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Constructing a Focal Formulation and Hypothesis in Family Therapy

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This paper is an account of the use of a focal formulation as part of a method of brief focal family therapy. The history of the focal approach is outlined and the concept of focal hypothesis examined. The theoretical basis of the approach is discussed by considering the way meaning in a family is expressed. Two forms of meaning are described: surface action, which is the current content of interaction, and depth structure, which is its context and is based in subjective history. A case example is provided to illustrate the application of the concepts, therapeutic implications, and the basis of outcome evaluation.

The Family Studies Group at the Hospital for Sick Children has been developing and evaluating a method of family therapy based on a brief focal approach. The initial phase, 1973-1976, consisted of pilot use of the method and systematic assessment of outcome in consecutive families brought to a specially convened workshop (Bentovim & Kinston, 1978; Kinston & Bentovim, 1978). This paper reports on the second phase, 1977-1980, which has concentrated on the conceptual rather than the empirical hurdles to the application and evaluation of our brief focal approach to families. The concepts are illustrated via a detailed case example: the Jones's; and we will introduce a system for laying out the essential details of a case: the *focal formulation*.

We now make a clear distinction between assessment and treatment techniques. This paper mainly concerns assessment. It discusses our clarification of the links between objective observation and interaction and subjective historical reports by the family; the conceptual confusion surrounding the use of the term *focus*; the refinement of the notion of *criteria of improvement*; and a potential typology implicit in the location of a crucial stress either in the family of procreation or families of origin.

Elsewhere we have discussed some of these matters with clinical examples (Bentovim, 1979; Kinston and Bentovim, 1981) and in another paper we will provide a protocol for recording the process of therapy from a focal point of view (Furniss et al., in preparation). This focal approach has been applied to specific problems such as a child sexual abuse (Beezley-Mrazek & Bentovim, 1981) and child care and custody cases (Bentovim and Gilmour, 1981).

DEVELOPMENT

A workshop was set up in 1973 to apply to disturbed families a methodology for shortening therapy and evaluating results (Malan, 1976a, b). This method had been developed for individual psychoanalytic therapy at the Tavistock Clinic and appeared relevant to family therapy. Table 1 compares the two procedures.

It will be seen from Table 1 that the pivotal feature is the clinical *focal hypothesis* which is developed to explain *all known disturbances* in the light of *family history*. The focal hypothesis was the reference point for therapeutic endeavours and the source of criteria whereby improvement could be assessed. The workshop attempted to develop focal hypotheses, form therapeutic plans and supervise treatment.

In 1975-76 we paused to review the method and study outcome in the twenty-nine families seen. Kinston and Bentovim (1978) reported brief details including hypotheses and criteria for improvement on every case and overall outcome. The symptomatic outcome for the identified patients was acceptable: 66% overall and 87% if families who

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TABLE 1

COMPARISON OF INDIVIDUAL AND FAMILY METHODS

	BRIEF INDIVIDUAL PSYCHOTHERAPY (after Malan (1976))		BRIEF FOCAL FAMILY THERAPY (after Kinston & Bentovim (1978))
A.	Basic Details —name, age, occupation —complaints	A.	Basic Details —name, ages, occupations, school —presenting problems
B.	All Known Disturbances —symptoms —relationships	B.	All Known Disturbances —symptoms of any member —observations of interaction
C.	Personal History —childhood experiences —recent events	C.	Family History —family life cycle —recent events —families of origin
D.	Focal Hypothesis to explain B in the light of C.	D.	Focal Hypothesis to explain B in the light of C.
E.	Criteria for the results of therapy	E.	Criteria for the results of therapy
F.	Therapeutic plan developed and implemented. Patient subsequently followed-up	F.	Therapeutic plan developed and implemented. Family subsequently followed-up
G.	Disturbances under B re-examined at follow-up	G.	Disturbances under B re-examined at termination and follow-up
H.	Assessment of results: compare E with G.	H.	Assessment of results: compare E with G.

failed to engage were excluded. The outcome for the family as a whole was less satisfactory, only 50% of engaged families showed any improvement.

Two other findings emerged: first, psychiatric illness in a parent was a poor prognostic sign; second, the greater the improvement in the family, the greater the improvement in the index child.

The research workshop and its findings deeply influenced our routine clinical work, and current policy is to consider every referral for brief family therapy. If this is judged appropriate, the usual intention is to provide between six and ten sessions over four to six months. The usual interval between sessions has been reduced from three weeks to two weeks.

Implementation of a clinical approach such as this had immediate teaching implications and so stimulated us to clarify our concepts, and tackle issues only touched on in our initial review. For example, we remarked (Kinston and Bentovim, 1978) that "the formulation of hypotheses ... appeared at times highly subjective and they varied in complexity and style" (p. 123). We also expressed particular concern as to whether, in the absence of the workshop, therapists could continue to perceive a significant focus. To further our efforts, the workshop was reconvened in 1979.

We found it necessary and possible to provide structure and definitions so as to put flesh on our initial model. We first clarified the use of the terms *focus* and *focal hypothesis*. This led us to the development of a *focal formulation*, by which we mean the systematic layout of relevant family details (A, B, C, and E of Table I). Use of the focal formulation with a series of families resulted in the discovery of a crisis-oriented typology (Reiss, 1980) of presenting families.

THE CONCEPT OF FOCUS AND FOCAL THERAPY

All forms of brief therapy use a focal approach, not just ours. Ursano and Dressler (1974) reviewed the literature and concluded that it was essential to place some delimited issue at the centre of the therapist's attention if therapy were to be completed in a matter of weeks or months. Much system-oriented structural and strategic therapy is highly focussed in this sense (Satir, 1967; Haley, 1971; Minuchin, 1974), and series of cases have been reported by Weakland et al (1974) and Leventhal and Weinberger (1975). Their use of the term *focus* has as its optical equivalent the placing of a magnifying glass over a particular part of the whole.

The term *focus*, as we use it, has as its optical equivalent the placing of a lens to bring clarity and definition to a whole pattern or image. Once the blurred confusion of the whole is precisely clarified, then some part of it may be examined in detail as indicated above.

Focus as used by most authors is intimately bound up with a therapeutic technique. Haley (1970) even argues that diagnosis and assessment are invidious and somehow anti-therapeutic. *Focus* as used by Malan and ourselves is a pre-therapy ordering of data, in other words, a clinical assessment. As such, it is distinct from and does not predict technique or treatability. Armstrong et al. (1979), for example, showed that focal hypotheses could be developed on patients assigned to behaviour therapy and the outcome of such therapy could then be assessed on psychodynamic criteria. Gurman (1978) pointed out that the practice of psychoanalytic marital/ family therapy is "largely 'analytic' in the way it organises the complex material at hand and conceptualises the nature of [disturbance], but is, of necessity, quite

pragmatic if not eclectic in its selection of actual therapeutic interventions".

In the initial phase, our therapists were relatively conservative in their application of therapeutic techniques. Currently, they are far freer and operate more flexibly with a variety of techniques that appear more suited to the needs of the family and less bound by dogma or anxiety. We have abandoned the term *focal plan* and now simply speak of a *therapeutic plan* with the understanding that its nature and implementation is an issue quite distinct from the assessment of the family.

A *focal hypothesis* is a clinical theory, developed ad hoc, to clarify or bring into focus a large number of disparate and, for the family, sometimes unrelated phenomena. These include the presenting complaint, reports of current events, the family history, family interaction, and family involvement with other social agencies.

It aims to integrate and provide continuity to these manifestations of the family in time and space. There are two crucial tasks in the construction of a focal hypothesis: the collection of the base of relevant data which the hypothesis is to explain (items A, B, and C of Table I); and the use of this data base to construct an hypothesis.

TABLE 2

COMPARISON OF COLUMNS OF THE FOCAL FORMULATION WITH THE ITEMS IN THE ORIGINAL METHOD (KINSTON AND BENTOVIM, [1978])

ORIGINAL METHOD	FOCAL FORMULATION
A. Basic Details	
—names, ages, occupations, school	Column 1 Family Composition
—presenting problems	
B. All Known Disturbances	Column 2 Current Complaints
—symptoms of any member	
—observations of interaction	Column 7 Surface Action
C. Family History	
—family life cycle	Column 3 Family of Procreation Events
—recent events	
—families of origin	Column 4 Family of Origin Events
D. Focal Hypothesis to explain B in the light of C	The focal hypothesis is a condensation of the whole assessment and does not appear within the assessment.
E. Criteria for the results of therapy	Column 8 Criteria for Improvement
(Something similar to the contents of these columns often appeared in the focal hypothesis.)	Column 5 Handling of Stressful Events
	Column 6 Active Meaning System

CONSTRUCTING A FOCAL FORMULATION

To order and restrict the amount of data inherent in family assessment, and to assist with the construction of a focal hypothesis, we have developed a specific layout called the "focal formulation". The connection between the focal formulation lay-out and the format in Table 1 is shown in Table 2.

The focal formulation lay-out is designed to fit on two A4 pages laid side by side, each page having four columns (See Table 3). The pages can be folded at the join to fit into A4 case notes, or reduced in size with a Xerox duplicator to a single A4 page. These eight columns permit a concise lay-out and reflect the logic of the assessment. The horizontal lay-out permits some of the individuals' components to be displayed.

The focal formulation is not a substitute for a full diagnostic work-up but an arrangement of the salient features. We will use the example of the Jones family to explain the formulation. The full conventional assessment summary of the Jones's as extracted from the case file is presented below. Names and some identifying features have been altered.

ASSESSMENT SUMMARY (January, 1980)

JONES FAMILY

Referred Patient:
Richard Jones, age: 7 years.

Referral Agency:
General Practitioner, because of Richards' disruptive behaviour at home and at school.

Family:

Mary: Mother, age: 30 years, housewife. Attractive woman with long blonde hair. Main spokesman for Richard, but often appeared reticent when other topics were being discussed. Somewhat cold in her manner.

Bob: Father, age: 34 years, runs own small electronics business. Slightly rotund man with a very friendly, open manner. Eager to co-operate and provide information. Joked.

Richard: Age: 7 years, referred patient. Attractive boy who appeared very wary and rarely answered direct questions. Spent most of the time drawing in a solitary way, occasionally squabbling with John.

John: Age: 4 years.
Attractive boy, much less inhibited than Richard. Spent time drawing but also joined in interview and readily interacted with other family members and the interviewer.

The family live in their own three-bedroomed house and there are no financial problems.

Presenting Problem:
Richard's behaviour. The problem was presented mainly by Mother who was extremely harsh and critical, but also appeared somewhat detached and unemotional. She complained that:

— Richard often does not respond or answer questions (even simple ones), but looks puzzled, cut off, stupid. This aspect of his behaviour is what annoys Mother most and she feels he does it to provoke her.
— He lies or tells half-truths so that they cannot rely on anything he says.
— He is defiant and often refuses to do what he is asked.
— He has frequent tantrums and screaming rages, to the extent that neighbours have complained or called to see what is wrong.
— He is restless and cannot concentrate on any one thing for any length of time.
— He is making very poor academic progress at school and can be very disruptive in class.
— He cannot get on with John, is jealous and always causing fights between them.
— He has very few friends.

Mother claimed that she was absolutely fed up with Richard and that she wished she did not have to see him. She feels he is deliberately getting at her. Father at first defended Richard to some extent and stressed he could be good and was very affectionate at times (Mother dismissed this as 'ingratiating' behaviour). He got on better with Richard but also found him difficult to talk to. Father also considered that Mother sometimes provoked Richard into showing difficult behaviour, and tended to play down his wife's rejecting attitude. He also felt she could get to like him more, to which his wife responded that she felt this would never happen and indeed, that she did not want to like him. She felt comfortable not liking him, and only wanted his behaviour to change. However, Father also backed up his wife, especially when challenged by her, and agreed Richard was extremely difficult. He became more critical and aggressive as contact with the family lengthened.

John, in comparison, was reported to be a very good boy with whom both parents have a good relationship, and who is very easy to manage.

Recent Physical and Emotional State:
General health: good;
Eating, Sleeping, Elimination: no problems;
Emotions, Temperament, Relationship with peers, siblings, parents: already reported (as stated by parents);
Relationship with other adults: poor;
Many antisocial trends;
Present school: doing badly, academically and socially, disruptive in class.

Personal History:
Pregnancy: unwanted (by mother), unplanned, conceived before parents married. Mother had secretly sought an abortion (Father previously unaware of this and visibly shocked). Vomited very much during pregnancy and felt terrible.
Delivery: 40 hour labour, difficult but normal birth. Bottle fed. Always a troublesome infant, vomited most of feed until he walked.
Milestones: walked early (before 1 year); first words early (six months), but slow progress until recently and occasionally still gets words and word order muddled. Not out of nappies until he was four years old. No separations.
School report: average I.Q. but underachieving; difficult, disruptive and aggressive in class. Attention-seeking, prefers one-to-one relationship with teacher, requires constant discipline. Becomes withdrawn if asked questions. Relates very little to other children, can be spiteful.

Family Life and Relationships:
The family lives in a comfortable house. They have little to do with neighbours and rarely go out ('because nobody will baby-sit for Richard'). The parents feel they get on very well with each other and that they have a lot in common. Mary does get bored at home and wishes she could go out to work; Bob is setting up a subsidiary company which she will manage. Both parents get on well with John but both find Richard exasperating and impossible to handle. Father has the more positive relationship with Richard and stresses he can be good and affectionate. Mother cannot stand being with Richard for any length of time and often feels like harming him. The parents have tried a great variety of tactics to deal with Richard, all with no success. Recently Mother has suggested that Father will have to choose between her and Richard, one of them must go.

The parents feel they communicate well with one another, although Bob feels Mary is over-sensitive to criticism and at times he is frightened of her anger. Mary feels Bob sometimes does not listen to her or understand her feelings.

Richard and John get on badly and cannot play together without fighting. This is seen as the result of Richard's jealousy.

Family life seems to be dominated by the problem of Richard. Mother feels he is constantly goading and exhausting her, and both parents are continually discussing him and actively disciplining him. They do not go out as he cannot be left with a baby-sitter (except occasionally MGM) and they live in fear of neighbours calling round to enquire what is happening when Richard has one of his screaming rages. In addition Father is preoccupied with his wife's ultimatum that he must choose between Richard and her.

Family History:

Mother: Mary (30 years). The eldest of four children, (two sisters, one divorced, one single; one brother: single and living in parental home). MGM and MGF both alive but divorced.

Mother never got on with MGM and feels she has never been close to her. She was, however, very close to MGF and was his favourite child. When Mother was aged five her relationship with MGF included overt sexual interaction which she remembers very warmly. This abruptly stopped when MGM found out, and shortly afterwards MGF disappeared (she later found out he had been sent to prison). Mother herself then went to hospital (aged 7 years) for three years because of fits. During this time she saw MGM regularly but really wanted MGF (who only visited twice). Mother has had no fits since this admission.

When Mother returned home MGF had gone, and it was only later she found out her parents had separated and divorced. She found it difficult to get to see MGF and blamed MGM for this. (Recently Mother discovered that after she had left home her parents remarried, only to divorce again two years later.) Mother found it difficult to settle at home after her time in hospital and had frequent rows with MGM. She remembers her adolescent years as stormy, and she twice ran away.

At 17 years Mother married, largely to get away from home. She describes her first husband (Derek) as a weak, lazy man; dominated by his own parents. He was often out of work and everything was left to her to do.

Children:

1. Jeremy (b. 1967) conceived after the marriage. Unwanted but Mother felt pleased during the pregnancy and looked forward to the birth. The baby had meningitis when a few days old and was separated from Mother for two months. Subsequently he was unresponsive and slow and later diagnosed as brain-damaged. Mother began to resent him and to wish he wasn't there. When Jeremy was 17 months she dropped him and his head fell on a stone step. He died almost immediately of a brain haemorrhage. Mother felt guilty for a while but does not think she was responsible. She feels she has never got over this shock, and that it took about 2 years to 'put it behind her'.
2. Sam (b. 1969) unplanned, unwanted. 3 months old when Jeremy died. A normal, happy baby; but reminded Mother of Jeremy and consequently he was put into foster care at age 1 and later adopted (aged 2 years). Mother has not seen him since he was 1 year old.
3. Julie (b. 1970) unplanned, unwanted. When she was 3 months old the parents separated. (The marriage had been steadily deteriorating and they had been evicted from their flat due to non-payment of rent.) Derek returned to his own parents' home, taking Julie. Mother returned to MGM. Mother had visited Julie once in the intervening nine years ('out of curiosity'). She does not plan to see her again.

Currently MGM lives locally but Mother still does not get on with her very well and she has to be paid to babysit. Father sees her as strange and stupid. Mother has not seen MGF since 1972 and is sad about this. She has tried to make contact only to be rebuffed, but feels this is understandable in that he has 'put the family behind him'.

Father: Bob (34 years). The youngest of three

children, (two sisters: one married, one divorced). PGF: alive and well. PGM: died five years ago.

Father remembers his childhood as very happy, albeit poor. His family was working class but both parents worked very hard to provide for the children. He describes both PGM and PGF as wonderful parents and feels very grateful to them. The expectation was that he would do better than his own father, who worked in the shipyards, and he went into the forces to learn a trade. He has done well and is very proud of his achievements and of escaping his impoverished background.

Father was very upset at the death of PGM five years ago, and explains the conception of John as a consequence of this loss. He sees PGF regularly and still gets on well with him.

The Marriage: Bob and Mary met at a party in 1972. From that evening they saw each other every day although neither wanted a serious relationship. Both feel that they are very similar to each other, even having the same birthday.

They started living together (Mary was awaiting her divorce) and Richard was 'accidentally' conceived during this time. Bob was delighted but Mary did not want a child and secretly sought an abortion. After Mary's divorce came through they suddenly decided to get married, although neither had planned for this. Bob's hopes were that they would 'live happily ever after', Mary's that it would 'work out this time'.

Mary never liked Richard and immediately felt trapped at home by him. Bob has always hoped this situation would improve with time. John was conceived after the death of PGM and Mary feels that Bob used this emotionally charged situation to persuade her to have another baby. Both parents have a good relationship with John.

They feel that it has been, and still is, a successful marriage. They get on well together and get over their occasional rows. However both have thought of leaving and, on one occasion, Bob packed his bags to leave. They blame Richard for their own arguments and disappointments and regard him as the only problem in their relationship.

Family Interaction:
(See Loader et al, 1981).

Atmosphere: Uncomfortable and tense. Humour is used (especially by Father) but mainly to cover nervousness and to relieve tension between the parents. Interactions are mainly supportive regarding John but both parents frequently get caught up in very negative, attacking interactions with Richard.

Communication: Clarity is good (except Richard occasionally mutters), but topics are rarely developed as this is disrupted by Richard's oppositional behaviour and/or his parents' attacks on him. Indeed Richard is rarely involved except during these times. Communication is dominated by control messages and criticism from the parents to Richard. When talking to each other the parents appear to become uncomfortable, uncertain and secretive.

Affective Status: Anger is the dominant feeling. Parents: express anger directly at Richard. Richard: passively aggressive, more indirect.

Boundaries: Family members are somewhat disengaged from each other (Mother and John appear closest), but both parents become intensely involved with Richard during attempts to discipline him. At other times he withdraws and is actively excluded.

Family Operations: Conflict resolution is poor, and the parents do not sort out their own differences. Decision-making often appears an unclear, arbitrary process, with one parent eventually taking unilateral action. Problem-solving ability: poor. Problems are attempted but any progress is disrupted by the repetitive negative interaction between Richard and his parents.

Alliances: Richard is triangulated with his parents. The main alliance is between the parents, one of whom (Mother) has a constantly conflictual relationship with Richard, the other (Father) being, at least occasionally, more positive and supportive. Despite their overt alliance the marital relation-

TABLE 3

FOCAL FORMULATION FOR THE JONES FAMILY

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7	Column 8
		Stressful Events Salient Features and Circumstances					
Family Composition	Current Complaint	Current Family	Family of Origin	Handling of Stressful Events	Active Meaning System	Surface Action	Requisite Criteria for Improvement
Father, Bob, 34. Own business — computer systems.	Sees some good in Richard, but very critical. Fears that Mother or Richard will have to leave the family.	Father reluctant to marry, but saw Mother as 'identical'. Now has vasectomy and parents are never separate.	Close, caring impoverished working class. Expected to achieve more than PGF.	Overcoming by leaving past behind.	Anything can be overcome. Past is meaningless. Present has to be clung to.	Marital negative feelings and conflict avoided and detoured onto Richard.	Parents to speak directly and openly to each other including handling conflict.
Mother, Mary, 30. Own company in father's company recently.	Cannot stand Richard. Wants him to be good, but does not want to like him.	Mother met father when in the process of divorce; reluctant to marry.	Mother enjoyed sexualised relationship with MGF. MGF imprisoned (? why) when Mother aet. Mother in hospital 7-10 for "fits". MGP divorced. Mother had a disruptive, stormy adolescence; poor relationship with MGM; married at 17.	Loss dealt with by denial, cutting off and replacement. Attempt to overcome threat of marital break-up by depositing on child.	Relationships between mothers and children cannot work; between fathers and children are the strongest. Children can break up marriages.	Atmosphere of secrecy.	Accurate perception of Richard, good and bad. Richard's not to be triangulated.
Richard, 7 Primary school.	Unresponsive, defiant disruptive, temper tantrums. Few friends and poor school progress.	Unplanned; unwanted by mother; father delighted. Very difficult pregnancy and labour. Mother uninterested. Difficult infancy, 'vomiting'.			Good people are intelligent and use their potential; bad people are stupid and fail.	Richard triangulated through mother's rejection and father's covert acceptance, despite overt criticism.	Richard's behaviour is to improve and he is to invite rejection less.
John, 4 Nursery School.	Richard jealous of him. Is a good boy.	Conceived following PGM's death; Mother felt tricked, but wanted him. Seen as opposite to Richard.	First husband was lazy and helpless. 3 children — all unplanned. Jeremy was wanted; had meningitis — retarded; died at 17 months after being dropped by mother. Sam — fostered at 12 months; resembled Jeremy. Julie — with her father since eviction and separation when 3 months.			John does not help Richard.	John to be described and related to realistically. Richard and John to relate more closely and age — appropriately.

ship appears fragile and the parents work best together when united in the management of Richard. In contrast both parents have a positive relationship with John. The two children are rivalrous and rarely play with each other.

Parental Function: This appears adequate with regard to John but is certainly deficient for Richard. Both parents (but particularly Mother) have great difficulty perceiving him accurately and are unable to adapt to his needs. Parental support is inconsistent and often lacking.

Relationship to the Environment: Detached frankness with interviewer. Generally guarded and suspicious of outsiders (e.g. regard neighbours as intrusive and to be avoided). Few friends, no involvement with the local community.

Having carried out a conventional assessment, the family therapist's task is to construct a focal formulation and focal hypothesis. The focal formulation of the Jones family is laid out in Table 3.

In Column 1, **Family Composition**, the current members of the family are listed with their Christian name, age, occupation/school, special status (e.g. adopted, fostered, cohabiting, etc.) and identifying features. Conventionally, the order is father, mother, children in descending ages. It may be clinically relevant to include extended family, or others who are actors in the family's problem. In the Jones family the mother was previously married with children but it seemed better to put these details in Column 4, **Family of Origin Stress.**

In Column 2, Current Complaints, we note the problem that brought the family to treatment. In this case, it was Richard's behaviour. Other complaints and individual problems related and unrelated to the index patient, are included here. The most important was Mother's cruel rejection of Richard.

Columns 3 and 4 describe the **Salient Circumstances and Stressful Events** affecting the family. Column 3, **Family of Procreation**, considers problematic phases in the family's life cycle and describes any particular stressful occurrences. Often these can be linked to particular individuals, e.g. the parents' different perspectives on their marriage were significant for the Jones' and could be placed in the respective horizontal line; while the conflicts and problems around Richard's and John's infancy were written in at the level of their names. Similar considerations apply to Column 4, **Family of Origin**, but generally the horizontal pattern is broken here.

Column 5, **Handling of Stressful Events**, describes the mechanisms which the therapist hypothesizes are being used by the *family members* to deal with the stressful experiences described in Columns 3 and 4. These accounts stay close to observation of the family culture and interaction but, unlike previous columns and column 6, might not be agreed upon by the family. In the Jones family, painful and disastrous past events were dealt with in pathologically defensive ways. In this and subsequent columns, horizontal correspondence is partial and used as a clinical guide to relevance.

Column 6, **Active Meaning System**, refers to current family beliefs and rules which are more or less explicit and characterise the family, and which relate to the previous columns. The family members express these readily and often endorse them if they are fed back appropriately. For example, no matter how bad things were, these parents repeatedly insisted that they could be overcome.

Column 7, **Surface Action**, contains the therapist's observations of family interaction including their verbal reports of home life. As in column 5, the family members might be reluctant to accept these descriptions. The use of Richard to avoid marital conflict was blatantly obvious but not acknowledged by Bob and Mary.

Column 8, **Criteria for Improvement**, lists the therapist's view of what form of interaction and family life would be requisite in the light of the particular problems being faced. The most important change for the Jones would be the parents' accurate perception of Richard whose behaviour should invite rejection less.

The therapist's task is to develop for himself a focal hypothesis, a brief statement, which condenses and captures the essence of this formulation. Before we offer a sample hypothesis for the Jones's, we need to explore the theoretical base for our approach. Data will only become recognisably relevant to this approach in the light of a theoretical understanding of the problem.

FORMS OF MEANING

The basic principle is that meaning is intrinsic to psychological and social activity (Hinde 1979; Winch 1958). In other words the therapist must always be considering the intentions, hopes, feelings, values, beliefs, wishes, fears, expectations and ideas associated with family activity. For our purposes we need to distinguish between *surface action* the overt activity, themes and meaningful experiences which characterise a family; and the *depth structure*, the historical basis of current family life and the underlying patterns and rules of belief

and expectation. This depth structure is the context which gives meaning to the surface action.

Surface Action

The clinician observes the family interacting and hears their reports of themselves and episodes from their family life. Sensitive understanding of what he sees requires the placing of behaviour in its current context. The therapist uses social conventions and norms of the man-in-the-street to ascribe meaning to many of the actions, and identification and empathy to become aware of the surface experience.

The surface action in the family includes the symptom or presenting complaint, usually a disturbance in behaviour or a dysphoric experience, and the overt patterns of interaction and events of family life. This is often referred to as the *family system* or *family state* (Kinston et al, 1979). The task of the clinician is to determine certain salient and characteristic features of the system. As described in Kinston and Bentovim (1981), these are pathological patterns of surface action, which have a number of well-defined characteristics.

1. Extreme repetitiveness; often to the point of defining the family or distracting the clinician from a recognition of family strengths.
2. Independence from external events and the needs of family members: these patterns of surface action are set off apparently for trivial reasons, or even haphazardly.
3. Circular causality: the patterns require the collusive involvement to a greater or lesser degree of all members of the family, and are self-maintaining because each segment of interaction leads on to the next and finally back to itself.
4. Compulsive production: the family cannot inhibit the pattern and simple requests to the family to cease the interaction cannot be complied with for any significant length of time.
5. The pathological patterns have a dominating and urgent quality which overrides the consequences.

These clinical observations have been reinforced by studies of research interviews in which the family is asked to perform a number of tasks (Kinston et al, 1979). The pathological surface action appears almost immediately during the interview and reappears with the presentation of each task. Quantitative work supports this clinical impression (Jacob and Davis, 1973; Zuckerman and Jacob, 1979). Characteristically in these latter studies the measured surface action is clinically remote e.g. number of speeches, attempted interruptions. By contrast, the surface action noted in our interview is directly relevant to clinical work.

> *When our Family Task Interview was administered to the Jones family, the following features were revealed. The parents, awkwardly and with difficulty worked with each other. John was included and attempted to help his parents, but Richard was excluded. When Father attempted to involve Richard he refused to join in and behaved in a frankly negative manner. The parents then joined in an increasingly critical approach to Richard. As he became more withdrawn and oppositional, the parents were provoked to more bitter attacks on him, and the cycle escalated. John, meanwhile remained a good boy and did not aid Richard, who was eventually written off as bad and unhelpful. Performance of tasks was severely disrupted by this scenario which was repeatedly observed during the interview and appeared to be uninfluenced by the nature of the particular task.*

However, families do not usually get referred for system dysfunction but for a symptomatic individual or following a gross inability to deal with some particular stress. The recognition of family dysfunction depends on what the therapist expects. This will be influenced by the physical, personal, social and cultural contexts of the family.

Beyond Surface Action

The clinician need go no further than recognising pathological patterns of surface action. He can claim to have a focus for work, focus in the sense of a delimited object for therapeutic attention. The therapist working with the Jones family initially chose the poor relationship between Mother and Richard as such a focus. However, there are a number of puzzles remaining if the clinician wishes to notice them. How does the family come to act in this particular fashion? Why does the family not switch to a more productive self-maintaining system? Why does the family not notice its own repeated patterns? These issues are often crucial to therapeutic efforts.

The response to such social puzzles involves *interpretation*, in other words an account is provided to make sense of them. To say that the family system requires interpretation is to claim not only that the interaction is in some way puzzling or confusing, but also that it occurs within a coherent field of meaning within which the puzzle might be resolved or said to make sense. The relevant field of meaning is the temporal context: surface action may be explained using the family history as

subjectively reported. This making sense must be valid for both the family members and the clinician. Any interpretation, no matter how good, which is not meaningful to the clinician is therapeutically useless. Similarly, the family members must accept the interpretation at some point if it is to be useful.

The clinician does not necessarily administer interpretations formally but his every statement and action will convey an unspoken, even unformulated, account (or explanation or meaning or sense — all these terms are sufficiently synonymous with interpretation).

In the technique of reframing, for instance, the therapist provides an alternative explanation of family events. This is possible because there is no one-to-one correspondence between the surface phenomenon and its explanation. A number of interpretations may underly a surface pattern and a number of surface actions may emerge from a particular account. It is our view that the depth meanings make up the family culture and do not readily change. It is to this depth structure that we must now turn our attention.

Depth Structure

A culture is the network of ideas (belief, values, etc.) which are embodied in the actions of individual and in their arrangements for functioning together. The family is a group of interacting individuals and a social unit, both of which develop through time, and it has its own culture. Family culture influences role expectations of members, interpersonal behaviour and the individual's perception of reality. Each member experiences the culture via common and intersubjective meanings. Understanding these experiences and the culture requires an appreciation of history. The significance of history in the current conflicts of people and social groups leads to theoretical models which employ the concept of structure to describe processes which repeat over time.

Common meanings are rooted in the psychic lives of the individual family members. Each member has a private world of experience, much of which is not directly relevant to the concerns of other family members or the family therapist. Each parent has, however, certain core meanings which are shared at the time of marriage and develop in common afterwards. When children appear, they assimilate and contribute to these. These common meanings are exchanged and shared unconsciously as well as by example and instruction, and include beliefs, values, attitudes, sentiments, fears, expectations, wishes. They are the root of belonging, loyalty, and cohesion within the family. Common meanings are essential for comfortable communication, pleasurable sharing of activities, and tolerance of each other's pain. They are the basis for *consensus* and conflict-resolution, and permit a coherent response to the environment. When a member leaves the family, he does not disrupt the system of common meanings; and he can and will use them in the creation of a new family. Disturbed families may show a lack of common meanings in relation to some particular issue, or excessive devotion to dysfunctional common meanings.

Intersubjective meanings are also the property of each member, but they depend upon relationships in the family and so are rooted in the family as a whole. The intersubjective meanings depend on the interlocking experiences and meanings of all members of the family. If a member leaves the family then this system is disrupted. The member who leaves can only recreate a particular intersubjective reality with the assistance of other willing people. In their absence he feels that something is missing. The part family that remains must endeavour to find a substitute for the lost member or restructure itself. At the family level of description we may say that a form of family organisation reasserts itself but with different members taking on different roles (Jackson, 1957).

Common and inter-subjective meanings interact: strongly held interests, values, fears, etc. will lead to the creation and stabilization of certain forms of family organisation, and particular forms of organisation can become shared experience as part of the self-definition of the family. As a result, experience within a family has characteristics of its own and its description in individual terms (for example, via the concepts of externalisation or projective identification) blocks investigation and is unnecessarily reductive. It has been noted, for example, that members of healthy families appear weaker when seen separately at interview, while in poorly functioning families separate interview reveals strengths (Lewis et al, 1976). This suggests that the family culture has an obscuring effect on members' psychological characteristics. The world of meaning for an individual is that of "psychic reality" (Laplanche and Pontalis, 1973). Family culture is the equivalent for the family: apparently similar concepts used by other authors include "family matrix" (Ackerman, 1958), "family identity" (Wolin et al, 1979), "family reality" and "family myth" (Byng-Hall, 1973).

The repetitive and apparently meaningless patterns of pathological surface actions thus acquire a deep foundation and meaning in the context of common and intersubjective meanings revealed by

the family histories. The family history of clinical significance is that reported subjectively by the presenting family, particularly in the light of stressful events, and the way that these were handled.

FAMILY STRESS: A CLASSIFICATION

The recognition of an event as stressful depends on already existing meaning systems based on urges for survival, well-being and attachment. Other meaning systems are necessary for the psychological handling of stress and the activation or inhibition of action. Both the recognition and the resolution of stress are frequent, mainly unconscious, experiences. Systems of meaning develop during childhood and subsequently undergo relatively minor modifications. Alteration in adulthood can be brought about through psychoanalysis and has also been noted following massive trauma (Kinston and Rosser, 1974).

For our purpose we refer to the parents and children who present for help as the Family of Procreation (FoP), and the previous generation (grandparents, parents and siblings of parents) as the two Families of Origin (FoO). In the Families of Origin, the parents obtained personal and family life experiences which results in their developing unique systems of meaning (psychic reality). Marital choice depends on both similarity (common meanings) and complementarity (intersubjective meanings) drawn from the partners' psychic realities. Children are born into this marital reality and immediately alter it. Events which occur in the Family of Procreation have minimal adverse effects on the children if the parents can sustain the mental impact and connote them positively. Children cannot be totally shielded from traumatic events and the healthy processes of acceptance, integration, resolution and working through of meaning are usually incomplete in childhood and are the basis of vulnerability to stress in adulthood.

Our experience leads us to propose, tentatively, a classification of stress, meaning and surface action in families who attend our clinic. It appears possible to distinguish families where the relevant stress is experienced in the families of origin, from those where attendance is related to an event in the family of procreation. In other cases the presentation implicates both the families of origin and procreation. This may be because events in the previous generation have so affected matters that events in the family of procreation are precipitated, or because family of procreation events have activated buried, but not dead, family of origin issues.

CONSTRUCTING THE FOCAL HYPOTHESIS

The notions discussed in the previous section underpin the way in which the focal formulation was completed for the Jones family and indicate the logic of its lay-out. The therapist is initially confronted by a family with complaints (Cols. 1 and 2). In order to make sense of these he takes a history (Cols. 3 and 4) and observes recurrent pathological patterns of meaning (Col. 6) and interaction (Col. 7). Column 5, the method of handling the stressful experiences, highlights the integrated nature of the focal approach. It is often difficult to know which surface actions are salient without the detailed history. Similarly, to decide which historical events are stressful requires looking for possible sequelae and the use of pathologically defensive operations.

In the Jones family the crucial stress site was the family-of-origin of the mother, in which the father-child relationships competed with the marital relationship. The child (now the mother in the family of procreation) saw this as resulting in her going away to hospital for three years, divorce of her parents, and loss of the father. The stressful events in Mother's previous and current marriage and family are seen as consequent on the primary FoO stress rather than a crucial FoP stress, although they certainly compounded the original stress.

Both parents' method of handling stress depends on overcoming by leaving the past behind. For Mother this is seen in the handling of her losses by denial, cutting-off and replacement. Father uses similar mechanisms: he explained John's conception as a consequence of his own mother's death (replacement); and described how he had overcome his past by leaving his working class background behind.

This pattern of past events and their handling is at the root of the active meaning system in the family of procreation. There are powerful common meanings that the past is meaningless, the present is all that matters; and that being stupid equals being bad. In addition there are intersubjective meanings resulting from the interaction of attitudes prevalent in families of origin. When the parents were requested to choose a proverb and explain it to the children, Mother chose 'Let sleeping dogs lie' whilst Father selected, 'If at first you don't succeed, try, try and try again'. This clash of complementary beliefs resulted in an intersubjective arrangement in which Mother wrote off Richard and left all the trying to Father. Mother then had a basis for her ultimatum that Father must choose between her and Richard. In such a culture, parents cannot cooperate or resolve conflicts.

Richard's behaviour, the presenting problem, can thus be seen as his part in a repeated family scenario, the surface action, which itself represents the family's attempt to overcome the threat of a marital break-up due to a competing parent-child relationship, the depth structure. They are doing this by extruding the 'bad' child. Richard is the fourth child in this position and we would predict that if he was extruded, it would only be a short time before John became the problem child.

The therapist can sum this up in a focal hypothesis as follows: *the family is extruding Richard so as to overcome a marital break-up as occurred in the family of origin due to a competing parent-child relationship*. It can be seen that this sentence contains elements from all the columns.

CRITERIA FOR IMPROVEMENT

Because the focal formulation and hypothesis integrate the pathologically relevant surface action and deep structure of family life, it is a useful base from which to lay down criteria for the assessment of changes in the family. These criteria are suitable for research use: they can be laid down before the institution of therapy and can be used by "blind" assessors at follow-up. Symptomatic or systemic alteration is always desired, but this may reflect a "false" solution or only a partial solution to the central problem. Examples of this were provided in our early paper (Kinston & Bentovim, 1978).

The healthy family works through and grows via the resolution of stressful events. The families who come for treatment have found inappropriate solutions to such events based on avoidance, depositing or enactment (Kinston & Bentovim, 1981). These solutions are growth-inhibiting and interfere with a flexibly responsive mode of interaction. The family's situation worsens as a by-product, in other words, pathological surface action is simply a cost sustained in the pursuit of other goals. In order to deal with some particular aspect of human experience, the family finds itself caught in a pattern in which the essence of human experience may be lost.

The issues which family members may have difficulty dealing with run the gamut of human experience: commitment, intimacy, loss, authority, separation, painful affects, individuation, disappointment, change, historical reality. When the avoided issues are confronted therapeutically, possibilities open up and the family can regain control and a sense of order and progress.

Ascertaining whether avoided issues have been faced and resolved requires a return to the level of surface action, and sensitive clinical judgement of changes. The aim of therapy is not to play around with abstract notions but to promote actual changes in family life. Consideration of the underlying meaning structure of the family makes it possible to specify, within broad limits, changes in family interaction which are suitable and desirable for that particular family. We call such surface action *requisite for the family* to avoid the danger of specifying some normative ideal interaction to which all families might be expected to conform. In the Jones family the criteria for improvement are listed in Col. 8 (Table 3).

The criteria for improvement do not have the explicit detail of targets for change because of the open-system nature of the family. A variety of forms of surface action may contain and express the therapeutically achieved resolution or expression of underlying meaning. Clinical judgement is therefore necessary to decide whether the change in interaction following therapy actually meets the criteria for successful outcome. Inevitably family reports of how they feel and what they think are important evidence, as is the current family interaction and actual episodes of family life.

These criteria are essentially objective, as they are socially sharable events. They can be used with any modality of treatment or in association with any theoretical stance. They may be initially unknown, unnoticed or unimportant to the family, unlike the symptom or change targets, and so can sometimes provide stringent and convincing evidence of therapeutic effect.

IMPLICATIONS FOR THERAPY

Therapeutic effectiveness depends on the meaningfulness of the intervention. This holds even for paradoxical and behavioural prescriptions. The formulation provides a context within which any intervention, structural, psychodynamic, communcational or strategic, may be considered. In addition it highlights a variety of potential approaches. It does not prescribe or proscribe any particular plan, tactic or technique.

The formulation also open up different ways into the family for the therapist. He may choose to work on the complaint, on the vicious circles, on modes of handling stress, on the events themselves or on some combination.

In the Jones family the therapist had initially used a structural approach (Minuchin, 1974). He attempted to de-triangulate Richard from the marital sub-system and to encourage a more positive relationshop between him and his mother. When this proved unsuccessful he tried to utilize Father's more positive attitude and to increase his involve-

ment in Richard's management at home. At this point the situation deteriorated; both parents complained that Richard was totally impossible and he would have to be taken into care. An attempt to focus on the marital relationship was dismissed as irrelevant. Both parents considered the marriage to be successful; and the only problem to be Richard. Somewhat in desperation Richard was admitted to the psychiatric in-patient unit at the Hospital for Sick Children. On the ward he was difficult, often behaving in a manner that invited anger and rejection, but he also showed many positive qualities and was well-liked by the unit staff. He went home at weekends when his parents, particularly his mother, continued to find his presence almost unbearable although it was often difficult to elucidate what provoked this extreme reaction.

It was while Richard was on the in-patient unit that a full family history was taken and the focal formulation constructed. In the light of this the therapist modified his approach to the family. He emphasised the similarities between the way Richard was currently behaving and Mother's own past experiences (e.g. her not getting on with her own mother, going away to hospital at seven years of age, the break-up of her parents' marriage). His behaviour was also positively connoted and reframed as an attempt to help his parents, just as Mother had tried to help hers. This new approach appeared immediately meaningful to the family. Mother clearly stated she did not want Richard to go through what she had been through, and both parents expressed their wish for him to come home. The relationship between Mother and Richard improved although she still found it difficult to be with him for any length of time. The parents started to discuss issues, including their own relationship, more openly with each other. This shift allowed the therapist to carry out some work on the sensitive issue of loss, with regard to the death of Jeremy, and the loss of Mother's father. Although Mother remained very guarded, this work proved helpful in putting her and her husband more in touch with her past. Mother became able to admit she was terrified her husband would leave her, and that Richard was a testing ground for his allegiance.

In terms of the outcome criteria the parents are now able to speak more directly and openly to each other, and they can face their own differences and conflicts. Richard is triangulated into the marital relationship less often, and the issue of Father's cross-generational choice between his son and his wife has been dropped. Father's perception of Richard is more accurate and he is able to support Richard appropriately. Mother's perception of Richard remains distorted but is more accurate than previously and she is able to let Father deal with him without feeling threatened. John is no longer seen as 'all good' and the two boys are not viewed as extremely different. At the time of writing Richard has been back at home for three months after discharge from the in-patient unit. He is less inviting of rejection and is managing well at school. The parents are making plans for their first ever family holiday. There are still serious problems but progress does seem to have been made.

CONCLUSION

In this paper we have described a clinically useful method for systematically assessing the family and recording the findings. The plethora of family data is organised within a focal formulation. This formulation is grounded in a view of the family as having a culture patterned by meaning and action. The focal hypothesis is a brief statement which captures the essence of the focal formulation and serves as a beacon guiding the therapist as he becomes involved with the specifics of family work. This method has implications for therapy and research. It allows evaluation of any changes in the family as a whole to be made in a relevant, objective and individualised way.

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REFERENCES

Ackerman, N.W., 1958. **The Psychodynamics of Family Life**, Basic Books, New York.

Armstrong, S., Yasuna, A. and Hartley, D., 1979. "Brief psychodynamic psychotherapy: Inter-rater agreement and reliability of individually specified outcomes", Paper presented at European Conference of Society for Psychotherapy Research, Oxford.

Beezley-Mrazek, P. and Bentovim, A., 1981. "Incest and the dysfunctional family system", In: Beezley-Mrazek, P. and Kempe, C.H. (Eds.), **Sexually Abused Children and their Families**, Pergamon, Oxford.

Bentovim, A., 1979. "Towards creating a focal hypothesis for brief focal family therapy", **J. Family Ther.**, 1: 125-136.

Bentovim, A. and Gilmour, L., 1981. "A family therapy interactional approach to decision-making in child care access and custody cases", **J. Fam. Ther.**, 3: 65-77.

Bentovim, A. and Kinston, W., 1978. "Brief focal family therapy when the child is the referred patient. 1. Clinical", **J. Child Psychol. Psychiat.**, 19: 1-12.

Byng-Hall, J., 1973. "Family myths used as defence in conjoint family therapy", **Brit. J. Med. Psychol.**, 46: 239-250.

Furniss, T., Bentovim, A. and Kinston, W., 1983. "Clinical process recording in focal family therapy", **J. Marit, Family Therapy**, 9: (due April).

Gurman, A.S., 1978. "Contemporary marital therapies: a critique and comparative analysis of psychoanalytic, behavioural and systems theory approaches", In: Paolino, Jr., R.J. and McGrady, B.S. (Eds.), **Marriage and Marital Therapy: Psychoanalytic Behavioural and Systems Theory Perspectives**, Brunner/Mazel, New York.

Haley, J., 1970. "Approaches to family therapy", **Int. J. Psychiatry**, 9: 233-242.

Haley, J., 1971. **Changing Families**, Grune and Stratton, New York.

Hinde, R., 1979. **Towards Understanding Relationships**, Academic Press, London.

Jacob, T. and Davis, J., 1973. "Family interaction as a function of experimental task", **Fam. Proc.**, 12: 415-427.

Jackson, D.D., 1957. "The question of family homeostasis", **Psychiat. Quart. (Suppl.)**, 31: 79-90.

Kinston, W., 1978. The Family Task Interview on Audiotape and Videotape. Working Paper: Family Studies Group, London.

Kinston, W. and Bentovim, A., 1978. "Brief focal family therapy when the child is the referred patient. II. Methodology and results", **J. Child. Psychol. Psychiat.**, 19: 119-144.

Kinston, W. and Bentovim, A., 1981. "Creating a focus in brief marital and family therapy", In: Budman, S. (Ed.), **Forms of Brief Psychotherapy**, Guilford Press, New York.

Kinston, W., Loader, P. and Stratford, J., 1979. "Clinical assessment of family interaction: A reliability study", **J. Fam. Ther.**, 1: 291-312.

Kinston, W. and Rosser, R., 1974. "Disaster: Effects on mental and physical state", **J. Psychosom. Res.**, 18: 437-457.

Laplanche, J. and Pontalis, J.B., 1973. **The Language of Psychoanalysis**, Hogarth Press and the Institute of Psychoanalysis, London.

Leventhal, T. and Weinberger, G., 1975. "Evaluation of a large scale brief therapy program for children", **Am. J. Orthopsychiat.**, 45: 119-133.

Lewis, J.M., Beavers, W.R., Gossett, J.T. and Phillips, V.A. 1976. **No Single Thread: Psychological Health in Family Systems**, Brunner Mazel, New York.

Loader, P., Burck, C., Kinston, W. and Bentovim, A., 1981. "A method for organising the clinical description of family interaction: The "Family Interaction Summary Format"." **Aust. J. Fam. Ther.**, 2: 131-141.

Malan, D.H., 1976. **Towards the Validation of Dynamic Psychotherapy**, Plenum Press, New York.

Malan, D.H., 1976. **The Frontier of Brief Psychotherapy**, Plenum Press, New York.

Minuchin, S., 1974. **Families and Family Therapy**, Harvard University Press, Cambridge, Ma.

Reiss, D., 1980. "Pathways to assessing the family: some choice points and a sample route", In: Hofling, C.K. and Lewis, J.M. (Eds.), **The Family: Evaluation and Treatment**, Brunner/Mazel, New York.

Satir, V., 1967. **Conjoint Family Therapy** (Revised Edition), Sci. Behaviour Books Inc., Palo Alto.

Ursano, R.J. and Dressler, D.M., 1974. "Brief vs. long-term psychotherapy: a treatment decision", **J. Nerv. Ment. Dis.**, 160: 164-171.

Weakland, J.H., Fish, R., Watzlawick, P. and Bodin, A.M., 1974. "Brief therapy: focused problem solution", **Fam. Proc.**, 13: 141-168.

Winch, P., 1958. **The Idea of a Social Science and Its Relation to Philosophy**, Routledge & Kegan Paul, London.

Wolin, S.J., Bennett, L.A. and Noonan, D.L., 1979. "Family rituals and the recurrence of alcoholism over generations", **Am. J. Psychiat.**, 136: 589-593.

Zuckerman, E. and Jacob, T., 1979. "Task effects in family interaction", **Fam. Proc.**, 18: 47-53.