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## THEMATIC REVIEW OF FAMILY THERAPY JOURNALS 2005

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**Running head:** Review of Family Therapy Journals 2005

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## **ABSTRACT**

In this paper the principal English-language family therapy journals published in 2005 are reviewed under these headings: research in family therapy, couples, families and wider systems, parental alimentation syndrome, diversity, training, and deaths.

## INTRODUCTION

In 2005 many developments in a broad range of areas were covered in the family therapy journals. In this review, reference will be made to particularly significant papers and also to less significant, but representative articles in the areas of research in family therapy, developments in couples therapy, developments in therapy for families and wider systems, parental alienation syndrome, diversity, training, and the loss of pioneers in the field of family therapy.

## RESEARCH IN FAMILY THERAPY

In 2005 significant research papers of interest to systemic practitioners focused on the efficacy of marital and family therapy, medical cost-offset, and the research methods.

**Efficacy.** there were a number of important review papers and meta-analyses on the efficacy of systemic therapy for a range of problems including depression (Gilliam & Cottone, 2005), eating disorders (Eisler, 2005), chronic illness (Martire, 2005) and marital distress (Wood et al., 2005). With increasing demands from funders and clients for proof that marital and family therapy works, such reviews are particularly important. Gilliam and Cottone (2005) concluded that couples therapy is as effective as individual therapy for the treatment of depression and may also have the advantage of improving marital functioning in addition to depressive symptoms, while individual therapy typically does not. For adolescent anorexia nervosa, family therapy is more effective than individual therapy (Eisler, 2005). The inclusion of family members in psychosocial interventions for chronic illness in some instances is more efficacious than individual interventions (Martire, 2005). Wood et al. (2005) in a meta-analysis of marital therapy studies

concluded that emotionally focused therapy is significantly more effective than isolated behavioural marital therapy interventions for the treatment of moderate marital distress.

**Medical cost-offset.** In an important medical-cost offset study, Crane et al. (2005) investigated cost savings associated with individual and family therapy for over 3,000 adolescents with conduct disorder in the Kansas Medicaid system, who were also receiving a comprehensive range of other health services. Family therapy led to a much greater reduction in health care costs over a two and a half year period. The average cost of healthcare for adolescents who received individual therapy was \$16,260, while for those who received clinic-based family therapy, it was \$11,116. Those who received home-based family therapy were least expensive of all, averaging at least 85% less than any form of clinic-based therapy.

**Research methods.** The *Journal of Family Psychology* contained a special issue on research methods. The papers in this issue on how to conduct treatment outcome research (Christensen et al., 2005); the assessment of costs benefits, and cost-effectiveness of marital and family therapy (Fals-Stewart et al., 2005); and qualitative research in family therapy (Gilgun, 2005) will be of interest to clinicians and researchers alike.

## COUPLES

In 2005 papers on couples in the family therapy journals may be divided into those that focused on intervention with couples and those that addressed characteristics of couples with a variety of problems.

### Intervention with couples

Papers that focused on intervention with couples covered relationship education, couples therapy, and sex therapy.

**Relationship education.** In a special section in *Family Process* on relationship education, a useful introductory overview was provided by Markman and Halford (2005). A number of papers in the section deserve mention. Stanley et al. (2005) in an evaluation of marriage education provided by Army Chaplains in two separate samples of couples in which at least one member was on active duty in the US Army, found that marriage education was well received by this population and resulted in improvements in relationship functioning. Thuen and Laerum (2005) gave an overview of the relationship education field in Norway. A variety of relationship education programs are offered by public and private organizations, with the US developed Prevention and Relationship Enhancement Program (PREP) being the most widely used. Preliminary evaluation data on this programme in Norway are positive. Halford and Simons (2005) in an overview of relationship education in Australia mention that this service is offered by a variety of community and church-based providers, with a strong emphasis on locally developed programs. They argue that in Australia, relationship education providers need to do a better job reaching out to couples at high risk for future relationship problems, and more research is needed on the effects of education on long-term marital outcomes.

**Couples therapy.** *The Australian and New Zealand Journal of Family Therapy* included a series of interesting clinical papers on couples therapy. Dattilio (2005) provided a good case example which illustrates how cognitive restructuring and specific cognitive behavioural homework assignments may be used in couples therapy. Crawley and Grant (2005) in a paper on emotionally focused couples therapy showed how it draws upon experiential, systems and attachment theory to explain the dynamics of couple relationships and guide the therapeutic process. Madden's (2005) paper on five useful questions which open up new areas for discussion in couples therapy, and which avoid a narrow focus on specific problems is a useful clinical contribution. So too is Hoang's (2005)

paper on the use of autobiography sessions in couple work. Partners are invited to shift the focus from their current difficulties and participate in autobiography in the presence of their partner.

**Sex therapy.** Goodwach's (2005a, 2005b) two papers on sex therapy in the *Australian and New Zealand Journal of Family Therapy* give a good overview of the history of the field and the contributions of psychoanalytic, behavioural, biomedical and systemic traditions to the practice of sex therapy, along with an outline of how to conduct a first interview. The systemic approach adopted and illustrated with case material, explores the interrelationship between the symptom, the partners, the sexual aspect of their relationship, biological factors, and cultural factors associated with sexuality, and this exploration provides a focus for problem resolution.

### **Characteristics of couples with specific problems**

Papers that addressed characteristics of couples with a variety of problems covered so many topics that space limitations prevent a comprehensive overview. Instead some illustrative examples on a number of common topics are mentioned. The topics include family of origin issues, individual vulnerability schemas, gender inequality, infidelity, anxiety and depression.

**Family-of-origin issues.** Topham et al (2005) in a study of 367 married couples assessed before marriage and 4-7 years later found that certain family-of-origin issues assessed before marriage affected hostile conflict after 4-7 years of marriage. Wives' mother-child relationships and the quality of parental discipline, as well as the husbands' perceived quality of their parents' marriage, were predictive of wives' perception of hostile conflict in their marriages. Only wives' quality of parental discipline was predictive of husbands' perception of hostile marital conflict. Perren et al. (2005) in a study of 62 first

time parents found that the challenge of parenthood was associated with changes in marital quality and these changes were consistent with an intergenerational transmission of marital quality. Those who recollected that their parents' had a negative relationship reported more negative changes in the quality of their own marriages following the birth of their first child.

**Individual vulnerability schemas.** Tilden and Dattilio (2005) through case material showed how vulnerability schemas of individuals may have a significant impact on couples' relationships and how this vulnerability can be restructured during the course of couples' therapy.

**Gender inequality.** Knudson-Martin and Mahoney (2005) in a qualitative study of couples with children in two time-cohorts (1982 and 2001) found that movement toward equality was facilitated by (1) stimulus for change, including awareness of gender, commitment to family and work, and situational pressures; and (2) patterns that promote change, including active negotiation, challenges to gender entitlement, development of new competencies, and mutual attention to relationship and family tasks.

**Infidelity.** Blow and Hartnett (2005a, 2005b) in two papers on infidelity in committed relationships, concluded that little methodologically robust research has been conducted on the topic, and that key findings from available research concern attitudes toward infidelity; prevalence data; types of infidelity; gender dynamics and infidelity; issues in the primary relationship and their relationship to infidelity; race, culture, and infidelity; education, income, employment, and infidelity; justifications for infidelity; individual issues and their relationship to infidelity; same-sex couples and infidelity; attachment and infidelity; opportunity and infidelity; the aftermath and recovery process from infidelity; and clinical practices.

**Anxiety and depression.** Hickey et al. (2005) in a quantitative study compared couples in which one partner was depressed, couples in which one partner had an anxiety disorder, and nondistressed control couples on measures of (1) quality of life, stress, and social support; (2) family functioning; (3) marital functioning; and (4) relationship attributions. The depressed group had significant difficulties in all four domains. In contrast, the control group showed minimal difficulties. The profile of the anxious group occupied an intermediate position between those of the other two groups, with some difficulties in all four domains, although these were less severe and pervasive than those of the depressed group.

In all of the research papers mentioned in this section, authors linked research findings to clinical practice by suggesting how therapy might be tailored to take account of specific couple characteristics.

## **FAMILIES AND WIDER SYSTEMS**

In 2005 papers on families and wider systems in family therapy journals may be divided into those that focused on (1) intervention, (2) physical health problems, and (3) mental health problems.

### **Intervention**

In 2005 a number of important papers were published on narrative psychiatric assessment, home-based therapy, family-directed structural therapy, integrative module-based family therapy, the not-knowing position and blame and responsibility in family therapy.

**Narrative therapy.** In two special issues of *The International Journal of Narrative Therapy and Community* on narrative therapy with trauma survivors, there are papers on working with survivors of different types of trauma including the tsunami (Arulampalam et

al., 2005); prisoner rape (Denborough, 2005a); and war (Blackburn; Sliep, 2005). There are also important innovative papers by Michael White (2005) on subordinate storyline development in traumatized children, and by David Denborough (2005b) on receiving and documenting testimonies of trauma. In a clinical paper, Hamkins (2005) conceptualized initial psychiatric consultations as re-authoring conversations in which questions which generate experience and gather information assist in the development of a history of resistance to the problem. The use of letter writing and other narrative and literary methods are routinely incorporated into this approach, and refreshingly a client offered reflections on the Hamkin's paper.

**Multiple-family therapy for eating disorders.** The Journal of Family Therapy included a special issue on multi-family therapy for eating disorders based on presentations from the first International Conference on Multi-Family Day Treatment which was held in Dresden, Germany, in March 2004. The papers covered the key components and different phases of this treatment, indications and contra-indications (Scholz et al, 2005); working with families of children (Rhodes & Madden, 2005), adolescents (Fleminger, 2005) and adults (Treasure et al., 2005); and the empirical and theoretical base of multiple family therapy (Eisler, 2005).

**Home-based therapy.** Yorgason et al. (2005) found that a home-based model of family therapy led to significant improvements in family functioning and presenting problems. Clients with higher problem levels had the greatest rates of change, and clients receiving more hours of services fared better in therapy. Families in which the primary care givers had good social support; in which family members fulfilled their school or work roles well; and in which there were low levels of self-harm had better outcomes than those that fared less well in these areas.

**Family-Directed Structural Therapy.** McLendon et al. (2005) developed and described Family-Directed Structural Therapy (FDST) as an approach to family therapy built on traditional concepts of Structural Family Therapy, the Strengths Model, and Group Work Theory. FDST is a goal-oriented, time limited approach that enables families to identify strengths and areas of concern, as well as to enhance family functioning. This process is facilitated through the use of a common vocabulary and a concretely organized, easily administered FDST Assessment Tool that is completed by adult family members.

**Integrative, Module-Based Family Therapy.** Wendel et al. (2005) developed and described Integrative Module-Based Family Therapy. The model for training and treatment is designed for use in multidisciplinary mental health settings. The model integrates theory, research findings, and practices and can be taught to trainees with limited training in systemic practice.

**The not-knowing position.** There were two thoughtful papers in *Family Process* on the not-knowing position (Anderson, 2005; Rober, 2005). Rober (2005) argued that not-knowing refers to, not only to the therapist's receptivity and respect, but also implies that therapists are aware of their experience and reflect on how their inner conversations might inform and enrich therapeutic conversations with clients. Anderson (2005) pointed out that the not-knowing position does not mean therapists know nothing or that they do not use what is known. Rather, it indicates that therapists' contributions are presented in a way that communicates respect for clients and an openness to them.

**Blame and responsibility.** There was a special issue of the *Journal of Family Therapy* on blame and responsibility. In his editorial Eisler (2005) justified devoting a special issue to this theme by arguing that transforming beliefs about blame and responsibility can be crucial in promoting therapeutic change, and that blame and

responsibility are particularly challenging for therapists to address because they are associated with power and control, and related ethical dilemmas. Two of the papers in the special issue deserve special mention. Bowen et al. (2005) conducted a qualitative analysis of family therapists' comments on video-clips of blaming events in therapy. Therapists tended to construe the events in these clips as being influenced by fear and control issues from family members' past relationships. Two significant themes in the qualitative analysis were unhealthy allocation of responsibility for problems, which is arguably the main source of overt blaming, and family identity and cohesion. Stancombe and White (2005) argued that for therapists to achieve neutrality when family members offer competing blame-laden accounts of family problems, therapists use complex linguistic strategies to craft accountability-neutral descriptions and explanations of family difficulties. In producing such accountability-neutral versions of families' troubles, therapists make practical and moral evaluations of family members' competing accounts of their difficulties. As part of their professional development, therapists need to master these subtle skills for conveying neutrality. However, the profession as a whole needs to address the practical and moral implications of advocating neutrality.

### **Physical health**

Many papers in 2005 addressed physical health problems, so space limitations prevent a comprehensive review. To illustrate the range of topics covered, some examples of papers in the following areas are summarized below: the biopsychosocial model, cancer, head injury, phenylketonuria, diabetes, chronic pain, paediatric headache, fibromyalgia, and children's reactions to parental illness.

**Biopsychosocial model.** *Families, Systems and Health* contained a special issue on the current state of the biopsychosocial approach. Two papers on family therapy and

genetic conditions were particularly impressive. Rolland and Williams (2005) described a Family System Genetic Illness model of psychosocial challenges of patients and families associated with genomic conditions. This model clusters genomic disorders based on key characteristics that define types of disorders with similar patterns of psychosocial demands over time. Key disease variables include the likelihood of developing a disorder based on specific genetic mutations, overall clinical severity, timing of clinical onset in the life cycle, and whether effective treatment interventions exist to alter disease onset and/or progression. For disorders in which carrier, predictive, or presymptomatic testing is available, core nonsymptomatic time phases with salient developmental challenges are described pre- and post-testing, including a long-term adaptation phase. The model may inform research, preventive screening, family assessment, treatment planning, and service delivery in a range of healthcare settings. McDaniel (2005) in a related paper argued that evolution of genomic science and its impact on health care has created opportunities for family therapists to contribute to the care of patients and families with genetic disorders. The paper gives an overview of clinical and research findings about the experience of patients and families facing these genomic conditions. Guidance is provided on helping patients and families address decisions about testing and treatment; decisions about disclosure and secrets; challenging emotional issues such as anger, ambivalence, and guilt; conflict resolution; differing coping and communication styles; developmental issues; and transgenerational family dynamics.

**Cancer.** Walsh et al. (2005) in a study of 204 young women with breast cancer, found that their condition had a negative impact on their relationships with their partners and children, with a clear implication that family intervention is important to consider in cases of breast cancer. Davey et al. (2005) in a qualitative focus group study found that adolescents whose mothers had breast cancer reported that they felt burdened with

additional roles and responsibilities. These adolescents suggested that intervention programs should include psychoeducational support groups for adolescents followed by multiple-family therapy groups.

**Head injury.** Carnes and Quinn (2005) in a study of the families of 65 people with head injury found that social support, reframing, coping skills and the availability of financial resources, all enhanced adaptation to head injury, while concerns with insurance, and emotional and behavioural changes that accompanied head injury exacerbated distress experienced by family members. The results highlight the potential value of family interventions in cases of head injury.

**Phenylketonuria (PKU).** Lord et al., (2005). In a study of the parents of 65 children with PKU found that intrusive reactions were more common than avoidant reactions and more mothers than fathers reported clinical levels of trauma (12% vs. 5%). For mothers, greater trauma occurred where children were younger and where less support was available from partners and other members of the family and social network. The results highlight the potential value of family interventions in cases of PKU.

**Diabetes.** Hoff et al. (2005), in a controlled trial involving parents of 34 children with newly diagnosed diabetes, found that a psychoeducational family intervention in which parents learned skills for managing uncertainty led to significant reductions in parental distress and children's behaviour problems and these gains were maintained at 6 months follow-up.

**Chronic pain.** Lemmens et al. (2005) is an evaluation study involving 19 patients with chronic pain and 41 family members, found that participation in 4 consecutive family discussion groups led to a reduction in pain-related distress; enhanced coping with pain; increased patients' social activity; and improved family communication and support. Experiencing communality, having a place to discuss things with each other, gaining

insights, and learning from fellow sufferers were the principal beneficial factors identified by participants in the family discussion groups.

**Paediatric headache.** Ochs et al., (2005) in an evaluation study of 38 children that met the International Headache Society criteria for paediatric headaches, found that for a distinct subgroup of children a family-based psychosocial treatment programme led to a reduction in headache burden and improvements in headache-associated family interaction patterns.

**Fibromyalgia syndrome (FMS).** Preece and Sandberg (2005) in a study of 150 people with FMS found that family stressors, strains, and distress were associated with increased health problems functional disability and medication usage, whereas social support from families and family hardiness were associated with better health and adjustment. The study highlights the potential value of medical family therapy intervention in cases of FMS.

**Children's reactions to parental illness.** In a theoretical, empirical and clinical review Pedersen and Revenson (2005) presented a family ecology model for understanding adolescents' reactions to parental illness. The model emphasizes a greater understanding of the mediational pathways and moderator variables, such as the developmental stage, social support, and cultural norms which may enhance or impede adolescents' adaptation to serious parental illness.

## **Mental health**

A large number of papers in 2005 were concerned with mental health problem. What follows are summaries of illustrative papers on mental health problems in children, adults and older adults.

**Mental health in children.** Lange et al (2005) compared families of children with attention deficit hyperactivity disorder, emotional disorders and normal controls on (1) stress, support and quality of life; (2) current family functioning; (3) parental adjustment; and (4) parenting style and satisfaction in the family of origin and current family. Compared with controls, the two clinical groups showed deficits in all four areas, and in addition, parents of ADHD children reported higher levels of authoritarian parenting styles. It was concluded that family therapy for children with ADHD and emotional disorders may target the difficulties pinpointed in this study. Brotman et al. (2005) in a controlled evaluation of a family intervention programme aimed at helping parents of delinquent adolescents manage behaviour problems in their at-risk preschool children found that, not only did the preschoolers show improvement in their behaviour, but so too did their older siblings.

**Adult mental health.** MacDonald (2005) in a post-treatment survey of 118 cases found that 70% of adults with mental health problems who attended an average of 4 sessions of solution-focused brief therapy reported a good outcome. Hoffman et al. (2005) evaluated a 12-week multi-family psychoeducational program for 44 relatives of 34 persons with borderline personality disorder. The programme was facilitated by trained family members and was based on Dialectical Behaviour Therapy. It led to significant reductions in grief and burden and a significant increase in mastery. These improvements were maintained at six-month follow-up.

**Mental health in older adults.** Curtis and Dixon (2005) in a clinical paper showed how family therapy and systemic practice is particularly relevant in providing mental health service for older people.

## **PARENTAL ALIENATION SYNDROME (PAS)**

A new departure this year, in the family therapy journals, was a smattering of papers on parental alienation syndrome. What follows are accounts of some illustrative examples. In a study of 138 divorce experts and divorced, non-resident parents in the Netherlands, Spruijt (2005) found that 58% thought Parental Alienation Syndrome PAS either does not, or rarely occurs in the Netherlands, and 42% thought it does occur. A factor analysis identified four separate aspects of the syndrome: two of them concerning alienation due to the resident parent and two concerning alienation due to the child. The study pointed to the importance of mediation, since PAS occurred more often when child-related decisions were not taken conjointly by parents but were determined in court. Baker (2005) in a qualitative study of the adult impact of having experienced parental alienation as a child found that it led to low self-esteem, depression, drug or alcohol abuse, lack of trust, alienation from their own children, and divorce. In a clinical paper Ellis (2005) described strategies for helping the alienated parents following divorce including eroding the negative image by providing incongruent information; refraining from actions that put the child in the middle of the conflict; considering ways to mollify the hurt and anguish of the alienating parent; looking for ways to dismantle the coalition and convert enemies to allies; and maintaining contacting despite adversity.

### **DIVERSITY**

A special issue of *Contemporary Family Therapy* was devoted to family therapy in India. This issue included a useful overview (Mittal & Hardy, 2005), a discussion of clinical issues unique to working with Indian families (Sonpar, 2005), the history of the profession of marital and family therapy in India (Rastogi et al. 2005), the treatment of conduct disorders with marital and family therapy (Anant & Raguram, 2005), the use of the

cognitive-behavioural family therapy immigrant Indian families (Dattilio & Bahadur, 2005); and experiences of families living with HIV/AIDS in India (Krishna et al., 2005).

In the *Journal of Systemic Therapies* there was a special section on diversity. The goal of this special section was to create a critical multicultural lens that values diversity while acknowledging the politics of cultural differences and social location (McDowell, 2005). The section included useful papers on Moslem-Christian marriages (Ata & Furlong, 2005); involving family members in adolescent drug rehabilitation in a Chinese context (Sim, 2005); the use of a form of systemic intervention involving storytelling referred to as testimony therapy for working with African-American families (Akinyela, 2005); working systemically with Arab-American couples where the focus is on social justice issues (Beitin & Allen, 2005); and the "care-full listening and conversations" narrative-systemic program for working in schools with teachers and students in Israel (Shalif, 2005).

## TRAINING

In 2004 a special issue of *Family Process* and a special section in the *Journal of Family therapy* devoted to training. Key papers from these journals and other sources are summarized below in sections on training models, diversity in training, and training health professionals in family work skills.

**Training models.** Stratton (2005) showed how practices based on research into adult education and autonomous learning may be applied in the field of family therapy training. A model of a spiral process of learning that has been developed within the Leeds Family Therapy and Research Centre was proposed. Boston (2005) described the how deconstruction practices have been incorporated into the same programme.

Deconstruction practices have been imported into narrative therapy, as a means of

offering alternatives to problem-saturated self-narratives and unhelpful dominant cultural discourses. Hodgson et al., (2005) described how the Boulder scientist-practitioner model may be adapted for use in training marital and family therapists by encouraging students to question the therapy process; integrating research in the curriculum and supervision; discussing the positives and negatives of empirically supported treatments; focusing on change; and developing creative classroom experiences to use within the scientist-practitioner model. Rolland and Walsh (2005) described the Families, Illness, and Collaborative Healthcare programme developed at the University of Chicago. The approach is based on a systemic model of family illness, with a strong emphasis on family resilience, collaborative practice, and an advocacy orientation. It incorporates a significant training dimension.

**Diversity in training.** There were a couple of significant papers on training and diversity (Divac & Heaphy, 2005; Kaplan & Small, 2005; Singh, 2005). Kaplan and Small (2005) found that recruitment strategies, mentorships, partnerships with outside organizations, provision of a long-term institutional commitment, biracial collaborations, and institutional change were key components of their programme for increasing the recruitment of people from ethnic minorities into their family therapy training programme in the US. Divac and Heaphy (2005) described an approach to building cultural competence into family therapy training. They refer to this as 'Space for GRRACCES' (Gender, Race, Religion, Age, Abilities, Culture, Class, Ethnicity and Sexual Orientation). Singh (2005) described a training programme for developing therapeutic skills for working with refugee families at the Institute of Family Therapy in London. The courses comprised lectures, skill workshops and group discussions given by specialists from the field of refugee studies and systemic practice.

**Training health professionals in family work skills.** There were papers on training psychiatrists (Berman and Heru, 2005) clinical psychologists (Kaslow et al., 2005), and medical students (Wannan & York, 2005) in family work skills. For psychiatrists in the USA, learning skills for working with families is now mandatory (Berman and Heru, 2005). Kaslow et al, (2005) argued that clinical psychologist in training should learn specific skills for working with families in the following domains: the application of scientific knowledge to practice, psychological assessment, psychological intervention, consultation and interprofessional collaboration, supervision, professional development, ethics and legal issues, and individual and cultural diversity. Wannan and York (2005) in a comparative evaluation study randomly allocated medical students to learn about family therapy either by watching a video of a family or through role-play and found both approaches to be equally effective in facilitating learning.

## DEATHS

Since the last review of the family therapy Journals, we have lost two major innovators.

**Mordecai Kaffman (1917-2005).** In *Family Process* there is a obituary for Mordecai Kaffman who was the founding father of family therapy in Israel and for more than 30 years the medical director of the Kibbutz Child and Family Clinic (Elizur, 2005).

**Elisabeth Kubler-Ross (1926-2004)** In *Families, Systems, and Health* there is an obituary for Elisabeth Kubler-Ross a pioneer in the field of thanatology whose work influenced the practice of many family therapists (Blaylock, 2005).

## CONCLUSION

In light of this thematic review it is clear that 2005 was an important year for family therapy. There was a continuing move towards practices based on a solid foundation of

empirical research. With respect to interventions for couples, families and wider systems, innovations in practice and training continued apace. This was a year in which family therapists began to focus their attention on parental alienation syndrome. Sensitivity to cultural diversity within the field continued to be an important issue. A number of innovations in training occurred. This was also a year in which we lost two important pioneers.

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