapies. *American Journal of Psychiatry*, 143, 1507-1517.
- Wachtel, E. & Wachtel, P. (1986). *Family Dynamics in Individual Psychotherapy*. New York: Guilford.
- Walker, A. (1985). Reconceptualizing family stress. *Journal of Marriage and the Family*, November, 827-837.
- White, M., (1986). Negative explanation, restraint and double description: A template for family therapy, *Family Process*, 2, 169-174.
- Wolkind, S. & Rutter, M. (1985). Separation, loss and family relationships. In M. Rutter & L. Hersov (eds.), *Child and Adolescent Psychiatry* (2nd ed.). Oxford: Blackwell.
- Wynne, L. (1988). *The State of the Art in Family Therapy Research: Controversies and Recommendations*. New York: Family Process Press.
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