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BRIEF FOCAL FAMILY THERAPY WHEN THE CHILD IS THE REFERRED PATIENT—I. CLINICAL

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INTRODUCTION

OVER THE past two decades there has been considerable interest in finding ways to shorten psychotherapeutic work, and generally increase the efficiency of psychiatric professionals via brief intervention methods (Malan, 1963; Sifneos, 1967; Parad and Parad, 1968; Small, 1971). This trend has only relatively recently become evident in the field of child and adolescent psychiatry, coincident with the development of theories and techniques which recognize the parents, extended family, and social network both as targets for change and agents of change (Skynner, 1969; Rosenthal and Levine, 1970; Argles and Mackenzie, 1970; Leventhal and Weinberger, 1975; Minuchin *et al.*, 1975).

Within the broad rubric of "family therapy", many treatment approaches have been used. Most of the shorter methods require an active technique with the therapist engaging directly with the family members, setting family tasks, openly acting as a model of healthy functioning, providing videotape feedback of interactions, interfering with dysfunctional behaviour patterns, advising, or consciously double-binding (Alger and Hogan, 1969; Beels and Ferber, 1969; Zuk, 1968; Haley, 1971; Crowe, 1973; Minuchin, 1974). Even those techniques more directly emerging from psychoanalytic theory, as described by Ackerman (1958), Dicks (1967), Zinner and Shapiro (1974) and Boszormenyi-Nagy and Spark (1973), involve considerably more therapist activity and direction than is customary in individual psychoanalytic therapy.

In our own growing experience of working with families conjointly over the past 10 years in the Department of Psychological Medicine at The Hospital for Sick Children, London, we have become impressed by the value of family intervention whatever the orientation of the therapist. Diagnostic work usually takes place in a family setting and wherever possible treatment aims are rapidly clarified so as to harness the charge of potential associated with the first meeting between a disturbed family and the professional (Haley, 1970). The problem then arises to determine an appropriate treatment technique to maintain and foster alterations in family functioning. Without a clear purpose or technique it is easy to allow work to become diffuse, commonly followed by various family members opting out. A particular problem is the emergence during family work of hidden problems and demands,

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most commonly in our experience in relation to long-standing, but carefully avoided, severe marital disturbance.

The success in shortening individual psychoanalytic therapy by using a focal approach (Malan, 1963; Balint *et al.*, 1972) suggested the application of a similar model to family work. A work-shop was set up to enable staff to develop a "family focus". An experienced staff member of the Tavistock Clinic's Brief Psychotherapy Work-shop agreed to act as Consultant and Group Leader during the first year (1973–1974) and cases were brought, family sessions written up, and the treatment process followed. This paper exemplifies the clinical work done with this "brief-focal" model. The results are set out in a second paper (Kinston and Bentovim, 1978).

THE WORKSHOP PROCEDURE

Following the Department's full diagnostic procedure, the case was brought by the therapist(s) who provided the workshop members with details of the referral, a brief description of the family, and the salient pathological factors with elaboration as necessary. The workshop developed a hypothesis to explain the symptom in terms of the salient factors and a minimum of psychodynamic understanding. This "focal hypothesis" then became a reference point for therapeutic progress, and a source of predictions for assessment of success or failure of the treatment. The actual treatment is determined by the "focal plan" which suggests how the desired change is to be brought about. This plan varied from straightforward direction to the therapist, e.g. "interpret the dynamics, i.e. the focal hypothesis", or "get Father to go out more with Mother", to more subtle demands, e.g. "clarify communication" or "increase sharing of feelings". The values of the workshop were psychodynamic insofar as there was emphasis on the importance of developmental factors, the needs of the family members to feel understood, and the necessity for a working alliance. As the treatment unfolded, new phenomena or information sometimes came to light which demanded a revision of the focal hypothesis or focal plan. To illustrate the process of developing a focal hypothesis and arriving at and implementing a focal plan, two cases will be described. In the first a focal plan could be formulated early and worked with consistently to termination, while in the other it could only be arrived at over a period of time as the therapists worked to create a "shape" in the diffuseness of the pathology.

CASE 1: MARGARET AND HER FAMILY

Family

Margaret's family consisted of her father (43 yr) and mother (37 yr), both secondary school teachers, and two sisters. Margaret at 10 yr was the youngest, Alice was 13 yr and June 15 yr.

Referral

Although Margaret had suffered from complex tics since the age of four, these had become increasingly frequent and severe. The abnormal movements included sniffing, coughing, snorting, sudden teeth clenching, flapping of the elbow, slapping her chest or thighs with both hands, and sudden stamping on the floor.

Salient facts from the history

Family history of illness: Maternal grandmother—chronic arthritis. Three paternal uncles—all with moderately severe depression.

1964: Mother suffers a depression (Margaret is 6 months).

1967: The family moves from the north of England to London, Margaret (4 yr) commences school and her symptoms appear. Mother starts at a teachers' training college.

1970: Father becomes redundant, but appears unconcerned. June (12 yr) has tension headaches followed by eye-blinking. Mother has a recurrence of her depression.

1971: Father then takes up teachers' training. June's symptoms remit.

1973 (time of referral): Margaret's symptoms worsen. Father is in his first year as a teacher at a school with high academic standards but pupils of mediocre ability, and mother is also teaching. Both parents are extremely conscientious about their jobs and work hard to be successful. This attitude extends to home life, with father doing chores which could be done by other family members and Mother doing a great deal for the children and effectively treating them as if they were much younger than they are.

Observations of family interaction

(a) There was a marked restriction of verbal and non-verbal expression of feelings, and communication generally was marked by inhibition of activity.

(b) Feelings of anger, depression and areas of conflict were avoided by all family members. Father, particularly, was not able to tolerate and respond supportively to his wife's depression.

(c) The family as a group depreciated itself, and members failed to express appreciation of each other.

(d) Each family member had excessively high standards of performance for himself and for the others, resulting in a sense of failure in the family atmosphere. This extended to the parent's sexual relationship.

Dynamic hypotheses

After combining the salient facts with the observations at interview, two focal hypotheses were determined.

1. Margaret's tics were a way for her to deal with feelings which could not be communicated within the family atmosphere of inhibition, and with a desire for activity which had to be suppressed in accord with the same family rule.

2. The excessively high standards together with the lack of mutual support and appreciation within the family meant that the members' self-esteem and sense of well-being could not be maintained.

Focal plan

In this case, the plan follows from the hypotheses in that the aim is to help the family appreciate the extent of the inhibition they impose on themselves, to promote freer communication of feelings, and to encourage expression of mutual appreciation within the family. A series of 10 interviews were suggested for the carrying out of this plan . . . the interviews to be scheduled at 3 weekly intervals approximately.

Developments in treatment

The 10 interviews extended from November 1973 to June 1974. Initially sharing of feelings and free communication between family members was frustrated by June who routinely came between the parents and overwhelmed Mother at the expense of the other children. This was observed in the sessions and reported by the family. At home she monopolized Mother, particularly late in the evenings, and so prevented the parents from being together. She was actively in competition with her younger siblings and failed to appreciate their interests and capacities. The therapists pointed out that the parents were allowing June to cross the generational boundaries and prevent them having an adult relationship. They were also letting her prevent them from responding to the other children and their needs. June's role in the family and the family's collusion in its maintenance having been clarified and challenged, Mother's difficulties became apparent. She had a tendency to take over for the children and to speak for them. This over-protectiveness was foiling their emancipation which she both wanted and dreaded. Mother's dependency needs had not been adequately met due to her own mother having suffered from an arthritic condition. She took her needs to professional colleagues rather than to her family. Father emerged as a family scapegoat in spite of, or perhaps because of, his efforts to live up to family expectations and meet his own ideals. His efforts left him and the family frustrated.

An extract from the second interview will illustrate some of these points:

After a period of limited spontaneous conversation, therapist B asked June, who had been lively in the previous session, why she was less lively on this occasion. The family informed the therapist that June was writing examinations. Mother added that June had got up early, panicked and did not seem to realize that panic would not help. June was at the stage where she did not have enough confidence—her parents had, her teachers had, but June did not. Therapist A commented that the family as a whole seemed frightened of trying anything new. He observed that although it was only June who had the exam, no one else seemed lively either. There then followed a spirited discussion as to how they had gone half a mile west of the hospital and had walked back from the tube station because they were early, and father had taken them the wrong way. Alice retorted that "he always did". June said: "I told him before we started but he wouldn't listen". Father then explained that he had done this to check whether cheap seats were available at a theatre for him to take the family after the interview. He did not tell them because he was afraid that they would be disappointed if his plan was not possible. He was also half afraid that June might say she wanted to go to a different show and he wanted to avoid challenging her over this. The family said that he tended to be secretive like this and wanted to make decisions silently, expecting others to read his mind without telling them what or why. Therapist B suggested that perhaps Father wanted to keep the plan secret to avoid arguments since he always wanted to be right. He agreed and the rest of the family laughed. June said Margaret was like that as well.

This extract illustrates the inhibition of communication, the fear of confrontation, the lack of appreciation, and the failed attempt to be ideal with consequent frustration. It also shows the style of therapist intervention and the family response. A

subsequent interview with the parents alone clarified the patterns further. June had been conceived too soon after the marriage, at which time Father became increasingly concerned about financial security and the need to work more and Mother became depressed. This set the stage for distance between the parents, June's monopoly of Mother and conflict with Father, and subsequent dysfunction. The parents were poorly synchronized with each other in various areas of living, e.g. when one was sleepy, the other was wakeful. Their difficulty in achieving pleasure, emotional and sexual, within the family relationship was reflected in their over-emphasis of the importance of work, and cast a shadow on family life. When the family was more relaxed during holiday periods, Margaret's tics were very much less in evidence.

The family attended from a considerable distance and could accept that Margaret's tics were only a part of the problem and everybody and the family as a whole were in need of help. The inhibition of talking and involvement was particularly marked in the two younger girls. Alice behaved as a rather amused onlooker, while Margaret was quite passive apart from her tics which became more directly related to family stress during the course of therapy. Haloperidol was tried with some benefit at one stage, but was discontinued due to its side effects. The problem of inhibition within the family was raised by the therapists and worked on repeatedly, especially in relation to pleasure. There was a shared fear, most marked in Mother, that airing of such wishes might prove catastrophic, with the wish for pleasure taking over and stopping any work at all. Inhibition of anger was not dealt with in as much depth, except in relation to June's controlling ways with Mother. Father's fear of depression was also barely touched. The problems of self-esteem were worked on in various ways. Father was able to admit his anxieties over his performance at work. At home he was set the task of getting the children to do household chores and get round on their own. Both parents were encouraged to appreciate their children and vice versa. Previously efforts had been unnoticed, e.g. the children's achievements at work and music, or taken for granted, e.g. Father's organization of outings.

The workshop consensus was that the focal plan had been adhered to. Issues unrelated to the focal plan had emerged and been bypassed, e.g. sexual problems between the parents and sexual anxieties in the relationship between Father and June. The focal plan had been clearly understood by the family and they had changed in response to the therapeutic effort.

Short-term follow-up

The method we have employed lends itself to meaningful follow-up assessments, as the focal hypotheses by their nature provide criteria by which assessment of change may be evaluated (Malan, 1959). In the case of Margaret's family the criteria would be as follows: each member should have access to the whole range of emotions and be able to communicate freely within the family; intra-family criticism should be low and mutual support and appreciation should be evident; the atmosphere generally should be pleasant with no member suffering undue depression; the tics should be absent.

A follow-up interview 3 months later confirmed the impression of real change in the family and its members. At this interview the girls were more relaxed and

interacted more freely. The family began by describing a recent incident when June was out with Margaret. Margaret had tried to take over the parental role, telling June not to eat chewing gum just before dinner. In order to change the subject June got Margaret to race her home, but June slipped in the mud and got quite plastered in mess—so much so that she felt quite unable to cope. This was recounted with much amusement. Margaret at this point stopped fidgeting and pointed out that she had helped June by picking up the shopping and making her a cup of tea. Therapist A suggested that it was as if June really felt knocked out of her grown-up role and thrown in a baby one, and half-expected Margaret to pick her up. The family laughed at the incongruity. Both June and Alice then talked about their grown-up activities. June described her recent boy-friend and Alice her drama classes. Margaret had also shown she was more grown-up: once her parents had forgotten to collect her from her girl's club and instead of just sitting down and crying as she would have done previously she telephoned to remind them. The interview contained much less mutual criticism although Mother felt that Margaret was more provocative and sometimes more babyish. The tics were much reduced. The family did not wish further help but wanted to keep a line open to the therapists if necessary.

Conclusion

In this family the focal plan was aimed at promoting freer communication, increasing mutual appreciation, and loosening inhibition of feelings. It was adhered to and succeeded in considerably alleviating the presenting symptom (tics), releasing the maturation processes in the "well" siblings, and permitting the parents a closer relationship with each other and a more realistic and gratifying relationship with their children, particularly with respect to fostering their emotional growth and development. Limitations are clearly apparent: the symptom is not totally removed, marital difficulties are still present, and individual members are still struggliug with significant emotional problems. This family was given a rating of "some improvement"—on our scale of "no improvement", "some improvement" and "much improvement", and Margaret was rated as "much improved".

CASE 2: RACHEL AND HER PARENTS

Family

Rachel was a 5 yr old girl with a sister, Beth, 2 yr younger. The parents are in their early 30s and work professionally, having been brought up and trained abroad.

Referral

Rachel was referred with temper outbursts and excessive fearfulness and anxiety. Initially the case was dealt with by providing individual therapy for Rachel. Over 6 months a social worker saw mother or father (depending on who brought Rachel up for her session). However, while Rachel made good progress, the parents became increasingly disturbed. Both parents formed intense and somewhat sexualized relationships with the social worker and the mother became increasingly dependent. It was felt that such strong feelings might be appropriately directed towards each other rather than to the social worker who was not seeing them in a therapeutic

setting which permitted resolution. Conjoint meetings including both parents, the social worker and a psychiatrist were arranged specifically to work on these problems after individual therapy with Rachel ceased. Beth's development and psychiatric status were within normal limits and as the focus was a marital one it was decided not to involve her in specific treatment.

Salient facts from the history

Both parents had major difficulties in their families of origin. Father's father, a school headmaster, was often absent during his childhood, and his mother was depressed and suicidal for many years. Mother, in her family, had always felt pushed out by a younger sibling, and her father had been absent also while being idolized by her mother. She denigrated her mother but felt identified with her. Both Rachel's parents found a solution (partially) in their work, and used their work role as a source of identity and a means of valuation as individuals. Even after marriage they had continued to use people, work and situations outside the marriage to obtain satisfaction for their needs, and did not turn to each other. Both worked very long hours, father especially leaving mother at home alone and depressed. They led separate lives.

Observations of marital interaction

Neither parent perceived the needs of the other and both avoided communicating about their own needs and pain. They expressed intense anger about their parents, their marriage and the therapists in a messy way, scattering cigarette ash around the room and using sexual talk similarly. Simultaneously they were frightened of the damage they might cause. They were unable to help each other; each emphasized his own vulnerability while being patronizing and critical of the other.

Dynamic hypothesis

Both parents have been unable to find their own identity and have obtained security via self-idealization. Each is frightened of intense primitive rage and neither is able to see the other in a real and caring way.

Focal plan

It took a number of sessions to formulate the above hypotheses and develop a workable focal plan. It was decided that the therapists should aim at making the therapeutic situation a containing environment where better communication could be established with consequent reduction of primitive fears, opportunity for contact with each other's personal reality, and the possibility of sharing and mutuality. Contact with their own capacity to care would both enable them to support each other and permit greater responsiveness to the children. It was decided that meetings should be held weekly for 6 months.

Developments in treatment

Not surprisingly, the focal plan was not easy to implement. Both parents wanted to be therapists: father was critical and mother patronizing, and the sessions were initially vague, messy and permeated with hostility. Mother was particularly angry

about having to share the sessions and give up her idealized relationship. She had affairs which upset the marriage as well as disrupting the basis of the focal plan. Father was no less disturbed. Both showed defensive play-acting in the sessions with little openness or change in their behaviour and ways of relating. They initially pretended to meet the focus while looking for magical solutions outside the marriage as they had always done. Mother was pushed by father into the "sick role" and used it to gain attention.

An extract from an early session exemplifies the issues: Father reported his absolute fury and anger at finding that his wife was having an affair with a man whom he sees as being in a position of responsibility. He stated that he was so furious that he thought of leaving his wife, writing to the man (her boss) and "bashing him up". By the time of the session he just wanted to get rid of such awful feelings. He described his idea of marriage: an ordinary ideal everyday middle-class existence with extra stimuli from intellectual things and with each partner making the other stronger and cutting out weaknesses and failings. Therapist C queried the possibility of strength being built up by meeting each others needs rather than ignoring them. While father was saying that needs were not important, the therapist believed that weaknesses were just as important as strengths. Mother was distressed that therapist D did not share her view that there was nothing to apologize for over the whole affair. She suggested that forgetting was the best way of coping with anger and perhaps she just needed another man: Father had been unfaithful and she was just testing him to see if he cared. She knew that what he wanted was what she did not want. She wanted to be herself. Therapist C suggested that perhaps she did not really want to be married at all, and that there had been a good deal of deception and falsity in the marriage—playing at being married. Mother agreed that she liked to seem close to her husband in public, whilst being very distant at home; and father said that he was not ready for marriage. Both felt that there were many skeletons in both their cupboards. The therapists emphasized that despite its hurtfulness, Father's anger about the affair had not been destructive but rather evidence that he cared and provided attention for her. Mother claimed it was the attention that a naughty girl got from father and not the response she expected from a husband.

The next extract from a session about 2 months later shows the beginning of change which subsequently progressed further: Father stated that "when we talk, we block about needs—we don't seem to get anywhere". He then asked mother what her needs were. Mother replied "Can't we talk about them later? . . . well I need tenderness". Father said that he needed commitment. Mother then spoke about how unsatisfied she was with her mother, and therapist C referred to the difficulty she had in foregoing her individual sessions (with therapist D) and wondered about dependency. Mother reacted strongly: "dependency!? a horrid word—surely we don't have to be dependent on each other?" Father asked what was wrong with dependency and mother replied that it meant being controlled—people who are dependent on her are so puny and they are demanding and she cannot bear demands. She preferred angry people and then she could respond. Therapist C then pointed out that she seemed to perceive dependency as controlling and being controlled, overwhelming and being overwhelmed, and involving total sub-

mission rather than a part of herself being dependent on her husband and part of her husband being dependent on her. Father then asked "Why, if you are so afraid of dependence, why do you stay with me?" Mother broke down in tears and sobs, acknowledging she wants her husband, likes him, and really is dependent on him. Father moved his chair so he could comfort her and though mother said she liked it, she simultaneously shifted her position so that she was turned away from him. Her non-verbal contradiction of her verbal acceptance was made explicit in the therapy, and discussed.

Therapy was completed in 6 months as planned, and over this time communication improved and became more real and direct. The couple ceased attacking each other, and reduced their mutual denigration, hence they could move closer together. Their capacity to care for each other increased and at the end of the period, Mother became pregnant. Trust remained fragile and communication at times was difficult. Both showed changes as individuals: Father becoming more open, and Mother less attention seeking.

Short-term follow-up

In the case of Rachel's family the criteria derived from the focal hypotheses would be: the parents should obtain need gratification within the family as indicated by spending time together with pleasure; practical and emotional support should be evident; the parents should be able to describe themselves and each other in a realistic and sympathetic way; no member should be symptomatic.

At 5 months after the last session most of these criteria were met. Rachel's symptoms were fully abated, Beth continued well, Mother was enjoying domestication, and Father though angry and authoritarian was good humoured. The parents remained able to discuss problems and see each others point of view, sharing conflict and giving in when necessary.

Conclusion

Following a period of individual treatment of the child, marital problems became evident. Although a simple operational focus could not be defined, a plan was devised which enabled the therapists to sustain a therapeutic relationship and help the parents examine the similar personal problems which led them to marry and inevitably run into difficulties. The dynamic hypothesis guided the interventions which consistently aimed at confronting the idealized expectation of the other, and revealing each as a real person with needs which could be meaningfully gratified within the marriage. In this case both the family and the index patient received ratings of "much improved".

DISCUSSION

The two cases described above demonstrate the applicability of a time-limited active focal approach. The first case described was an integrated family with high motivation for change. The members showed willingness to accede to therapist directions and had no difficulty in accepting the authority of the therapist. The presenting symptom could be easily linked to family stresses, and the nature of the

stress as experienced by individual members was in terms of easily understandable emotions. The required changes in interaction were not difficult to define and once the family were in a working alliance simply indicating problems led to alterations in family functioning. In the second case the therapists were faced with a quite different situation. Both parents were suffering from severe characterological disturbances and the marital relationship had few positive qualities for the therapists to begin work with. A simple description of dysfunctional aspects was impossible and the setting up of a working alliance was not to be taken for granted. It took longer to formulate a meaningful dynamic hypothesis and focal plan. Each of the parents were seen as similar: ignorant and frightened of their own needs and infiltrating their interactions with primitive aggression. The treatment focused on helping them form a real relationship rather than altering a number of unhelpful interactions. Not surprisingly more intensive work was required: 25 weekly sessions.

Other cases seen in the workshop improved as much as, or more than, the cases presented here; but many did not. This paper aims at characterizing the approach which we are convinced is a worthwhile and important one. It is not possible to comment in detail on the technical aspects of the work. The therapists were psychoanalysts, psychiatrists, psychologists and social workers, and their backgrounds and styles varied considerably. Using the criteria of the G.A.P. Report (1970) they were Position M therapists. They encouraged interaction between family members and took up verbal and non-verbal aspects of the interaction. The experiences and problems of individuals were not avoided but related to the family context and to other family members. The psychoanalytic method of connecting present feelings, thoughts, and behaviour patterns to past events and experiences in the family and to aspects of the families of origin was used and found to be helpful. The therapists aimed to foster integration for the individual members as well as for the family, and also to provide the opportunity for corrective experiences. They provided education about developmental and emotional factors in family life, set tasks, modelled parental roles, and used challenges to dysfunctional value systems. The most characteristic aspect of psychoanalytic therapy—vigorous and detailed examination of the transference—was not a feature of the work, although working with marital couples brought such issues more to the fore where they could not be ignored. The various specific techniques currently being developed by family therapists (e.g. sculpting, genograms, videotape feed-back) were not used, though they are clearly adaptable for the type of approach described here.

We agree with Rosenthal and Levine (1970) that the high therapist motivation for short-term work, the pressure due to the time-limit, the collaboration between family and therapist, the clear definition of goals, the clarification and use of family strengths, and the open invitation to the family to return if necessary are all major factors in the success of a brief approach. Goals, by themselves, are not enough to guide the therapist as it is commonly not apparent why the family members let themselves persist in interacting dysfunctionally. The perception of a "workable/meaningful focus" is an important aid to the therapist enabling him to use his skills and abilities without the diffusion of effort or inappropriate narrowing of attention which can occur so easily in work with families. Although our therapists have had considerable experience in many forms of individual and group treatments of vary-

ing orientations, none have had formal training in family therapy—for which, in any case, no standard technique has emerged. The focused approach became an easily assimilated "technique". A further factor in our success in this venture requires mention: the workshop. Malan (1963) indicated the power of the group to foster a particular philosophy and way of working. Not only does the discipline of having one's work scrutinized increase involvement and enthusiasm for the work itself, but its supportive (and sometimes critical) function enables the therapists to maintain role and not drift into colluding with the family system or lose the focus. Sharing one's knowledge of the family and reporting sessions enables transference and counter-transference difficulties to be more rapidly recognized. They need to be understood and dealt with, even though they will usually not be interpreted to the family. At this stage we cannot know how far being a workshop member increased the effectiveness of the work, and whether the skill of recognizing and pursuing a workable focus without support and lengthy discussion has been retained.

CONCLUSION

This paper describes a style of family work which initially derived from the brief individual psychoanalytic therapy developed at the Tavistock Clinic by Malan and co-workers. The approach is highly suitable for use in busy Child Guidance Clinics where the alternatives are no treatment at all, or occasional supportive interviews with counselling. Even where resources are available, the method may prove a treatment of choice offering an opportunity for the improvement of the context of the individual's emotional life. The approach emphasizes seeing the whole family or marital couple, determining a few dynamic hypotheses which organize the salient facts from the history with observations of family interaction, and then constructing a focal plan. This plan links with the hypotheses but is operational and serves as a guide and reference point for the therapist in his work with the family. The frequency of sessions varies from once- to six-weekly, and period of contact is between 3 and 9 months. The therapeutic technique is an active one which does not rest on any rigid theoretical ideas. A contract and working alliance are set up in the initial sessions which also provide further opportunity for alteration of the hypotheses or plan. The role of the workshop group in supporting the therapist and helping the therapeutic work is emphasized. Two cases with very different psychopathology and family pathology have been described as examples of the clinical process.

SUMMARY

The development of a method to carry out time-limited focused work with families is briefly described. Two case examples are provided to demonstrate the process of formulation of dynamic hypotheses, the development of operational plans for therapists, and the changes in the family with therapy. The value of the method and the importance of the workshop where it is being fostered and documented is discussed.

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