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NARRATIVES OF HOPE

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INTRODUCTION

This chapter will begin with a case example which illustrates an integrative approach to the practice of family therapy (Carr, 2000). In the remainder of the chapter the broad principles of practice which underpin the case study will be sketched. I will also illustrate how this approach helps clients develop hopeful narratives about themselves and their lives. This approach to practice, particularly the formulation of exceptions, has been informed by developments within the positive psychology movement (Carr, 2004).

CASE EXAMPLE

Tom and Sue, a couple in their mid 20s, were referred by a social worker for therapy at a psychology clinic attached to a general hospital. In the referral letter the social worker said that the couple had multiple problems. Tom had an explosive temper, which was frightening for Sue and her two children. Sue, who had a history of panic attacks, had developed a constricted lifestyle because of fears of having panic attacks when away from home. The couple argued constantly. Although no actual violence had occurred, the potential for violence was the central issue leading to the referral. The case was referred to social services by a health visitor who became concerned for the welfare of the couple's children, Maeve (4 years) and Mike (1 year), when conducting a routine developmental assessment visit with Mike around the time of his first birthday. The social worker visited the couple at their home and met with a frosty reception. The couple initially insisted that everything was OK and that no family evaluation and support was required. The social worker explained that she had a statutory obligation to evaluate the capacity of the parents to provide a safe and secure home environment for the children. One recommendation arising from the social worker's assessment was that the couple complete a programme of therapy to address the conflict between them, since this was interfering with their capacity to co-operatively meet their children's needs.

Contracting for assessment

Because of the couple's ambivalence about attending therapy, invitations to an initial contracting meeting were sent to the referring social worker and the couple, with a request

that the social worker arrange transportation for the couple to attend the our clinic. In the intake meeting the couple expressed their ambivalence about attending therapy, but the social worker pointed out that if the couple decided not to attend therapy, then their children's names would be placed on an at-risk register held at her department. In light of this information, the couple agreed to attend two sessions during which an assessment would be conducted. If that indicated that they were suitable for therapy a further contract for 10 sessions of therapy would be offered.

Formulation of problem episodes

In the assessment sessions, it became clear that during episodes of couple-conflict, Sue would not do something that Tom aggressively demanded, such as soothing the children or being attentive to his needs. In response Tom would criticize her, and she would initially fight back, but eventually withdraw into silence or following stressful exchanges have a panic attack. Tom would then back off. The couple would then not be on speaking terms for a few days. Gradually they would have increasingly more contact until the next episode. Sue's personal narrative, which underpinned her behaviour in these episodes, was that the demands of life, her children and her partner were too great for her to manage and she would usually fail. In this story she saw herself as a helpless victim. She also believed that arguments between couples were competitive exchanges that were won or lost. She believed that she could never beat Tom in an argument and this is why she gave up each time, a process that reinforced her beliefs in her own lack of power to influence Tom. Also, when she became frustrated she believed that her increased physiological arousal was a sign that she was about to have heart attack, a belief that often preceded her panic attacks. Sue had learned this pessimistic narrative from her mother, who had longstanding depression, and from observing her parents' very unhappy marriage. Tom behaved as he did during problematic episodes because his personal narrative entailed the view that Sue was being purposefully uncooperative to punish him and that it was unfair that she didn't cherish him, because he was devoted to her. Another aspect of his personal narrative was the belief that others were trying to take advantage of him – a hostile attributional bias - which he had learned from his father. Tom had a conflictual relationship with his father,

who treated his mother as Tom treated Sue. A detailed diagram of this three-column problem formulation is given in Figure 1.

Formulation of exceptional episodes

In contrast to these problematic episodes, represented by the problem formulation, there were exceptional episodes in which the problem was expected to happen but did not. During these episodes, Tom helped rather than criticised Sue when she was having difficulty soothing the children or cooking his dinner, doing the washing or some other household job. In response, she smiled at him and good feelings between them followed. Tom had learned from his mother that 'a little kindness goes a long way' and it was this story that underpinned his generous behaviour. Sue had learned that 'one good turn deserves another' from her dad with whom she had a good relationship and this story underpinned her good feelings when Tom was kind to her. A three-column formulation of exceptional episodes in which the problem was expected to occur but did not is given in Figure 2. Figure 3 is the family's genogram, which threw light on some of the contextual factors included in the third column of the problem and exception formulations in Figures 1 and 2.

Contracting for treatment

On the basis of the assessment and the problem and exception formulations, the couple were offered and accepted a contract for 10 sessions of therapy. The overall goals for therapy agreed between the couple, the referring social worker and the therapist, was to help the couple reduce the level of conflict in their home and increase the safety of the children's parenting environment.

Therapy

The 10 sessions of therapy covered the following issues

- Interactional reframing
- Externalizing the problem
- Pinpointing strengths

- Building on exceptions
- Tom's challenge: Self-regulation
- Sue's challenge: Being courageous
- Managing resistance
- Parenting
- Building support
- Disengagement
- Relapse management

The issues were broadly covered in the order listed, although the therapy was by no means as neat and packaged as it appears in the following description.

Interactional reframing

In the early sessions of therapy the problem formulation was revisited repeatedly. The couple's difficulties were reframed as an interactional problem rather than as a reflection of personal psychological or moral deficits. There was a gradual moving away from the dominant narrative that each of them suffered from individual psychological problems. This narrative, couched in deficit discourse entailed the view that the main problem was either Sue's 'bad nerves' or Tom's 'short fuse'. Rather the couple came to understand the family's difficulties as the problematic interaction pattern described in Figure 1.

Externalizing the problem

In the early sessions of therapy the couple's difficulties were externalized and framed as peripheral to the core of their essentially positive relationship. They were invited to name their problem in a metaphorical way, and in response they began to talk about their problematic episodes, mapped out in Figure 1, as 'the North Wind that blew through their house'. They began to monitor the occurrence of problematic episodes and to withdraw from these if they spotted themselves contributing to them. They referred to this as 'closing the shutters to keep the North Wind out of their house'.

Pinpointing strengths

Reframing the problem in interactional rather than individual terms, externalizing the problem, naming it in a metaphorical way, and adopting joint ways of combating the problem offered many opportunities to highlight Tom and Sue's personal strengths (for example, thoughtfulness, courage, persistence) and strengths that characterized their relationship (for example, loyalty, warmth, steadfastness). Through naming these strengths, Tom and Sue began to develop a more hopeful narrative about their relationship.

Building on exceptions

The therapy also involved revisiting the exception formulation. The couple were repeatedly invited over the course of therapy to remember and recount, in emotive detail, many exceptional episodes in which the problem was expected to occur but did not. Invitations to give accounts of such episodes initially focused on the pattern of interaction, then the underlying personal narratives and then finally the constitutional, historical and contextual factors that underpinned the positive personal narratives. Then the similarities between these and other similar past episodes were explored. The couple were also invited to consider what the occurrence of these episodes said about them as a couple and how they expected such episodes to recur in the future. Through this process, the couple developed a narrative about their relationship marked by kindness, concern, sensitivity, warmth, closeness, understanding, compassion and many other positive qualities, which they recognized, had always been there and would probably persist into the future. In this way the seeds for a narrative of hope were sown

Tom's challenge: Self-regulation

A third aspect of the therapy focused on helping Tom to define himself as a man who was engaged in learning to identify and express his attachment needs in a direct way. He came to talk about himself as a man who was learning to sooth his own sense panic or anger when he feared his attachment needs would not be met by Sue immediately. In developing this new narrative about the sort of man he was, Tom gradually gave up the story that Sue

was to blame for his aggression. He adopted a more hopeful narrative about himself as a man in charge of his own feelings and responsible for his own behaviour. Some skills training was offered to Tom to help him identify and state his needs, and to monitor and contain rising frustration if his needs were not met.

Sue's challenge: Being courageous

A fourth aspect of the therapy focused on helping Sue to define herself as a courageous woman who was learning to accept that a racing pulse and sweaty palms were signals to relax, not panic. To help her revise her personal narrative, Sue was invited to set herself challenges in which she made her pulse race and her palms sweat, and then deal with these challenges by using relaxation skills and support from her partner. She and Tom planned and completed a series of graded challenges. Earlier challenges involved containing and soothing Sue's increased physiological arousal in the therapy sessions. In later challenges the couple travelled away from the house for gradually increasing distances, until eventually they both went on a date in the city. This was a major achievement for the couple. It consolidated Sue's optimistic story about herself as a courageous woman who was increasingly ready to take on greater challenges in her life.

Managing resistance

Progress in therapy was intertwined with periods of slow movement, and ambivalence about change. Managing resistance was the main therapeutic activity during these periods. Indeed, as part of the contracting process, we explained to Tom and Sue that ambivalence about change and resistance were an inevitable part of therapy and to be welcomed, since they are an indicator that the therapy is working and change is really happening. Resistance showed itself in many ways. Here two examples will be mentioned.

While Tom was moving towards defining himself as a man who was engaged in learning to identify and express his attachment needs in a direct way rather than blame Sue for his aggression, progress was not straightforward. He would occasionally doubt that the benefits of defining himself in this new way outweighed the costs of giving up the view that Sue, and not he, was responsible for his aggressive and violent outbursts. When this

occurred, we invited Tom to address his personal dilemma about the costs of maintaining the status quo and the costs of changing his situation. He came to see that if he maintained the status quo he could preserve a story about himself as a good man provoked to violence by Sue, but he would have to give up any hope of a truly intimate and loving relationship with her and the two children. This, we suggested was because Sue could not be fully intimate with a man who attacked and blamed her for things that she had not done.

Similarly, progress was far from straightforward when Sue was learning to define herself as a courageous woman. She would occasionally doubt that the benefits of defining herself in this new way outweighed the costs of giving up the view that she was a helpless victim who could justifiably remain cocooned at home forever. When this occurred, we invited Sue to address her personal dilemma about the costs of maintaining the status quo and the costs of changing her situation. She came to see that if she maintained the status quo she could avoid the terror of facing her fear, but she would have to give up any hope of defining herself as a powerful woman in her own right, a competent role model for her daughter, and an equal partner for Tom.

For both Tom and Sue, the theme of abandonment underpinned the catastrophic narrative that fuelled their ambivalence about change. Tom's personal narrative was that if he accepted full responsibility for his anger and violence, then this meant that he was not a good man, and so Sue would have to leave him. Sue's personal story was that as long as she was a helpless terrified victim, Tom would remain to protect her, but if she showed signs of sustained courage and strength, he would leave her to fend for herself. To address these catastrophic narratives, Sue and Tom were invited to explore alternative more hopeful narratives of the future in which Tom could allow himself to be forgiven and accepted by Sue and Sue could allow herself to be on an equal footing with Tom (rather than in a one-down position). The pessimistic narrative of abandonment and the related ambivalence about change receded over the course of therapy as Tom and Sue's more hopeful story about their lives came to the fore.

Parenting

Therapy also focused on inviting the couple to explore their story about themselves as good-enough parents. Invitations were offered to them to describe ways in which they successfully met their children's needs for safety, security, nurturance, control, intellectual stimulation, and age appropriate responsibilities. Through describing many examples of good-enough parenting, Tom and Sue, developed a story about themselves as competent, but not perfect parents. This hopeful parenting narrative, led them to ask us for expert advice on parenting skills so that they could improve the way they managed the challenges of child-rearing. It was into this context, that behavioural parenting skills training was offered. This covered all the usual skills to enhance parent-child interactions, increase positive behaviours and extinguish aggressive and destructive behaviours. The couple incorporated these skills into their own parenting styles and into their own story about themselves as good-enough parents.

Building support

The couple were invited in the middle and later stages of therapy to strengthen their ties with their families of origin. This was not an easy invitation for the couple to accept. Over the years both couples had become increasingly distant from their parents, because in each of their families they felt triangulated. This is illustrated in the genogram in Figure 3. During her teens Sue had gradually become a confidant for her father and was estranged from her depressed mother. Tom, in contrast had become a confidant for his mother and had frequent conflicts with his father. In both Tom and Sue's families of origin their parents were locked into rigid, close, conflictual patterns of marital interaction. Despite all this, as Tom and Sue's narrative about their own relationship became more hopeful, they became more understanding of their parents difficulties and were prepared to visit their families of origin more frequently. They let their parents know that they had come through difficult times, but were now hopeful that there were better times ahead, and that they were strong enough to build a good family. This admission of vulnerability and declaration of hope strengthened ties between Tom and Sue and their families of origin. Also the grandparents, Roger and Teresa , and Conor and Rachel, welcomed the opportunity to

spend time with their grand children, Maeve and Mike. This, created a context within which they could be more supportive of Tom and Sue.

Disengagement

The first 6 sessions were held at weekly or fortnightly intervals. As the family began to make progress, the final 4 sessions were spaced at three to five weekly intervals. Much of the therapy in the last three sessions focused on helping the couple make sense of the change process, develop relapse management plans, and understand the process of disengagement as the conclusion of an episode in an ongoing relationship with the clinic rather than the end of the therapeutic relationship. Tom and Sue were invited to forecast the types of stressful situations in which relapses might occur, their probable negative reactions to relapses, and the ways in which they could use the strengths they had discovered in therapy to deal with these relapses.

After 10 sessions a review conducted with the referring social worker indicated that the family was doing much better. The social services department decided that frequent monitoring of the family was no longer necessary. At the review, the following specific treatment gains were noted. In the social worker's view the conflict between the couple no longer placed the children at risk. The frequency of episodes of conflict between Sue and Tom had reduced from 5 to 1 per week and the couple was confident that these arguments would never become violent. Both children were healthy, well adjusted and were being well cared for. There were marked improvements in Tom's anger management and Sue's panic disorder with agoraphobia. The couple said their marital satisfaction improved. Supportive links with each of their families of origin were strengthened. In short, the therapy goals had been attained.

Relapse management

A relapse occurred a couple of years later at a time when Sue began working outside the home for the first time since the birth of the first child. After two sessions in which the couple explored ways that they could use their strengths to jointly manage the new

challenges in their lives, the frequency of the couple's unproductive arguments reduced again.

AN INTEGRATIVE APPROACH

The integrative model of marital and family therapy which guided the therapy in this case example, draws on a wide range of family therapy theory, practice and research (Carr, 2000; Gurman & Jacobson, 2003; Liddle et al., 2002; Pinsof & Wynne, 1995; Sexton, Weeks & Robbins, 2003). The variety of traditions, schools and models of marital and family therapy may be classified in terms of their central focus of therapeutic concern and in particular with respect to their emphasis on

- (1) Repetitive problem-maintaining behaviour patterns;
- (2) Constraining narratives and belief systems which subserve these behaviour patterns; and
- (3) Historical, contextual, and constitutional factors which predispose families to adopt particular narratives and belief systems and engage in particular problem-maintaining behaviour patterns.

In the same vein, hypotheses and formulations about families' problems and strengths may be conceptualized in terms of these three domains. Also, interventions may be classified in terms of the specific domains they target. Three-column formulation is central to this integrative approach and it is to this that we now turn.

Problem formulation

For any problem, an initial hypothesis and later formulation may be constructed in which the behaviour pattern which maintains the problem is specified, the constraining narratives and beliefs which underpin family members' roles in this pattern are outlined, and the broader contextual factors that predispose family members to have these beliefs and behaviour patterns are given. For example, in the case example that opened this chapter, our initial hypothesis was that the family got involved in regular conflictual patterns of

interaction in which the children's expression of their needs, Tom's anger control problems and possibly Sue's panic attacks might have played a part. Our second hypothesis was that the narratives and beliefs which underpinned their roles in these interaction patterns involved Tom having views about being entitled to certain things from Sue, and Sue believing that she was either in danger or powerless. Our third hypothesis was that these beliefs and behaviour patterns had their roots in adverse family-of-origin experiences. These hypotheses were checked out during the assessment interviews and led to the development of the three-column problem formulation in Figure 1. This specific formulation drew on the general problem formulation model in Table 1. (A detailed review of the literature on which this model is based is contained in Carr, 2000).

Exception formulation

Using the three column formulation approach, strengths may be conceptualized as involving exceptional interaction patterns within which the problem does not occur, empowering narratives and beliefs which inform family members' roles within these interaction patterns, and broader contextual factors that underpin these competency-oriented narratives that provide a foundation for resilience. For example, in the case study that opened this chapter, our first strengths-oriented hypothesis was that occasionally Tom and Sue became involved in co-operative patterns of interaction. Our second hypothesis was that the narratives which underpinned their roles in these interaction patterns involved Tom's and Sue's commitment to their marriage and to raising their children together. Our third hypothesis was that these narratives and behaviour patterns had their roots in positive family of origin experiences and positive experiences within the family of procreation. These hypotheses were checked out during the assessment interviews and led to the development of the three-column exception formulation in Figure 2. This specific formulation drew on the general exception formulation model in Table 2. (A detailed review of the literature on which this model is based is contained in Carr, 2000 and Carr, 2004).

Three categories of interventions

In light of formulations of families' problems and strengths, a range of interventions which address interaction patterns, narratives, and broader contextual factors may be considered. Those which fit best for clients, make best use of their strengths, and for which there is best evidence of effectiveness may be selected. Some interventions aim primarily to disrupt problem maintaining interaction patterns. In the case example, the self-regulation work we did with Tom, the graded challenges work we did with Sue and the parenting skills training we did with the couple fall into this broad category. Other interventions aim to help couples evolve more liberating personal and family narratives. Some such interventions were mentioned in the case example. These included reframing the family's difficulties in interactional rather than individualistic terms, externalizing the problem, pinpointing strengths, and building on exceptions. A third group of interventions aim to modify the negative impact of broader contextual factors, or drawn on positive historical, contextual or constitutional resources and factors that may promote resilience. In the case example, building support was an intervention that fell into this category. A three-column framework within which to conceptualize a wide range of marital and family therapy interventions is given in Table 3. (A detailed review of the literature on which this framework is based is contained in Carr, 2000; Carr & McNulty, In Press b).

Stages of therapy

In the integrative approach which informed the therapy in the case example, the overall strategy is to work co-operatively with families to formulate their difficulties and exceptional episodes where their difficulties were expected to occur but did not using the three column models outlined above. Once this has been achieved, treatment goals are set and a therapy plan developed which aims to increase the occurrence of exceptions, disrupt problematic behaviour patterns, transform problematic personal and family narratives, address problem-maintaining contextual factors, and draw on historical, contextual and personal resources.

However, marital and family therapy is not that straight forward. Sometimes clients have difficulty engaging in therapy. In the example that opened this chapter, Sue and Tom probably would not have attended therapy at all, without careful planning about who to invite to the initial sessions and what the focus of these meetings should be. Furthermore, many families show marked improvement following assessment only. That is, once they develop a shared understanding of their difficulties and exceptional situations where their problems were expected to occur but did, they spontaneously avoid problematic interactions and engage in exceptional non-problematic interactions instead. Finally, some families come to therapy with one problem, such as parenting difficulties and when this is resolved, request therapy for other difficulties such as sexual problems. To address these various challenges, the process of therapy is conceptualized as a developmental stagewise process.

The framework, set out in Figure 4 outlines the stages of therapy from the initial receiving of a referral letter to the point where the case is closed (Carr, 2000). The first stage is concerned with planning, the second with engagement and assessment, the third with treatment, and the fourth with disengagement or recontracting for further intervention. At each stage, key tasks must be completed before progression to the next stage occurs. Failure to complete the tasks of a given stage in sequence or skipping a stage may jeopardize the consultation process. For example, attempting to conduct an assessment without first contracting for assessment may lead to co-operation difficulties if the couple find the assessment procedures arduous or threatening. Failure to complete assessment before treatment, compromises decision making about goal setting and selecting specific

therapy strategies. Therapy is a recursive process insofar as it is possible to move from the final stage of one episode to the first stage of the next.

PROBLEMS AND STRENGTHS

Throughout the history of family therapy different traditions have placed more or less emphasis on clients problems and strengths. Structural, strategic, systemic behavioural and psychodynamic traditions have highlighted the importance of the role of systemic factors in the formation and maintenance of problems. Solution-focused and narrative traditions have privileged the importance of emphasizing solutions, strengths, exceptions, resilience and potential for growth in therapy (Carr, 2000).

Therapeutic conversations which focus on the role of systemic factors in the formation and maintenance of problems have many benefits for clients. They invite clients to recognize, and by implication avoid re-enacting, problematic behaviour patterns. They allow clients and non-systemically oriented colleagues, to understand problems in contextual rather than individual terms. They also provide opportunities for clients to process painful emotions associated with the development of these problems at earlier stages of the lifecycle. However, exclusively problem-focused therapeutic conversations have one major drawback. They privilege deficit-oriented personal and family narratives. They invite clients to think of themselves as members of problem families or members of families that cope with problems. When families become involved with therapists in these problem-saturated narratives, they may feel demoralized, despondent, and pessimistic. This in turn may compromise the therapeutic alliance and the possibility of therapeutic progress.

Indeed, this very difficulty has been an impetus for the development of theories and practices that focus on strengths. Where strengths and solutions are privileged in therapeutic conversations, important possibilities emerge. Clients may come to recognize exceptional circumstance in which problems were expected to occur but did not, by implication pointing to exceptional patterns deserving re-enactment. Personal and family narratives and belief systems that underpin such exceptional non-problematic transactional patterns may come to the fore, and these may come to supplant deficit-oriented stories

about the self and the family. So clients may come to describe themselves as members of strong families, loyal families, families with special talents, skills and potentials. Therapeutic conversations premised on the search for strengths, may uncover or bring forth historical, contextual and constitutional factors that form the bedrock of clients' resourcefulness and resilience in the face of adversity. Clients may come to talk about the good things they have learned from past generations, the supports they receive from their networks, and the personal attributes that make them the sort of people who keep going where others might fall by the wayside. However, exclusively strengths-oriented therapeutic conversations have their shortcomings too. They, close down opportunities for developing systemic framings of problems and opportunities to process traumatic emotions and 'unfinished business'. When clients notice these avenues being closed off, they may feel unheard. They may feel that in the urgent pursuit of solutions, the therapist has failed to take their problems seriously. This in turn may compromise the therapeutic alliance and hinder therapeutic progress.

A central challenge in family therapy practice is to balance the focus on problems with the focus on strengths. In the integrative model of practice described here, the use of problem and exception formulations is one practice that facilitates this balance and the development of narratives of hope.

EXCEPTION FORMULATION AND POSITIVE PSYCHOLOGY

The literature on problem formulation in family therapy and the related literature on developmental psychopathology are vast, have been reviewed elsewhere extensively (e.g., Carr, 1999, 2000; Carr & McNulty, In Press a) and will not be re-visited here. In contrast the literature on exception formulation in family therapy and the related literature on positive psychology is relatively sparse and has only recently come to the fore (Carr, 2000; 2004; Carr & McNulty, In Press b; Luthar, 2003; Snyder & Lopez, 2002). Key findings from this literature which may be incorporated into exception formulations will be sketched below.

Exceptional Behaviour Patterns

Hypotheses and formulations about exceptional behaviour patterns may include a description of what happened before, during and after the problem was expected to occur but did not. Commonly, the exceptional pattern will also include positive feelings. These offer clues as to how the exceptional pattern may be strengthened. For example, in the exception formulation given in Figure 2 the good feelings that followed co-operation offered a reason for Tom and Sue to co-operate more in future. Exceptional behaviour patterns are often characterized by effective problem solving and clear communication. They usually entail a higher rate of positive, supportive rather than negative, critical exchanges. A clear expression of needs, particularly attachment needs, a degree of psychological intimacy, and greater balance in the distribution of power (within the cultural constraints of the family's ethnic reference group) are common features of exceptional behaviour patterns, particularly within the marital subsystem. Exceptional patterns of parenting typically involve consistent, authoritative, co-operative co-parenting. Exceptional family behaviour patterns often involve emotional support and flexibility about rules, roles and routines. Within professional networks, exceptions tend to occur more commonly when there is good interprofessional co-ordination and co-operation between families and professionals.

Exceptional Narratives

Exceptional non-problematic behaviour patterns may be subserved by a wide variety of positive personal and family narratives. These narratives often entail acceptance rather than denial of the problem, a willingness to accept responsibility for contributing to problem resolution, and an interactional rather than an individualistic framing of the problem. Commitment to resolving the problem and conviction that one is competent to so do are common features of positive narratives. When family members have useful and empowering stories about the nature of the problem and its resolution exceptions may also occur. The occurrence of exceptional behaviour patterns may be associated with the development of the belief that the advantages of resolving the problem outweigh the costs of change. Clients may construct narratives in which once feared consequences associated with their presenting problems come to be seen as not so dreadful or likely

after all. Exceptions may occur when family members have positive and empowering narratives about their relationship and about their roles in the family. This may include a realization of how much family members care for each other and how important it is to be loyal to the family.

Exceptions may also occur when family narratives entail benign beliefs about the intentions and characteristics of family members and where the prevailing view is that family members are good people who are doing their best in a tough situation rather than vindictive people who are out to persecute others. An optimistic attributional style may also underpin exceptional, non-problematic behaviour patterns and typify empowering narratives.

When exceptional behaviour patterns occur, sometimes they are associated with the use of healthy defence mechanisms to manage anxiety arising from conflicting desires to follow a course of action but also avoid rejection or attack from others. Healthy defence mechanisms include self-observation, looking at the humorous side of the situation, being assertive about having ones needs met, and sublimation of unacceptable desires into socially acceptable channels such as work, art or sport.

Contextual Factors associated with Resilience

Exceptional behaviour patterns and the hopeful narratives that subserve these arise from protective factors which foster resilience. These protective factors may be rooted in family members' constitutional characteristics, the family's broader social context, or their historical family-of-origin experiences. Important personal characteristics which contribute to resilience are physical health, high intelligence, specific talents, creativity, wisdom, easy temperament and positive personality traits. These include emotional stability, extraversion, openness to experience, agreeableness and conscientiousness.

A good social support network including friends and members of the extended family and low extrafamilial stress enhance a family's chances of resolving the problems they bring to therapy. Well balanced home and work roles, moderate or high socio-economic-status, a positive parental work environment, positive preschool or

educational placements for children, and empowering cultural norms and values also contribute to resilience in the face of adversity.

Positive family of origin experiences and positive family of origin parent-child relationships lay the foundations for resilience in later life. Good parent-child relationships characterized by secure attachment, authoritative parenting and clear communication in the family-of-origin foster later resilience and strength. Successful experiences of coping with problems in the family-of-origin and the current relationship, flexible organization in the family-of-origin, good parental adjustment and a positive relationship between parents in the family-of-origin may also engender later resilience.

SUMMARY

In the integrative model to marital and family therapy presented in this chapter, therapy is conceptualized as a developmental and recursive process involving the stages of planning, assessment, treatment and disengagement or recontracting. Specific tasks must be completed at each stage before progressing to the next. For any problem, an initial hypothesis and later formulation may be constructed in which (1) the behaviour pattern which maintains the problem is specified; (2) the constraining narratives and beliefs which underpin the family members' roles in this pattern are outlined; and (3) the broader contextual factors that predispose family members to become involved in these narratives and behaviour patterns are given. In addition a similar three-column formulation may be constructed to explain exceptional episodes in which problems were expected to occur but did not happen. These three column formulation models provide a template for guiding the assessment of problems and strengths and for planning therapy. Therapeutic interventions may be classified in terms of the specific domains they target within three column problem and exception formulations, with some interventions targeting behaviour change, some targeting narratives and beliefs, and others focusing on contextual risk and protective factors. A central challenge in family therapy practice is to balance the focus on problems with the focus on strengths. The use of problem and exception formulations is one practice that facilitates the development of narratives of hope. Key findings from

positive psychology have been incorporated into the exception formulation model used in this approach to practice.

REFERENCES

- Carr, A. (1999). *Handbook of Clinical Child and Adolescent Psychology: A Contextual Approach*. London: Routledge.
- Carr, A. (2000). *Family Therapy: Concepts Process and Practice*. Chichester: Wiley.
- Carr, A. (2004). *Positive Psychology*. London: Brunner Routledge.
- Carr, A. & McNulty, M. (In Press a). Couples therapy. In A. Carr & M. McNulty (Eds.), *Handbook of Adult Clinical Psychology: An Evidence Based Practice Approach*. London: Brunner-Routledge.
- Carr, A. & McNulty, M. (In Press b). *Handbook of Adult Clinical Psychology: An Evidence Based Practice Approach*. London: Brunner-Routledge.
- Gurman, A. & Jacobson, N. (2002). *Clinical Handbook of Couple Therapy* (Third Edition). New York: Guilford.
- Liddle, H., Santisteban, D., Levant, R., & Bray, J. (2002). *Family Psychology: Science based Interventions*. Washington, DC: American Psychological Association.
- Luthar, S. (2003). *Resilience and Vulnerability: Adaptation in the Context of Childhood Adversities*. Cambridge: Cambridge University Press.
- Pinsof, W. & Wynne, L. (1995). *Family Therapy Effectiveness: Current Research and Theory*. (Special Edition of Journal of Marital and Family Therapy, Volume 21 , Number 4). Washington, DC: AAMFT.
- Sexton, T., Weeks, G., & Robbins, M. (2003). *Handbook of Family Therapy: The Science and Practice of Working With Families and Couples*. New York: Brunner-Routledge.
- Snyder, C. & Lopez, S. (2002). *Handbook of Positive Psychology*. New York: Oxford University Press.
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Table 1. Three-column problem formulation

CONTEXTS	NARRATIVES & BELIEFS	BEHAVIOUR PATTERNS
<p>Constitutional</p> <ul style="list-style-type: none"> • Genetic vulnerabilities • Debilitating somatic states • Early illness or injury • Learning difficulty • Difficult temperament <p>Contextual</p> <ul style="list-style-type: none"> • Current life-cycle transitions • Home-work role strain • Lack of social support • Recent loss experiences • Recent bereavement • Parental separation • Recent illness or injury • Unemployment • Moving house or school • Changing jobs • Recent bullying • Recent child abuse • Poverty • Secret romantic affairs • Constraining cultural norms and values <p>Historical</p> <ul style="list-style-type: none"> • Major family of origin stresses <ol style="list-style-type: none"> 1. Bereavements 2. Separations 3. Child abuse 4. Social disadvantage 5. Institutional upbringing • Family of origin parent-child problems <ol style="list-style-type: none"> 1. Insecure attachment 2. Authoritarian parenting 3. Permissive parenting 4. Neglectful parenting 5. Inconsistent parental discipline 6. Lack of stimulation 7. Scapegoating 8. Triangulation • Family of origin parental problems <ol style="list-style-type: none"> 1. Parental psychological problems 2. Parental drug or alcohol abuse 3. Parental criminality 4. Marital discord or violence 5. Family disorganization 	<ul style="list-style-type: none"> • Denial of the problem • Rejection of a systemic framing of the problem in favour of an individualistic framing • Constraining narratives about personal competence to solve the problem • Constraining narratives about problems and solutions relevant to the presenting problem • Constraining narratives about the negative consequences of change and the negative events that may be avoided by maintaining the status quo • Constraining narratives about marital, parental and other family relationships (e.g. differences are battles which can be won or lost) • Constraining attributional style (internal, global, stable, intentional attributions for problem behaviours) • Constraining cognitive distortions <ol style="list-style-type: none"> 1. Maximizing negatives 2. Minimizing positives • Constraining defence mechanisms <ol style="list-style-type: none"> 1. Denial 2. Passive aggression 3. Rationalization 4. Reaction formation 5. Displacement 6. Splitting 7. Projection 	<ul style="list-style-type: none"> • The symptom or problem behaviour • The sequence of events that typically precede and follow an episode of the symptoms or problem behaviour • The feelings and emotions that accompany these behaviours, particularly positive feelings or payoffs • Patterns involving ineffective attempted solutions • Patterns involving confused communication • Patterns involving high rates of negative exchanges and low rates of positive exchanges • Patterns involving expression of negative emotions due to fears of attachment needs being unmet • Symmetrical and complementary behaviour patterns. • Enmeshed and disengaged behaviour patterns • Rigid and chaotic behaviour patterns • Coercive interaction patterns • Patterns involving inadvertent reinforcement • Patterns involving lack of marital intimacy • Patterns involving a significant marital power imbalance • Authoritarian, permissive, neglectful, punitive and inconsistent parenting patterns • Patterns involving triangulation of children • Patterns including lack of co-ordination among involved professionals and family members

Table 2. Three-column exception formulation

CONTEXTS	NARRATIVES & BELIEFS	BEHAVIOUR PATTERNS
<p>Constitutional</p> <ul style="list-style-type: none"> • Physical health • High IQ • Specific talents • Creativity • Wisdom • Easy temperament • Positive personality traits (stability, extraversion, openness to experience, agreeableness and conscientiousness) <p>Contextual</p> <ul style="list-style-type: none"> • Good social support network • Low family stress • Balanced home and work roles • Moderate or high SES • Positive work environment • Positive preschool or educational placement • Empowering cultural norms and values <p>Historical</p> <ul style="list-style-type: none"> • Positive family of origin experiences • Positive family of origin parent-child relationships • Secure attachment • Authoritative parenting • Clear communication • Flexible family organization • Good parental adjustment • Parents had good marital relationship • Successful experiences of coping with problems 	<ul style="list-style-type: none"> • Acceptance of the problem • Acceptance of a systemic framing of the problem • Commitment to resolving the problem • Empowering narratives about personal competence to solve the problem (self-efficacy) • Empowering narratives about problems and solutions relevant to the presenting problem • Narratives in which the advantages of problem resolution outweigh the negative consequences of change and the negative events that may be avoided by maintaining the status quo • Empowering narratives about marital, parental, and other family relationships particularly those which privilege loyalty • Positive or benign narratives about the characteristics or intentions of partners and other network members • Optimistic attributional style (internal, global, stable, intentional attributions for productive behaviour and situational attributions for problem behaviour) • Healthy defence mechanisms <ol style="list-style-type: none"> 1. Self-observation 2. Humour 3. Self-assertion 4. Sublimation 	<ul style="list-style-type: none"> • The sequence of events that occurs in those exceptional circumstances where the problem or symptom was expected to occur but does not occur • The feelings and emotions that accompany these behaviours, particularly positive feelings or payoffs • Patterns involving effective solutions and good problem-solving skills • Patterns involving clear communication • Patterns involving high rates of positive exchanges and low rates of negative exchanges • Patterns involving clear expression of attachment needs • Emotionally supportive (rather than enmeshed or disengaged) behaviour patterns • Flexible behaviour (not rigid or chaotic) patterns • Patterns supporting marital intimacy • Patterns supporting marital power sharing • Patterns involving consistent, authoritative, co-operative co-parenting • Patterns including good co-ordination among involved professionals and family members

Table 3. Three categories of interventions

CONTEXTS	NARRATIVES & BELIEFS	BEHAVIOUR PATTERNS
<p>Addressing constitutional factors</p> <ul style="list-style-type: none"> • Psychoeducation about condition • Facilitate adherence to medication regime • Refer for medical consultation • Arrange placement appropriate for person with constitutional vulnerability (e.g. intellectual disability) <p>Addressing contextual issues</p> <ul style="list-style-type: none"> • Network meetings • Child-protection interagency meetings • Home-school liaison meetings • Advocacy • Changing roles • Building support • Rituals for mourning losses • Exploring secrets <p>Addressing family of origin issues</p> <ul style="list-style-type: none"> • Facilitate exploration of transgenerational patterns, scripts myths and relationship habits • Facilitate re-experiencing, expressing and integrating emotions from family of origin experiences which underpin destructive relationship habits • Coach clients to reconnect with cut-off parental figures 	<p>Reframing problems</p> <ul style="list-style-type: none"> • Frame problems in interactional terms • Frame problems in solvable terms • Frame intentions in positive terms <p>Pinpointing strengths</p> <ul style="list-style-type: none"> • Find unnamed obvious strengths • Attribute them to clients as defining characteristics <p>Relabelling</p> <ul style="list-style-type: none"> • Find negatively labelled behaviours • Relable them in positive non-blaming terms <p>Presenting multiple perspectives</p> <ul style="list-style-type: none"> • Split messages • Reflecting team practice <p>Externalizing problems and building on exceptions</p> <ul style="list-style-type: none"> • Separate the problem from the person • Identify and amplify exceptions including pre-therapy improvements • Involve network members • Link the current life exceptions to the past and future • Build a new positive narrative based on the series of exceptions <p>Addressing ambivalence</p> <ul style="list-style-type: none"> • Explore ambivalent narratives about the pro's and cons of change and maintaining the status quo • Explore narratives about catastrophes associates with change • Explore narratives about powerlessness and change 	<p>Creating a therapeutic context</p> <ul style="list-style-type: none"> • Contract • Lay ground rules • Facilitate turn taking • Manage time and space <p>Changing behaviour patterns in sessions</p> <ul style="list-style-type: none"> • Facilitate enactment • Coach new behaviours • Unbalance system • Mark boundaries <p>Facilitating expression of unmet attachment needs</p> <ul style="list-style-type: none"> • Distinguish primary (vulnerable/adaptive) emotions from secondary (hard/maladaptive) emotions • Facilitate intense expression and reception of primary emotions and attachment needs <p>Changing rates of positive and negative behaviour in couples</p> <ul style="list-style-type: none"> • Facilitate behaviour exchange • Build acceptance <p>Changing rates of positive and negative behaviour in parent-child interactions</p> <ul style="list-style-type: none"> • Schedule special time • Introduce reward systems • Coach behaviour control skills <p>Problem solving and communication skills training</p> <ul style="list-style-type: none"> • Communication skills training • Problem solving skills training <p>Tasks to change behaviour patterns between sessions</p> <ul style="list-style-type: none"> • Symptom monitoring • Restraint • Managing graded challenges • Practicing symptoms • Self-regulation

Figure 1. Three column formulation of Tom and Sue's problematic episodes

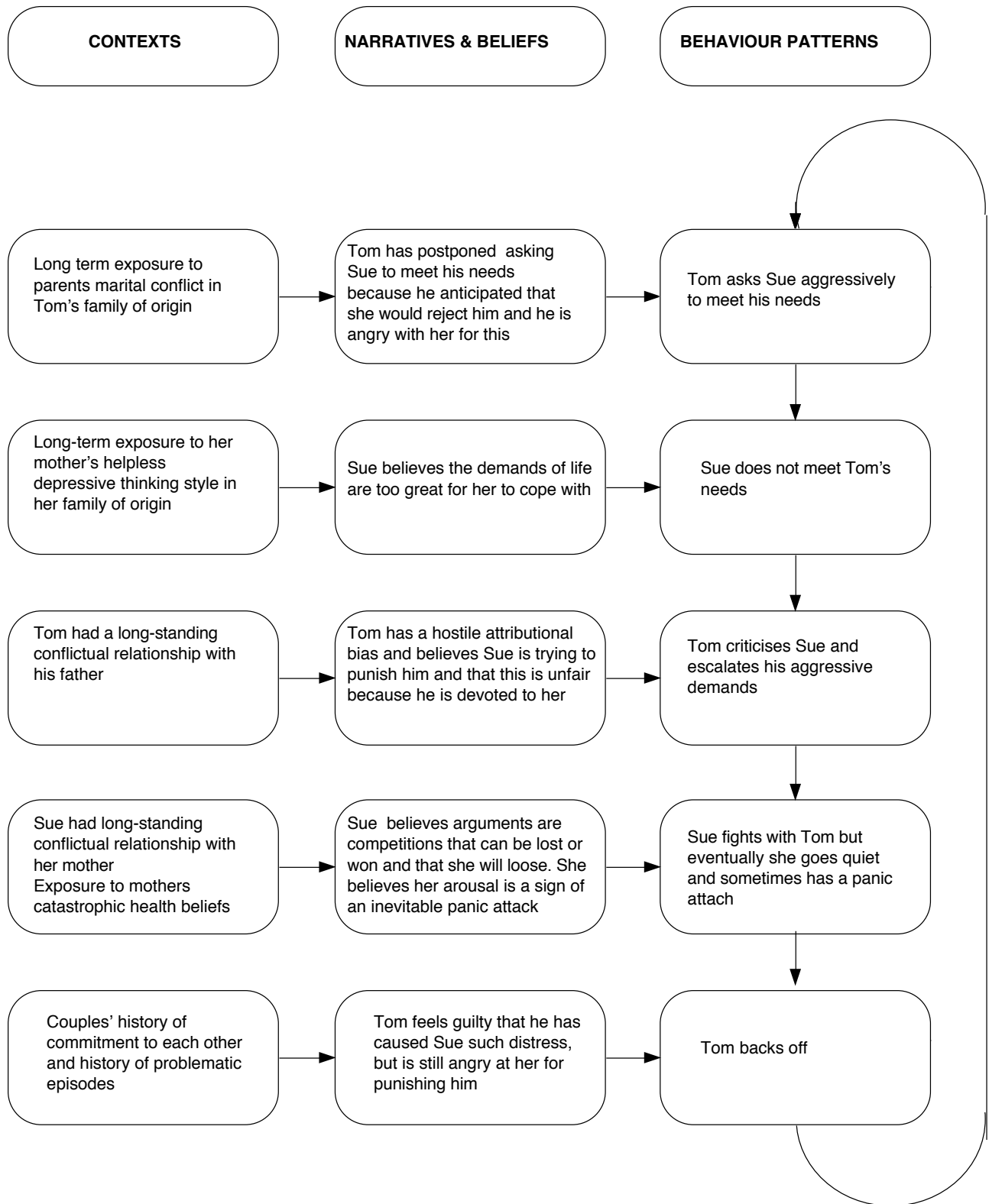


Figure 2. Three column formulation of Tom and Sue's exceptional episodes

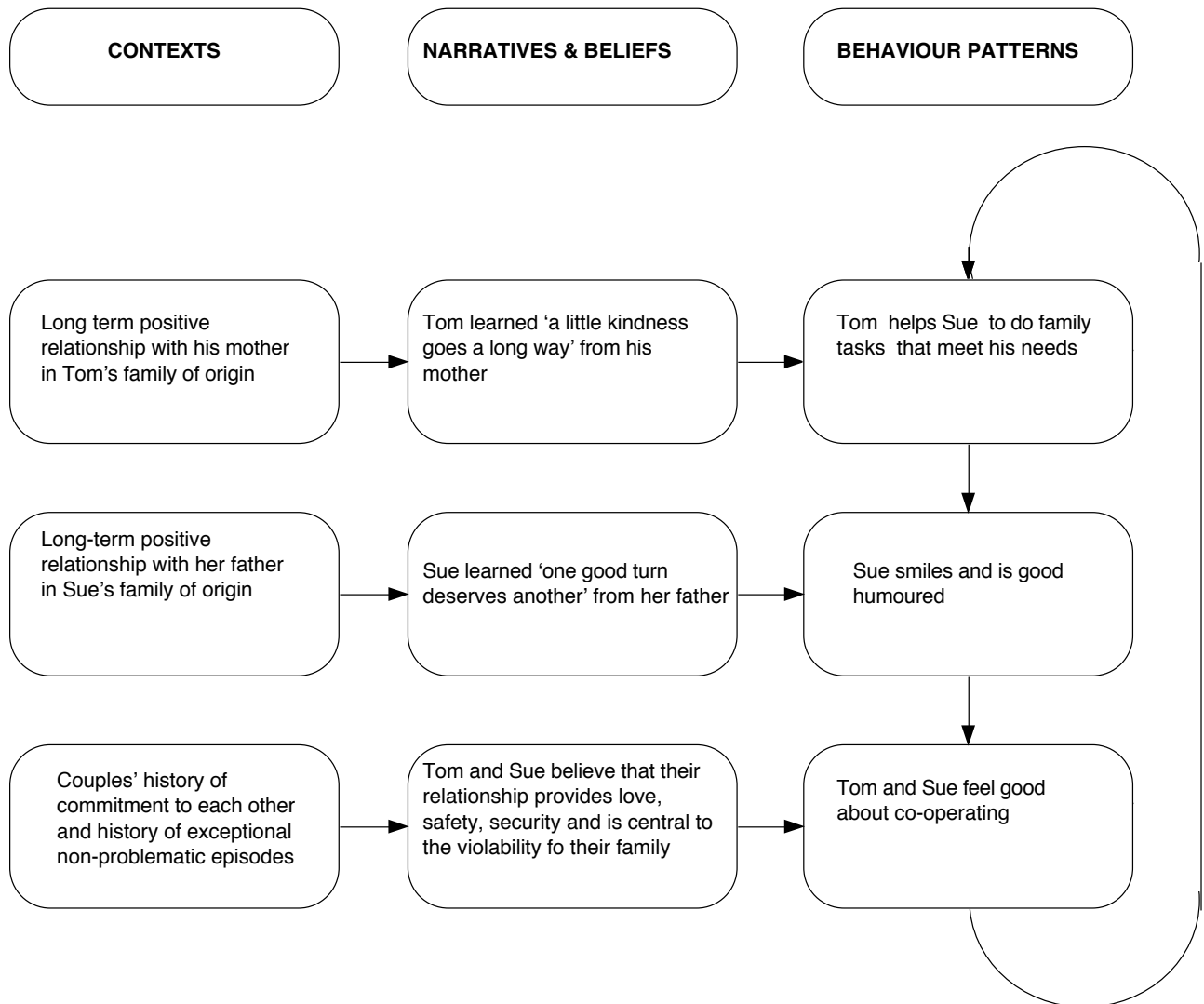


Figure 3. Tom and Sue's genogram

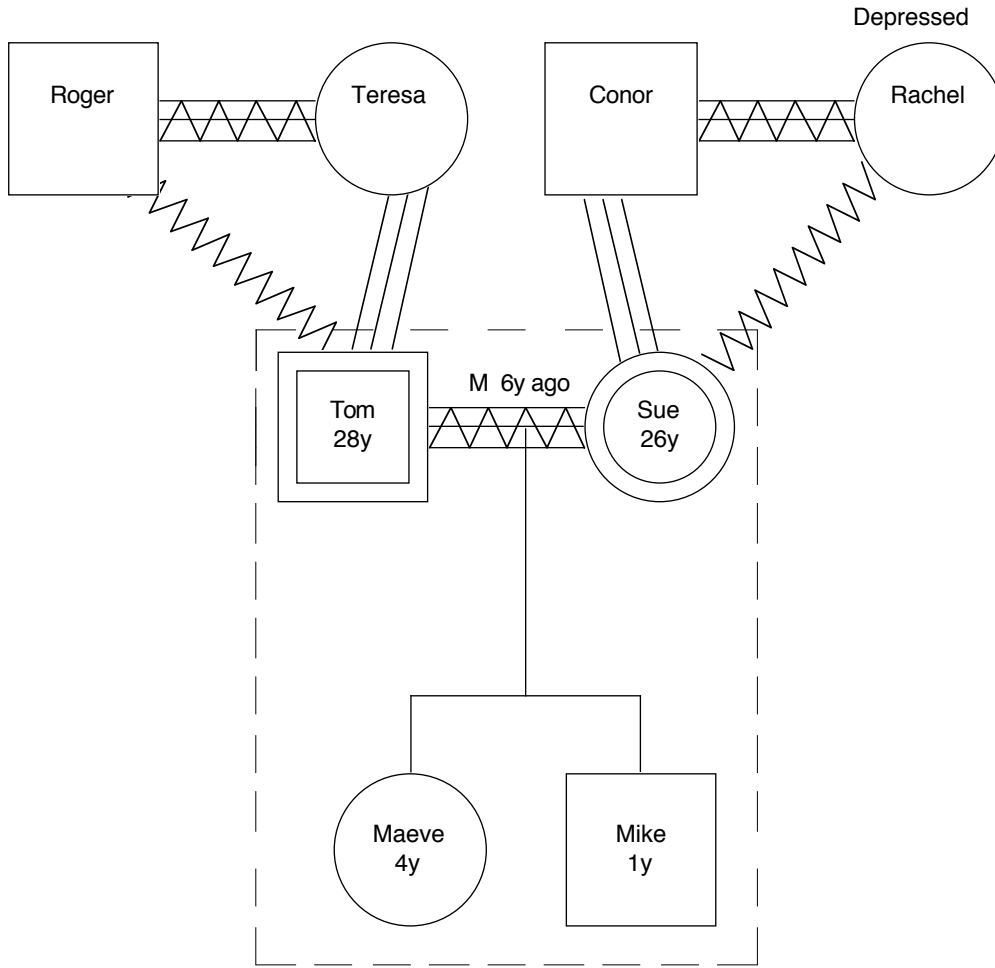


Figure 4. Stages of therapy

