TYPES OF PSYCHIATRIC TREATMENT

Change the family, change the child?

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This is the fourth of a series of articles on treatment of child psychiatric disorders.

The psychological health and the normal course of development of a child are closely determined by the nature of the security, predictability, and appropriateness of the immediate social environment. For most children, in Western postindustrial culture, this environment centres upon the nuclear family. Over the last four decades there has evolved a psychotherapeutic intervention that takes family life as its subject matter. This is now known, simply, as family therapy.* In its earlier stages it was designated whole family therapy or family group therapy.

Application of family therapy

Family therapy has become a widespread clinical practice within child and adolescent psychiatry. The research basis for this extensive application is slim, as is the case for most psychotherapeutic methods. There are also problems in the interpretation of the research: 'In sum, the search for an assessment of family therapy effectiveness has been frustrated by a research base that past reviewers have found difficult to synthesize'.¹ Hence, the justification for the use of family therapy in child psychiatric settings is largely based on 'clinical experience': it appears sensible to approach problems of behaviour and effective disturbance through the family context. None the less, in reviewing evidence for the efficacy of family therapy, Gurman and Kniskern report that the usefulness of family therapy is established for behavioural and emotional disturbance in childhood and adolescence.² Likewise, in the review of Hazelrigg *et al* there is a conclusion, from a meta-analytic study of a number of control trials of family therapy, that it can be shown to be more effective than no treatment or control treatments.¹ Most of the effective treatments reported by these authors, where the presenting problem is described, concern children with behaviour problems. Patterson has reported extensively on the effectiveness of his form of family intervention, based on social learning theory in behavioural disorder in primary school aged children.³

Alexander and Barton showed the effectiveness of another form of family therapy (using an admixture of systems and behavioural theory) in the management of behavioural disturbed children.⁴ Lask and Matthews have shown the usefulness of family therapy as an adjunct to physical treatments in asthma.⁵ (The therapy here was 'structural' in form.) Ro-Trock *et al* have shown that family therapy added to the milieu treatments in an adolescent unit improves the benefits of the inpatient regimen.⁶ In our own studies at the Institute of Psychiatry we have shown that family therapy is superior to a supportive individual therapy in the management of anorexia in adolescence.^{7 8} Our as yet unpublished findings demonstrate that the benefits of family therapy, in comparison to the control treatment, persists at five year follow up. Our family therapy can be designated as including psychoanalytic as well as structural and strategic elements.⁹

In addition to family therapy being used in the management of a child's presenting problems, it has also been used to alleviate family distress and to optimise family functioning in chronic physical illness.¹⁰ In principle family therapy is to be considered as part of the treatment plan in a wide range of chronic and distressing childhood illness.

In the course of this introduction, defining labels have been attached to reported outcome studies. This is necessary as there are many forms of family therapy. Although there have been very few studies of the specific strengths and applications of the different schools of family therapy, it is necessary to describe them in order to understand the diversity of techniques used within the therapy. Examination of the origins of family therapy and the context in which it developed provides a way of defining the different theoretical origins and styles of current practice.

Origins of family therapy

Family therapy grew from dissatisfaction with the psychotherapeutic techniques that were available in the 1950s.¹¹ In the early 1950s therapeutic techniques of psychoanalytic psychotherapy and psychodynamic casework were, essentially, the only well established treatment methods in child psychiatry departments and in child guidance clinics. These techniques came to be addressed to the child and to the two parents, so that in a well staffed clinic three professionals were involved in the

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*Throughout this paper the word family refers to the household of a family of creation. That is to say, it consists of a parent or parents with children for whom the adults are responsible for the foreseeable future. Other members of the household related or unrelated by blood may be included in a therapy session.

†Gurman and Kniskern point out that the efficacy of family therapy is best established in the form of marital therapy for marital problems.² Clearly, many children are seriously troubled by parental discord and marital therapy is not, therefore, irrelevant to child health professionals. However, any discussion of marital therapy is beyond the range of this paper.

treatment of one case. Such treatments, usually long term, if carried out conscientiously led to the discovery that other children in the family than the first one to be presented, had psychological difficulties. A fourth or even a fifth therapist might be recruited to the management of what had been, in the first instance, one case. Three problems arose: first, this technical development of multiple therapists was hopelessly uneconomic. Second, there were difficulties in coordinating the different therapies. Third, the unavailability of most child mental health problems to such intensive therapy was obvious as family resistance to long term psychotherapy became apparent.¹²

Family therapy began to be applied pragmatically to children's problems in the decade after the second world war.¹³⁻¹⁵ The concepts and techniques largely resembled a psychodynamic group therapy with some psychodrama (in the therapies of Ackerman).

However another context, derived from the second world war, had a unique and crucial influence. The Veterans Administration (VA) was responsible for the health care of the former conscripts into the US armed forces. Given the age group and numbers of men recruited into the forces, and the stresses that they endured, it was unsurprising that, in the postwar period, the VA found itself looking after a large number of young men with psychotic illnesses which were, at that time largely untreatable. Modern psychopharmacological agents were unavailable and a few heroic experiments in the psychotherapy of these patients were yielding poor results. The National Institute of Mental Health (NIMH) and the VA set up research programmes investigating the families of young adult schizophrenic patients. The NIMH research¹⁶ and the VA group both had long term effects not upon the development of a family therapy effective in the management of schizophrenia, but upon the conceptual framework and practices of the family therapy in child mental health settings.^{17 18} Both groups observed processes within the family as a whole. The NIMH used psychological tests on all family members (the thematic apperception test, a projective test akin to the Rorschach ink blots) and identified discrepancies between verbal meaning and the affective implications of communication in families ('pseudomutuality' and 'pseudohostility'). The Pal Alto group looked at the family as it sat talking together with a member of the research team. The VA group was remarkable in that it drew upon unusual talents: Jay Haley, a communications expert; Geoffrey Bateson, a cultural anthropologist; Virginia Satir, a social case worker; and Don Jackson, a psychoanalyst, a follower of the American founder of 'interpersonal' psychoanalysis Harry Stack Sullivan. All of these made distinctive contributions that have shaped modern family therapy. For example, Haley as a communications expert was specifically interested in the patterns of verbal and non-verbal communication. Bateson from previous anthropological field studies had experience of the discrepancy between overt and covert communication and its effects upon social be-

haviour.¹⁹ Jackson was skilled in construing the nature of the psychological effects of one family upon each other and in mobilising psychotherapeutic interventions that addressed these effects. Satir drew upon knowledge of family and group processes observed in social work practice. The well known but inaccurately understood 'double bind' form of communication summarised some of the group's views.²⁰

Family systems theory and family therapy

However the distinctive contribution of the Pal Alto research group derived from the introduction of systems theory²¹ and ecology²² into an understanding of families. The family members' mutual dependence and influence upon each other was seen to create a system that had properties in its own right and which were not necessarily predictable from the qualities of the individuals ('the whole is greater than the sum of the individual parts'). This concept, that the family could be defined as a totality, had a momentous effect upon the development of family therapy, far beyond the potential usefulness of family therapy in the management of schizophrenia in young adults. It has become incorporated as a 'family systems theory' approach. The Pal Alto group dispersed (after the early death of Jackson) but came to influence family therapy turning it from a marginal activity of a small group of child mental health workers to a major movement in contemporary thinking about families and children.

The family therapy movement has become synonymous with the concepts of family systems theory. As such it has had a large impact on child and adolescent psychiatric practice and is beginning to influence studies of child development^{23 24} and on the scientific study of interpersonal relations.²⁵

Family therapy techniques and practice

Despite the percolation of family systems thinking into empirical studies, family therapy remains, like much of psychotherapy, a practice driven by clinical observation and experience rather than by scientific studies. Despite the fact that systematic reports of treatment trials⁷ and of family systems investigations²⁶ are occurring, the description of most family therapy practice rely upon accounts derived from clinical know how. Contemporary family therapy can be described under the headings of 'schools' of practice.

Strategic family therapy

The roots of much modern psychotherapy lie in psychoanalysis with its tradition of listening, non-directiveness, and a belief in the therapeutic potency of insight promoting interpretation. The growth of other psychological treatments based on empirical psychology, especially learning theory, challenged these tenets of psychoanalysis. However, even before behaviour therapy had become well known, Haley as a family therapist (1963) had proposed that psychotherapy could be directive and goal

orientated and he coined the phrase 'strategic' therapy.¹¹ What he meant by this was that the therapist had a responsibility to identify the end point of treatment, which should then be sought by whatever means. The viewpoint tends to be associated with a mistrust of theory based treatment goals and takes the problem as presented by the patient or the family consensus as the principle guide to the direction of treatment. Hence if the family nominate the child's faecal soiling as the problem then the therapist helps the family devise strategies to eliminate the soiling. The problem as stated is the problem, not a putative underlying psychopathology of the individual or of the family. This particular approach to therapy has been definitively described by Haley²⁷ and it characterises most therapies, especially those that are short term. It is especially relevant to work with young children and with acute problems. Almost any technique that can produce change can be called upon in the pursuit of a potent strategy to augment the power of the family over the problem. For example behavioural therapy techniques (especially the keeping of a diary of the unwanted and wanted behaviours), quasihypnotic suggestion, challenging interpretations and so on, may all be used. Some of the most striking methods are labelled as paradoxical interventions. The therapist raises the family's anxiety by suggesting that the symptom may have to get worse, remain indefinitely, or be deliberately enacted. Commonly a persuasive rationale for the suggestion may be given. Such techniques may have an effect by increasing the family's determination to counteract the problem or its effects. Likewise, the child with the symptom may be helped to feel more in control of the problem when instructed to perform the symptomatic behaviour deliberately. For example, an enuretic child may be advised to wet the bed deliberately ('You choose a time when the flood can be best dealt with'). Or the whole family might be encouraged to take on a symptom: a tic, nervous cough, or whatever. The use of strategic techniques, like all family therapy, is embedded within an approach to the family that is positive, supportive, and non-critical. The therapist tries to put the family into a frame of mind that they will be able to take charge of the symptom, if not immediately, in the longer term.

Structural family therapy

The great achievement of the Pal Alto group had been to produce a language whereby the space *between* the family members was attended to as much as to processes *within* the individuals themselves. That is to say the family was described as a whole, as an organisation with identifiable rules and structure. A family can be defined as existing to provide psychological support, companionship, and fulfilment to the adults (if there is more than one parent in the family) and to nurture children from infancy to young adulthood. To achieve these there must be systems of communication, of control, of nurturance, and of affect management. There have to be rules governing the balance of selfish

and altruistic behaviour as well as establishing the demands of intimacy and separateness. Family members have different roles usually determined, in part, by age, gender, state of physical and psychological health, and by family traditions. A family has implicitly a definition of who is inside and who outside the family and of maintaining the distinction between the two areas. All of these aspects are especially important in inducing children into membership of the family and contribute significantly to the personality of the growing child. As these areas are examined and specified for different families the structure of a particular family is being described.

All family therapy, by definition, attempts to change the structure of the family but a particular group of family therapists has taken such change as its specific aim. This school centres around the teaching of Salvador Minuchin especially that emanating from the Philadelphia child guidance clinic.^{28 29} Minuchin was most interested in the hierarchical structure of families, in the coalitions between family members, in the clarity or otherwise of its rules and controls, and in the clarity or otherwise of the boundaries between individual family members. In the form of family therapy associated with Minuchin, the therapist contrives a symptom as being an expression of a disorder of family organisation. Society and individual needs are taken to be best met by families with an optimal organisation. If that organisation does not pertain, dysfunction in the family can be said to occur and disturbance ensues in the individual. The therapy in seeking to identify and reverse family dysfunction facilitates the relief of the individual bearing the symptom.

Stated in this simplified way there are obvious dangers to structural family therapy in seeking to define socially determined organisations as 'normal' and the reverse as 'abnormal'. The main thrust of much structural family therapy is to clarify and enhance parental authority over the children, to strengthen the marital couple in their rule setting, and to make the children more separate from and subject to the parents. The structural therapist functions by adding professional authority to that of the parents. Instructions and directions are given to the parents as to how they should conduct family life with more clarity of organisation. Tasks are prescribed that in their completion, between sessions, will continue to augment the precision of family rules and to give the family practice in their maintenance. Such activities are manifestly beneficial, if successful, in chaotic and under-organised families.³⁰ Such structurally based interventions are also sensible in families where there is an apparent ideology of democracy that leaves children confused as to what are the differences between children and adults and what are the rules expected of them inside and outside of the family. Most families lie away from the extremes of chaos and ill placed democracy but none the less the techniques of structural therapy are widely applicable. A 'family diagnosis' will always attend to enduring structural qualities.

Behavioural family therapy

Many family therapists, as has been made clear in the descriptions so far, are directed towards explicit behaviours and, as such, have implicitly accepted the underlying principles of behaviour therapy. Some family therapists have made a wholehearted adaptation of behavioural practices to whole family intervention.^{3 31} Such an approach will clearly be akin to aspects of the strategic, problem solving approach in that the unwanted behaviour will be accepted as the problem. A very detailed behavioural analysis will be made, the pattern of antecedent and subsequent events will be carefully investigated, and the frequency and timing of the problem behaviours identified by, for example, a diary. The symptom is attacked, directly, by alteration of the behavioural contingencies; the family is taught to ignore unwanted behaviour and to reward wanted alternatives systematically and enthusiastically.

Such an approach can be highly effective with troublesome misbehaviour, especially in young children. However the effectiveness of such an approach extends beyond simple behavioural management. Many children presenting with problems ranging as widely conduct disorder, depression, somatic disorders, or phobias may have poor self esteem. This can be continually reinforced both by the manifestations of the child's disturbance but also by the parents' sense of failure and helplessness consequent on their child's difficulties. It is easy for families to get into a cycle of blame and recrimination and the implementation of a simple behavioural programme as described can alter the family atmosphere. The parents and other children are directed to be positive and approving of what is acceptable while ignoring the negative and unacceptable.

Falloon has used behavioural notions of social skills and problem solving to help families with a schizophrenic member.³¹ Epstein and Bishop have elaborated a programme, the McMaster's model, that likewise uses a great deal of direct behavioural instruction to change identified areas of apparent family dysfunction as well as individual misbehaviour.³²

Transgenerational family therapy

So far the emphasis has been upon techniques that are widely used in family therapy and that are distinct from the mainstream of psychodynamic psychotherapy that dominates individual therapy. It can be argued that these differences are more apparent than real,^{9 33 34} but in the description of family therapy given so far the emphasis has been upon the family as an organisation that is defined by its transactional qualities: by those qualities that are directly observable or construable from the current pattern of interaction between family members. However, a family also has a history. The parent (or parents) has experienced family life during childhood and will draw upon those experiences in forming a new family. A child's experiences of nurturance and the formation of attachments will come into play, when the child is now adult, in the pattern of bonding and

loving in the new family.³⁵ Bowen,³⁶ Framo,³⁷ and Byng-Hall³⁸ have described a variety of techniques whereby the family therapist calls upon the history of the family in order to gain therapeutic power. The tool of the transgenerational family therapist is the construction and examination of a family tree (also known as a geneogram). In this process each family member is asked to cooperate in the actual drawing of a family tree. Often it is most advantageous to ask the least involved, disengaged family member to tell of the present family and its forebears. Likewise it may be sensible to ask designated patients, the 'naughty' children about the family story so that they can show their affiliation by their knowledge and interest in that story. As the family members tell the therapist about who makes up the family and its genealogy, questions about the personality and relationships as perceived around that individual can be discussed. Different viewpoints illustrate generational and gender perspectives and allow the therapist to endorse both the sense of family membership, of loyalty, and of the normality of difference. The technique of drawing up a family tree is akin to psychodynamic work because it allows for the interpretation of rules, of patterns, of unconscious, and conscious identifications and so on. At the same time, the manner in which the therapist addresses the family can support and strengthen the family's hierarchical strength and intergenerational boundaries and so 'structural' work can be done.

Milan systems family therapy

Most of the techniques described so far have required the therapist to be rather active, to give strong direction to the therapy, and to invite the family to change by doing things differently. Such a style of therapy is most obviously appropriate for short term treatments, for those brought about by urgent problems, and for those cases in which the presenting problem is the management of misbehaviour in children. There are other situations, in which the therapy must be more reflective, exploratory, and more ambiguous in its ostensible aims. There are also therapists whose personal style tends more in these directions. Such a style resembles more the practice of psychoanalytic psychotherapy and it is not surprising that a form of family therapy embodying some of these qualities has evolved. What is less predictable is that this school has been extremely influential throughout the field of family therapy. This school was initiated by the Italian psychiatrist/psychotherapist, Mara Selvini Palazzoli. Because she worked and taught in Milan and because early in her move from individual to family therapy she was strongly influenced by Bateson, her school has become known as that of Milan systems therapy. Selvini-Palazzoli has outlined the development of her theory³⁹ and her co-workers and followers have written extensively on the methods of what has now become a worldwide school.

The Milan systems therapist does not seek to produce change by deliberately directing or

restructuring the family. Instead the therapist tries to evolve an analysis of the family's history and relationship patterns by asking a series of questions that invite the family to reflect on their own and each other's experiences of their lives together. The aim is to expose the assumptions that underlie the attitudes and behaviour patterns of the family. This exposure, when successfully facilitated, leads the family itself to attempt new ways of relating to and treating each other without direct suggestions coming from the therapist. In passing, it can be noted that many of the interpretations that Milan systems therapists use to understand families are *transgenerational*, emphasising, for example, the rigid loyalty that families may show in adhering to particular patterns that determine the family organisation.

Common themes in family therapy practice

In the development of family therapy the designation of distinctive schools has been important in helping different ideas to be pursued rigorously and extensively but it has also led to counterproductive notions of orthodoxies and to competitiveness. Although the distinctive schools persist, the average practitioner will use a mixture of ideas and techniques derived from a variety of schools. Nichols, among others, has propounded the view that the different schools of family therapy share more than their adherents sometimes acknowledge.⁴⁰ The mixture that forms a particular therapist's style will depend upon the training, reading, and personal qualities of the therapist. There are regular themes in these eclectic therapies. In principle, all family therapy aspires to change family structures, respects hierarchical organisations and the differing needs of children and adults. All family therapies accept that the family will need to be engaged by a discussion of what they perceive to be the problem. Most family therapists accept that patterns of family functioning are transmitted from one generation to another resulting in what can be called a *family culture*. All family therapists will observe ethnocultural sensitivities.

Concept of the family life cycle

One particular concept shared by most family therapists is that a family is an evolving, growing structure going through distinctive stages with transitions denoting the move from one phase to another. This is the basis for the concept of the *family life cycle*, a major theme in all family therapy and relevant to any practitioner wishing to consider the family of a child.³³⁻⁴¹ The main implication of the concept is that at different phases of the evolution of a particular family there are likely to be characteristic tasks and preoccupations. For example, the family can be said to begin when a couple chose, or have forced upon them, the necessity to accommodate a child. The couple is a two person organisation, principally involved in the creation of a mutually supportive and enhancing personal relationship. The arrival of a baby

demand a family unit organised around the need to maintain the biological integrity and healthy development of an infant. The couple's need as a pair takes second place. The pace of family adaptation becomes dominated by the changing needs for protection and nurturance of the infant growing from babyhood to the school child. At the point of entrance to whole time education there begins a period when, although child care remains a dominant activity, the parents' attention to their own interests and ambition can increase. The school age child changes as he or she matures, contributing a share to the changing needs of the family, and this process is accelerated as adolescence is reached and the potential for adulthood is signalled in the child. This requires further family adaptation and offers the possibility of more freedom for the parents. However, in childhood, the pace of change in the family tends to be dominated by the rate of development of children. The life cycle does not come to a halt in adulthood. The changes of midlife and of old age impinge on families, especially for young families, in the lives of the grandparents. The greater the number of people in the family going through major life cycle transitions, the greater the demand for change is imposed on the family as a whole. These demands for change are potentially stressful and family therapy can be seen as centering around the process of acquisition of skills to overcome these stresses.

Conclusion

All clinicians working with children will know the importance of the family's influence in determining the care of children and the management of their psychosocial life. Common sense, both social and clinical, will enable most problems to be handled by most of us. However, from time to time, common sense is of no use and then uncommon solutions are necessary. That is often the case where there are psychological problems in childhood whether arising *ab initio* or deriving from other difficulties such as chronic illness. Family therapy has some of the qualities of uncommon sense: convening a whole family meeting to discover solutions to problems does not come naturally to professionals or to patients. However many of the techniques of family therapy make clinically cogent and are powerful influences on family behaviour. These powers can be harnessed for the good of children in our professional care.

The author's research described in this paper has been generously supported by the Medical Research Council of Great Britain.

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