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FAILURE IN FAMILY THERAPY: A CATALOGUE OF ENGAGEMENT MISTAKES

ABSTRACT

Eleven key positions within the social system which evolves around a presenting problem are set out. A catalogue of common mistakes which arise from failing to distinguish between these elements and take account of their significance during the engagement process is presented, along with specific suggestions for avoiding these clinical errors.

INTRODUCTION

In a quarter to a third of cases, family therapy leads to little improvement in the presenting problem. In about a tenth of all cases the presenting problem becomes worse during the course of therapy (Gurman, Kniskern and Pinsof, 1988). Analyses of treatment failures have pointed to a wide variety of factors which may contribute to unsuccessful therapy (Coleman, 1985; Foa & Ellemkamp, 1983; Mays & Franks, 1985). Engagement difficulties loom large in these analyses.

The central thesis of this paper is that a failure to distinguish between important elements of the overall problem-system¹ may lead the therapist to engage with members of the problem system in ways that inhibit problem resolution. A catalogue of such engagement mistakes drawn from my own practice over the past 10 years and from the family therapy literature will be presented below. First, however, definitions of the 11 key positions within the problem-system will be given.

ELEVEN ELEMENTS OF PROBLEM SYSTEMS

While some of the elements defined below are well recognized, others are less frequently labelled in an explicit manner. The definitions are presented to enhance the clarity of the engagement mistakes listed in the subsequent section.

1. The Problem Person is identified by the customer as the individual with difficulties requiring professional help. There may be more than one such person in a problem system.

2. The Customer is the member of the problem system most eager that the referral be made so that treatment for the problem person may be secured (Fisch et al., 1982).

3. The Emotionally Attached Caregiver is the person who offers the problem person the greatest emotional support and nurturance. Close positive attachments tend to protect people from mental and physical breakdown (Barrera, 1988; Quinton & Rutter, 1988). Emotionally attached caregivers may therefore be viewed as a significant therapeutic resource.

4. Persons Legally Responsible for the Problem Person are vital members of the problem system since the problem person may not enter into a therapeutic contract without their consent.

5. System Members who Promote Stuckness are those who, by their actions or influence, prevent the resolution of the presenting problem. Usually, the homeostatic influence that these people exert is unintentional. System members who promote stuckness may be members of the problem person's family, peer group, school, work situation or professional helping network. Introjects and family ghosts may also be identified as members of this subsystem.

6. System Members who Promote Change are those members of the problem system whose energy may readily be deployed so as to resolve the presenting problem. This subsystem may include the therapist and the therapeutic resources to which she has access. It may also include individuals from those areas of the problem person's life listed in the previous paragraph.

7. The Referring Agent is that pivotal member of the problem system who connects the therapist, the team and the agency to the extant problem system.

8. The Therapist is that person who must engage with the problem system and intervene in it in a way that allows its members to find alternative and effective methods for dealing with the presenting problem.

9. The Team is that group of people which helps the therapist form hypotheses and decide about intervention strategies. The team also helps the therapist monitor her pattern of engagement with the problem system. The role of the team may also be filled by a supervisor or a co-therapist. Techniques which may be used by solo-therapists whose team offers indirect rather than live supervision have been described elsewhere (Carr, 1986).

10. The Agency is the context within which the therapist and the team offer their therapeutic services. Agencies employ therapists and teams and provide them with managerial and administrative support and control.

11. Agents of Social Control are system members who exert actual or potential statutory power over the problem person or members of her family. They are representatives of the State empowered to intervene in clients' lives without consent, for the common good. Social workers, psychiatrists and probation officers commonly find themselves in this role.

From this list of definitions, it is clear that in any problem system one person may carry out the function of more than one element. For example, in a self-referred single parent family the mother may be one of the problem people, the customer, the person legally responsible for the problem person and the referring agent.

A CATALOGUE OF ENGAGEMENT MISTAKES

1. Assuming that the nuclear family of the problem person is the unit of treatment. This faulty assumption stems from the notion that a dysfunctional family structure is the primary cause of the problem person's difficulties, which in turn reinforce the dysfunctional family structure. This view neither fits with the results of empirical studies of risk factors in various disorders (Rutter and Garmazy, 1983) nor is it clinically useful in many cases (Wynne et al., 1987). The common practice in family therapy of arbitrarily drawing a boundary around the nuclear family is a similar error to that made by psychotherapists who routinely draw a boundary around the individual. Most of the engagement mistakes described below derive from the mistaken

assumption that the family is the unit of treatment

An alternative position for the clinician is that the occurrence of a problem (for whatever reason) may lead various people to come together in an attempt to solve it (Goolishian & Winderman, 1988). This group may include members of nuclear, extended, step, adoptive and foster families. It may include peers and colleagues from work settings, and members of religious, recreational and other community-based organizations. It may also include a variety of statutory and non-statutory professionals such as physicians, social workers, probation officers, health visitors, dieticians etc. Occasionally, this group of people becomes organized into a problem system which is ineffectual in solving the presenting difficulties. The therapist is invited by the customer to join this system and to attempt to participate in it in a way that leads to problem resolution.

For the therapist to be of assistance to the problem system, she must engage the minimum sufficient network and establish a therapeutic contract (Skynner, 1968). This network always includes the problem person, the person legally responsible for the problem person and the customer. The contract must include the possibility that other members of the problem system beyond the minimum sufficient network be included in the therapy process. The contract may be written or verbal implicit or explicit.

2. Assuming that the person legally responsible for the problem person is the customer, when the referring agent is customer. This mistake usually occurs in cases where the problem-person presents with 'social control' problems such as conduct problems in children or addictive behaviour in adults (e.g., Carl & Jurkovic, 1983).

Example 1. A school principal referred a boy and his family for therapy, via the GP, because of the boy's school-based conduct problems. The family did not attend the intake interview. A phone call to the GP revealed that the parents felt antagonistic towards the school and were ambivalent about our unit which they viewed as aligned with the school. Here, the school was the customer.

Example 2. A probation officer referred a problem drinker and his cohabitee for marital therapy. The therapy was requested with a view to helping the husband gain control of his drinking problem. Initially the couple appeared to be committed to therapy however, after a few sessions, it became clear that they were only *going through the motions* to appease the probation officer. Here the probation officer was the customer.

To avoid this error it is useful to clarify by phone if the referring agent is the customer. If this is the case, the referring agent may be asked to

be responsible for the family's attendance at the intake interview and to attend this meeting themselves. The focus of such meetings is to help the person legally responsible for the problem person and the referring agent clarify the pro's and con's of the problem and the person and the person legally responsible for the problem person committing themselves to a therapeutic contract.

3. Assuming that the problem person's emotionally attached caregiver is the customer when the referring agent is the customer.

This mistake usually occurs in cases where attachment difficulties between parents and children or husbands and wives are the central presenting problem.

Example 1. A Social Worker referred a young single mother and her 2-year-old daughter for therapy. The Social Worker described the mother and child as having *poor bonding*. The mother often left the child to cry for periods of up to an hour and frequently felt as if the baby were trying intentionally to annoy her. The mother said that she wanted help with finding a way to deal with her child's crying. She also agreed to explore ways in which she could increase the social support available to her as an isolated single parent. However, her attendance at therapy was erratic and she rarely completed homework assignments. I invited her and the referring social worker to a meeting to explore reasons for the therapeutic failure. It transpired that the mother believed that the social worker had decided to take the child into care. The referral had been an attempt on the social worker's part, she believed, to prove that she could not be helped. No matter how hard she tried to benefit from the therapy, she believed that ultimately the social worker would take her baby into care. Therefore, she put little effort into the venture. The social worker was, in this case, the customer.

Subsequently, the Social Worker attended a series of sessions in which she stated explicitly, in behavioural terms, the expectations held by her department of competent parents. This convinced the mother that her parenting was indeed competent. I then offered a contract to the mother for therapy that would focus on *enriching* her relationship with her child, since the social worker's criteria had demonstrated that remedial therapy was not required.

Example 2. A concerned husband (the emotionally attached care giver) and his depressed wife were referred for marital therapy by their GP. Initially the husband behaved as if he were the customer. The therapy went well at first but later

floundered when the husband's attendance became erratic. A phone call to the GP revealed that he had been advising the couple for months to engage in marital therapy although the husband had always opposed this. The husband believed that only medication could solve his wife's difficulties. Thus, in this case the GP was the customer.

The GP and I met the couple and negotiated a compromise whereby a trial of antidepressant medication would be given in conjunction with a series of marital therapy sessions.

In cases such as these, the referring agent and the therapist must meet the problem person and the emotionally attached caregiver to negotiate a mutually acceptable set of therapeutic goals and methods. In this contract the commitment of the emotionally attached caregiver to the therapeutic process must be made explicit. Outlining the significance of enriched emotional attachments for the mental and physical well-being of children and spouses is a useful tactic to use in these interviews serving to raise the motivation of attached caregivers. Often emotionally attached caregivers have become demoralized by the time they are referred for therapy. They feel angry and may mistreat the problem person. These experiences may lead them to blame themselves for the problem person's difficulties. Reminding them that they are a vital therapeutic resource may go some way towards removing this sense of demoralization.

4. Assuming that the referring agent has a positive alliance with all family members. If the referring agent has a very strong alliance with one or two subsystems of the overall problem-system and neutral or negative alliances with others, the therapist may be sucked into a particular role in the family drama which renders her impotent. Usually this role is one that was previously occupied by the referring agent. Selvini Palazzoli (1980) and her colleagues have described this problem in cases where the referring agent is a close friend of one family member. Physicians (either GPs or specialists) who have been treating one family member for years, counsellors who are very supportive of the mother in the family and social workers who act as middlemen between the patient and the parents, are the three main categories of referring agent identified by the Milan group in their study of this problem. The referring agent's relationship with the family progresses from one of apparent co-operation to a state where little progress is made and the referring agent feels disqualified and trapped. In the final stage, the referral is made when the referring agent has become exasperated.

The Milan group noted that when they accepted referrals like

these without including the referring agent in the initial meetings, or at least without discussing the family's relationship with the referring agent, therapy was ineffective. The team slipped into fulfilling the same function as the referring agent. They dealt with this problem by prescribing continued contact with the referring agent and positively connoting all that he or she had done.

Selvini Palazzoli (1985) and her colleagues have also described the difficulties that arise in cases where a prestigious sibling of the problem person is the referring agent. Usually the sibling has a close relationship with one parent and holds a privileged and powerful position within the family. The demands of new relationships outside the family, however make the sibling feel tied down. He sees family therapy as a way of liberating himself from his exacting role. There is also the possibility that the prestigious referring sibling has begun to grow envious of the love and attention which the problem sibling commands. The key to the Milan group's approach has been to avoid slipping into the referring sibling's shoes by attempting to do therapy with the remainder of the family.

Example 1. Selvini Palazzoli (1986) describes how she and the Milan Team first offered a family referred by a sibling an assessment, so as to check if they were suitable for family therapy. During the assessment, the pattern of interaction which surrounded the problem person and included the parents, the siblings and the referring sibling was established. At the conclusion of the assessment, the therapist then described this pattern, positively connoting the role of problem person in creating a prestigious position within the family for the referring sibling to occupy. She then said that family therapy was not indicated, since it would lead to improvement in the problem person which would destroy the privileged position of the referring person in the family and lead to him becoming depressed. The problem daughter spontaneously improved and referring sibling left home to live in his own apartment.

5. Failing to Identify System Members that Promote Stuckness. This error can occur when the therapist assumes that the nuclear family is the unit of treatment but where the boundaries of a nuclear family are fairly diffuse and family members rely on close ties with members of their community or the extended family for carrying out the tasks of day to day living.

Example 1. A single parent of borderline intelligence and her 9 year- old son, who had mainly home-based conduct problems, were referred by the GP. An assessment showed that

when the mother asked the boy to do something to which he objected, he would often throw a tantrum. The mother managed these tantrums inconsistently; it appeared that the tantrums continued because most of the time they got him what he wanted, it seemed that the mother's inconsistency persisted because she did not know what else to do. It was not related to emotional exhaustion since the mother was well supported emotionally, both by her sister who lived locally and by members of her church.

At the conclusion of first session the mother and son agreed to carry out two homework tasks. The first involved the mother spending half an hour a day with her son doing painting, his favourite activity. They understood that this regular period of positive interaction was to rebuild the positive side of their relationship which had become tainted with bitterness. The second task involved the boy going to *time out* under mother's supervision anytime he lost his temper, so that he could learn how to control it himself.

The mother and son consistently executed the temper control task incorrectly. Mother would let the boy out of his bedroom immediately he began swearing and cursing. Careful interviewing revealed that she abhorred swearing because of her religious beliefs. She would rather her boy got his own way than be eternally damned for swearing—and she was certain that her vicar would take the same view. Thus the vicar (and possibly God) were up to this point *system members promoting stuckness* whom I had failed to identify. I made arrangements to meet the vicar and after some discussion about the rationale behind the tasks he convinced the mother to go along with the homework assignments. In the long run, he said, they would help her son avoid sin and keep to the path of righteousness.

The assumption that the boundaries of a problem system are rarely the boundaries of the family is helpful in identifying system members who promote stuckness. It helps inform clinical practice in various ways. For example, during assessment it becomes necessary to draw an ecomap as well as a genogram. It provides a context within which the therapist remains uncertain about the principal characters in the problem person's drama for longer. This helps the therapist to cling less tenaciously to an initial formulation or hypothesis.

System members who promote stuckness may reside not only out in the wider community but also in the memories of members of the nuclear family. When therapists focus on current patterns of interaction without reference to past relationships, and where introjects or ghosts

are a significant part of the family drama, they may fail to identify these system members. These stuckness-promoting-system-members may be estranged or deceased and so physically absent from the problem system. However as introjects or ghosts, they continue to have a powerful constraining influence on the search for a workable solution to the presenting problem. Usually the member of the problem system influenced by the ghost will require a forum within which to complete unfinished business.

Example 2. In an initial interview with the mother of a 13-year-old girl referred because of her aggressive and defiant conduct, it emerged that the girl's problem behaviour only occurred in specific circumstances. When mother, stepfather and daughter were together and stepfather showed more interest in the girl than in his wife, or where mother believed that this scenario was imminent, mother and daughter would fight. So as to establish how the presenting problem would have been dealt with in the mother's family of origin, I asked the mother how her mother would have *shared her father*.

The mother became distressed in response to this enquiry. It emerged that at 13 she had become involved in an incestuous relationship with her father and feared that her daughter and husband might be about to replicate this pattern. The deceased grandfather in the family was a ghost who promoted stuckness

The parents of the 13-year-old were seen on a number of occasions without their daughter so that the mother could address the unfinished business with her incestuous deceased father. Concurrent family work focusing on straightforward parent-adolescent negotiation progressed without any major impasses.

6. Failing to identify system members who can promote change. The belief that family therapy may be ineffective if one or more family members receive concurrent individual counselling, group therapy, psychotropic medication or are placed in a therapeutic or custodial institution led many family therapists to take a negative view of other treatment modalities. However, in doing so, therapists cut their clients off from many valuable resources. Numerous examples of effective multimodal treatment approaches where family therapy plays a central part in the programme or where concepts drawn from family systems theory are used to construct the overall treatment programme have been described. A statutory treatment package involving family therapy, peer group therapy for individual family members and the temporary placement of the father outside the family home has been used to

rehabilitate families where incest has occurred (Giaretto, 1982). Family therapy, peer group therapy and neuroleptic medication is an effective treatment for schizophrenics who live in families where parents score high on the expressed emotion scale (Berkowitz, 1984). Concurrent individual play

therapy or behaviour therapy for the problem person may be effectively integrated with family-based treatment in child psychiatry or paediatric settings (Carr and Afnan, 1989; Carr, McDonnell and Afnan, 1989). These examples differ from the cases which led pioneering family therapists to outlaw concurrent involvement in other forms of treatment in two ways. First, the various therapeutic inputs are co-ordinated by co-operating professionals. Second, these interventions are guided by a systemic case formulation or hypothesis. If the activities of system members who can promote change are not co-ordinated in this way, the problem system may gradually lapse into patterns of behaviour that promote stuckness.

7. Replicating dysfunctional patterns which occur elsewhere in the problem system. When a referral is made to a therapist, the positions taken by various members of the problem system usually form a pattern which is dysfunctional in so far as it precludes the resolution of the presenting problem. Haley's (1967) perverse triad is one such pattern. The most commonly sighted instance of this, is the enmeshed mother child dyad and the peripheral father. The mother, within the context of an exclusive relationship protects the symptomatic child whom she sees as frightened, sick or sad. The father, who has little involvement in child care, views the problem child as naughty, manipulative or bad. A danger exists that when a therapist and team join this problem system, the therapist and the mother child dyad, for example, will become involved in an enmeshed and exclusive relationship to which the team (and the father) are peripheral (Westheffer, 1984).

If a therapist and team accept that the tendency to replicate dysfunctional patterns is inevitable (particularly in highly dysfunctional problem-systems) and are prepared to consider them as an impediment to problem resolution when a case becomes stuck, then it is unlikely that they will lead to protracted impasses. First, the problem system will become stuck less often because the therapist and team will be anticipating pattern replication. Second, when the system becomes stuck, the therapist, the team and the family can map out the patterns of alliances that they experience and search for alternative solutions that do not involve these dysfunctional alliances.

In larger problem systems that involve multiple agencies such as those which evolve in cases of child abuse, it is more difficult to anticipate alliances because the group members do not know each other

or each others' agencies' policies well (Carr,1989). Also, the process of exploring patterns of alliances as a springboard for finding more functional patterns of organization requires a basic level of interpersonal trust and professional respect. In large groups of professionals this is often difficult to achieve because the members do not know each other at a personal level and professional rivalry rather than respect seems to be quite common (e.g. Butler-Sloss, 1988).

This problem may be tackled by attempting to form positive alliances with all those professionals within the district where the therapist practices who are likely to become involved in large problem systems. Thus a level of basic trust is established which permits problem solving rather than polarization when agency groups begin to replicate patterns present in highly dysfunctional families with which they are involved

8. Failing to distinguish the role of therapist from the role of agent of social control. An agency may have statutory functions but also offer a therapeutic service. This is true of departments of social services, probation, police, psychiatry and education. A social services department, for example, is empowered by the state to protect children by requesting that a court remove them from the custody of their parents. The department may also offer a family therapy service, but if a worker confuses these two functions, a good therapy will not be offered. When workers exercise statutory powers, they act as social control agents for the state. They define and control the limits of an individual's or family's liberty. Inevitably, the client whose freedom has been limited through the exercise of statutory power will feel antagonistic towards the statutory worker. For these two individuals then to attempt to develop a therapeutic alliance is difficult. It requires the client to distinguish between the *worker as therapist* from the *worker as agent of social control*. Maintaining this distinction requires a constant input of energy from both parties over and above that necessary for therapy. If the distinction is not maintained, the client may go through the motions of therapy so as to appease their *statutory controller* or the client may drop out of therapy.

There is also a danger of this process occurring even when the statutory worker and the therapist are separate individuals. This is well illustrated by the example given in paragraph number 3 of this section where a mother and child referred to me by a social worker because of attachment difficulties. Although I was in a different agency from the referring social worker, and no threat of statutory action had been made, the client still viewed both me and the referring agent as agents of social control.

In cases where statutory action has been taken or is likely to

occur and therapy is offered, the therapist must devise a set of strategies to convince the client that the therapy is distinct from the social control. One useful arrangement is for the statutory worker to set clearly defined and observable criteria which must be met before the statutory limits which have been placed on the client's freedom may be wholly or partially withdrawn. The worker may then refer the case to a therapist requesting that the client be offered a contract for therapy which involves searching for ways to meet the criteria posed by the statutory worker. The statutory worker may then periodically assess therapeutic progress according to the predefined criteria (Cottrell et al., 1990).

9. Failing to take account of the image projected by the agency to prospective clients. The image the agency projects will affect engagement and the therapy process. For example, clients may view probation offices and social work departments as being staffed by social control agents. Hospitals and private therapeutic institutes may be viewed as the workplaces of helpful professionals. Family therapy was originally developed in the latter type of settings. However, a sizeable number of practitioners now practice within the former types of agencies.

In taking family therapy lock stock and barrel as practised in one agency context and attempting to replicate this in another without taking account of how the agency is perceived by the client group may lead to engagement problems. For example, Howe (1989) found that clients attending a social services staffed family therapy agency had difficulty participating in family therapy and experiencing benefit from the live supervision which was available to the therapist. In fact the live supervision provided by the team via close circuit television was one of the key factors leading to clients' sense of powerlessness. These difficulties occurred, in part, because the therapist and team assumed that their clients were well informed customers who wanted the form of intervention being offered. Howe's study suggests that many of the clients were frightened to voice their opinions and none asked to be referred to another practitioner. Howe's study points to the importance of redressing the perceived imbalance of power for clients who seek therapeutic services from statutory agencies through providing an brief educational induction programme prior to therapy. Such a programme should highlight the details of how the therapeutic process will proceed, the voluntary nature of the treatment contract and the other locally available treatment options (Pimpenell and Treacher, 1990). If we are to be truly systemic in our outlook we must include therapist, team and agency in our initial formulations. We must make hypotheses about how we are perceived by our clients, test these out and take steps to correct misapprehensions. This is precisely the course of action taken

by the team which Howe studied, although regrettably this information was omitted from his book (Reflection, 1989).

10. Failing to engage the agency's management and secure the support necessary for a high quality of clinical practice. While therapists and teams are providing a service for clients and their networks on the one hand, they should be in regular contact with management so as to secure and maintain the resources necessary for their practice on the other. They need their managers to provide them with the time, space, supervision ongoing training and facilities to do this type of work. If these needs are not met the therapist and team will develop burnout and the quality of the service offered will plummet. Therapists and teams must view securing resources and maintaining them as part of their function and use a variety of skills and tactics, including those drawn from an appreciation of systems theory.

Therapists should schedule time to assess and map out their organization in much the same way as one would map out any problem system. This map may include resources outside the agency such as training courses, other premises, trust funds etc. In the light of this assessment they should plan to secure appropriate resources.

If family therapy is being introduced into an agency from *the bottom up* a useful tactic is for therapist to describe some small aspect of clinical work in detail in an informal meeting with the person who holds the required resource. This gives the resource holder an opportunity to empathize with the therapist. The request for increased resources may then be made with reference to the clinical example. Negotiation is less likely to escalate into confrontation if it begins with empathy. Once the demand for family therapy has been established through such small pilot projects, other tactics may be used to consolidate and expand the service offered. Broadly speaking, the team and the referring agents who avail of the therapy service must present an argument to management indicating that the demand for family therapy outstrips the supply and that certain resourcing requirements must be met if the project is to continue (Lieberman, 1989).

DISCUSSION

Taken individually, each of the issues addressed in this paper has been a concern for many family therapists. However these difficulties have rarely been dealt with collectively as a constellation of problems requiring a cohesive set of interrelated solutions. The work of Carpenter and Treacher is a notable exception to this generalization (Carpenter et al., 1983; Carpenter and Treacher, 1989, Treacher and Carpenter, 1982). The relationship between the ideas set out in this paper and those of Carpenter and Treacher deserve some elaboration.

Carpenter and Treacher (1989, Chapter 1), in keeping with the position advocated in this paper, argue that it is unhelpful to assume that the boundary of the problem system is coterminous with the boundary of the problem person's family. The therapist must be prepared to consider other systems in her formulation. These include the clients extended family, work or school system, other agencies involved with the case, the therapist's own team and agency and the therapist's own family.

The second main area of overlap between Carpenter and Treacher's position and that taken here concerns the importance of the worker understanding their role when practising family therapy in their agency (Carpenter and Treacher, 1989, Chapter 2). In two important papers, Carpenter and Treacher identified four sets of difficulties which may inhibit therapeutic progress (Carpenter, Treacher et al., 1983; Treacher and Carpenter, 1982). First, factors related to the context of therapy and the therapeutic contract; of particular importance here is the accuracy with which the therapist identifies the customer and clarity with which the customer's presenting problem and related goals are defined. Second, therapy may become stuck because the style of therapy used or the way in which techniques are employed do not fit with the clients' needs. Third, the therapist may inadvertently (usually through the development of countertransference reactions) become sucked into the problem maintaining system or excluded from the problem resolving system. Fourth, the therapist and her supervisory team may develop a working relationship which inhibits the therapist from helping the clients resolve the presenting problem.

With the exception of the second set of factors (therapeutic style and technique), the difficulties associated with therapy becoming stuck identified by Carpenter and Treacher overlap substantially with those outlined in this paper. The central difference between Treacher and Carpenter's work and the position taken here, is the view that the catalogue of engagement difficulties described in the body of this paper can be viewed as arising from a failure to distinguish between the eleven elements of problem systems listed at the beginning of the article.

NOTES

1. Throughout this paper the term problem-system is used to refer to the social organization which comprises the problem person and those members of her social network who are trying to help her solve the presenting problem. Once a therapist accepts a referral, she and those colleagues from her agency involved in the case become part of this problem system.

REFERENCES

- Barrera, M. (1988). Models of social support and life stress. Beyond the buffering hypothesis. In L. Cohen (ed.), *Life Events and Psychological Functioning*. Beverley Hills, CA: Sage.
- Berkowitz, R. (1984). Therapeutic intervention with schizophrenic patients and their families a description of a clinical research programme. *Journal of Family Therapy*, 6, 211-233.
- Butler-Sloss (1988). *The Cleveland Report*. London: HMSO
- Carl, D., & Jurkovic, G. (1983). Agency triangles: problems in agency-family relationships. *Family Process*, 22, 441-451.
- Carpenter, J. & Treacher, A. (1989). *Problems and Solutions in Marital and Family Therapy*. Oxford: Basil Blackwell.
- Carpenter, J., Treacher, A., Jenkins, H. & O'Reilly, P. (1983). Oh no! Not the Smiths again' An exploration of how to identify and overcome 'stuckness' in family therapy, part II: Stuckness in the therapeutic and supervisory systems. *Journal of Family Therapy*, 5, 81-96.
- Carr, A. (1986). Three techniques for the solo family therapist. *Journal of Family Therapy*, 8, 373-382.
- Carr, A. (1989). Countertransference reactions to families where child abuse has occurred. *Journal of Family Therapy*, 11, 87-97.
- Carr, A. & Afnan, S. (1989). Concurrent individual and family therapy in a case of elective mutism. *Journal of Family Therapy*, 11, 29-44
- Carr, A., MacDonnell, D. & Afnan, S. (1989). Anorexia Nervosa: The treatment of a male case with combined individual behaviour therapy and family therapy. *Journal of Family Therapy*, 11, 335-351
- Coleman, S. (1985). *Failures in Family Therapy*. New York. Guilford.
- Cottrell, D., Jog, S., Jackson, E. (1990). Casework towards the family reintegration of a sexually abusive father - a single case study. *Journal of Family Therapy*, 12, 341-353.
- Fisch, R., Weakland, J., & Segal, L. (1982). *The Tactics of Change. Doing Therapy Briefly*. San Francisco: Jossey Bass.
- Foa, E. & Emmelkamp, P. (1983). *Failures in Behaviour Therapy*. New York: Wiley.
- Giaretto, H. (1982). *Integrated Treatment of Child Sexual Abuse: A Treatment and training Manual*. Palo Alto, CA. Science and Behaviour.
- Goolishian, H. & Winderman, L. (1988). Constructivism, autopoiesis and problem determined systems. *Irish Journal of Psychology*, 9, 130-143.
- Gurman, A., Kniskern, D. & Pinsof, W. (1986). Research on marital and family therapies. In S. Garfield and A Bergin (eds.), *Handbook of Psychotherapy and Behavior Change* (3rd. Edition.) New York: Wiley.
- Haley, J. (1967). Toward a theory of pathological systems. In: G. Zuk and I. Boszormenyi-Nagy (eds.), *Family Therapy and Disturbed Families*. Palo Alto, CA: Science and Behaviour.
- Howe, D. (1989). *The Consumer's Views of Family Therapy*. Aldershot, Hants. Gower.
- Lieberman, S. (1989). The birth pains of establishing an NHS family therapy clinic. *Context*, 3, 8-10.
- Mays, D. & Franks, C. (1985). *Negative Outcome in Psychotherapy and What*

- to Do About it*. New York: Springer.
- Pimpernell, P. & Treacher, A. (1990). Using a videotape to overcome clients reluctance to engage in family therapy. *Journal of Family Therapy*, 12, 59-71
- Quinton, D. & Rutter, M. (1988). *Parenting Breakdown*. Aldershot, Hants: Avebury-Gower.
- Reflection (1989). Howe's the FT consumer champion. *Context*, 2, 25-26.
- Rutter, M. & Garmazy, N. (1985). Developmental psychopathology. In E. Hetherington (ed.), *Handbook of Child Psychology, Vol. 4. Socialization, Personality and Social Development*. New York: Wiley.
- Selvini Palazzoli, M. Boscolo, L. Cecchin, G. & Prata, G. (1980). The problem of the referring person. *Journal of Marital and Family Therapy*, 6, 3-9.
- Selvini Palazzoli, M. (1985). The problem of the sibling as the referring person. *Journal of Marital and Family Therapy*, 11, 21-34.
- Skygger, A. R. C. (1968). The Minimum sufficient network. *Social Work Today*, 29.
- Treacher, A. & Carpenter, J. (1982) . Oh no! Not the Smiths again! An exploration of how to identify and overcome 'stuckness' in family therapy, part I: Stuckness involving the contextual and technical aspects of therapy. *Journal of Family Therapy*, 4, 285-303.
- Westhefer, C. (1984). An aspect of live supervision: the pathological triangle. *Australian Journal of Family Therapy*, 5, 169-175.
- Wynne, L., McDaniel, S. & Weber, T. (1987). Professional politics and the concepts of family therapy, family consultation and systems consultation. *Family Process*, 26, 153-156.
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