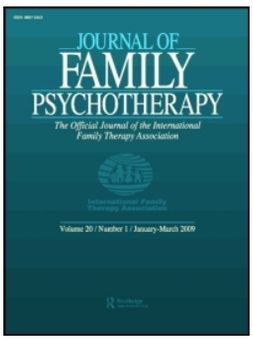

Journal of Family Psychotherapy

ISSN: 0897-5353 (Print) 1540-4080 (Online) Journal homepage: http://www.tandfonline.com/loi/wjfp20

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To cite this article: Ulia Fisher (2017) Use of Structural Family Therapy With an Individual Client Diagnosed With Intermittent Explosive Disorder: A Case Study, Journal of Family Psychotherapy, 28:2, 150-169, DOI: 10.1080/08975353.2017.1288989

To link to this article: http://dx.doi.org/10.1080/08975353.2017.1288989

JOURNAL OF FAMILY PSYCHOTHERAPY
2017, VOL. 28, NO. 2, 150–169
http://dx.doi.org/10.1080/08975353.2017.1288989

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Use of Structural Family Therapy With an Individual Client Diagnosed With Intermittent Explosive Disorder: A Case Study

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ABSTRACT

While significant contributions have been made in analyzing the efficacy of the systemic approach with individual clients, debate on the subject continues to cast a shadow of doubt on the practice. In this article, the author presents the use of Structural Family Therapy with an individual adult client, diagnosed with intermittent explosive disorder. The use of the systemic approach as the foundation for the treatment plan was shown to be effective, as demonstrated by the client's reduction in hostility and improved overall well-being. The outcomes revealed this approach to be effective in improving the individual client's functioning, without working directly with the entire relational system.

KEYWORDS

Case study; intermittent explosive disorder; structural family therapy; systemic approach with individual client

Introduction

The scope of practice for systemic clinicians often includes work with individual clients. However, most training for family therapists focuses on working with couples and families, leaving systemically trained clinicians without guidance on applying systemic theories to individual clients (Tramonti & Fanali, 2015). Furthermore, early research on the use of the systemic approach with individuals presented unclear results, which stalled the development of the approach. In 1978 Gurman and Kniskern (1978) reviewed studies that analyzed the efficacy of Individual Marital Therapy (IMT), concluding that IMT was only marginally effective, with a high rate of post-treatment decline. It was not until 1986 that these studies were reviewed again by Wells and Giannetti, who concluded that the studies were poorly designed and thus, the results were not valid (1986a).

While the debate persisted (Wells & Giannetti, 1986b), clinicians recognizing the effectiveness of structuring individual work through the systemic lens, continued to conduct research studies. The first article published to support the approach was by Jenkins and Asen, who outlined the use of the psychodynamic model with individual clients (1992). In their article, the authors present a diagram of the therapist–client-context approach, outlining the expansion of a client's

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The current study is a composite case study and does not reflect an actual case or client material.
Color versions of one or more of the figures in the article can be found online at www.tandfonline.com/wjfp.

understanding of the role that external forces play in his or her well-being through time (Jenkins & Asen, 1992). Adding to the knowledge base, Boscolo and Bertrando dedicated a seminal book on the subject by publishing *Systemic Therapy with Individuals*, where they propose a unique method to work with individuals from a systemic perspective (1996), which provided a solid foundation for clinicians to practice from with confidence.

Influential reports published with regard to studies conducted with women experiencing substance abuse, to whom clinicians provided couple-focused individual therapy, provided solid evidence of the efficacy of systemic work with individuals. Systemic Individual Therapy (SIT) was developed for the study and implemented with successful results (Lewis, Trepper, McCollum, Nelson, & Wetchler, 1990; McCollum, Trepper, Nelson, Wetchler, & Lewis, 1993; Trepper, McCollum, Dankoski, Davis, & La Fazia, 2000; Wetchler, McCollum, Nelson, Trepper, & Lewis, 1993). More efforts on the subject include a successful adaptation of a psychodynamic systemic approach, Solution-Focused Therapy, with individual clients suffering from anxiety and depression disorders (Knekt, Lindfors, Härkänen, Välikoski, & Virtala, 2008; Knekt, Lindfors, Laaksonen, Raitasalo, & Haaramo, 2008); the use of narrative therapeutic interventions with clients with Acquired Immune Deficiency Syndrome (AIDS; Rothschild, Brownlee, & Gallant, 2000); as well as, systemic techniques used to treat clients with obsessive–compulsive disorder (Lowe Jr., 2006).

A meta-analysis of studies was conducted in 2010, exploring the use of systemic therapies with a variety of clients. The analysis included 38 worldwide studies conducted with individuals, couples, families, and groups, with presenting concerns being: mood disorder, substance use, eating disorders, anxiety, schizophrenia, and medical conditions. It was found that systemic therapies were effective with not only larger systems, but also with individuals (Von Sydow, Beher, Schweitzer, & Retzlaff, 2010).

The two most recent works that support clinicians in using systemic therapy with individuals include a newly developed Systemic Individual Marital Therapy (SIMT; Shah & Satyanarayana, 2011) and an integrative approach (Tramonti & Fanali, 2015). SIMT was developed in India, to use with individuals seeking relationship therapy. The authors note: "The main objective is a stable restructuring of the individual system, which might take the form of a firmly changed perception of the problem" (p. 299). An integrative method is suggested by Tramonti and Fanali, presenting the possible combination of systemic theories to use with individual clients (2015). They make a strong case for the need to continue generating concrete systemic approaches that may be applied in practice with individual clients (Tramonti & Fanali, 2015).

The aim of the current study is to contribute to the body of knowledge, by analyzing the efficacy of Structural Family Therapy (SFT) with an adult individual client. The case study outlines the use of SFT with a client diagnosed with intermittent explosive disorder (IED), as the foundation of

the treatment plan, with additional individually focused techniques to improve the functioning of the client's own self-subsystem.

Structural theory: The self-subsystem

SFT was developed as an approach to work with family systems in the early 1960s (Minuchin & Fishman, 1981). Its effectiveness has been demonstrated for alternative systems, specifically couples (Greenan, Tunnell, & Long, 2004; Nichols & Minuchin, 1999; Simon, 2008). However, research to date has not focused on the effectiveness of SFT therapy with adult individual clients. Although a gap in research exits, a strong assertion may be made for its use with individuals based on the foundational concepts of the model.

According to the SFT model, a family system is the "whole" and its members are the "parts" of the system (Minuchin, 1974; Minuchin & Fishman, 1981; Nichols, 2013). This is also supported by Bertalanffy's (1969) notion that every living organism is a system, with functional parts that make up the whole. The system itself, even though indivisible, is separated into units—or subsystems (Minuchin, 1974; Minuchin & Fishman, 1981; Nichols, 2013).

Thus, individual family members are subsystems onto themselves—the self-subsystems. The self-subsystem is equally affected by the family, community, and society systems (Minuchin, 1974; Minuchin & Fishman, 1981; Nichols, 2013). Moreover, in his seminal work *The Presentation of Self in Everyday Life*, Erving Goffman argues that the individual has a great amount of influence on a system as a whole (Goffman, 1956). It stands to reason that the system as a whole and the self-subsystems, are mutually dependent and are affected by each other. That is, the individual is affected by the rules generated by the system, and the greater system is affected by one individual. Thus, a constant struggle is present among the parts of a system (Bertalanffy, 1969).

SFT dictates that symptoms are manifested due to a dysfunctional structure; which could include unclear boundaries and/or an unhealthy hierarchy. Thereby, an individual member may become the symptom barrier of the dysfunction. As in family and couple units, dysfunction in an individual may manifest as open conflict (i.e., anger) or conflict avoidance, coalitions, detouring, and over-involvement. Symptoms may be exacerbated by significant internal life changes, unexpected external stressors, or when the individual's homeostasis (status quo) is challenged (Minuchin, 1974; Minuchin & Fishman, 1981; Nichols, 2013). Furthermore, the individual may be setting up similar "types of structures" with other individuals and systems, as he or she learned in their family of origin (i.e., diffuse boundaries), and presenting similar symptoms (i.e., open conflict). Therefore, it makes clinical sense to practice with individuals from a systemic model, guiding the client to generate insight into manifested symptoms, in order to improve systemic functioning.

IED

IED is classified under the disruptive, impulse-control, and conduct disorders, in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; American Psychiatric Association, 2013). This group of disorders is distinguished by dysregulation of emotions and a lack of control of behaviors. Individuals diagnosed with IED experience impulsive episodes of verbal (American Psychiatric Association, 2013; Look, McCloskey, & Coccaro, 2015) and behavioral aggression which significantly affect the individual's life, and potentially result in assaults and property damage. Further, aggressive reactions are not proportionate to the triggers that cause outbursts (American Psychiatric Association, 2013). The lifetime prevalence rate of IED in the U.S. population is estimated at 7% (Kessler et al., 2006). Thus, of the current U.S. population total (approximately 323 million; United States Census Bureau, 2015), over 22 million individuals are potentially suffering from IED. The 12-month prevalence rate is estimated at 4%, with interpersonal violence occurring in up to 71% of the time (Kessler et al., 2006).

The consequences of IED are significant for those who suffer from it, their families, and our society. IED affects individuals in their social context and work-related performance (Kessler et al., 2006). In a study examining the individual experience of IED relevant to social, work-related, and legal aspects, it was found that individuals are not able to feel as much remorse before and during the aggressive episode, as they do after the outburst (Kulper, Kleiman, McCloskey, Berman, & Coccaro, 2015). Interpersonal violence (Kessler et al., 2006), property damage (American Psychiatric Association, 2013; Kessler et al., 2006), and self-harm behaviors (Jenkins, McCloskey, Kulper, Berman, & Coccaro, 2015) are among the more serious consequences of IED.

Conventional treatment for IED includes Cognitive-Behavioral Therapy (CBT), which focus on relaxation training, self-inoculation training, cognitive restructuring, and multi-component treatments (Beck & Fernandez, 1998; Bowman-Edmondson & Cohen-Conger, 1996; Del Vecchio & O'Leary, 2004; DiGuiseppe & Tafrate, 2003; Tafrate, 1995), which take the form of group and individual formats (DiGuiseppe & Tafrate, 2003). However, individual therapy was shown to be more successful in lowering aggression (DiGuiseppe & Tafrate, 2003). Individuals who exhibit highly aggressive behaviors, such as interpersonal violence, experience only a slight reduction of aggression after receiving CBT (Babcock, Green, & Robie, 2004).

Prior to 2008, no randomized clinical studies analyzed the effectiveness of psychotherapy treatments for clients with IED. A study examining effects of a multi-component treatment, including group and individual interventions, provided positive results. That is, IED symptoms of aggression anger, hostile thinking, and depression were reduced, and control of anger was higher than in the

participants in the wait-list group (McCloskey, Noblett, Deffenbacker, Gollan, & Coccaro, 2008). However, the efficacy of individual therapy alone, including CBT and systemic treatments, has not been analyzed in clinical studies to date.

Current study

While prior research has demonstrated the efficacy of systemic therapies with families and couples, its use with individual clients has not been examined. The goal of the current case study was to analyze whether the use of SFT with an individual client, diagnosed with IED, was an effective means to improve the client's functioning without working with the whole system. Considering that family and marital systems consist of individual subsystems, which are affected by familial interactions, it is sensible to hypothesize that individuals may be treated just as effectively with a systemic therapy. To present the application of structural therapy to an individual client, a case study approach was used. The case study presented includes the client background, the treatment plan with specific phases and techniques, and outcomes.

Client background

Client demographics

The client, Laura (name has been modified to preserve privacy), is a middle-aged, Caucasian female, living in the Midwestern part of United States. At the time of treatment, she was married and employed full-time at a medical institution. The client reported financial struggles; however, not being below the poverty line.

Past treatments

The client reported receiving treatment for IED in the past, including anger management groups and individual counseling. She stated that past treatments have been ineffective and she was losing hope. Laura called the clinic to sign up for an anger management group, but decided to receive individual treatment instead. The clinic director assigned her to a doctoral level marriage and family therapy student, due to current and past abuse.

Presenting concern

Laura stated her presenting concern to be a lifelong struggle with the ability to manage anger. Client reported that she usually becomes histrionic in adverse situations, which lead to anger and verbal aggression. She stated that her reactions have become unbearable, and were affecting every facet of her life (i.e., the relationship with her husband, work, and friendships). She

stated that she was physically and verbally abused by her parents, and is currently verbally abused by her father.

Diagnosis

Laura was diagnosed by the therapist with IED (American Psychiatric Association, 2013). Through structural theory, the therapist diagnosed Laura to have unclear boundaries (Figure 2), and an unhealthy hierarchy, which manifested in conflict. Specifically, Laura was enmeshed with her parents, emotionally "residing" within their subsystem, helping to maintain homeostasis (status-quo). She also developed rigid boundaries with her husband, which resembled her mother's relationship with her father. Further, Laura generated enmeshed boundaries with friends and colleagues, in order to maintain homeostasis and reduce tension in her marriage; however, causing tension with friends and colleagues. Enmeshment with her parents and external sub-systems led to the loss of her own independence, low self-confidence, and hopelessness. She was not able to express her concerns constructively, often becoming over-emotional. Rigid boundaries with her husband let to emotional distress and questioning commitment level of the relationship.

Method

The client was treated for 20 sessions, over a span of 5 months. The client was successfully discharged after the treatment goals have been reached.

Procedure

Data for the case study were collected via a clinic assessment instrument for adult individual clients, video recordings, and treatment progress notes. The client signed an informed consent, in which limits of confidentiality were outlined, as well as giving the clinic permission to use the case in research. The client was assessed before the first session, and toward the end of treatment.

Data collection

Data regarding the client's background and the presenting concern was collected by conducting an adult diagnostic assessment, including: presenting problem; living situation; social information; education, employment, and military information; job performance history; mental health treatment history; past psychotropic medications; alcohol/drug history; alcohol/drug treatment history; legal history; abuse history; problem checklist including functional domains; and mental status examination. Furthermore, therapist noted visible changes and client's self-reported analysis of functioning.

Treatment plan

The focus of treatment was to develop insight into rules and patterns that she acquired from her family of origin, understand the role of boundaries in relationships and those she has generated, empower her self-subsystem in order to restructure boundaries to be clear, and to restructure relational hierarchies to be (culturally appropriately) healthy.

Treatment model

The treatment model used for the presented case was based on the SFT model—adapted for the use with an individual client. Treatment phases, assessment, and techniques applied are outlined below. Treatment phases and techniques are versatile, as several phases may occur simultaneously, and may also take the form of techniques. Likewise, techniques may be used in different phases to achieve different goals. The phases of treatment are: joining, understanding the presenting problem, assessment, goal setting, making change, and termination (Minuchin & Fishman, 1981).

Treatment phases

Phase 1: Joining

The first task of treatment in the structural model is joining with the client system (Minuchin & Fishman, 1981; Nichols, 2013). It was important to join Laura's subsystem, as the expert in order to create trust in the therapeutic process. As structural therapy is action oriented, Laura would need to trust the therapist as an expert in order to believe those actions would be beneficial. Initially, the therapist explained to the client the systemic perspective, and that symptoms are viewed as by-products of dysfunction in the family. Laura expressed disbelief in the notion that her issue with anger stemmed from her family. However, she reported that she has not addressed problems within her family with prior therapists, and that she is willing to do so, as "…nothing has worked in the past." Therapist reassured Laura, that she will not be required to tackle any issues that she is not conformable addressing. She seemed anxious and tentative, but expressed a willingness to proceed. However, joining as a leader is likened to walking the fine line between over-involvement and austerity (Nichols, 2013). The therapist had to maintain a professional stance, while empowering the client's latent abilities for self-regulation.

Joining with a family would normally mean to align with those members that have the most power and respect the current family hierarchy (Minuchin & Fishman, 1981). Thus, with an individual client, the therapist would accept the importance of those family members on which the client is focused. Laura was focused on her father as the most powerful member of her family

system. The therapist did not challenge that stance in the joining phase. Additionally, the current hierarchy was one where her father was first, Laura was second, Laura's mother was third, and Laura's husband was last. The therapist, likewise, was accepting of the current structure.

Joining with the client was critical within the first five sessions, as during those meetings Laura seemed especially vulnerable, and was seeking out support and validation. However, the joining technique was used in the span of the entire treatment. Being a structural therapist requires to constantly do a check and balance with oneself, in order to remain objective and keep a strong therapeutic alliance.

Phase 2: Understand presenting problem

Viewing the presenting concerns from Laura's perspective was essential, in order to understand their origins. The therapist entered the client's reality, by not challenging her perspectives, but taking the stance of wanting to understand. This allowed Laura to talk about her painful childhood experiences of emotional, verbal, and physical abuse. Yet, she felt convinced that her anger stems from cognitive dysfunction, not familial issues. While the therapist expressed the systemic stance on symptoms, at this stage the client was not challenged on her beliefs.

Instead, Laura's concerns and struggles were validated and normalized by the therapist. By acknowledging Laura's concerns and normalizing reactions, she began to feel less anxiety and felt more hopeful for her future. Normalizing was done systemically by highlighting Laura's abusive upbringing and role confusion. The therapist was keen to remain systemic, while respecting the client's perspective. Therefore, hope was generated by hypothesizing with Laura that her struggles may be alleviated by restructuring her patterns of relating.

Phase 3: Assessment

Assessment is one of the initial phases; however, it extends throughout the treatment process. That is, as client's patterns are restructured, the therapist continually assesses the client's new functioning. Assessment is also used as a technique to gain insight into client functioning and historical bases for patterns. During the initial assessment, the therapist assessed Laura's self-subsystem and her external systems, including the spousal, family of origin, and employment systems. It was important to learn about the client's external systems, as those are influential in the client's life and may be the source of dysfunction. Structural and systemic assessment techniques were used to gather rich data (e.g., genogram, family map, circular causality).

Phase 4: Goal setting

The treatment plan generated for Laura consisted of short- and long-term goals, taking into account the goals of the client and of the therapist. Laura's short-term terms goals were to learn anger management techniques and analyze triggers which cause anger episodes. The therapist's short-term goals, formulated through the structural theory lens, were to detect the patterns and rules within the client's family of origin and spousal dyad, and those that were passed down from her relatives. The client's long-term goal was improve anger management and strengthen the relationship with her husband. The long-term goal of the therapist for Laura, was to discover how her reactions of anger are based on the rules and patterns passed down (and are still present) from her family of origin; create insight into how the enmeshed boundary that she is prone to develop; to create clear boundaries and a healthy hierarchy in her parental and spousal subsystems. The outcomes of the plan for Laura were to improve her quality of life, by attaining independence from her parental subsystem.

Phase 5: Creating change

This phase is where the hard work takes place. The therapist takes the leadership role in guiding the client to restructure unhealthy patterns, boundaries, hierarchy, etc. *Homeostatic crisis* often takes place in this phase of structural treatment. Homeostatic crisis in a family occurs when it is not able to cope with a stressor that disrupts system's *status quo*, and previous patterns and coping techniques no longer function to keep a balance (Messer, 1971). In therapy, homeostatic crisis begins in the first session, as anxiety rises due to the understanding that old patterns will be challenged, and extends through most of treatment. However, it takes on acute form when the client challenges the effectiveness of new patterns, and fears creating permanent change. Laura began to display signs of therapeutic homeostatic crisis in the first session, stating that she feels anxiety at the thought of exploring familial issues. Although, she was willing to challenge her fears, she exhibited slight resistance to therapeutic interventions that challenged her usual coping mechanisms. For example, when the therapist gave her a directive to communicate a fear to her husband (creating a less rigid marital boundary), she provided reasons why that may not be possible. In practice, creating a more flexible and clear boundary with her husband was a frightening prospect. She stated not knowing how the change would look and resisted breaking through the rigid wall.

However, the acute form of homeostatic crisis took place when the therapist worked on empowering Laura's self-subsystem. Laura self-identified as the helper. She was comfortable self-sacrificing and not caring for her own needs. Challenging her to pay attention to her personal needs sent Laura on a soul searching journey, during which she re-evaluated her upbringing, spiritual beliefs, and personal values. During this time, the therapist used various techniques; however, the most effective tool was to remain constant. Laura would often question the

usefulness of therapy, challenge the therapist's approach, and question her own ability to improve. By remaining steady, the therapist modeled self-assurance and belief in the process of therapy. However, and most importantly, this broadcasted an unwavering belief in the ability of the client to reach permanent change. Typically, a homeostatic crisis in therapy persists until the clients feel confident and no longer fear change. Laura began to trust the therapeutic process by session 13, where less resistance was displayed and she began to take initiative in the change process.

Phase 6: Termination

Termination of therapy is at the forefront of treatment, as the goal is to reveal the latent abilities of the client to develop a systemic healthy structure, and not to become dependent on the guidance of a therapist (Minuchin & Fishman, 1981). Thus, the therapist worked to reiterate this throughout therapy, but placing the responsibility of change on to the client. Once Laura became confident in her approach to therapy and therapeutic goals were met, she and the therapist came to a mutual decision to terminate therapy. The goal of therapy was for Laura to gain insight into systemic family dynamics that have contributed to her current distress, and for her to restructure relational patterns, in order to construct clear boundaries and a healthy hierarchy.

Techniques

Reframing

Reframing the presenting concern as a reaction to structural dysfunction is one of the essential tasks in structural therapy. Reframing refers to redefining the problem (Haley, 1976) in such a way that motivates individuals to move toward their goal (Minuchin & Fishman, 1981). One tool used to reframe Laura's patterns was circular causality (Becvar & Becvar, 2003). Circular causality is a family systems term used to highlight patterns of communication in order to show a non-linear cause of issues (Becvar & Becvar, 2003). This technique was modified to be used with an individual client. Laura was asked to analyze her "anger cycle," in which she would need to change at least one step in order to change the cycle. Figure 1 presents the cycle that she generated with the guidance of the therapist. As may be observed, Laura was triggered by feeling hurt. Before doing the exercise, she was not able to separate the cycle into steps—feeling that the 'explosion' was instantaneous. She was able to see that the cycle had a specific trigger and all consequent reactions were triggered by previous reactions. This gave Laura more power over her anger explosions. She chose to work on the "mean words" step, where she would not begin using verbally abusive language, but would take a time-out. It was a struggle for her, but she later learned coping techniques to help off-set explosive reactions (see Figure 1).

Figure 1. Circular causality.

Family map and boundaries

Drawing a family map is one of the initial techniques used in order to understand the client's reality. While in family therapy, the therapist perceives family structure in interactions, in individual therapy, the client presents his or her view of the family structure. It is important how the client perceived his or her reality. The therapist hypothesizes, from a structural stance, the implications and consequences of that structure. In Laura's case, drawing family maps was used to understand and highlight the dysfunction which may be at the root of her reaction patterns. The initial and final family maps are presented in Graphs 1 and 2. The initial family map exposed dysfunctional interactional patterns in Laura's life, including a cross-generational coalition with her mother, enmeshed boundaries with her father, rigid boundaries with her husband, and enmeshed boundaries with other relationships (i.e., friends and coworkers). It was also revealed that her mother has a rigid boundary with Laura's father, which seems to have been inherited by Laura—as she created similar interactional patterns in her own marriage.

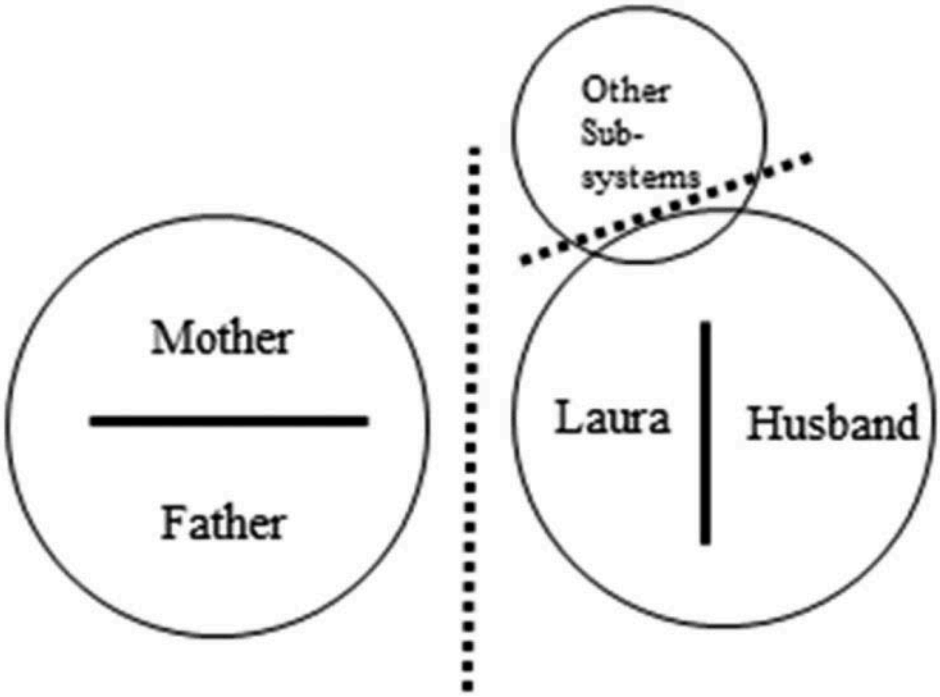

Figure 2. Family map—Initial.

The family map drawing was generated in the assessment phase and used throughout treatment, to reiterate the structural underpinning of Laura's presenting concern of IED. Specifically, it was used in the creating change phase, when the focus was on changing the inapt structure and relational patterns, as well as to empower her individual subsystem. The therapist provided explanations to the client on how manifestations of conflict (anger) are related to the dysfunctional family structure. For example, exploring the implications of being her mother's caretaker and protector, while suffering from her father's abuse, gave Laura a new perspective on the pent up anger she carries with her. Due to her rigid boundary with her husband, she was not able to share her concerns. Her enmeshment with friends and colleagues caused tension. Additionally, she felt that: "spending time and money on herself was a waste." Thus, Laura was full of anger and pain, but no healthy outlet for expressing them.

Significant was done in the change phase to guide Laura to strengthen her own subsystem. The therapist encouraged her to fulfill her needs. For example, working on her feet most of the day Laura needed specialty shoes, as she was suffering from severe pain in her feet. However, she felt that it would be a waste of money. With the encouragement of the therapist, Laura purchased proper shoes. This was a significant step for

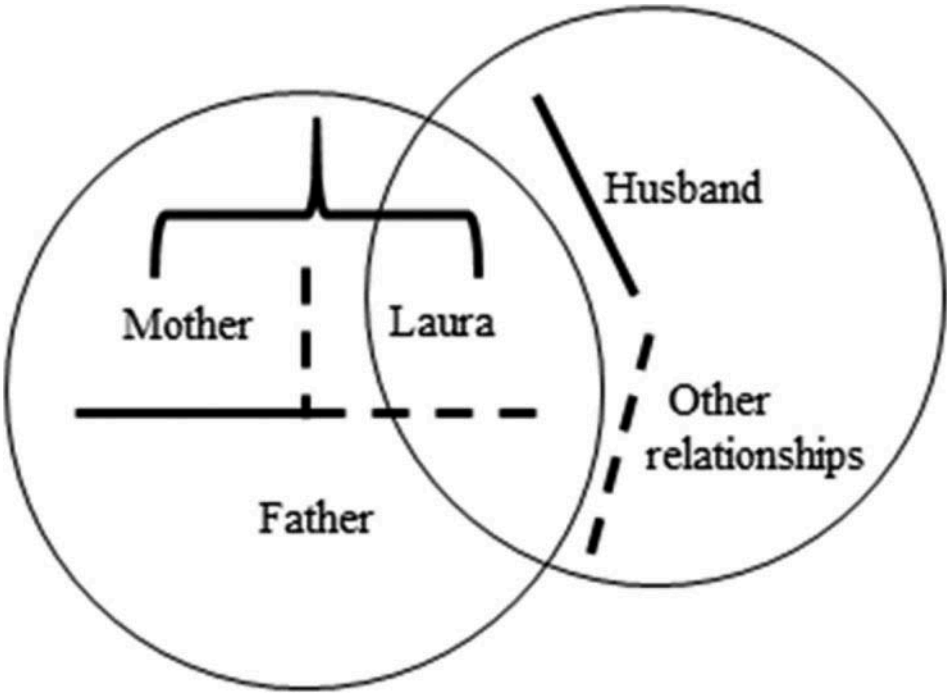

Figure 3. Family map—Termination.

Laura. This was followed by a purchase of a membership in a health club.

Further, therapist encouraged Laura to begin restructuring the boundaries with her parents and removing herself from the coalition with her mother. This was a lengthy and turbulent process. However, Laura took steps to remove herself from situations when arguments ensued between her parents. This was one of the main focus points of therapy, as it was the main source of stress in Laura's life.

At the end of therapy (Figure 3), Laura was able to empower herself and create a clear boundary with her parents. She stated that: "My parents choose to remain together, and I can't keep getting in the middle." She was also able to begin making her friendship/colleague boundaries more clear. She stated that her friends found her to be needy and intrusive. As she felt more self-confident, she was able to keep proper distance. Finally, the therapist encouraged her to restructure the rigid boundary in her marriage, but this was not a main task. The boundaries in her marriage remained rigid and marriage therapy was recommended.

Highlighting and modifying interactions: Enactments

Highlighting, or tracking, interaction is an essential task of a structural therapist. Tracking interaction is done in order to create insight into the

dysfunctional patterns that have become a habit. This may be achieved by pointing out the patterns (highlighting), intensifying interactions, and using empathy (Nichols, 2013). The therapist often used enactments to assess Laura's explosive episodes. Laura was asked to review the episode step by step, while the therapist asked what the reactions of others involved in the incident might be, or offered hypotheses in case Laura was not able to identify possible reactions of other. Laura struggled with focusing on others, and seemed to be hyper-focused on her own anger. Expanding her awareness of how others react to her in stressful situations, allowed her to slow down during future episodes and to pay closer attention to their feelings.

Unbalancing

The use of unbalancing is a powerful technique in family and couples therapy, where the therapist sides with a particular family member—who is usually in a lesser position of power (Minuchin & Fishman, 1981). In individual therapy with Laura, unbalancing was used in a similar manner. For most of the session, the therapist sided with Laura and unbalanced her father, as he was a prominent figure in her daily life. To unbalance her father, the therapist refocused attention on Laura; her feelings, needs, and intentions. This was aimed at highlighting Laura's strengths and abilities. Further, Laura's anger itself was unbalanced. Laura's anger seemed to take anthropomorphized form, as it seemed have a life of its own. She stated: "I can't control it;" "It has power over me." Unbalancing was used in much the same manner as with her father. The therapist did not acknowledge "anger," but kept the focus on Laura. Finally, in instances where her husband was discussed, the therapist unbalanced Laura and sided with her husband, as in that relationship he had less power.

Challenging unproductive assumptions

Various tools were used to challenge unproductive thoughts. For example, Laura tended to catastrophize, or assign more significance to insignificant issues. The therapist used an anger meter exercise, where Laura put stressors on a scale. She realized that she equated her husband being wrong in an argument, to him having an affair. That is, her stress level was the same during a minor argument as it might have been had the husband had an affair. Thus, she created a "rational" anger meter, where marked less stressful situations lower on the scale and more stressful higher. Additionally, the following interventions were used: "I" statements, relaxation techniques, and thought stopping exercises. Structurally, the therapist challenged Laura's assumptions of being unworthy, and reframed as an adverse effect being caught in a dysfunctional system. Challenging Laura's unproductive assumptions was aimed at empower her, in order for her to creating healthy distance in her relationships and feel in control of her life.

Results

Visible changes

At the onset of therapy, Laura was visibly distressed as evidenced by closed body language, fidgeting, looking down and crying, and sitting far from the therapist. As therapy progressed and she began to feel more confident, Laura's body language became less closed. She used a fuller range of gestures and sat closer to the therapist. Laura smiled more often and seemed less anxious when expressing thoughts. At the end of therapy, she appeared more relaxed and took time to express thoughts. She also appeared to pay more attention to her appearance, as was evidenced by a well-maintained hairstyle, new clothing, and a manicure.

Self-reported changes

Laura reported having fewer incidents of anger explosions. While she still experienced instances of feeling hurt, she was able to be rational and break the initial "cycle of anger." Instead of "flying into a rage" she was able to look at the situation from multiple perspectives, which allowed her to be more lenient with herself and others. Laura reported feeling more self-confident, and did not feel as guilty on spending time and resources on herself. She felt that she could be in control of her life, and decided to pursue marital therapy to continue improving her quality of life.

Discussion

Considering that family and marital systems consist of individual subsystems, which are effected by familial interactions, it is sensible to posit that individuals may be treated just as effectively with systemic therapies. SFT is the foundational systemic model; however, it has not been represented in research with regard to its application with individual clients. In the current study, it was presented that the use of the SFT model as the foundation of a treatment plan is effective when working with an individual adult client without the whole system of the client's family being involved in the therapy process. Additionally, appropriate individually focused techniques were used to strengthen the individual's own sub-system, where the SFT goal was to create stronger boundaries between the self and the family members. For example, relaxation techniques were used with the aim of improving the client's stress tolerance, which, in turn, allowed her to be less emotionally reactive and begin taking a more confident (clear boundary) stance in stressful family situations. The conventional CBT treatments focus primarily on individual pathology and overlook the relational components that contribute to the individual's past trauma history, or internal familial stressors.

Thus, the systemic piece is missing from the conventional treatment of clients struggling with IED.

IED has been shown to be passed down in families. In a study conducted by Coccaro with close relatives of individuals diagnosed with IED, it was discovered that those relatives were more prone to IED risk than relatives of non-IED diagnosed individuals (2010). While the possibility of genetic influence is present (Coccaro, 2010), it is plausible that such behavioral and emotional responses are learned and/or are due to current internal family stressors.

Additionally, treatment in childhood plays a significant role in adulthood. In a study conducted in 2014, researchers found childhood maltreatment to be statistically significantly associated with IED in adulthood (Fanning, Meyerhoff, Lee, & Coccaro, 2014). The researchers assessed participants for maltreatment in childhood, aggression, impulsivity, and history of suicidal attempts. It was concluded that factors in an individual's environment may be influential in the development of aggressive behavior (Fanning, Meyerhoff, Lee, & Coccaro, 2014). Further, results of a study examining the role of childhood parental bonding in adults diagnosed with IED, suggest an association between aversive parenting in childhood and later aggressive behaviors (Lee, Meyerhoff, & Coccaro, 2014).

Finally, a strong association was found between IED with exposure to trauma, including post-traumatic stress disorder (PTSD) and the first traumatic experience in childhood, and IED. Researchers state that, "IED is related to childhood exposure to interpersonal traumatic events (Nickerson, Aderka, Bryant, & Hofmann, 2012)." Thus, suggesting that the individual's context influences his or her consequent behavior. These studies underscore the need for the relational focus in clients with IED.

As presented in this case, improvement of the quality of relationships is central to decreasing episodes of IED. The quality of relationships refers to those external to the individual client (i.e., family of origin, spouse, work), as well as, internal—the relationship to the self (i.e. self-subsystem). Laura exhibited an enmeshed style of relating to her mother, and a disengaged style of relating to her father and husband. Unclear boundaries brought with them unclear expectations, and the loss of the sense of self. It also meant that Laura had no outlet for her frustrations, and the built up tension manifested in "anger explosions." Once Laura gained insight into the unhealthy patterns of relating, she became motivated to improve her quality of life, including learning appropriate communication and coping techniques.

While generating a systemic treatment plan for individuals, it important to take into account the life cycle stage of the individual and the family. The immediate family as a whole, and each individual family member, are affected by the unique forces of each stage along the family life cycle. For example, a family with an adolescent child is likely to begin the launching process. At this stage the family dynamics become more complex, with the

added component of adolescent independence, changing parent–child interactions, and refocusing of parental attention to other familial and personal elements (Nichols, 2013). Furthermore, external and internal stressors, such as a mental of physical illness, affect the family differently at each stage (Nichols, 2013; Petersen, Kruczek, & Shaffner, 2003), therefore, a tailored approach is necessary that fits each stage uniquely.

The use of systemic models with individual clients has been an ambiguous dimension of systemic therapy. In fact, Michael P. Nichols, Ph.D., argued that the individual became lost in systems work (Nichols, 1987). However, as shown in the case of Laura, the use of systemic therapy with individual clients may be applied successfully. Indeed, it may be argued that the relational focus is the missing piece in treatment of clients with IED.

Limitations

Limitations of the case study

Due to the qualitative nature of this study, there are important limitations to consider. First, the author of the article was the therapist providing treatment, and, therefore, possible experimenter biases may be present. To lessen the possibility of bias, the decision to write the article was made after therapy was concluded. While supervision was provided for the case, a thorough external review of the data was not conducted. Second, as this is a case study of a single client, it is only meant to serve as an example that provides rich data for this particular client. Thus, there are limits to generalizability of this case study and application to all adult clients with IED is not advised, as the specificities of the therapeutic relationship and client characteristics may have affected the outcomes. However, using SFT as a foundation is positioned as a possible platform for clincial work with this type of client.

Limitations of the approach

It is recommended to assess for possible intimate partner violence (IPV) and domestic violence (DV) in all clients; however, it is especially important when working with clients from a systemic lens, as it would affect the course of therapy. Implementing SFT with clients experiencing current and ongoing abuse may be contraindicated, as more immediate interventions (i.e., shelter, support) may be required. The client may need to be referred to an organization or agency specializing in IPV/DV. In case abuse is disclosed, clinicians are advised to follow the protocol of the organization in which they practice, follow the applicable ethical codes of their professional society, and if needed follow the Kitchener Ethical Decision Making Model to ensure proper action (Kitchener, 1984).

Future research

The need for more systemic research as it applies to individual clients is greatly needed. Given the successful treatment of a relapsed client with IED with SFT, it is warranted to continue analyzing systemic models with clients with this diagnoses, as well as others. Also, the application of systemic theories at different life cycle stages of individual and immediate family development should be researched. It is important to bridge the gap in systemic research in regard to approaching individual clients, with additional case studies exploring other systemic models, such as Bowenian and Contextual, among others. Case studies confirming the efficacy of the structural theory with adult clients diagnosed with IED are also needed. Currently, the body of literature gives little direction of how to apply system models to individual clients. Thereforex, future research must put more emphasis on this dimension of systemic work.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Babcock, J. C., Green, C. E., & Robie, C. (2004). Does batterers' treatment work? A meta-analytic review of domestic violence treatment. *Clinical Psychology Review*, *23*, 1023–1053. doi:10.1016/j.cpr.2002.07.001

Beck, R., & Fernandez, E. (1998). Cognitive–behavioral therapy in the treatment of anger. *Cognitive Therapy and Research*, *22*, 62–75. doi:10.1023/A:1018763902991

Becvar, D. S., & Becvar, R. J. (2003). *Family therapy: A systemic integration* (5th ed.). Boston, MA: Pearson Education.

Bertalanffy, L. V. (1969). *General system theory; foundations, development, applications*. New York, NY: G. Braziller. [1969, c1968].

Boscolo, L., & Bertrando, P. (1996). *Systemic therapy with individuals*. London, England: Karnac Books.

Bowman-Edmondson, C., & Cohen-Conger, J. (1996). A review of treatment efficacy for individuals with anger problems: Conceptual, assessment and methodological issues. *Clinical Psychology Review*, *16*, 251–275. doi:10.1016/S0272-7358(96)90003-3

Coccaro, E. F. (2010). A family history study of intermittent explosive disorder (English). *Journal of Psychiatric Research*, *44*, 1101–1105. doi:10.1016/j.jpsychires.2010.04.006

Del Vecchio, T., & O'Leary, K. D. (2004). Effectiveness of anger treatments for specific anger problems: A meta-analytic review. *Clinical Psychology Review*, *24*, 15–34. doi:10.1016/j.cpr.2003.09.006

DiGuiseppe, R., & Tafrate, R. C. (2003). Anger treatment for adults: A meta-analytic review. Clinical Psychology. *Science and Practice*, *10*, 70–84.

Fanning, J. R., Meyerhoff, J. J., Lee, R., & Coccaro, E. F. (2014). History of childhood maltreatment in intermittent explosive disorder and suicidal behavior. *Journal of Psychiatric Research*, *56*, 10–17. doi:10.1016/j.jpsychires.2014.04.012

Goffman, E. (1956). The presentation of self in everyday life. Edinburgh: University of Edinburgh Social Sciences Research Centre.

Greenan, D. E., Tunnell, G., & Long, J. (2004). Couple therapy with gay men (2003). *Journal of Feminist Family Therapy*, *16*(2), 83–84. Gender Studies Database, EBSCOhost (accessed August 13, 2015).

Gurman, A. S., & Kniskern, D. P. (1978). Research on marital and family therapy: Progress, perspective, and prospect. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change: An empirical analysis* (2nd ed., pp. 817–901). New York, NY: Wiley.

Haley, J. (1976). *Problem-solving therapy*. San Francisco, CA: Jossey-Bass.

Jenkins, A. L., McCloskey, M. S., Kulper, D., Berman, M. E., & Coccaro, E. F. (2015). Self-harm behavior among individuals with intermittent explosive disorder and personality disorders. *Journal of Psychiatric Research*, *60*, 125–131. doi:10.1016/j.jpsychires.2014.08.013

Jenkins, H., & Asen, K. (1992). Family therapy without the family: A framework for systemic practice. *Journal Of Family Therapy*, *14*, 1–14. doi:10.1046/j..1992.00439.x

Kessler, R. C., Coccaro, E. F., Fava, M., Jaeger, S., Jin, R., & Walters, E. (2006). The prevalence and correlates of DSM-IV intermittent explosive disorder in the national comorbidity survey replication. *Archives of General Psychiatry*, *63*, 669–678. doi:10.1001/archpsyc.63.6.669

Kitchener, K. S. (1984). Intuition, critical evaluation and ethical principles: The foundation for ethical decisions in counseling psychology. *The Counseling Psychologist*, *12*(3), 43–55. doi:10.1177/0011000084123005

Knekt, P., Lindfors, O., Härkänen, T., Välikoski, M., Virtala, E., & The Helsinki Psychotherapy Study Group. (2008). Randomized trial on the effectiveness of long- and short-term psychodynamic psychotherapy and solution-focused therapy on psychiatric symptoms during a 3-year follow-up. *Psychological Medicine*, *38*, 689–703. doi:10.1017/S003329170700164X

Knekt, P., Lindfors, O., Laaksonen, M. A., Raitasalo, R., Haaramo, P., & The Helsinki Psychotherapy Study Group. (2008). Effectiveness of short-term and long-term psychotherapy on work-ability and functional capacity—A randomized clinical trial on depressive and anxiety disorders. *Journal of Affective Disorders*, *107*, 95–106. doi:10.1016/j.jad.2007.08.005

Kulper, D. A., Kleiman, E. M., McCloskey, M. S., Berman, M. E., & Coccaro, E. F. (2015). The experience of aggressive outbursts in intermittent explosive disorder. *Psychiatry Research*, *225*, 710–715. doi:10.1016/j.psychres.2014.11.008

Lee, R., Meyerhoff, J., & Coccaro, E. (2014). Intermittent explosive disorder and aversive parental care (English). *Psychiatry Research*, *220*, 477–482. doi:10.1016/j.psychres.2014.05.059

Lewis, R. A., Trepper, T. S., McCollum, E. E., Nelson, T. S., & Wetchler, J. L. (1990). *Couple-focused therapy for substance-abusing women*. Rockville, MD: National Institute on Drug Abuse.

Look, A. E., McCloskey, M. S., & Coccaro, E. F. (2015). Verbal versus physical aggression in intermittent explosive disorder. *Psychiatry Research*, *225*, 531–539. doi:10.1016/j.psychres.2014.11.052

Lowe, J. W. (2006). An uncommon treatment of obsessive-compulsive disorder: A case study. *Journal Of Family Psychotherapy*, *17*(2), 1–18. doi:10.1300/J085v17n02_01

McCloskey, M., Noblett, K., Deffenbacker, J., Gollan, J., & Coccaro, E. (2008). Cognitive-behavioral therapy for intermittent explosive disorder: A pilot randomized clinical trial (English). *Journal of Consulting and Clinical Psychology*, *76*, 876–886. doi:10.1037/0022-006X.76.5.876

McCollum, E. E., Trepper, T. S., Nelson, T. S., Wetchler, J. L., & Lewis, R. A. (1993). *Systemic couples therapy for substance-abusing women: A treatment manual*. West Lafayette, IN: Purdue Research Foundation.

Messer, A. A. (1971). Mechanisms of family homeostasis. *Comprehensive Psychiatry*, *12*(4), 380–388. doi:10.1016/0010-440X(71)90076-9

Minuchin, S. (1974). *Families and Family Therapy*. Cambridge, MA: Harvard University Press.

Minuchin, S., & Fishman, C. (1981). *Family therapy techniques*. Cambridge, Massachusetts: Harvard University Press.

Nichols, M. P. (1987). *The self in the system*. New York, NY: Brunner/Mazel, Inc.

Nichols, M. P. (2013). *Family therapy: Concepts and methods* (10th ed.). Boston, MA: Pearson.

Nichols, M. P., & Minuchin, S. (1999). Short-term structural family therapy with couples. In J. M. Donvan (Ed.), Short-term couple therapy (pp. 124–143). New York: Guilford.

Nickerson, A., Aderka, I. M., Bryant, R. A., & Hofmann, S. G. (2012). The relationship between childhood exposure to trauma and intermittent explosive disorder. *Psychiatry Research*, *197*(1–2), 128–134. doi:10.1016/j.psychres.2012.01.012

Petersen, L., Kruczek, T., & Shaffner, A. (2003). Gender roles and the family life cycle: The case of women with cancer. *Journal of Feminist Family Therapy*, *15*(2/3), 99–119. doi:10.1300/J086vI5n02_06

Rothschild, P., Brownlee, K., & Gallant, P. (2000). Narrative interventions for working with persons with AIDS: A case study. *Journal Of Family Psychotherapy*, *11*(3), 1. doi:10.1300/J085v11n03_01

Shah, A., & Satyanarayana, V. A. (2011). The solo note: Therapy with one spouse through Systemic Individual Marital Therapy (SIMT). *Journal of Family Psychotherapy*, *22*(4), 297–312. doi:10.1080/08975353.2011.627800

Simon, G. M. (2008). Structural couple therapy. In A. S. Gurman (Ed.), Clinical handbook of couple therapy (4th ed., pp. 323–349). New York, NY: Guilford.

Tafrate, R. C. (1995). Evaluation of strategies for adult anger disorders. In H. Kassinove (Ed.), *Anger disorders: Definition, diagnosis, and treatment* (pp. 109–130). Washington, DC: Taylor & Francis.

Tramonti, F., & Fanali, A. (2015). Toward an integrative model for systemic therapy with individuals. *Journal of Family Psychotherapy*, *26*(3), 178–189. doi:10.1080/08975353.2015.1067531

Trepper, T. S., McCollum, E. E., Dankoski, M. E., Davis, S. K., & La Fazia, M. A. (2000). Couples therapy for drug abusing women in an inpatient setting: A pilot study. *Contemporary Family Therapy*, *22*(2), 201–221. doi:10.1023/A:1007781803665

United States Census Bureau. (2015). *U.S. and World Population Clock*. Retrieved from http://www.census.gov/popclock/

Von Sydow, K., Beher, S., Schweitzer, J., & Retzlaff, R. (2010). The efficacy of systemic therapy with adult patients: A meta-content analysis of 38 randomized controlled trials. *Family Process*, *49*, 457–485. doi:10.1111/famp.2010.49.issue-4

Wells, R. A., & Giannetti, V. J. (1986a). Individual marital therapy: A critical reappraisal. *Family Process*, *25*, 43–51. doi:10.1111/famp.1986.25.issue-1

Wells, R. A., & Giannetti, V. J. (1986b). Rejoinder: Whither marital therapy? *Family Process*, *25*, 62–65. doi:10.1111/famp.1986.25.issue-1

Wetchler, J. L., McCollum, E. E., Nelson, T. S., Trepper, T. S., & Lewis, R. A. (1993). Systemic couples therapy for alcohol-abusing women. In T. J. O'Farrell (Ed.), *Marital and family therapy in alcoholism treatment* (pp. 236–260). New York, NY: Guilford.