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BRIEF FOCAL FAMILY THERAPY WHEN THE CHILD IS THE REFERRED PATIENT—II. METHODOLOGY AND RESULTS

WARREN KINSTON* and ARNON BENTOVIM†

INTRODUCTION

OVER THE past 20 yr, consideration of the family as a target for change in child psychiatry has become established (G.A.P. Report, 1970; Sager and Kaplan, 1972). In our growing experience of working with families in the Department of Psychological Medicine at the Hospital for Sick Children, we have become convinced of its usefulness in producing symptomatic remission in children. However, despite this, and other positive impressionistic reports of the value of the family approach, there have been relatively few attempts to evaluate it. Wells *et al.* (1972) reviewed the literature and found only two studies, both of adults and from the same research programme, which could be considered methodologically adequate. Measurement of outcome in these two studies was based on rates of rehospitalization. From a family theory point of view, knowledge of family change is as important. However, despite a large number of attempts (Straus, 1969), few instruments exist with adequate psychometric properties to measure such changes. One widely used test (Ferreira and Winter, 1965) is a decision-making task: although it distinguishes normal and abnormal families, it showed no change after family therapy (Ferreira and Winter, 1966). Most studies (Wells *et al.*, 1972) relied on clinical judgement despite its drawbacks. More recently, the particular difficulties in this field have been reviewed by Framo (1972) and Cromwell *et al.* (1976).

We have been concerned not only about the conflicting merits of child vs family treatment (McDermott and Char, 1974) and the implications for resource allocation, but also with the question as to whether families were actually changing as a result of our therapy. These concerns led us to develop a time-limited focused technique for use with families and to organize our data collection to include evidence of family change. We were stimulated by the successful use of a focal approach to shorten individual psychoanalytic therapy, introduced by Balint *et al.* (1972) and developed by Malan (1963, 1976) at the Tavistock Clinic. In association with this therapeutic model, Malan has developed a methodology for the assessment of improvement on an "individualized" basis (1959).

Fiske *et al.* (1970) in their recommendations to researchers planning studies of effectiveness of psychotherapy note: "Little systematic consideration has been given

*Academic Department of Child Psychiatry, The Institute of Child Health, The Hospital for Sick Children.

†Requests for reprints to Dr. Arnon Bentovim, Department of Psychological Medicine, The Hospital for Sick Children, Great Ormond Street, London, WC1 3JH.

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to the design and analysis of studies oriented towards testing whether therapy produces particular effects designated as desirable for the individual patient". We wished to apply this to families. Practical and clinical factors precluded the organization of a controlled trial, but we aimed to be specific in our therapy and in our evaluation.

To this end a weekly workshop was set up for staff to develop and work on a family focus and to record relevant data. An experienced staff member of the Tavistock Clinic's Brief Psychotherapy Workshop agreed to act as a consultant and Group Leader during the first year (1973–1974). Cases were brought, focal hypotheses and plans made, criteria for success laid down and family sessions written up and circulated so that the treatment process could be followed. The clinical aspects of the work are described in an accompanying paper with two cases presented in detail (Bentovim and Kinston, 1977). The present paper describes the assessment methodology, the operation of the workshop and all families seen in the first 2½ yr. The implications of the data and difficulties in evaluating families are discussed.

METHODOLOGY

Origins of the method

As developed for brief individual psychotherapy, the assessment carried out by Malan (Malan, 1959; Malan *et al.*, 1968, 1975) included:

A. Basic details (name, age, complaints and their duration).

B. All known disturbances in the patient's life with evidence (usually under two headings: relationships and symptoms).

C. A minimum psychodynamic hypothesis required to explain B (varying from a simple description of overt conflict, to more conventional psychodynamic unconscious motivation).

D. Evidence required for an assessment of the results of therapy as determined by C (usually divided into the "ideal" result, and a discussion of the value of partial results).

At this point the brief therapy is instituted and subsequently followed up.

E. All disturbances listed under B are re-examined at interview and changes noted.

F. Tentative psychodynamic assessment of the results by comparing D with E.

The principles of psychodynamic assessment required an identification of the patient's "predisposition" as well as the "specific stress" to which he was vulnerable. The predisposition referred to those aspects of the patient's constitution that rendered him vulnerable. The stress was sometimes an event and sometimes a "vicious circle" which interacted with the predisposition.

The requirements for improvement psychodynamically were (a) that the patient should be better than he was before the breakdown, i.e. the predisposition must be altered (and any other personality changes achieved are secondary). The proof of this required that the patient had been exposed again to the specific precipitating stress and had reacted in a new and better way. Any vicious circles that were present must have been broken by the patient's efforts. (b) Not only must disturbances (symptoms and vicious circles) have disappeared, but they must be replaced by something positive, i.e. withdrawal or avoidance responses are not enough. This

requirement was particularly important when predisposition or stress could not be identified.

Finally as an essential part of the presentation of the findings, Malan claimed it was necessary to provide the case material and assessment in reasonably complete detail so that the reader could critically draw his own conclusions about the final ratings of improvement.

Procedure in the workshop

Following the Department team's full diagnostic procedure (typically multidisciplinary and family oriented) a case could be brought by the team members to the weekly 1¼ hr workshop. The workshop accepted any out-patient case excluding psychotic children and this meant that initially "problem" cases were brought. In the discussion, hypotheses were developed which could encompass the reason for referral and presenting symptoms, salient facts from the history and observations of family interaction—using a minimum of psychodynamic theory. These focal hypotheses then became the reference point for therapeutic progress and the source of predictions for evaluation of outcome. At times new information came to hand which made it necessary to modify the original hypothesis. The workshop then determined a "focal plan" which aimed to provide the therapist with guidance as to how the desired changes were to be brought about. The duration and frequency of sessions for the successful completion of the focal plan were also estimated. These conclusions formed the basis of the contract to be offered to the family. All families were seen by two therapists, a common Department practice, and both were required to be workshop members. Usually cotherapists were male and female. Sessions were written up by one or both therapists in detail and pre-circulated. The workshop then functioned as a "supervisor" for the therapy.

Constructing a focal plan is required because the hypothesis does not imply any therapeutic method. Malan (1959) omitted this step presumably because the individual psychoanalytic therapy he used implied a standardized therapeutic attitude and technique. More recently, however, he has included discussion of a "therapeutic plan" (Malan, 1976).

Therapy

Members of the workshop included psychiatrists, psychoanalysts, social workers and psychologists. They varied in expertise and theoretical orientation and many had experience in other forms of individual and group treatments of children and parents. Their styles differed and none had had formal training in specific techniques of family therapy. The treatments had very little more in common than that they were influenced by a focal plan constructed by psychodynamic hypotheses. In contrast to individual therapy with its few powerful schools that serve as reference points, family therapy is a melange of tactics and techniques (Beels and Ferber, 1969; Haley, 1971; Bloch, 1973). Using the criteria of the G.A.P. Report (1970) on the field of family therapy, our therapists were encouraged to be "Position M" therapists, i.e. to regard both individual and family factors as important. The technical aspects of therapy are outlined in the clinical paper (Bentovim and Kinston, 1977).

REVIEW OF THE CASES

Demographic data

In the 30 months under review a total of 29 cases were managed under the auspices of the workshop. As a child psychiatry facility we treated families referred for disturbance in the child. Table 1 summarizes the distribution of ages, social class and family size of the cases.

TABLE 1. DEMOGRAPHIC DATA

Number of children referred	32	
Number of familes (cases)	29	
Age range of children in years		
Pre-school (2–4)	3	(9%)
School (5–10)	20	(63%)
Adolescent (11–14)	9	(28%)
Social class of families		
Class I	8	(28%)
Class II and III	14	(48%)
Class IV and V	7	(24%)
Family size		
1 child	4	(14%)
2 children	10	(34%)
3 children	11	(38%)
4 or 5 children	4	(14%)

The majority (63%) of referrals were pre-pubertal, school-age children and most of the rest were in early adolescence. The absence of children (i.e. referred children) over 14 yr is a reflection of the population which is referred to the Hospital for Sick Children. In comparison to the Department population, the social class distribution showed an upward trend. About half of our cases were in classes II or III and the rest were evenly divided amongst class I or classes IV and V. In all cases but one, both parents were alive, together, and required to participate actively in the treatment. The unusual case, the "B family", consisted of three sisters and a brother between 3 and 8 yr, in care of the Local Authority, living together and referred as a group. Treatment involved the Housemother and a female helper from the residential home. Most of the families were small: only 14% (4) contained more than three children.

Referral data

Excluding the B family, 75% of the referrals were boys and 25% were girls. Sixty-one per cent of referrals were for neurotic disturbances, and this included three asthmatic children involved in a trial assessing the use of family therapy in asthmatics irrespective of psychiatric presentation. The children showed a large range of presenting symptoms: school refusal, separation anxiety, excessive fearfulness, temper tantrums, stealing, learning problems, depression, irrational or immature behaviour, isolation, excessive masturbation, encopresis, tics, psychosomatic

TABLE 2. REFERRAL DATA
$N = 28^*$ (100%)

Sex of referred child		
Male	21	(75%)
Female	7	(25%)
Diagnosis		
Preschool behaviour problem	2	(7%)
Neurotic disorder (including psychosomatic)	17	(61%)
Conduct or mixed conduct–neurotic	9	(32%)
Duration of problem		
Acute	0	(0%)
Chronic	28	(100%)

*The "B Family" is excluded.

disorder (polymyositis, migraine), and others. All cases reflected longstanding disturbance in the child (and usually the family) and referral was instigated either by an exacerbation of the symptoms, or by external agencies, e.g. in several, the school was threatening expulsion. In a few cases, psychological precipitants were apparent. In other cases, a symptom which was not considered serious at a younger age was either worsening slowly or was becoming more handicapping in relation to increasing demands on the child. General practitioners played an important part in coaxing some parents to seek psychiatric help.

Therapy process data

The data presented in this section were extracted from the circulated reports and summaries of the meetings and were not part of the Departments records (case files). All case numbers refer to Table 5.

Focal hypotheses were formulated in 27 of the 29 cases. They were lacking in two families which failed to engage after the initial interview, and Case 10, Beth. The formulation of the hypotheses, looked at in retrospect, appeared at times highly subjective and they varied in complexity and style. Commonly two or three were required for a family. Focal plans were developed in 25 of the 27 cases for which focal hypotheses were formulated. A focal plan was not developed for two other families which failed to engage. A plan could be made for Case 10 despite the lack of a focal hypothesis. The focal plans also varied greatly. They might be directly implied by the focal hypotheses or only indirectly linked to them.

Twenty-four per cent (7) of the cases failed to engage. In one case (No. 24) the failure to engage was spread out over 4 months of missed and attended sessions till the family explicitly rejected the offer of therapy: such an experience might well be considered "treatment". The more usual pattern involved various family members opting out and therapy discontinuing over a few weeks after the first or second session. Four of the seven failures to engage involved children with conduct disorders; the others had neurotic disorders.

The commonest recommended treatment programme was for six sessions at 3 or

TABLE 3. WORKSHOP DATA

Number of families	29
Focal hypotheses formulated	27
Focal plans formulated	26
Engagement in therapy	22
TREATMENT PROVIDED	
1 course of therapy	20
2 courses of therapy	2
Total number of therapies	24
SYSTEM WORKED WITH	
Family only	16
Marital only	4
Family and marital	4
PLANNED NUMBER OF SESSIONS/COURSE	
4 sessions	1
6–8 sessions	14
10–20 sessions	8
Contract not established	1
FREQUENCY OF SESSIONS	
Weekly	6
Fortnightly	4
3–4 weekly	12
5–8 weekly	2
Completed courses	19
Uncompleted (includes drop-outs and missed final sessions)	5
THERAPEUTIC WORK IN RELATION TO THE FOCAL PLAN	
Yes	19
No	5

4 weekly intervals. When a patient was seen more frequently, a larger number of sessions was usually planned, i.e. the duration of the therapy was usually 5–9 months, but the intensity varied. Although the contracted number was generally adhered to, in many it was not possible and often not appropriate to stick to the planned timing of the sessions: either the therapists could not be regular or the families required alterations to be made. Several of the families were offered second courses of brief therapy with the focus on the marriage; this was only accepted in two cases (Case 12 and Case 17). Therapeutic work could be maintained in relation to the designated focal plan in 77% (17) of the engaged cases. The other five cases (Nos. 6, 7, 9, 10, 14) showed complex or severe marital or family pathology. Five cases did not complete the course they had initially contracted for (Nos. 1, 4, 6, 7, 8).

Outcome data: short-term results

Implementation of the focal plan took place under supervision from the workshop and changes in plan or tactics were determined only following discussion. At the conclusion of the therapy or on short-term follow-up (3–6 months), the family

was judged for improvement against the criteria developed from the focal hypotheses. Improvement for the index patient was a criterion for each case. A simple three-point scale was used for both the index patient and the family-as-a-whole: worse or no improvement, some improvement, much improvement. Rating of improvement was by workshop consensus using therapist reports.

TABLE 4. SHORT-TERM OUTCOME

Number of families	29 (100%)
Failed to engage	7 (24%)
Engaged	22 (76%)
Completed full course	19 (66%)
Subsequently seen long-term	4 (14%)

IMPROVEMENT RATINGS IN ENGAGED CASES $N=22$

Improvement	Index patient	Family-as-a-whole
Nil (or worse)	3 (14%)	11* (50%)
Some	12† (55%)	7 (32%)
Much	7 (32%)	4 (18%)

*In one case the family was assessed as functioning adequately, the child being the site of the pathology.

†The B family children have been given a single rating.

Families fell into only five of the nine (i.e. 3 × 3) possible combinations of index patient and family improvement. Table 5 lists all cases (pseudonyms provided) according to this schema: three cases showed no improvement for the index patient or the family, eight cases showed some improvement for the index patient but none for the family, four cases showed some improvement for both the index patient and the family, three cases showed much improvement for the index patient and some for the family and four cases showed much improvement for both the index patient and the family. The seven cases which failed to engage are also listed. We found that the index patient's rating was never lower than the family rating and that we had no cases of major symptomatic change in the absence of family improvement. To allow statistical comparisons an overall score of improvement was developed using a nine-point ordinal scale as follows: failure to engage or no change for either the index patient or the family scored 0 or 1 for minor changes. The appearance of symptoms in a previously well sib nullified the effect of symptomatic improvement in the index patient (e.g. Case 4). Some symptomatic change without family change scored 2 or 3. Some family change scored 4 or 5 depending on how much improvement there was for the index patient. Much family change, always associated with much symptomatic change, scored 6 or 7. Total recovery according to all criteria scored 8. From a family therapy point of view any case scoring less than 4 cannot be considered a result of "successful" therapy. On this criteria our success rate is 50% (11 families) excluding cases which failed to engage. Using a 2 × 2 contingency table for success (11) vs failure (11) and the Fisher Exact Probability Test (Lindgren and McElrath, 1966), psychiatric disturbance in the parents (four cases) was significantly related to failure ($P < 0{\cdot}05$). Unexpectedly,

TABLE 5.

Case no.	Index patient and sibship	Presentation	Focal hypotheses	Focal plan
NO IMPROVEMENT FOR EITHER THE INDEX PATIENT OR THE FAMILY				
1	Patrick 8 yr Only child	Slowness of thought Poor coordination	Failure of integration of sexuality and aggression with isolation of family members Failure of communication of feelings preserves status quo	Help each member listen to the others, and bring out feelings that are attached to words and actions
2	Anna 6 yr Youngest of 3 sibs	Eccentric behaviour Learning problems	Parents' own deprivation makes it difficult for them to respond to the needs of their children	Help parents meet each other's needs
3	Paul 4 yr Only child	Asthma	Excessive self-consciousness and need for control	Reflect to family what they are like Discover something lively
SOME IMPROVEMENT FOR THE INDEX PATIENT, BUT NONE FOR THE FAMILY				
4	Darren 10 yr Second of 3 sibs	Encopresis	Depression is not acknowledged by mother or rest of family Darren is being scapegoated	Tell the family to ignore the encopresis and let Darren manage it Help all members acknowledge depressive feelings in others
5	Henry 11 yr Oldest of 3 sibs	School phobia Migraine Obsessional traits	Henry carries father's denied fears Henry fears success in relation to father's absences and bears guilt over a previous stillbirth	Interpret dynamics to the family
6	Richard 12 yr Third of 5 sibs	Irrational and impulsive behaviour Enuresis	"Normal" aggressive feelings are excessively inhibited	Help the family appreciate their inhibition and intolerance of criticism

Criteria to be met for successful outcome	Treatment	Outcome	Score
Emotional distance between family members to be reduced: manifested by their listening to each other and recognizing and responding to feelings, both positive and negative Patrick to assert himself more outside the family	Series of 6 fortnightly sessions was not completed. Focus was adhered to—family opted out after 4th session	Family acknowledged their problems Father's alcoholism worsened	0
Parents to turn to and be satisfied by each other, e.g. sexual relations to be re-established Parents to respond appropriately to the needs of the children Anna's behaviour to mature	After 5 family sessions, 20 weekly marital sessions given. Mother, Anna and one sib then entered individual therapy	Parents became aware of problems with a high motivation for continuing therapeutic work Intra-familial criticism had diminished	1
Family to interact freely and more confidently Asthma to lessen	6 sessions (3 weekly) regularly attended	Family not pathogenic. Family behaviour within sessions became more relaxed Asthma lessened in association with medical management	1
Depression to be acknowledged and shared within the family with expression of mutual care to increase Darren to regain normal bowel habits	6 sessions (monthly) planned Family missed an appointment after each attendance. Soiling stopped by fifth session and final session missed. Further therapy refused	Soiling ceased; sib's asthma returned; depression worsened but was not acknowledged Family showed slightly more positive support	1
Father to acknowledge his fears and weakness, but to be relied on by Henry despite this Parental coalition to become more effective thus freeing children from sick roles Henry's symptoms to lessen	6 fortnightly sessions	No change in family apart from an improvement in Henry's relation to Father Henry returned to school prior to initial session. He remained a loner but had fewer headaches and obsessions. Sib developed mild phobic symptoms (2 years later both Henry and family showed much improvement)	2
Family to acknowledge and express assertiveness and mutual appropriate criticism to be possible Parents to expect and allow age appropriate behaviour, children to mature	After 3 of 6 planned monthly sessions family opted out of therapy using Richard's improvement as an excuse. Only 1 session attended by whole family. Focus poorly adhered to	Family agreed in principle to therapeutic formulations but did not wish to pursue the implications Richard's behaviour settled and he was less scapegoated	2

TABLE 5—continued

Case no.	Index patient and sibship	Presentation	Focal hypotheses	Focal plan
7	George 10 yr Twin with a younger sib	School refusal Fears Depression	Inability of the family to cope with the unexpected	Relate George's symptoms to marriage and help parents recognize their marital problems
8	John 11 yr Youngest of 3 sibs	Separation anxiety Fearfulness	Overprotective mother, passive father and son with early separation experiences	Increase John's self esteem Increase father's effectiveness Separate mother and son
9	Anthony 13 yr Middle of 3 sibs	Depression with suicidal ideation, secondary to polymyositis treated with steroids	Family expectations of perfection make them unable to tolerate a chronic illness "Bad feelings damage" is a family belief	Promote open communication to enable sharing of feelings and acknowledgement of the distress of others
10	Beth 8 yr Oldest of 3 sibs	Excessive masturbation since infancy now occurring at school	(Connections made with parental sexuality and deprivation—but no hypothesis was fully satisfactory)	Reformulate the problem around unhappiness and deprivation; and explore the marital relationship
11	Barry 9 yr Only child	Behaviour problems Learning problems Asthma Tension in family School refusal	Parents are uncertain about parenting and their marital relationship Closeness is frightening	Work on positive aspects of the marital relationship
SOME IMPROVEMENT FOR BOTH THE INDEX PATIENT AND HIS FAMILY				
12	Nigel 12 yr Older of 2 sibs	Obsessions Learning problems	The children in the family take over and express parental conflicts	Clarify children's fears that their needs will not be met, and deal with their fears of frail parental unity

Criteria to be met for successful outcome	Treatment	Outcome	Score
Family to recognize impossibility of total control of events and to respond adaptively to stresses George's symptoms to improve, including return to school	11 sessions at irregular intervals over 6 months with various combinations of family members, but work on focus could not get started	Serious marital disharmony uncovered; but parents had no wish to work on this George returned to school and was happier in himself	2
Change in marital pattern: with mother to be less overprotective, father to be more active and assertive John to be less obstructive, spoiling and provocative	8 sessions (3-weekly) mainly attended by parents plus John. Last appointment missed	John's behaviour improved at home and school but mother refused to perceive this and regarded him as "deeply disturbed". She spoiled father's attempt at assertion	2
Family to bear sadness and threats of loss directly Family, including Anthony, to accept Anthony's illness	8 family, individual and marital sessions over 6 months. Focus proved insufficient in context of severe family disturbance. Continued long-term individual therapy for Anthony with parents seen by social worker	Anthony became less depressed but remained unable to tolerate his parents Parents could not allow examination of their relationship	2
Unhappiness and deprivation to be expressed and met more satisfactorily by family Masturbation to reduce	7 sessions over 6 months with various combinations of family members. Father's absence prevented marital work	Mother less resentful towards Beth Reduction in public masturbation	3
Parent's confidence in their ability to increase and they should control Barry more Marital relationships to improve: parents to do things together with enjoyment Barry's symptoms to improve	Previously seen in long-term individual therapy. Focal therapy comprised 8 fortnightly sessions. Subsequently family seen long-term	Tension in the family reduced, Barry returned to school and was less of a problem at home Family's attitude to treatment improved	3
Parents to acknowledge conflicts Parental coalition to improve and children's needs to be more adequately met Symptoms to lessen	Family sessions at monthly intervals but after 3 interviews (of 6 planned) a crisis arose leading to weekly sessions. After 18 family sessions, 20 weekly marital sessions given. Nigel received concurrent remedial teaching	Parents become aware of their problems and the pressures on the children diminished. Their relations with families of origin improved Obsessions diminished and learning improved (2 years later parents were living apart; Nigel's symptoms were fluctuating at previous level)	4

TABLE 5—continued

Case no.	Index patient and sibship	Presentation	Focal hypotheses	Focal plan
13	David 13 yr Younger of 2 sibs	Abdominal pains and missing excessive school	Family has conflicts over dependency and assertiveness	Show the family that "bad" parts of the self can be constructively used
14	Judith 13 yr Older of 2 sibs	Antisocial behaviour at school	Adolescence is stirring unresolved adolescent conflicts of parents who are simultaneously stimulating and trying to control Judith	Help parents with their adolescent conflicts
15	B Family 8 yr 7 yr 5 yr 3 yr	Referred by social services for preparation to meet father who is in prison for killing a half sib Various nervous symptoms, e.g. sleep-walking, enuresis, tantrums	Children still experience after-effects of killing of half-sib by father They are coping with separations and a new life in the Children's Home	Emphasize and openly discuss the reality situation (including preparation for visit to father)
MUCH IMPROVEMENT FOR THE INDEX PATIENT AND SOME FOR THE FAMILY				
16	Margaret 10 yr Youngest of 3 sibs	Tics and mannerisms	Overprotection and excessive inhibition of aggression within the family Shared self-depreciation and unrealistically high expectations	Make the family aware of the extent of its inhibition Promote free communication with mutual appreciation and tolerance
17	Graham 2 yr Only child	Separation problems Excessive stranger anxiety	Very poor marital situation: marriage unconsolidated due to failure of expectations following previous marital failures on both sides	Explore failures and expectations in marriage Help couple talk through problems and create a future together
18	Lynette 9 yr Oldest of 3 sibs	Asthma	Fear of madness Guilt about the genetics (maternal grandmother was psychotic)	Modify sib's shrieking Discuss guilts and fears

Criteria to be met for successful outcome	Treatment	Outcome	Score
Family members to demonstrate their need for each other and to do things together with pleasure Family members, especially David and father to assert themselves more positively David to attend school regularly with less abdominal trouble	6 sessions monthly Some difficulty in keeping to the focus	David's symptoms abated and all family members showed individuation Better relations between David and his father	4
Parents to treat daughter appropriately to her age School behaviour to improve	6 sessions (3-weekly) Further marital therapy was refused	Both children improved at home and Judith settled well in a new school During therapy focus moved to a severe hidden marital problem which was not helped	4
Children to openly refer to father and his imprisonment and to make a satisfactory visit to father Children to attach to house-staff and to reduce aggressive behaviour there Symptoms to lessen	10 sessions 2–4 weekly with children, housemother and female helper Focus adhered to with difficulty Subsequently seen 2-monthly	Some acknowledgement of past events Visits to father have been satisfactory 3 of 4 children showed symptomatic improvement	4
Family to obtain whole range of emotions and to be able to communicate freely about them Family to diminish criticism and to increase mutual support and appreciation among its members Margaret's tics to disappear	10 sessions over 7 months (without the children at 2 of these)	Family atmosphere was less inhibited and parents developed a closer relationship Margaret's symptoms abated and all children became more relaxed (18 months later the family atmosphere and interaction had further improved)	5
Parent's expectations to become more realistic Parents to communicate and make family decisions jointly	Graham was referred to Day Centre to enable him to separate from parents. Parents given 2 series of 6 and 10 weekly sessions over 5 months	Parents become more involved in the marriage and with each other Graham's anxieties diminished	5
Family to accept and understand maternal grandmother's illness Lynette and mother to become more separate persons Lynette's asthma to improve and sib's shrieking to lessen	6 sessions 3-weekly, 2 family, and 4 marital but father did not attend 2 of the marital sessions	Shrieking stopped rapidly and asthma lessened Fears of madness persisted especially for mother, but guilt was less Marital relations stabilized freeing Lynette to be herself	5

TABLE 5—continued

Case no.	Index patient and sibship	Presentation	Focal hypotheses	Focal plan
MUCH IMPROVEMENT FOR BOTH THE INDEX PATIENT AND HIS FAMILY				
19	Kevin 9 yr Only child with older step-sister	School refusal Temper tantrums	Kevin has problems in separation and competition Family has problems with aggression Psychic pain has to be kept secret in the family	Help parents adopt a more realistic attitude to discipline and painful matters
20	Thomas 8 yr A twin (no other sibs)	Asthma Anxieties	Fears of death Parental denial of asthma	Explore fears openly and discuss the asthma
21	William 12 yr Oldest of 3 sibs	Excessive sibling rivalry Behaviour problems Moderately educationally subnormal Depressed mother	Despair (especially about handicap) is unacknowledged Family members make inappropriate demands on each other	Share painful feelings and clarify positive realities Realistic assessment of of William's handicap
22	Rachel 5 yr Older of 2 sibs	Temper outbursts	Parent's unresolved maturational problems are being projected on to the children Unable to find their own identity the parents have obtained security by self-idealization They are frightened of rage inside and are unable to be caring	Provide a containing setting for the marital relationship to help parents cope with their needs, drives and rage Focus on fears preventing sharing and commitment within marriage
FAILURE TO ENGAGE				
23	Christine 6 yr Younger of 2 sibs	Temper tantrums Isolation	Fear of madness in family, with resulting problems in behavioural control	
24	Giles 9 yr Youngest of 4 sibs Adopted	Epilepsy Behavioural problems at school	(Preliminary observation: problems of communication and secrecy)	
25	Jake 8 yr Youngest of 4 sibs	Encopresis Immature and destructive behaviour Asthma	Lack of adequate parenting Jake identifies with father "the failure" Marital conflict	Work on infantile needs and deprivation

Criteria to be met for successful outcome	Treatment	Outcome	Score
Open acknowledgement of psychic pain within the family Parents to enforce discipline despite Kevin's protests Kevin to attend school regularly	4 sessions over 7 months	Parents expressed their own experience of pain Parental discipline improved Kevin was left with a tension cough but no school problems	6
Fear of death to decrease Realities of asthma to be openly discussed Severity of asthma to lessen	6 sessions (3-weekly)	Family cooperated and discussed the issues (Mother temporarily immobilized with slipped disc during therapy) Asthma improved and family tension diminished	6
Parents to make demands within William's capacities and vice versa Family to look positively towards the future Marital relationship to improve	6 sessions 4/6 weekly	Marriage became more mutually supportive Mother less depressed William's behaviour improved	7
Parent's needs to be met within the family; they should provide each other with practical and emotional support Parents to describe themselves and each other in a realistic and sympathetic way Rachel to remain asymptomatic	20 marital sessions weekly (this followed 6 months of weekly individual therapy for Rachel and single parent casework)	Increased caring, communication and commitment in the marriage Parents settled in themselves and relations with children improved	7
	Contract not established 2 sessions with members absent Mother resistant to therapy	No improvement Comment: Mother's mother and aunt were psychotic Family dysfunctional in all major areas	0
	Refused family therapy at initial session but agreed to 6 marital sessions. Only 2 attended	No improvement Comment: Giles suspended from school. Parents contemptuous of psychiatric help	0
Marriage to stabilize and parenting to improve Mother to become less over-protective and father less harsh	Contact not established 1 session only	No improvement Comment: Mother became determined to leave family and divorce occurred subsequently	0

TABLE 5—continued

Case No.	Index patient and sibship	Presentation	Focal hypotheses	Focal plan
26	Sam 14 yr Youngest of 3 sibs	Learning problems Behaviour problems at home and school	Father's chronic malignant illness dominates the household Excessive demands made on Sam conflict with his neediness	Decrease split between parents and children Discuss father's illness
27	Marlon 9 yr Older of 2 sibs	Panic states Temper tantrums	Marlon's dwarfism is associated with vulnerability to parental conflict Mother has not separated from maternal grandmother	(Preliminary plan: discuss whether to continue in family or marital format)
28	Joseph 10 yr Younger of 2 sibs	Obsessions and compulsions	Joseph used as container for mother and marriage Symptomatic behaviour enacts unconscious impulses and conflicts	Explore marital problems
29	Charles 10 yr Fourth of 5 sibs	Temper tantrums Stealing at home Asthma (also in father and a sib)	Family myths: Men bear symptoms and are attacked by women. Men cannot hate Use of opting out as a family defence	

there was no significant association between marital disturbance and success (Fisher Exact Probability Test) or the ordinal ratings of outcome [Mann–Whitney *U*-test (Lindgren and McElrath, 1966)].

Summary of cases

The cases are described in Table 5 to inform readers of our hypotheses, therapy plans, outcome criteria and results. For reasons of space we have not been able to provide the salient factors from the history and observations of family interaction, nor our reasoning. A full account of two cases (No. 16 Margaret and No. 22 Rachel) illustrating the derivation of the data presented in the table is given in the accompanying paper (Bentovim and Kinston, 1977).

DISCUSSION

Evaluation of results

About two-thirds (66%) of the children referred showed some improvement from the treatment offered. The figure is conservative as it assumes no improvement in families that did not engage. Sigal *et al.* (1976) found that families that refused contact after no more than two interviews did as well as those who received treatment: their "no treatment" group would correspond to our failures to engage. For the purposes of considering the effects of brief focal therapy, we may exclude this group

Criteria to be met for successful outcome	Treatment	Outcome	Score
Family to free itself from father's illness and to express feelings about it Parenting to improve Sam's symptoms to diminish	After initial interview mother demanded individual therapy to protect father. This was provided, with parents only seen occasionally	Sam improved symptomatically, but a sib took on relinquished symptoms	0
	The family had been previously treated with 6 sessions of marital/family therapy when 1 cotherapist left Family did not return for course of therapy	No improvement assumed	0
Marital conflict to be openly dealt with Joseph's symptoms to lessen	1 session No alliance with mother achieved and family did not return	No improvement assumed	0
Family to abandon stereotypes and to be more flexible in role allocation Charles' symptoms to lessen	1 session attended Contract not established	Charles improved slightly Family was resistant to therapy	0

in any case on the grounds that they did not receive therapy. Eighty-seven per cent of those accepting therapy improved. Such a result could be described as "typical" (Kaffman, 1963; Safer, 1966; Sigal *et al.*, 1967; Wells, 1971); it complements the finding in psychotherapy research that a high percentage of patients receiving any psychotherapeutic treatment (including being assessed and put on a waiting list) show improvement (Meltzoff and Kornreich, 1970; Luborsky *et al.*, 1975). The common non-specific factors of psychotherapy (Rosenzweig, 1936; Frank, 1965; Strupp, 1975) are present in family therapy.

Although therapy was specifically aimed at the family, only 11 of the families, 38% of the referrals and 50% of those engaged, were rated as having improved, i.e. scored 4 or more. It is difficult to know whether this is typical of family therapy. Some workers (Weakland *et al.*, 1974) are only concerned with the presenting complaint in their evaluation of outcome, others (Sigal *et al.*, 1976) rely on parental reports of satisfaction with family functioning, whilst others (Minuchin *et al.*, 1967; Sigal *et al.*, 1967) rate the family comprehensively and lose specificity. This study was concerned only with change in a specified way: a particular area of family pathology was delineated and its resolution was a requirement for a rating of improvement irrespective of how well the family might be functioning in other respects—for example, as a consequence of a reduction in stress following the symptomatic improvement of the index patient.

e.g. Case 4, Darren.
The disappearance of Darren's soiling reduced stress within the family and they responded with increased support and positive feeling for him. However, the family's handling of depression remained unaltered.

The family might make helpful alterations which facilitate improvement in the index patient and terminate treatment without having fully dealt with the underlying problem (as defined by the workshop).

e.g. Case 14, Judith.
Judith benefitted when her parents arranged for her to attend a new school. However, the parent's handling of her adolescence was not fully satisfactory.

This may correspond to what Malan calls a "valuable false solution". A valueless false solution occurs when the index patient's loss of symptoms is rapid and this is used by (perhaps produced by) the family to maintain their dysfunction or deny their problems (e.g. Case 7, Richard). The paradox of the index patient routinely improving more than the family is partially explained by such manoeuvres. However, the main reason for it is simply that improvement on dynamic criteria is a far more stringent test of improvement than target symptom improvement or global rating of improvement. It is a requirement that the patient or family improve just in the area where they have maximum problems and prove it. As we did not rate the index patients for improvement on dynamic criteria, they appear to have done "better" than our families.

We present our findings as a preliminary attempt to assess family therapy in an individualized way. In the absence of controls we cannot say how specific our results are to our form of therapy nor how much a factor of natural remission is contributing. Nevertheless, this study provides indirect evidence that therapy related to improvement. Although all children had been suffering for long periods, the symptomatic child was regarded as a manifestation of a family problem; this problem was diagnosed and a treatment carried out on the basis of the diagnosis. Changes in the family which were predicted to occur if therapy was successful were always associated with improvement in the referred child, and the greater the improvement in the family the greater the improvement in the index patient ($P < 0{\cdot}001$, Sign Test).

Malan's methodology and family therapy

Our short-term follow-up assessment as described uses a goal attainment procedure based on Malan's methodology. This methodology was developed for the evaluation of dynamic (intrapsychic) change in individual adults. We found problems and limitations in its application to families and family therapy.

A full application would demand assessment and, if required, focal hypotheses about each individual (at least the index patient), the marital subsystem, and the family-as-a-whole. The complexity of such a procedure in a clinical situation is immediately apparent. We were mainly concerned with establishing a technique for brief family therapy and therefore constructed our hypotheses in terms of family functioning. In view of the type of referral, the index patient's symptomatic improvement was always a criterion of outcome; but psychodynamic hypotheses for individual members were not made. The result is an inversion of Malan's procedure

where assessment of marriage and family life is kept at a "symptomatic" level. From our experience, an individual's reports do not provide an accurate guide to the interactional status of his marriage or family. Many of Malan's cases were married at follow-up: in one "untreated neurotic" patient with "apparently genuine improvement" (1975), No. 16—The Printer's Assistant, the patient simply refused to discuss his marital and sexual life.

We are raising the difficult problem of the assessment of the relation between intrapsychic states and external behaviour; it cannot be assumed that one is the direct correlate of the other. For instance, relationships may be used to externalize and relieve disturbed intrapsychic states (Dicks, 1967; Zinner and Shapiro, 1972, 1974). A spouse may be chosen on this basis [see Case 22, "Rachel" described more fully in Bentovim and Kinston (1977)], and children may be used similarly (e.g. Case 8, John). Malan's basic assumption is that relationships improve when intrapsychic changes occur—the family therapy assumption is that intrapsychic changes occur when relationships improve. Clearly these formulations are interdependent; in the first case, relationships do not always improve (Malan gives examples), and in the second, intrapsychic change is not an inevitable concomitant of an improved environment (unfortunately our study did not permit this to be demonstrated). Relatively healthy individuals may become caught in dysfunctional patterns of interaction from which they are unable to extricate themselves. Family therapists are used to the striking improvements in disturbed children following family intervention, often when individual therapy appears to have failed (Skynner, 1969). Modification of the family may permit intrapsychic change occurring during the individual therapy to show itself.

> e.g. Case 11, Barry.
> Individual therapy had continued over 15 months without appreciable effect. Following six family sessions at monthly intervals, Barry was less symptomatic, happier and functioning better at both home and school.

Psychoanalysts (Freud, 1966; Winnicott, 1971) have observed that problems are not always internalized permanently by the child, i.e. by implication needing psychoanalytic therapy. Even long-standing situations can be unlocked. The question is: Why do children take such a part in the family problem and how can they respond so promptly? One explanation is that the child shows symptoms in order to support "to be loyal to" (Boszormenyi-Nagy, 1972) some aspect of family life, often a disturbed parent or a bad marriage.

> e.g. Case 12, Nigel.
> Nigel's obsessional symptoms were related to his loyalty to his mother and maternal grandfather. When father and mother acted in concert and his symptoms were no longer necessary, they reduced. They returned again when mother was isolated.

When both individual disturbance and family disturbance are present, one would expect prognosis to be poor. Some evidence for this comes from our poor results with families which had a member with a history of psychiatric illness. Difficulties remain in disentangling family and individual disturbance, e.g. Beiser (1972) described a case in which, against all predictions, a woman improved markedly rather than collapsed following the death of her mother with whom she had lived in symbiotic dependency.

In Malan's work evidence for improvement is based upon alterations in the individual's "predisposition", the breaking of "vicious circles" and the individual handling specific stresses in a new and better way. This evidence comes from the individual's behaviour in his outside life. For assessment of family change we must look for evidence in the family's life, as well as the way the family and its members relate to the outside community.

Vicious circles are characteristic of family pathology and can be relatively easily recognized. Improvement requires that they disappear and be replaced by something positive.

More complex is the problem of specific stress. If this stress is external to the system (as it not uncommonly is for the individual: authority, social relations, sex) then repeated exposure is likely and can be awaited. For example, if the stress centred purely around a developmental phase of one child, then the handling of the next child going through the same phase could provide evidence as to improvement. However, if the stress is internal, i.e. an aspect of developmental change for an individual, such as puberty, then repetition will be impossible. The corresponding example in the family might be the youngest child starting school. In cases where stress is not, or cannot be, repeated, then we must have evidence that the predisposition has altered. "Predisposition" in a family is a difficult concept. From the viewpoint of systems theory and psychodynamic theory it would refer to the family boundaries (rules, myths), family coalitions (alliances, affective bonds), inter-member channels (the nature of communication, control and exchange) and the family's relation to the community. Presumably accurate reliable clinical descriptions of families along these lines are possible; however, the field of family therapy is at a disadvantage here. The vocabulary for describing family interaction is confused in the literature. The field is comparatively young and although many terms and categories do exist, clear definitions and consensus on them do not. For reliability it is necessary to use terms which are generally accepted and understood, even if the cost is a loss of discrimination. For our research the cost was excessive. An accepted terminology is a form of "short-hand" description. Without it the amount of relevant data from an interview with a family increases enormously. Reporting, particularly of non-verbal behaviour, becomes a complex and problematic aspect of the whole procedure. Video-tape recording of interviews would have been a valuable addition to the circulated reports. True intrapsychic change is stable but many of the family parameters, though relatively stable, e.g. family decision making (Ferreira and Winter, 1966), may be altered by the natural life cycle of the family. This complicates evaluation of change in the predisposition. Further research into the natural history of the family from the interactional point of view is necessary.

Clinical findings

The workshop accepted all cases referred and it was hoped to discover which families would respond favourably to a brief focal approach. Severity of disturbance or chronicity of the problem had no obvious bearing on outcome, but we failed to engage larger family groups containing 4 or 5 children.

Prognosis in individual and group therapy relies on introspectiveness, curiosity and willingness to understand oneself, and realistic expectations of therapy (Bento-

vim and Wooster, 1968; Sifneos, 1968). These qualities do not seem so pertinent to family work. This is probably because of the possibility of focusing on behavioural and emotional interactions as they occur. It did seem that an inability to recognize and accept that the presence of a symptomatic child might be indicative of a family problem was a poor prognostic sign.

> e. g. Case 6, Richard.
> The family accepted their problem "in principle" (i.e. complied with the therapists), but discontinued therapy when he improved.

It is likely that when a whole family accepts and shares in the responsibility for the problems of one of its members, this will be a sign of strength. Older sibs clearly wished to be involved despite practical difficulties in some families, e.g. Case 13, David; Case 16, Margaret. One specific factor emerged as possibly an important predictor for selection of families for our approach. If one or both parents has been or could be) given a formal psychiatric diagnosis then the family is probably unable to work briefly and intensively, e.g. Case 1, Patrick (father: alcoholism); Case 2, Anna (mother: puerperal depression); Case 4, Darren (mother: depression); Case 8, John (mother: unspecified breakdown with psychiatric hospitalization in the past). This association was confirmed statistically. Two factors appear to be operating. First, the parents are vulnerable and threatened by psychotherapeutic approaches so time is required to involve them. Second, the psychopathology is complex. A child may be required to be a container for the sick aspect of the parent, e.g. John, Case 8; or if psychiatric illness is present in the family of origin the parent may need a relationship to a "sick" person.

> e.g. Case 23, Christine.
> Christine's temper tantrums were regarded as evidence that she carried the family psychosis (maternal grandmother and maternal aunt suffered) and hence controls were not appropriately supplied. Despite this fear that another member of the family was showing signs of madness, there was resistance to attending, particularly on mother's part.

The most important factor affecting the plan of intervention was the state of the marital relationship. The existence of marital disturbance when the child is the referred patient is not a new finding. Epidemiological studies (Rutter, 1971; Richman, personal communication) have shown that there is a high rate of marital disorder in children of all ages presenting with psychiatric disturbances. Satir (1964) wrote: "The marital relationship is the axis around which all other family relationships are formed". Outcome in cases with severe marital disturbance varied greatly: the family failed to engage (Case 25, Jake; Case 28, Joseph), or did not improve (Case 7, George; Case 10, Beth) or continued in long-term therapy of some form (Case 2, Anna; Case 11, Barry; Case 12, Nigel). Case 14, Judith, improved as a family but the marital subsystem remained disturbed and marital therapy was rejected. Improvements occurred in Case 17, Graham (two courses; 6 and 10 weekly sessions) and Case 22, Rachel (20 weekly sessions) where the marital disturbance was intensively taken up. Characteristically the disturbance was covert and had been missed during the initial diagnostic procedure. During therapy exposure becam e inevitable and the parents experienced this as a major emotional crisis to which they reacted by flight or request for help. Careful assessment of the marriage of any case considered for brief focal family therapy is necessary, and this

may require separate interviews if it is suspected that long-standing denied or hidden problems exist. In other words, marital diagnosis must be a primary concern for treatment planning.

Evaluation of the workshop

The family therapy approach is becoming widely accepted as part of the therapeutic armamentarium in child psychiatry. In the absence of developed training facilities, it is worth examining the functioning of the workshop: its capacity to foster family work and the problems we encountered.

The particular therapeutic approach outlined here has considerable value for the beginning family therapist (Cleghorn and Levin, 1973). It provides a comprehensible and assimilable method in a complex field, encouraging a meaningful ordering of the data and demanding a determined therapeutic effort. One of the problems that our therapists had in their previous work with families was maintaining the impetus of change in family functioning which often commenced during the diagnostic interview. Therapeutic diffuseness leads to non-attendance of family members and loss of meaning in the therapy. The focal time-limited method placed a useful pressure on our therapists to recognize and describe family interactions and transactions, and then to face the families with their disturbance. It required a defined contract and specific goals.

The workshop was probably an important factor in the efficacy of treatment. It provided enthusiasm, discipline and supervision. It ensured the examination of transference and counter-transference difficulties and acted as a countervailing system to minimize the usual tendency of the therapist to become enmeshed in the interactions of families. Whether therapists can continue similar work creatively perceiving a significant focus via integration of the family history, presenting complaints and observations of family interaction, is uncertain at this stage.

The major problem of the workshop was the lack of a coherent generally accepted conceptual framework for family therapy. Neither developments from psychoanalytic theory (Boszormenyi-Nagy and Spark, 1973; Zinner and Shapiro, 1972, 1974), nor the precepts of system theories (Zuk, 1968; Minuchin, 1974; Fleck, 1976) were integrated effectively; and resistance to conceptualizing at a family level persisted (Jackson, 1966; Sluzki, 1974). Our members were able to work together on clinical problems but full discussion of families was seriously limited. Description of families qua families was crude and simplistic in comparison with the richness and complexity of description of the individuals. The G.A.P. Report (1970) remarked on the absence of a common vocabulary for the family and urged that its formulation be given priority. Without a clear theoretical base indicating the data to be gathered, our research efforts were handicapped.

A moderately standardized semi-structured approach can be applied to the interview of a child or parent, and such interviews have been shown to have acceptable reliability and validity (Rutter and Graham, 1968; Graham and Rutter, 1968). Development of a technique for interviewing the whole family to assess current patterns of interaction, i.e. a "family state" is now under way.

SUMMARY

The experience of a workshop set up within a Department of Child Psychiatry to foster family therapy and to develop a brief focal technique is described. Details are provided of the first 29 cases. Twenty-two families engaged in therapy and the referred child improved in 19 (87%) of these cases. Family change was measured using a methodology developed by Malan to assess psychodynamic change in individuals and problems in adapting it are discussed. Eleven (50%) of the engaged families improved. The pattern of child and family improvement supported the theory that a symptomatic child can be a manifestation of family pathology. A contraindication to the brief focal approach is past or present formal mental illness in a parent. Marital disturbance was frequently covert: this affected the therapeutic plan but was not related to outcome.

WORKSHOP PERSONNEL

Dr. A. Bentovim, Mrs. M. Boston, Mr. S. Dorner, Miss A. Elton, Mrs. E. Gasper, Miss L. Gilmour, Dr. W. Grant, Dr. G. Hsu, Dr. W. Kinston, Mrs. M. Kirk, Mr. R. Lansdown, Dr. B. Lask, Mrs. R. Szur, Miss A. Tobias, Dr. S. Woollacott.
Workshop Consultant: Mr. J. Boreham.

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