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KARL TOMM'S APPROACH TO SYSTEMIC PRACTICE

Alan Carr

INTRODUCTION

Karl Tomm occupies a pivotal position in the evolution of systemic family therapy. He played an important role in bringing the work of the original Milan systemic family therapy team to the attention of family therapists in North America, the UK and Ireland (Tomm, 1984a, 1984b). He then went on to extend and elaborate their work and also to integrate work from the narrative therapy tradition into systemic family therapy. The account of some aspects of his work presented in this chapter are based on a presentation he made over two days at the Mater Hospital in Dublin in April 1997. The presentation and this account of Karl Tomm's work clusters around four central themes. They are:

- Situating Karl Tomm's work within the main mental health traditions and the tradition of family therapy
- Problems with individual classification of interpersonal difficulties
- An approach to classifying interpersonal difficulties
- Interventive interviewing.

SITUATING THE WORK OF KARL TOMM WITHIN THE TRADITION OF FAMILY THERAPY

Tomm took the view that all approaches to understanding and solving problems rest on a single core assumption. In order to situate himself in within the main mental health traditions generally the tradition of family therapy specifically, he

began by highlighting the core assumptions of a variety of explanations of human problems and a variety of different approaches to family therapy. Within the tradition of biological psychiatry the core assumption is that an underlying disease process is the problem (e.g. Klein et al, 1980). Within the psychoanalytic tradition it is assumed that the person's developmental history is the central underlying difficulty (e.g. Bateman & Holmes, 1995). Behaviourists take the view that reinforcement contingencies are the central difficulty (e.g. Falloon, 1988). From a sociological perspective family dysfunction is the core problem (e.g. Gelles, 1995). Anthropologists, on the other hand, would take the view that cultural practices underpin most human difficulties (e.g. Krause, 1993) whereas a hermeneutic perspective would point to life stories and significance's attached to life events are central to the development of human problems (e.g. Rainwater, 1995).

Within the family therapy tradition, a core assumption has been that some aspect of the family system or the therapeutic system formed by the family and therapist underpins the problem. However, different theorists make unique assumptions about which precise aspect of the family or the therapeutic system is problematic. Within the structural family therapy tradition Minuchin took the view that maladaptive family structures underpinned clients' problems (Colapinto, 1991). Within the strategic tradition Haley's core assumption was that a poorly aligned power hierarchy led to the development and maintenance of interpersonal difficulties (Madanes, 1991). Virginia Satir (1967), whose approach to family therapy evolved out of the human potential movement, took the view that low self-esteem was the core difficulty for most clients seeking therapy. Murray Bowen, who highlighted the centrality of trans-generational issues in problem development, worked from the assumption that most difficulties arise from a lack of differentiation from one's family of origin (Friedman, 1991). The cybernetic viewpoint put forward by the MRI Group assumed that the attempted solution was always the core problem (Segal, 1991). A similar viewpoint was taken by the original Milan group. They worked from a

core assumption that the problem with which people presented was itself a solution to some other central difficulty (Campbell, Draper and Crutchley, 1991). According to Tomm, Michael White's position is underpinned by the assumption that the problem with which the person presents is a restraint (White and Epston, 1990). The constructivist position, as typified by, for example, Ben Furman, is underpinned by the view that the client's explanation for his or her difficulties is the core problem (Furman & Ahola, 1992). de Shazer's (1985,1988) solution-focused viewpoint rests on the idea that the focus on the problem is the core problem.

In contrast to these other positions, Karl Tomm said that his core assumption is that the distinction of the problem is always the central problem. He termed this viewpoint a *bring-forthist* view. In line with this core assumption Tomm argued that all clinical practice and interviewing involves helping clients co-create different views and practices with respect to the problem through co-creating different distinctions. Central to this approach to practice is the conceptualization of all aspects of therapist-client communication as interventive. For this reason, Karl Tomm refers to his approach to clinical practice as interventive interviewing. His earlier ideas on interventive interviewing have been documented in a series of papers in *Family Process* (Tomm, 1987a, 1987b, 1988) and presentations on ethical postures in family therapy (e.g. Tomm, 1991). These evolved from his interest in the approach to practice developed by the original Milan family therapy team which Tomm documented in two important papers (Tomm, 1984a, 1984b).

PROBLEMS WITH THE INDIVIDUALISTIC CLASSIFICATION OF INTERPERSONAL PROBLEMS

Like most family therapists and systemic practitioners, Karl Tomm argued that attempts to classify interpersonal system problems within an individualistic framework inevitably entail a variety of difficulties (e.g. Mikesell, Lusterman &

McDaniel, 1995). However, his articulation of these problems are perhaps clearer than those offered by others within the field. He addressed his criticisms of individual classification systems specifically to the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) which was published by the American Psychiatric Association in 1994. This document is highly significant from a client's perspective, because insurance companies will only pay for treatment of psychosocial difficulties where a DSM IV diagnosis has been given. From a mental health professional's perspective, it is also a significant document there is pressure from administrators, insurance companies and research funders to use the DSM IV system, if clinicians wish to secure and maintain resources.

Tomm's first objection to DSM IV he termed the ontological criticism. He argued that it is erroneous to assume that most problems of living are located within the person. Rather, it may be more valid to assume that most problems of living arise in the interactions between people and the context within which they live. Tomm's second criticism of the DSM IV is based on empirical grounds. He argued that diagnostic criteria for disorders contained within DSM IV and the boundaries of DSM IV diagnostic categories have been, in part, decided by committees rather than by empirical research. For example, the diagnosis of homosexuality was removed from an earlier edition of the Diagnostic and Statistical Manual by a vote among members of the American Psychiatric Association rather than by any scientific process. Tomm's third criticism of the DSM IV was political. He argued that the classification system promotes the medical model and psychiatric supremacy within the mental health field. This individualistic approach to classification, he argued, has been used to marginalize and exclude people who receive diagnoses. His fourth criticism of the DSM IV was that the system dehumanises clients by focusing on personal limitations and failures rather than resources and possibilities. Interviews aimed at arriving at a diagnosis lead clients to feel diminished and disempowered. Once diagnosed, they are at risk for being stigmatised because of their diagnostic label. The fifth

criticism of the DSM IV offered by Karl Tomm was that, from a clinical perspective, it is not useful. DSM IV diagnoses are of little clinical use in planning and carrying out treatment programmes. With both pharmacological and psychosocial treatments, clinicians must take account of the unique characteristics of the individual and their social context, rather than broad diagnostic labels, in planning multimodal intervention programmes. Karl Tomm's final and ironic criticism of the DSM IV was that it fails to include the category of *spiritual psychosis* which is characterised by a false belief that pejorative labelling actually helps rather than demeans people. The criteria for this prevalent psychotic state is an obsessive preoccupation with pejorative adjectives, inclusion and exclusion criteria, cut-off points, incidence and prevalence rates and so forth.

These criticisms of individual diagnostic systems are, of course, not new. For example, the ontological criticism was most forcibly put in the past by Bateson (1973). The empirical criticism has long been voiced by psychologists who pointed to the dimensional rather than the categorical distribution of behavioural characteristics within populations (Carr, 1996). The political criticism is an old hobby-horse of Tom Szasz (1974). The humanitarian criticism was originally voiced by Karl Rogers (1951) and colleagues from the client-centred tradition. The pragmatic criticism has previously been put in the past by behaviourists (e.g. Falloon, 1988). However, what is unique about Karl Tomm's attack on the DSM IV is the way that he has marshalled these arguments and, with great courage, withstood political and administrative pressure within his work context to use the DSM IV system.

My only concern about the approach adopted by Karl Tomm is that, when such an extreme position is taken, there is a real danger of throwing the baby out with the bath water. Systems like the DSM IV permit accurate communication among researchers and allow clinicians to access vital resources for their clients. For example it is far easier to obtain remedial tuition resources for a child with a diagnosis of dyslexia or a specific reading difficulty than for a youngster who has reading problems but who does not have the benefit of a

diagnosis. Unfortunately the DSM IV diagnostic system has been constructed in pejorative terms and is often abused. Tomm has published an earlier version of this critique of DSM IV in the *Dulwich Centre Newsletter* (Tomm, 1990).

























It is fortunate the European equivalent of the DSM IV, the tenth revision of the International Classification of Diseases which is published by the World Health Organization (ICD10, WHO, 1992), wields less power in Ireland and other European countries than the DSM IV does in North America. However, it is likely that in the longer term in Europe, there will be pressure to use the ICD10 in a destructive way.




THE CLASSIFICATION OF INTERACTIONAL PROBLEMS AND COMPETENCIES: THE IPSCOPE

Arising out of a dissatisfaction with the DSM IV and responding to the need for some form of classification system, Karl Tomm developed what he calls the *IPscope*. IPs or Interpersonal patterns are recurrent interactions between two or more people. They typically involve a coupling of two classes of behaviours, beliefs or emotions, which are mutually reinforcing, so the pattern tends to be self-maintaining. Within therapeutic situation, three classes of IPs are of particular concern. PIPs, or pathologizing interpersonal patterns, are those which increase distress or negativity for the involved people. HIPs, or healing interpersonal pattern, are antidotes to PIPs and bring forth positive experiences for those involved in PIPs. A TIP is a transforming interpersonal pattern and it helps clients move from a PIP to a HIP. Examples of PIPs HIPs and TIPs associated with a variety of problems are set out in Figure 3.1.

Tomm also identified two other classes of interpersonal patterns. These are WIPs and DIPs. WIPs are wellness interpersonal patterns which enhance clients' competence or effectiveness. They tend to maintain the health of a relationship and productive relationships tend to be characterised by a large number of WIPs. DIPs are deteriorating interpersonal pattern that lead to slips from HIPs to PIPs. Slips tend to occur when unexpected demands or stresses are placed on people. Common slips include humiliation, shame, guilt, retaliation, being controlled and so forth.

Figure 3.1. Elements of Tomm's IPSCOPE

	PIPS Pathologizing Interpersonal Patterns	HIPS Healing Interpersonal Patterns	TIPS Transforming Interpersonal Patterns
Psychotic Behaviour	Social ostracism & disqualification  Unusual thoughts and behaviour & incoherence	Social inclusion  Enactment of valued responses	Support & accept  stabilize and trust
Dyscontrol	Correction and control  Protest and rebellion	Support inner control  Protest problem not person	Externalize problem  Separate from problem
Irresponsibility	Protect from natural consequences  Failure to learn	Exposure to natural consequences  Learn from consequences	Withdraw protection  Accept exposure to consequences
Lying and Dishonesty	Condemning judgements, demanding disclosure, & threatening intrusiveness  deceptive evading, secrecy, & lying	Celebrating openness  Revealing failings	Selective noticing of openness  Increasing openness
Living down to one's expectations (Underachievement)	Reduced expectations  Reduced performance	Enhanced expectations  Enhanced performance	Rejection of reduced expectations  Rejection of reduced performance
Workaholism	Excessive expectations  Overdriven performance	Relaxed expectations  Relaxed performance	Rejection of excessive expectations  Rejection of overdriven performance
Paranoia	Withholding information  Reactive suspiciousness	Giving information  Accepting truth of information	Acknowledging that information was withheld  Relief that suspicions were confirmed
Avoidance Withdrawal	Pursuing  Distancing	Waiting  Re-turning	Acknowledging pattern  Accepting pattern

Depression	<div>Oppressive behaviour</div>  <div>Depressive behaviour</div>	<div>Nurturing & Supporting</div>  <div>Growing and developing</div>	<div>Acknowledging autonomy</div>  <div>Accepting autonomy</div>
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Note: Some of the IPs presented in this Figure were presented by Karl Tomm. Others were co-constructed by Dr Imelda McCarthy, Dr Nollaig Byrne and myself during a workshop exercise.

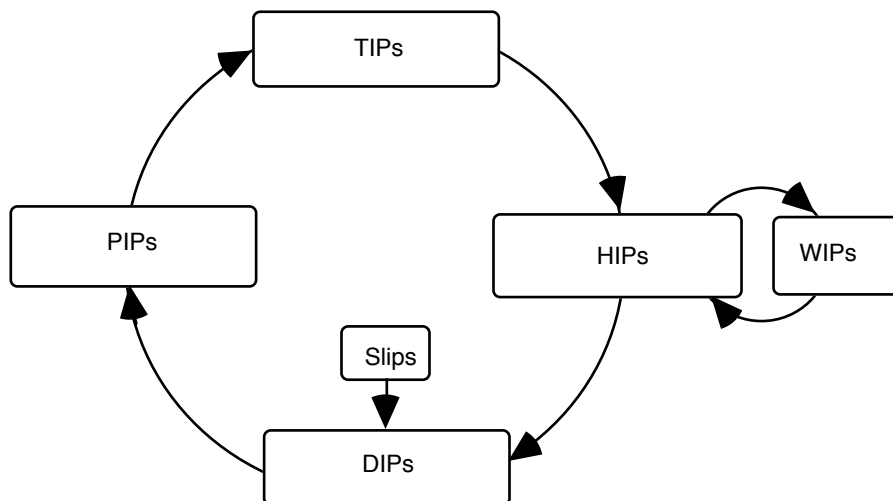
Wellness interaction patterns (WIPs) include nurturing supporting/growing and developing; acknowledging autonomy/ exercising autonomy; accepting emotion/expressing emotion; respecting the other/respecting the self; distinguishing intent and effect/recognising mistakes; accepting mistakes/admitting mistakes; giving constructive feedback/seeking correction, and so forth.

Within Figure 3.1 the interpersonal patterns have been presented using Karl Tomm's most recent notation. In this notation system that part of the interactional pattern associated with greatest power is put above the arrows and the slash and that part with least power is put below the arrows and the slash. The contextual force of the upper half of the interaction on the lower half of the interaction is represented by a solid arrow and the implicative force of the lower half of the interaction on the upper half of the interaction is represented by a broken arrow. The coupling of the two halves of the interaction is represented by a slash. This notational system is based partly on Cronen and Pearce's co-ordinated management meaning model (Cronen and Pearce, 1985).

Karl Tomm described scales that have been developed to measure the reported and experienced severity of WIPs and PIPs. Research conducted at his unit in Calgary indicates that the longer the period of time families remain in therapy the greater the strength of WIPs and the less the strength of PIPs.

The relationship between the various interpersonal patterns described by Karl Tomm are presented in Figure 3.2. From the Figure it may be seen that pathologizing interpersonal patterns (PIPs) may be replaced by healing interpersonal patterns (HIPs) through engaging in transforming interpersonal patterns (TIPs). If all goes well, healing interpersonal patterns may lead to development of wellness interpersonal patterns. On the other hand, if people are faced with stressful events that lead them to slip out of the healing or wellness interpersonal pattern then may develop a deteriorating interpersonal pattern (DIP) which in turn will lead back to the development of a wellness interpersonal pattern.

Figure 3.2. Circular relationships between Pathologizing Interpersonal Patterns (PIPs), Transforming Interpersonal Patterns (TIPs), Healing Interpersonal Patterns (HIPs), and Deteriorating interpersonal Patterns (DIPs) which are triggered by Slips.



Note: WIPs are wellness interpersonal pattern which may occur in conjunction with HIPs

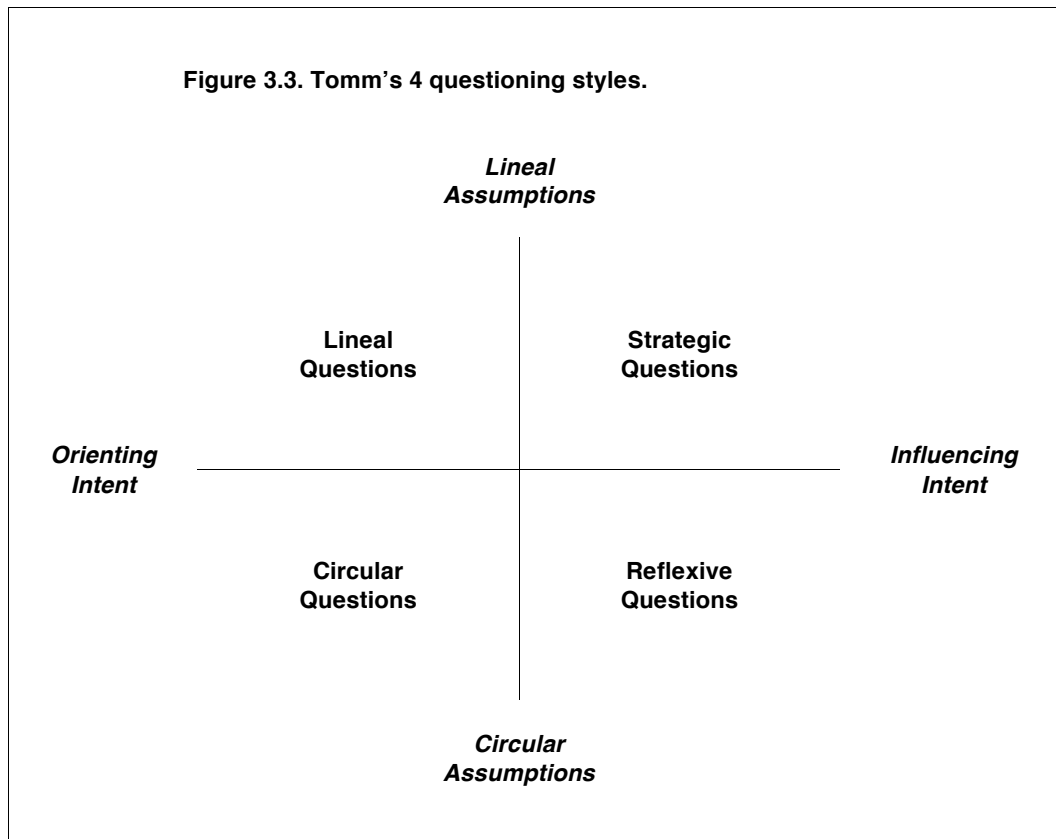
Tomm's work on the definition and classification of interpersonal events falls squarely within the tradition of interpersonal psychology, a tradition which began with the work of Harry Stack Sullivan and which is well described in Donald Kiesler's comprehensive resume of this tradition (Kiesler, 1996).

During an exercise on the use of the IPscope Dr Imelda McCarthy and Dr Nollaig Byrne suggested that all classes of IPs could also be classified as symmetrical or complementary using Bateson's (1973) system for distinguishing between two core types of relationship patterns. With symmetrical IPs there is a concurrent escalation of two classes of similar behaviour. For example, aggression being countered with aggression. With complementary IPs there is a concurrent escalation of two different classes of behaviour. For example, an increase in oppression co-occurring with an increase in depression.

A problem with all interpersonal and interactional classification systems is that they may lead to pathologizing not only individuals but also families. Thus, there is a danger that the IPscope system may, for example, lead to labelling men and women who are struggling with the issue of balancing relational power as oppressive/depressive couples. In response to a question about this issue, Karl Tomm argued that the IPscope is for classifying interactional patterns and not people.

INTERVENTIVE INTERVIEWING

Tomm (1987a, 1987b, 1988) distinguishes between four questioning styles in terms of the intentions and assumptions that they entail. With respect to intentions, therapists may pose questions with a view to orienting the therapeutic system through information gathering or influencing the therapeutic system so as to bring about therapeutic change. With respect to assumptions, therapists may ask questions based on lineal/cause-and-effect assumptions, or circular/cybernetic assumptions. Lineal assumptions break the ongoing flow of events into discrete segments, where A causes B causes C. Circular assumptions, on the other hand, emphasise the interconnectedness and recursiveness of human actions. An intersection of the two continua of intent (with the poles of orienting and influencing intent) and assumptions (with the poles of lineal and circular assumptions) constitutes the framework diagramed in Figure 3.3 for distinguishing between lineal, circular, strategic and reflexive questions.



Source: Adapted from Tomm (1988).

Lineal questions seek clearly defined causes or explanations of actions, events or feelings. For example:

- *Are you having difficulty sleeping? (No)*
- *Have you lost or gained any weight? (No)*

Lineal questions reinforce an assumption that certain characteristics, such as depression, are intrinsic to the person.

Circular questions are also used to gather information, but they do so in an exploratory manner, as distinct from the investigative approach of lineal questions. For example:

- *How is it that we find ourselves together today' (I called because I am worried about my husband's depression)*

- *Who else worries? (The kids)*
- *What do you do when they show you that they are worrying? (I don't bother them, just keep to myself)*

This type of questioning invites the family to be more aware of the circular nature of their interactions, thereby making it easier for them to disrupt such patterns than when they view them from their own lineal-based personal perspectives.

When a therapist wants to take a corrective and decisive role in bringing about change in a family, he or she can employ a strategic style of questioning. For example:

- *Why don't you talk to him about your worries instead of the kids? (He just won't listen, and stays in bed);*
- *What would happen if for the next week at 8 a.m. every morning you suggested he take some responsibility?' (It's not worth the effort)*

The confrontational nature of strategic questions is a double-edged sword, as it can mobilise clients to change, but it can also jeopardize the therapeutic alliance.

Reflexive questions aim to influence clients but not in the directive or confrontational manner of strategic questions. The therapist does not try to impose his or her views but facilitates the family's ability to reflect on its own belief systems and make new connections. For example:

- *If you were to share with him how worried you were and how it was getting you down, what do you imagine he might think or do? (I'm not sure)*
- *Let's imagine there was something he was resentful about, but didn't want to tell you for fear of hurting your feelings, how could you convince him that you were strong enough to take it? (Well, I'd just have to tell him I guess)*

Because reflexive questions mobilise a family's own problem-solving resources. Tomm argues that is more likely that family members will experience respect, novelty, and spontaneous transformation as a result of circular questioning and reflexive questioning. In contrast they are more likely to experience judgement, cross-examination and coercion as a result of lineal and strategic questioning.

Tomm's later ideas about interventive interviewing grew out of his earlier work on the four questioning styles (Tomm, 1987a, 1987b, 1988). In his earlier work Tomm argued that therapy conducted within the tradition which crystallised in the early work of the four Milan associates, has an impact on symptom severity primarily because of the style of questioning used rather than the intervention that is delivered at the end of the session. This led him to a position where he believed that everything that a therapist says or does should be regarded as an intervention which could be helpful to detrimental to clients. This approach to working with clients requires that therapists carefully plan moment by moment interactions within the session and that they are sensitive to the immediate effects of their interviewing style on clients. It runs the risk of paralysing novice therapists who may become so preoccupied with planning each question that the quality of their relationship with the client suffers. However, Tomm argues that therapists may be trained to interview from specific conceptual or ethical postures.

Unfortunately space, precludes an extended discussion of Tomm's ideas on conceptual and ethical postures here. Suffice it to say that Tomm extended the principles of practice of the original Milan team to include not only hypothesizing, circularity and neutrality but also strategizing. He then operationalized these principles of practice by defining the intentions associated with each and the four types of questions that may be asked in the service of these intentions as outlined in the previous section (Tomm, 1987a, 1987b, 1988).

In a later development he has described the four ethical postures of empowerment, succorance, confrontation and manipulation (Tomm, 1991). For each of these ethical postures, a clear set of intentions were defined and types of questions associated with each set of intentions were specified. These principles, guiding sets of intentions and sets of related questions may be used as a basis for training novice therapists to develop fluency in generating fluent interventive interviews with clients. In his more recent work he has developed frameworks for conducting interventive interviewing focusing on assessment; the co-construction

of hope; and the co-construction of responsibility and forgiveness and it was these developments that will be addressed below.

Five levels of complexity in assessment

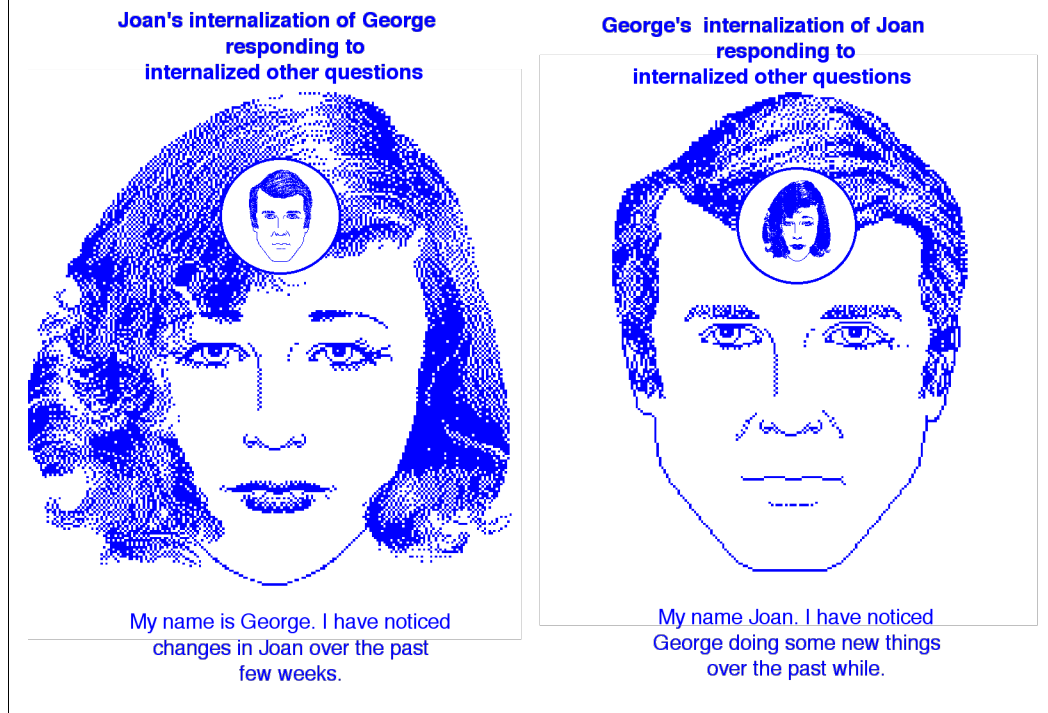
While all interviewing is interventive, Tomm acknowledged that one feature of the interviewing process may be described as assessment and five different levels of complexity may be identified within interviews where the co-construction of an understanding of the client's problems is a core therapeutic direction. At the first level, assessment interviewing may aim to bring forth characteristics of personal events. Included here are questions which lead to clients describing their beliefs, thoughts, behaviours, emotions and intentions. Such questions may be framed to bring forth narratives of competence (as in the case of solution focused interviewing) or narratives of deficiency (as in the case of traditional psychiatric diagnostic interviewing). At the second level of complexity, assessment oriented interviewing may bring forth interpersonal patterns. At this level questions may be used to co-construct specific patterns which fall into the categories identified in Figure's 3.1 and 3.2. Questions asked at this level may also be used for genogram construction and other relational maps. At the third level of complexity assessment oriented questions may contextualise patterns within the belief systems of the local community or wider culture. Questions at this level bring forth community and culture based expectations, values and beliefs and the processes by which clients become recruited into or liberated from these dominant belief systems. At the fourth level assessment questions may historicise aspects of a selected interpersonal pattern. Questions that invite clients to co-construct narratives about the way in which past relationships have led to current interpersonal patterns are included here. At the fifth level of complexity, the position, prejudices and knowledge base from which the therapist is working with the clients is disclosed. At this level therapists differ in the way in which they manage disclosing their own viewpoint. Some, such as

those working within the psycho-educational tradition, take an authoritative stance. Others, working within the non-directive tradition, take a *not knowing* stance. Tomm's own position is to inform clients of his viewpoints and the knowledge base from which he works and to invite them to evaluate his viewpoint to their own satisfaction.

Internalised other interviewing

One of the interview strategies that Karl Tomm described and illustrated with videotape interviews, was internalised other interviewing. In using this strategy he said that he explains to couples that they may make some interesting discoveries about their relationship if they listen closely to the internalised version of themselves their partner has. This is schematically represented in Figure 3.4. Were a clinician to conduct an internalised other interview with Joan (the woman in Figure 3.4) he or she would invite Joan to respond to a series of questions as she believes her partner (George) would truly respond. The clinician would then address her by the name George and would ask her, for example, how she felt about coming to the session, what she finds appealing about her partner, what aspects of the relationship are valued, what are her principle worries and difficulties, how things have changed over the course of therapy and so forth.

Figure 3.4. Internalized other interventive interviewing.



In all instances, although the clinician is talking to Joan he or she addresses her as George, since the internalised other of George within the woman is being addressed. At the end of an internalised other interview both partners are asked to give their views on the accuracy of the answers given and the person interviewed is invited to consider the circumstances under which they might develop a more accurate understanding of their partner. Surprises which emerge from the interview may also be discussed. The process can then be reversed so that the partner who has been interviewed remains silent and listens whereas the other partner participates in an internalised-other interview with the therapist.

Internalised-other interviewing permits the speaking partner to access understanding of the silent partner of which they may have been unaware. For the silent partner, internalised-other interviewing permits them to see the degree

to which they are understood (or indeed misunderstood) by their partner. Ensuing discussion about the accuracy of responses made in internalised-other interviews allows couples to deepen their understanding of each other and increase acceptance of the other's position. It is a highly creative approach to interviewing which has resonances with role-change or dramatic introject-exploration techniques from a variety of other psychotherapeutic traditions such as psychodrama (Moreno, 1946), gestalt therapy (Perls, 1969) and Kelly's (1955) fixed role therapy.

Co-constructing hope

Many deteriorating interpersonal patterns and pathologizing interpersonal patterns involve exclusion, isolation, marginalization and loss of hope. In co-constructing hope with clients Tomm has developed sets of questions which bring forth interests, desires and passions such as:

- *What moments of happiness or joy have you had in your life that stand out as special among your memories?*
- *What kinds of activities which you were involved with in the past have you found most exciting and pleasurable?*
- *What kinds of feelings arise when you recall these events?*

In co-constructing hope he has also developed sets of questions which bring forth possibilities such as:

- *Which of these kinds of experience would you be interested in having again?*
- *Under what circumstances do you imagine that something similar could happen in the future?*
- *What settings might create the best conditions for a preferred outcome to unfold?*
- *How could you best prepare yourself for such a possibility?*

Co-constructing responsibility

Within relationships where one person has hurt another, Tomm argued that patterns of blaming and evading may be tackled through the co-construction of responsibility. This process involves a search for positive intentions using questions like:

- *You must have had some good reason to take that course of action.*
- *What outcome were you hoping for in that situation?*

A distinction should then be made between intended effects and actual effects through the use of questions like the following:

- *Can you imagine that there could be a difference between intended effects and the actual effects of your action?*
- *What do you hear the injured person saying about the effect it had on her/him in the situation? Would you agree that was not what you had intended?*

An awareness of the aggressor's feelings about the actual effects of this action may then be brought forth using the following:

- *What kind of feelings do you have when you realise that there are some effects on the other person that you did not intend?*
- *Is it reasonable to feel good about one's intentions but bad about the effects of one's action.*

Reflections on alternative actions may then be required about using questions like:

- *If you could have known in advance what the actual effects would be would you have chosen some other action?*
- *What other actions would be more likely to have the desired effect?*

This method for co-constructing responsibility holds much in common with Jenkins (1990) approach to working with violent men.

Co-construction of apology and forgiveness

Where clients have been hurt within intimate relationships, Tomm argued that a number of processes should be facilitated to promote the co-construction of

apology and forgiveness. First the therapist should open space to permit protest against the act of betrayal. In addition there is a requirement for space to be opened for listening without defensiveness. The next step is to facilitate acknowledgement of responsibility and apology for wrongful actions. Thereafter space may be opened for restoration following wrongdoing. The final task is to facilitate forgiving but without forgetting. Tomm argued that it was unfortunate that in our cultures forgiving and forgetting are often coupled together. In the co-construction of apology and forgiveness, wrongdoing and restoration must be remembered if past mistakes are to be avoided.

Goals and Directions

While behavioural (Falloon, 1988) and problem oriented (Segal, 1991) traditions within the family therapy field have privileged the concept of therapeutic goals, many systemic practitioners who align themselves with the post-modern tradition have rejected the idea of intentionality and explicit therapeutic goals altogether (e.g. Anderson, 1995) . Karl Tomm took a middle ground on this issue of intentionality and goals, and said that his approach to systemic practice involved empowering clients to move in particular directions, rather than equipping them to achieve specific defined goals.

In conceptualizing the process of directionality in therapy, he distinguished between problems and anti-problems, solutions and dis-solutions. People may be helped to move from problems to anti-problems through externalising conversations such as those described by Michael White (White and Epston, 1990). With externalising conversations the client is helped to make a clear distinction between the self and the problem and then to de-construct the problem and de-pathologise the self.

The movement from problems to solutions rather than from problems to anti-problems involves attentions to exceptions (deShazer, 1985,1988) and unique outcomes (White and Epston, 1990) . Rather than deconstructing the

problem the aim is to reconstruct naturally occurring solutions. White has called this process *re-storying* and de Shazer refers to it as *exception amplification*.

Some problems are solved by solutions which themselves may become serious problems. Tomm gave the example of the person who solved an alcohol problem through attendance at AA meetings but these then began to interfere with family-life routines. Dis-solutions may be dealt with, he argued, by letting go of the solution and accepting circumstances as they are. Precisely how this process of letting go can be co-constructed without leading to relapse remained unclear. However, workaholism, exercise addiction and so forth are good examples of dis-solutions requiring this type of approach.

CLOSING NOTE

Karl Tomm gave a stimulating and thought-provoking two-day workshop. I was left at the end feeling that the patchwork quilt of ideas he presented are probably part of a highly systematic and subtle approach to practice which deserves exposition in a full length book. No doubt this will be forthcoming.

FURTHER READING

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