# ECOSYSTEMIC STRUCTURAL FAMILY THERAPY

## Published Version

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**Published in 2002:**

**F. Kaslow (Series Ed.) & R. Massey and S. Massey (Vol. Eds.),**
**Comprehensive Handbook of Psychotherapy: Vol III, Interpersonal, Humanistic, and Existential Models. New York: John Wiley & Sons.**

# Ecosystemic Structural Family Therapy: An Elaboration of Theory and Practice

## History of Therapeutic Approach

### Early Foundations

The earliest published version of the highly pragmatic Structural Family Therapy (SFT) model appeared on the psychotherapy landscape in 1967 (Minuchin, Montalvo, Guerney, Rosman, & Schumer). The model was further elaborated in 1974 (Minuchin), 1978 (Minuchin, Rosman, & Baker), 1981 (Minuchin & Fishman), 1989 (Elizur & Minuchin), and 1993 (Minuchin & Nichols; Fishman). While Salvador Minuchin, the primary exponent of SFT, preferred the language of organization and role theory in describing this theoretical model, his conceptual thinking was influenced by his colleague Jay Haley and others who were well-versed in communication and systemic theories (e.g. Bateson, 1979; Haley, 1963; Jackson, 1957; Watzlawick, Jackson, & Beavin, 1967). Minuchin, known as much for his dramatic and compelling therapeutic style as for his theory development, credited both Nathan Ackerman's passionate clinical work and Braulio Montalvo's clinical complexity and sensitivity for his inspiration as a clinician (Minuchin, 1985; Nichols & Schwartz, 1998).

Minuchin, Montalvo, and Haley collaborated in the early development of what became known as Structural Family Therapy. Haley, however, eventually developed his own therapeutic model termed "Problem-Solving Therapy," which emphasized a narrower focus on symptoms. Both therapy models highlight the importance of reconfiguring non-adaptive family coalitions and tie theory to a family developmental framework (Minuchin, 1974; Haley, 1976). Minuchin's life experiences, his longstanding commitment to working with low-income, multi-problem families, and his collaborative relationship with E. H. Auerswald (1968) sensitized him to examine a family's ecology. An ecological approach involves giving attention to the total field of a problem, including extended family, friends, other professionals, community agencies, and institutions. For more detailed description of the historical origins of Structural Family Therapy see Colapinto (1991), Minuchin and Nichols (1993), or Nichols and Schwartz (1998).

In this model, Minuchin directed clinical attention to the recurring, often enduring, patterns of interaction which come to organize and structure daily family life. This meant that understanding problem formation, problem maintenance, and change in the treatment of children and adolescents could be found within an analysis or "mapping" of family structure. Since core relational patterns are revealed primarily during family interactions, the hallmark of practice within this model has been its here-and-now, action orientation to helping. In the SFT model, therapists work from within a family system. They connect with and learn about the uniqueness of the family and its members, as well as facilitate and support change, by creating or capitalizing on natural emotional and relational challenges within ongoing interaction. In vivo learning through the use of in-session enactments is one of SFT's distinctive contributions to family therapy (Simon, 1995; Diamond & Liddle, 1999).

These foundational elements of the model remain solid and intact in the contemporary theory and practice of SFT. However, like the entire child-and-family-therapy field, the model has undergone considerable development and refinement over the last thirty years, stimulated by advances in theory and research from many fields. One major set of influences on current SFT practice has been findings from treatment studies that have examined the major constructs of the model and the mechanisms of change as applied to specific clinical populations. These studies utilize integrative models which were derived from classic SFT and include Multi-Dimensional Family Therapy (MDFT; Liddle, 2000), Attachment-Based Family Therapy (ABFT; Diamond, Diamond, & Siqueland, in press), Multi-Systemic Family Therapy (MST; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998) and the Bio-Behavioral Family Model (BBFM; Wood, Kleba, & Milller, 2000). Other influences stem from empirical and conceptual advances in developmental science and developmental psychopathology (e.g. Cicchetti, Toth, & Lynch, 1995; Greenspan, 1992; Sameroff & Emde, 1989; Siegal, 1999; Sroufe, 1997) and family psychology (e.g. Gottman, Katz, & Hooven, 1997). SFT continues to be a highly popular model among clinicians, in part because of its reputation for effectiveness, conceptual clarity, strong training programs, and a capacity for incorporating new ideas and research advances over time.

**Recent Elaborations**

Much of the updating of SFT theory and practice described in this chapter has evolved within the Philadelphia Child and Family Therapy Training Center, Inc., as well as from staff within its former parent organizations, the Philadelphia Child Guidance Center and the Children's Hospital of Philadelphia. The model, as currently practiced and taught by the authors, has changed in three major ways.

First, the array of information considered important for deciding on goal setting, treatment planning and treatment implementation has significantly broadened. Data regarding individual biological, developmental, affective, and psychological processes are as likely to be included in the thinking that goes into case formulations as is information about family- and larger-system processes. Originally, in a first interview, therapists were encouraged to focus narrowly on the assessment of family interactional patterns in relationship to a child's symptoms, and then be prepared to implement immediate change-producing strategies in the session. This confined therapists to here-and-now interactional data, which often contributed to underdeveloped pictures of the child or the family in either historical context or a larger community context. Having been influenced by best-practice standards emerging in the public-mental-health arena, SFT therapists are encouraged to obtain a comprehensive bio-psychosocial assessment of a child or adolescent within relevant social contexts at both the macro and micro levels (Engels, 1980)

Second, the posture toward the therapist-child-family relationship has shifted toward one of greater collaboration and partnership, building upon the model's historical strengths-based approach. As in many of the classic models of family therapy, the therapist's role in early SFT highlighted the

therapist's expertise, setting up a clear hierarchical position vis-à-vis the family. Today, practitioners of SFT directly recognize and capitalize on the respective expertise and resources of a family, child, or adolescent, other involved helpers, as well as themselves. Families, and often the focus child or adolescent, are fully and actively involved in the planning of assessment and treatment, as well as in the evaluation of treatment outcomes (Hodas, 1997).

Third, emotions and emotional development in the family receive increased focus. Particular attention is given to family styles of regulating or soothing the strong affective states of members (*family emotion regulation)* and to family members' subjective internal experience of emotional connection and attachment (*affective proximity)*. Building relationships in a family, as well in other social settings, which will promote and nurture the development of specific social-emotional competencies has assumed a central role in the current theory and practice of SFT. This goal has become a critical anchor for shaping the types of assessments and interventions used.

Minuchin (1974) highlighted the importance of preparing children to navigate their worlds competently in his early articulation of principles regarding family functioning, but the individual skills necessary for this remained vague and were rarely targeted for direct change. In part, this occurred because, until recently, not much certainty existed in the developmental field as to the nature of these skills. Now a large body of work is devoted to identifying key social-emotional skills (Mayer & Salovey, 1993), understanding the internal processes and milestones in their development (Greenspan, 1992; Denham, 1998), and specifying parenting practices or family processes which promote or constrain their development (Saarni, 1999; Gottman, et al., 1996).

A focus on an individual child's social-emotional development necessitates a broadening of the overarching goals of therapy. In the earliest versions of the model, therapy was considered successful when symptoms were resolved and the family was assumed to be more "functional." Functionality was broadly defined as the fit between the demands confronting the child and family and the organizational structure in place to meet these demands. While this concept remains very useful, it has lacked a clear referent to the developmental literature and current thinking about what constitutes "healthy" social-emotional functioning and the vast array of individual differences among children and adolescents impacting both developmental outcomes and family functioning. A strict focus on organizational functionality as a treatment outcome risks placing too much value on form over meaning.

Contemporary SFT involves focusing on *growth-promoting practices* and the strength of emotional connections. This captures specific dynamic, fluid processes at work in families and other systems that are directly tied to child outcomes. Assessment and treatment are anchored firmly in developmental theory. This allows for a more evenly dispersed emphasis between the short-term clinical goals of symptom relief and family change, and the long-term preventive goals of growth and development. This signifies fostering change at multiple system levels, including the individual child, the

family, and the child-family-community interface. The current overarching goals of SFT are now defined as:

- ***To resolve presenting problems and to eliminate negative interaction cycles;***
- ***To shift the developmental trajectories of children, such that they are moving toward greater capacity for self-regulation and social-emotional competence;***
- ***To enable a family to organize and emotionally connect in such a way that they become more growth-promoting in their interactions with one another; and***
- ***To enable relevant community systems to organize in such a way that a family's efforts toward creating a growth-promoting context is nurtured.***

**Theoretical Constructs and Principles**

Contemporary SFT embraces an appreciation that the structure and dynamics of family relationships are strongly shaped by forces within the broader social context, such as culture, race, gender, politics, and economics (McGoldrick, 1998). However, the specific relationship adaptations that result from these and other influences constitute both the primary target and locus of change in the SFT model. Four major theoretical constructs guide therapists in determining the focus of observations and change in particular family relationships: *family structure, family emotion regulation, individual differences, and family development.*

Identifying structural patterns informs therapists about what family members are expecting from and doing with one another. This provides a snapshot of interactional sequences promoting or constraining mastery of specific challenges. Family emotion regulation shows therapists the emotional meaning embedded in these interactions and how members help one another to handle emotional distress. Therapists observe the specific types of family interactions around family member's emotional experiences which need strengthening in order to support the development of children's social-emotional competencies. Recognition of individual differences within the family help a therapist attune to unique needs (e.g. temperament, learning styles, vulnerabilities to emotional disorders) and histories (e.g. trauma) requiring adjustments of approach, timing, and pacing of change. A focus on family development enables therapists to understand the specific emotional challenges being faced by a child and family as they move through time within a particular cultural context.

A basic assumptions in contemporary SFT, rooted in the developmental work of Fraiberg (1959) and White (1959), is that children enter the world wired to move forward and to adapt, despite the natural challenges and conflicts that come their ways. Likewise, families are presumed to be generally oriented toward mastery and self-regulation, regardless of how poorly they may appear to be functioning at a particular point in time. The orientation toward personal and family mastery remains a powerful motivating force and a key to understanding the strengths-based approach to treatment in SFT. In practice this implies that therapists must tap into this powerful, though often dormant, mastery orientation

in order to help children and their families to become unstuck or to overcome barriers to moving toward greater competency and adaptation.

The four major interrelated constructs--family structure, family emotion regulation, individual differences, and family development--inform therapists about the multiple interacting forces supporting or constraining children and their families' movement toward greater mastery and development of core social-emotional competencies. These contemporary SFT constructs can be found within each of the major integrative variants of the model (e.g. MDFT, ABFT, MST, and BBFM), albeit with differing levels of emphasis and elaboration. These ideas guide assessment, intervention, and evaluation of treatment outcomes.

**Family Structure**

Families serve both as major resources for children in mastering difficult emotional challenges and one of the major sources of these challenges. Families represent the matrix of identity development. From its earliest days, a fundamental premise guiding SFT is the "inextricable association of family and individual: the family exists for the individual, the individual exists within the family" (Colapinto, 1991, p. 422). In order to understand children's mastery efforts, therefore, it is important to construct a map of a family regarding how challenges are most likely to be generated from within and their preferred pathways for helping children to negotiate challenges, whatever their sources.

Over time, families tend to develop recurring, often enduring, patterns of interaction organized around the various day-to-day instrumental tasks and emotional challenges associated with living together. These patterns have been designated "family structure," a construct used to describe the manner in which families organize themselves (Minuchin, 1974). These interactional patterns are set in motion by family-member expectations about how tasks, needs, and connections are to be managed. Over time and with repetition, these interactions often become fixed presumptions that are prescriptive for maintaining future interactions. When similar patterns of interactions and expectations repeat themselves across a variety of family tasks and situations, they take on the status of core "rules" or "norms," invisibly regulating family-member behaviors and creating coherence.

Family structure is comprised of both universal and idiosyncratic components. Universally, all families have a hierarchical structure, and family members tend to have reciprocal and complementary functions (Minuchin, 1974). Role complementarity or reciprocity refers to the degree family members accommodate to one another and to the level of rigidity or role exaggeration present. The idiosyncratic component of family structure includes the mutual expectations of particular family members governing interactions around daily routines, such as meals, sleep, work, recreation, intimacy, and homework. This component of family structure is often strongly influenced by culture, particularly with respect to gender-role prescriptions.

Families take many shapes and forms, including those which are single-parent, remarried, multi-generational, same-sex, or traditional. Regardless of form, all families tend to be differentiated into subsystems of members who join together to perform various instrumental and emotional tasks, generally determined by generation, age, gender, nature of task, or common interests (Minuchin, 1974). These subsystems include the individual, the couple, the parent(s), each parent-child dyad, the siblings, the grandparents, the grandchildren, the relatives, or the non-biological kin. Each individual belongs to more than one subsystem within a family. This can be a source of stress and strain when the demands of each subsystem are at odds or there are strong loyalty conflicts between different members. In growth-promoting families, each subsystem creates a context for learning a range of important life skills through experiencing different types of challenges, patterns of closeness and distance, emotional relationships, and levels of power. The particular family form or composition of family subsystems is far less important than how members organize along the two dimensions of family structure - - boundaries and affective proximity.

**Boundaries**. Boundaries prove most critical for understanding the unique manner in which families actually function or regulate themselves within the organization they have created. Boundaries refer to a family's "rules defining who participates, and how" (Minuchin, 1974, p.53) in a given transaction, i.e., who is in, who is out, and who is for or against. Boundaries help moderate both involvement and hierarchy, thereby protecting the autonomy of the family and its subsystems. Boundaries are conceptualized along a continuum of permeability whose poles are the two extremes of "diffuse" and "rigid."

Wood (1985) distinguished between the boundaries separating physical or psychological space among family members and boundaries dividing family roles. Role boundaries or "generational hierarchy" clarify differentiation among responsibilities between generations, such as between grandparent, parent and child roles. A reversed generational boundary occurs when children parent their parents and become responsible for controlling or taking care of them emotionally. A collapsed generational boundary refers to situations in which parents act as peers to their children or when cross-generational alliances exist between a parent and their children against the other parent. The clarity and permeability of role boundaries impacts how power is distributed within a family. Power describes "the relative influence of each [family] member on the outcome of an activity" (Aponte, 1976, p.434). In growth-promoting families, the amount of status or power afforded to different family members or subsystems is based primarily on their generational membership or developmental levels.

Boundaries also refer to the amount of contact or involvement between individual family members, family subsystems, and with people or institutions outside the family – particularly with respect to carrying out specific tasks. In this sense, the concept of boundary is about physical or psychological space, describing the amount of separation or distance between two or more personal domains of

influence. Wood (1985) drew on Goffman's (1971) list of physical and psychological territorial preserves over which the individual has "entitlement to possess, control, use, or dispose of the object or state in question" (p.28) to highlight six common areas of life around which family members tend to regularly negotiate. These territorial preserves include contact time, personal space, emotional space, information space, conversation space, and decision space.

The family system or each subsystem can be described as excessively involved or under-involved with one another around some or all of these personal domains. Subsystems which are highly involved and have highly permeable boundaries have been termed "enmeshed." Individuals in enmeshed subsystems function as if they are parts of each other. At the other end of the spectrum are subsystems in which individuals are minimally involved, show little interdependence and display a disengaged style. At the extremes, these types of relating can generate conditions for significant child and family problems. When adaptive mechanisms are evoked, an enmeshed family reacts to the slightest variation from the accustomed routine whereas the disengaged family does not respond sufficiently when action is necessary. Clear boundaries promote an optimal flow of contact and information between and within subsystems (Minuchin, 1974).

**Affective Proximity**. Another important dimension of family structure, which represents a major elaboration from earlier versions of SFT, revolves around the degree of *affective proximity* between family members. This concept describes family interactions associated with the subjective internal experiences of emotional connection and attachment (Lindblad-Goldberg, Dore, & Stern, 1998). In contrast to *involvement*, which captures the natural struggle in families between dependency and autonomy, the affective-proximity dimension of family structure refers to how secure family members feel in their relationships. This expanded concept--affective proximity--is based on Bowlby's (1969, 1988) perspective that security and emotional proximity are biologically based needs which drive relational behavior from the cradle to the grave. The attachment system is activated by conditions of stress and perceived threat. Close and securely attached relationships occur when the people in a relationship feel they can count on one another to be attuned and responsive to distress signals.

Attachment theory is increasingly recognized as critical in guiding treatment for a wide range of clinical problems in families with children and adolescents (e.g. Byng-Hall; 1991; Marvin & Stewart, 1990) as well as in adult couple relationships (Johnson, 1996). It is a core component within three of the four major variants of SFT, including ABFT (Diamond et al, in press), MDFT (Liddle, 2000) and BBFM (Wood et al, 2000). Developmental research indicates considerable support for the central role played by security of attachment in both psychological and behavioral outcomes (e.g. Cummings & Davies, 1996; Masten, Best, & Garmezy, 1990).

Unlike involvement, which can be overwhelming and stunting when excessive, an emotional connection in a family can never be too secure. The processes of emotional involvement, as marked by

boundaries, and emotional connection, as experienced in affective proximity, were often blurred together in earlier articulations of SFT, making it difficult to explain how relationships which were described as enmeshed could quickly transform into a system that looked disengaged. Involvement does not necessarily predict the security of an emotional connection. For example, a mother and her 14-year-old daughter appear to be highly enmeshed, with the mother involved in every aspect of her daughter's life, yet at the same time they behave as though their emotional connection with one another is very fragile. This happens because the mother abruptly disengages and becomes critical when her daughter attempts any autonomous action. When a child is taking the emotional risk of exploring new, more independent behavior, they are both most vulnerable, yet at this point her mother leaves her stranded and alone. On the other hand, a husband and his wife appear to have low levels of involvement with one another, yet are close because they both have faith that, if there were a crisis, the spouse would recognize it as such and respond with support.

Affective proximity calms and soothes the nervous system (Bowlby, 1988; Siegel, 1999), allowing other necessary instrumental and emotional tasks associated with being a family to be addressed. This proves essential for the development of emotion-regulation and other social-emotional competencies in children. In the face of an inadequate, inconsistent, or ruptured emotional connection between family members, perceived distance can generate considerable distress and anxiety, setting in motion a range of behaviors designed to restore the relationship. The more family relationships are marked by highly negative, rigidly repetitive interactions, the more likely a serious chronic disturbance with affective proximity exists. When attachments are insecure, family members become focused solely on the regulation and stabilization of their emotions and experience themselves as on the verge of being overwhelmed by absorbing negative emotional states (Johnson, 1996). Wynne's (1984) epigenetic model of relationship development and Diamond and Liddle's (1999) treatment-process research imply that family members must possess a fundamental basis for trust and attachment before they can have any hope of learning communication skills, engaging in joint problem-solving, or developing intimacy.

**Family Emotion Regulation**

In contemporary SFT, the processes in which emotions regulate and inform interaction among family members and in turn generate emotional experiences and meaning for family members have become central in both case formulation and treatment implementation. This emphasis flows from the increasing recognition from many disparate fields, including psychobiology (e.g. Siegel, 1999), that emotion and its regulation form the core of internal and interpersonal processes shaping the organization of self. With a model of emotions and emotional regulation within the family context, therapists can understand not only here-and-now interactions and the forces that fuel the evolution of various family structures and the experiences of connection, but also fathom the forces shaping developmental trajectories of children. Empirical studies over the last 15 years from the integrative field of

developmental science infer that emotional regulation plays a key role in the development of most major child-clinical problems (e.g. Cole, Michel, & O'Donnell, 1994; Cole & Zahn-Waxler, 1992; Malatesta & Wilson, 1988). For many clinical syndromes, such as disruptive behavior problems, anxiety, and depression, the dysregulation of emotions in one or more emotional arenas (i.e. anger, fear, or sadness) provides the defining feature of the disorder.

Emotion regulation, mediated in part by autonomic-nervous-system arousal processes, refers to an individual's ability to manage subjective experiences of emotion, especially its intensity and duration, as well as the ability to handle strategically one's expression or modulation of emotion in communicative contexts (Faude, Jones, & Robins, 1996; Saarni, 1999). The press to maintain some subjective sense of internal organization and to avoid out-of-control, reactive behavior or a disorganized thought process initiates a need for emotion regulation strategies, both at the individual and family-system levels. The impetus to retain some sense of emotional organization powerfully shapes emotional closeness and distance in family relationships over time. In SFT today, family emotional regulation connotes the overarching goal of all relationship systems to remain organized, emotionally connected, and emotionally balanced.

In earlier models of family therapy, the concept of homeostasis was utilized to describe how some families seem to resist change, thus emphasizing the family's need for stability and control (Hoffman, 1981). This focus was confined to form (interactional organization) rather than meaning (emotional organization). Now the emphasis has shifted to the extent to which family members perceive their capacities to regulate intensely felt negative emotions. In less adaptive families, fears that the family may spiral into chaos and fragmentation often accompany poor ability to regulate negative emotions. This frequently implies disconnection and isolation between family members. These fears become particularly pronounced when one or more family members have a history of trauma or a serious rupture of an attachment relationship has occurred. This leaves families with constricted, self-reinforcing relationship cycles (Johnson & Williams-Keeler, 1998). Although emotional arousal is unavoidable and usually desirable, both families and their members must possess ways to modulate, tolerate, or endure the experience of emotions which are perceived to be excessive (Denham, 1998). To some extent, how families approach or avoid this task of emotion regulation gives each family system and each relationship in it a unique shape and texture.

Individual emotion regulation is influenced by temperament (Kagan, Reznick, & Snidman, 1988), by cognitive capacities or neurobiological conditions (Bradley, 2000), by patterns of caregiving in families (Calkins, 1994; Cassidy, 1994), and by a child's access to coping resources, sometimes referred to as social-emotional competencies. Through a reciprocal developmental process, a child's emotional reactivity affects the ability to incorporate and construct higher-order social-emotional competencies. In turn, a child's social-emotional competencies affect the capacity to moderate intense emotions

(Greenspan, 1992). A developmental model is based on the assumptions of a relatively predictable progression in the growth of internal capacities which children bring to an interaction and that these capacities develop from the simple to the more complex. The core-component competencies associated with emotion-regulation predict the long-term relational success of children and adolescents (Mayer & Salovey, 1993). Although numerous important social-emotional skills have been identified (e.g. Goleman, 1995; Strayhorn, 1988; Mayer & Salovey, 1993), five emerge as most relevant to emotional regulation at both the individual-child and the family-system levels. They include:

- *The ability to monitor one's own and others' feelings and emotions;*
- *The ability to discriminate among various emotional states and to evaluate their intensity levels for both self and others;*
- *The ability to use this information to guide thinking and actions;*
- *The ability to soothe or calm oneself in the midst of strong affect; and*
- *The ability to empathize, that is, to go beyond identification of what is going on with oneself or with another person emotionally, and to also care.*

In contemporary SFT, therapists note the degree to which individual children and adolescents demonstrate these social-emotional skills, as well as the degree to which family interactions and relationships support their development. These core competencies represent real strengths when present and significant vulnerabilities when absent. The developmental lens puts into sharper focus observations of particular family interactions as they directly relate to the mobilization of specific social-emotional capacities in children. A major component of planning treatment begins with identifying and then encouraging specific types of interactions to promote movement of the child (and, in a preventative sense, other siblings) further up the ladder of development with respect to these core competencies. By challenging family interactional patterns which serve to detour or shut down conflict, and extending the length of a transaction, a therapist is working with family emotion regulation and attempting to shift distorted or irrational beliefs about negative emotions and their capacities to manage it.

Families vary considerably in definitions of what constitutes an extreme in emotional intensity, in attitudes or feelings about the role of emotions, in the emotional experiences or expressions that are favored or discouraged, and in how expressions of emotional expectations are to be handled. In his empirically based work on parental meta-emotion theory, Gottman (Gottman, Katz, & Hooven, 1996) identified how parental approaches to their children's emotions, particularly negatively charged ones such as anger and sadness, can promote or undermine the development of emotional regulation and its constituent social-emotional competencies. Gottman defined meta-emotion theory as the thoughts and feelings or philosophy parents have about their own emotions and those of their children.

The findings from this work bear important implications for the specific types of parenting responses that need to be nurtured by therapists in treatment. For example, Gottman et. al. (1996)

observed that an "emotion-coaching" approach to children's negative emotions resulted in more positive child outcomes. This involved parents who (1) were attuned to low intensity emotions in themselves and in their children; (2) viewed their children's negative emotions as opportunities for teaching or intimacy; (3) validated their children's emotions; (4) assisted their children in verbally labeling their emotions; and (5) problem-solved with their children, setting behavioral limits, and discussing goals and strategies for dealing with the situations. This style contrasts with more dismissive and critical approaches.

The focus on family emotion regulation places reciprocal interactional processes in key caregiving relationships at the center of all growth and development. Therapists in contemporary SFT attend to how negative emotions are managed in the family and how this links to patterns of affective proximity and involvement. Therapists note the content of the emotions expressed, how they are expressed, who expresses them, and how other family members respond to them. From this they discern the expectations and belief systems about different emotions. They design interventions to open avenues for supporting parents to move toward an emotion-coaching style of responding to their children, as well as address presenting problems or concerns. Working effectively with emotion regulation means attending to important individual-family-member differences affecting reactivity.

**Individual Differences**

Since the earliest writings on SFT, helping families construct systems to better fit individual family member needs and to promote positive growth and development has continued (Minuchin, 1974). To facilitate a good fit, however, therapists must have a clearly elaborated grasp of both sides of the intrapersonal-interpersonal equation. Case formulations in the early days of the model gave primary weight to observable family transactions, with little stress on less visible, yet powerful, intrapersonal differences which influence the particular shape of family systems as well as their responsiveness to change efforts. Although sometimes acknowledged, these factors were generally considered strictly background phenomena. In contemporary SFT, both the interpersonal and the intrapersonal receive attention, as in MDFT (Liddle, 2000), ABFT (Diamond, et al, in press), MST (Henggeler et al, 1998), and BBFM (Wood et al, 2000). Therapists are encouraged to investigate as much about who are the players as about how they dance together.

While intrapersonal differences could become the foci of a therapist's attention, the ones that are considered most important directly impact the quality of the therapeutic alliance, the selection of specific strategies, the structure of sessions, and the pacing of change. These individual differences include constitutionally based tendencies, such as ADHD, learning or processing differences, anxiety-proneness, temperament, and vulnerability for various emotional disorders. More psychologically based individual differences, such as emotion-regulatory styles and the developmental capacity for organizing or constructing meaning, also prove important and equally powerful. Because they directly influence cognitive, emotional, and behavioral flexibility, they can significantly limit or constrain an individual's

capacity for forming rich, deep emotional connections with family members. While biology does not determine destiny, biologically rooted characteristics do tend to set in motion their own unique sets of organizing dynamics distinguishable from the social contexts in which they exist. These individual-level biological and psychological characteristics are as likely to mold a family system as they are to be modified and shaped by ongoing interactions within these social systems.

Therapists working with children and adolescents must know how to identify these important individual differences, to understand the often predictable, associated interpersonal processes set in motion by them, and to appreciate the meaning attributed to them by a child and family. Far from being a search for pathology inside the individual (as early proponents of the model were concerned), the focus on individual differences enables a therapist to better understand how particular profiles of strengths and resources contribute to organizing interactions over time. Real strengths and resources come to light only in the context of grasping the possible trajectory of one's life given a specific personal vulnerability. As the nature of constraints and vulnerabilities come into sharper focus, the human drama of the emotional challenges faced by both a child and family become more easily visible, contextualizing the coping or mastery efforts of individual family members. Unless therapists grasp this interactional dramas in which individual differences significantly modulate outcomes, talking about strengths and resources with children and their families will likely ring hollow.

Individual differences themselves do not pose direct targets for change in SFT. Instead they present as forces to accept, work with, and incorporate into a therapist-family-child relationship system and into treatment. Calling attention to and giving a name to powerful life-impacting predispositions, such as ADHD and other neurodevelopmental processes, can foster greater empathy in a family and school for a child, and begin altering the quality and types of support available to master the unique challenges presented by them. Not uncommonly, misunderstood biologically based behavior becomes mislabeled as purposeful, resulting in blame, criticism and rejection, thereby paving the way for coalitions, boundary problems, and attachment ruptures in a family. Children can become symptomatic given their increased vulnerability to chronic failed-mastery efforts, negative self-assessments, and disrupted relationships. Naming enduring individual differences enables children and families to make a problem less central in their lives.

Empowerment of a child and family, always a major strategy in SFT, rests on knowledge and self-understanding, making psycho-education a very important component of treatment. This allows a therapist to highlight a family's emotional experiences of their situation and to amplify strengths with respect to how they have approached normative challenges within the contexts of their family's development, thereby furthering a meaningful therapeutic alliance.

**Family Development**

A family-life-cycle perspective draws attention to the normative and non-normative demands that children and families face in the present, along with those they have encountered over the course of time (Carter & McGoldrick, 1989). From this perspective a therapist better appreciates the nature of the current emotional challenges, which may originate from outside or within the family, and discovers clues as to a child's and family's previous experiences of mastery or failure. Information related to the life cycle best allows therapists to contextualize both presenting concerns as well as individual and family efforts to handle them.

The current emphasis on challenge and mastery in SFT implies that children and families are active agents in their own learning and development, continually exploring, experimenting, and practicing new ways of handling emotional demands that come their ways within the contexts of their relationships as they move through time together. All meaningful growth and development for both children and adults occur within an interpersonal context and are interactional by nature. According to Greenspan (1992), it is in the ongoing interactions between parents and their children that biological or constitutionally based factors and family/community-system dynamics meet, setting in motion internal processes which will move children toward greater internal organization and social-emotional competence. On the other hand, these interactions could also prompt greater disorganization and vulnerability.

Interactions become opportunities for significant child or adolescent growth and development when (1) a critical challenge triggers the process of active emotional exploration and dialogue between the child and family members and (2) both child and family engage emotionally in a sustained way around efforts to negotiate a resolution of the challenge. Mastery occurs when a shift occurs in both a child's internal organization of experience and in the organization of the family's relationships. The map used to navigate the territory for both child and family becomes more elaborated via the process of mastery. A critical emotional challenge refers to any set of affectively charged demands that become central in a child's interactions with family members, peers, teachers, or significant others that requires a change in thinking and an alteration in emotional or relational posture to the problem at hand.

Generally, critical emotional challenges contain multi-leveled implications for the child, the family, and other systems, setting in motion recurring feedback loops that can either promote or constrain mastery efforts. Children cannot have a critical emotional challenge separate from their close relationships, nor can the challenge be mastered easily without affective proximity. Critical emotional challenges with which children struggle may originate from their interactions with their families, teachers, or peers, and they may also stem from internal developmental shifts and conflicts. Challenges are mastered through an ongoing interplay between the challenge itself and sustained engagement in the effort to negotiate a solution while being supported by family members. Each challenge that is mastered moves the child toward more complex, differentiated and flexible emotionally based meaning-structures for organizing experience and for guiding behavior.

A family faces many challenges during the course of its life cycle. Some of these challenges relate to shifts in the primary family structures, particularly those involving the addition or subtraction of family members. These challenges are often coupled with other external stressors on the family. For example, the birth of the first child poses a fundamental emotional challenge to the existing relationship between a couple (Cowan & Cowan, 1990). Both individual self-definitions and the couple relationship now have to be re-conceptualized. The change from a dyadic adult couple relationship to the establishment of a triadic relationship between parents and child proves dramatic. With the birth of other children and the family's involvement with extra-familial systems such as day care/school, neighborhoods, church, recreation facilities, community agencies and institutions, new, complex structures of both intra- and interfamilial interaction and communication must form.

Additionally, throughout the family's life cycle each individual family member experiences developmental changes that uniquely impact on family interaction. The family will have to adapt to external stressful events as well throughout its life cycle. These internal and external changes generate challenges for all family members and their habitual attitudes, strategies, roles, and privileges. Families may react with rigidity and hold to old positions, or they may adapt new forms of interaction and communication. A dilemma for all families concerns how to simultaneously preserve a continuous family style for handling developmental transitions and stressors (i.e. maintain homeostasis or coherence) and to demonstrate the flexibility to change family patterns when necessary for growth to occur.

For example, the Jones family has a toddler, as well as a 13-year-old son. Two-year-old Sally's sudden escalation of temper tantrums is likely to have been triggered by a normative developmental push to test out her growing skills with mobility, words, and imagination. She displays readiness to act on her world, but is frequently thwarted when running into physical and parental limits. The critical emotional challenge for this youngster entails mastery of anger, frustration, and limits. Until two weeks before, Sally had not been faced with either the intensity of the desire to press the limits nor the intensity of anger she has experienced in bumping up against them. She consequently becomes easily disorganized because this is not what she expected to happen, and she does not have an internal map for representing and handling this set of emotional experiences.

At the same time, the parents are faced with a corresponding critical emotional challenge. Their easy-going young daughter's recent devolution into wild screaming fits are counter to the behavioral expectations of these somewhat conflict-adverse parents. In order for the girl to successfully master her emotional challenge, the parents will need to find strategies for supporting her growing desire for greater independence while holding firm on important limits and providing containment when her emotions appear overpowering. In this dance for mastery, the parents as individuals and as a couple, as well as their young daughter, will be simultaneously exploring through trial and error, new change strategies for handling the emotional challenges before them.

The parents will be observing each other's ability to tolerate Sally's expression of negative emotion and perhaps expanded tolerance of expressed negative feeling in their marital relationship. They will be attendant to the brother's role in enhancing or opposing Sally's new behavior. Moving beyond what has generally been defined implicitly in numerous transactions as "tolerable" within parent-child, spouse-spouse, or sibling-sibling interaction will signal the family's capacity to demonstrate change. How members of the family's social network react to preserve the status quo or to foster change will also prove important variables in determining whether or not change occurs. Many breakdowns are likely. The outcome of a specific interaction may displease all parties, yet the sum of interactions over time shapes mastery. A drama in every sense of the term unfolds.

Optimally, each parent will eventually become more comfortable with intense negative affect and learn to contain a tendency to overreact. At the family level, one positive structural outcome would be for the parents to form a close working alliance that fosters regular communication with one another, and perhaps with their son, about the emotions Sally's behaviors evoke in them, the meaning of the behaviors, and ideas about responding to her. Sally, hopefully, will attain increased ability to tolerate less-than-immediate gratification and develop an expanded repertoire of strategies for regulating negative affect, all while remaining securely emotionally connected with her parents and brother.

As illustrated by Sally and her family, anxiety and discomfort tend to accompany any change that requires a re-organization of internal experiences and/or a re-organization of family relationships. Actually, mild to moderate levels of anxiety or discomfort, if experienced within securely attached relationships, propel the mastery process and form natural and normal components for developing core social-emotional competencies. It is assumed that most of the time children and their families spontaneously discover strategies for handling critical emotional challenges, organizing and incorporating their experiences in a way that moves everyone to the next step in their social-emotional development.

When families interpret this anxiety or discomfort in one another as harmful, however, they may prematurely shut down the interactions necessary for mastery and derail the development of social-emotional competencies. Without access to these internal resources, both children and their parents become more vulnerable to the ordinary stresses associated with navigating day-to-day challenges, or more severe external stressors, and may more easily develop symptoms of distress. In this way, symptoms can be viewed as misguided or derailed mastery efforts on both the individual and family levels.

## Major Syndromes, Symptoms, & Problems Treated with SFT

SFT and its integrative variants (e.g. MDFT, ABFT, MST, and BBFM) have been applied to most clinical problems of children, adolescents, and their families, either alone or in combination with other treatment modalities, and within a variety of treatment settings. A modified version of Reiss's (1996)

framework for classifying treatment foci is used for organizing the broad array of developmental and relationship-based problems targeted by SFT into three categories.

The first includes problems in which disordered relationship patterns are highly prominent and serve as the primary focus of intervention. A child or his/her parents experience severe psychological distress as a direct result of negative family or larger system interactions, but individual-level DSM diagnoses (APA, 1994) have little influence in organizing interventions within this category of treatment foci. These include conditions associated with dissolution of the family and hostile post-divorce relationships, such as dislocation and parental-abdication syndrome (Abelsohn, 1983; Isaacs, Montalvo, and Abelsohn, 1986; Montalvo, 1982). Larger-system interventions targeting problematic family relationships with schools (Aponte, 1970; Power & Bartholomew, 1987), medical institutions (Moore, Cohen, & Montalvo, 1998; Sargent, 1985), child-welfare agencies (Colipinto, 1995; Combrinck-Graham, 1995; Minuchin, Colapinto, & Minuchin, 1998), and juvenile court (Jones, 1985) have also been a major focus in SFT.

A second category includes clinical situations in which a child or adolescent shows symptoms clearly meeting DSM criteria, and these symptoms are evoked, maintained, or exacerbated by relationship problems. Both family relationships and individual symptoms provide the focus of interventions and outcomes assessment. SFT has spawned many useful, richly detailed treatment applications for addressing this category of clinical problems among troubled young children (Combrinck-Graham, 1986; Jones, 1994) as well as with adolescents and their families (Fishman, 1988; Micucci, 1999). Clinical symptoms and syndromes addressed include suicidality (Landau-Stanton & Stanton, 1985), school-based problems (Eno, 1985), drug addiction (Stanton & Todd, 1979), anorexia nervosa (Dare, Eisler, Russel, & Szmukler, 1990; Minuchin, Rosman, & Baker, 1978; Sargent, 1987), juvenile sex offenders (Sefarbi, 1990; Stevenson, Castillo & Sefarbi, 1989), and selective mutism (Lindblad-Goldberg, 1986).

Children and adolescents with severe psychiatric and disruptive behavioral symptoms, often resulting in lengthy out-of-home placements, have also received significant attention in SFT, with treatment programs designed for hospital or day-treatment settings (Brendler, Silver, Habor, & Sargent, 1991) and intensive home-based settings (Lindblad-Goldberg, Dore, & Stern, 1998). Major contributions have also been made with SFT variants designed to treat highly troubled adolescents. For example, MDFT (Liddle, 2000) highlights adolescent substance abuse, MST (Henggeler et al., 1998) targets delinquent youth, and ABFT (Diamond & Siqueland, 1998) spotlights adolescent depression.

A third category of clinical situations addressed with SFT involves children or adolescents with biologically based illnesses or disorders, who are severely stressed, but who may or may not show diagnosable mental-health conditions. Intervention efforts are directed at family relationships primarily to enhance adaptation and to reduce exacerbation of physical- and emotional-health problems for both a

child and other family members. The treatment of families who have a child with ADHD or learning disabilities (Bogas, 1993) and developmental disabilities (Jones, 1987; 1991) is included here.

Supporting children with chronic illness and their families has received enormous attention among approaches influenced by SFT (Sargent, 1983; Kazak, Siegal-Andrews, & Johnson, 1995), ranging from a focus on life-threatening diseases such as cancer (Kazak & Simms, 1996) to inflammatory-bowel diseases (Wood, Watkins, Boyle, Nogueira, Zimands, & Carroll, 1989) as well as asthma and diabetes (Minuchin, Rosman, & Baker, 1978; Sargent, 1982). The Bio-Behavioral Family Model (Wood, et al., 2000) represents a major contribution to the treatment of clinical problems associated with a wide range of childhood physical illness. At the other end of the life cycle, SFT has been applied to supporting the elderly who are faced with deteriorating health within the contexts of family and medical facilities (Montalvo, 1994; Montalvo, Harmon & Elliot, 1998).

**Translating Theory Into Practice: Methods Of Assessment and Intervention**

Methods of assessment and treatment within contemporary SFT occur in relationship to four major stages of treatment, organized around meta-processes guiding a therapist's relationship with a family. Thinking in terms of these meta-processes steers therapists in their efforts to read a therapist-family relationship system and directs the timing and pacing of interventions. These overlapping stages include: (1) constructing a therapeutic system, (2) establishing a meaningful therapeutic focus, (3) creating key growth-promoting interpersonal experiences that lead to incremental changes, and (4) solidifying changes and termination.

While the processes implicated in these four stages of treatment occur sequentially, they are neither linear nor discrete in nature. Instead of one stage clearly beginning and another definitely ending, the stages operate according to developmental principles, with each new stage building on and enriching the other. In this manner, treatment becomes more textured and multi-dimensional in proceeding across time. For example, initial efforts toward constructing a therapeutic system begin in stage one. Subsequent stages, however, continue to deepen a therapist's relationship with family members, promoting the objectives of future stages. The processes of each stage often spiral and repeat over the course of psychotherapy.

Vignettes from a case study highlight how the theoretical principles and methods of assessment and intervention related to each of the treatment stages described above are translated into clinical practice. The case study involves seven-year-old Eric who was referred by the school counselor because of his frequent, intense and volatile tantrums that could last for hours. During these tantrums, he would yell, curse, hit, break household objects, and sometimes even urinate on the possessions of whoever was the target of his anger. These eruptions would often be accompanied by hopeless and disparaging self-statements, such as "*I shouldn't be alive; I'm so stupid and bad*." The behavior occurred at home, in the neighborhood, and at school.

The family is middle-class, living in an urban context. Both parents have advanced degrees. The father, Allen, age 40 years, works long hours each week in mid-level management and confines most of his family involvement to the weekends. The mother, Sue, age 39 years, works part-time as a graphic artist. She has placed her career on hold to devote time to taking care of the children. The parents have been married for fifteen years. Allen's parents and Sue's father are deceased. Sue's mother lives in a nearby retirement community. Eric's fourteen-year-old sister, Amy, is enrolled in the ninth grade. Her parents described her as a well-adjusted daughter with friends and as doing well in school. Amy spends a lot of time outside of the home with friends or in her room at home talking with friends on the telephone.

**Stage One: Constructing the Therapeutic System**

Two major objectives are accomplished in the beginning stage of the treatment process. One involves identifying key members of the family and/or extra-familial system who would be invited to participate in the treatment as needed. All four family members were initially considered key for involvement in the treatment. Also, after speaking with the referring school counselor, the therapist determined that Eric's teacher would be a potential supportive resource.

Persons who are critical for inclusion in the treatment process comprise (1) those who may be a part of the sequence of interaction around the problem and/or those who may be impacted by it, and (2) those who may have the potential to establish relationships to support growth and development. Primary caregivers (e.g., parents, step-parents, foster parents, grandparents) and siblings are generally considered desired participants. Treatment may also involve extended relatives and family friends. Since children spend a significant amount of time in school and/or daycare, some therapeutic involvement with these systems is also generally required. A genogram and eco-map can be important assessment tools in identifying significant familial and extra-familial resources (Lindblad-Goldberg, et. al., 1998).

The second major objective of this first stage of treatment entails laying the foundation for setting up a therapeutic alliance. Without a strong therapeutic alliance, no meaningful treatment occurs. This relationship allows conversations to emerge with sufficient depth and range for making sense of and addressing the presenting problems. Within SFT parlance, joining connotes the process of forming a therapeutic alliance (Minuchin, 1974). Joining means to actively demonstrate acceptance of the family by initially accommodating to the family's values and preferred styles of communication and problem-solving. A therapist introduces language that validates an individual's emotional experience and perspective. Language conveys a normalizing of problems as developmental challenges. Effective joining helps family members to feel understood, respected, and known. Joining instills a sense of hope and re-moralization in families who have felt defeated and demoralized by their problems. Joining builds an emotional scaffolding that supports the ongoing therapy. As collaborative alliances develop, a therapist can partner with each family member to clarify concerns and treatment expectations, foster a shared understanding of assessment issues, and ultimately to co-evolve treatment planning.

**Initial Contact with Parents.** The mother, Sue, called for an appointment and sounded very anxious about therapy. Her husband, Allen, entered the phone conversation. Both parents described feeling besieged and overwhelmed by their son's behaviors. They also seemed protective of him, frequently qualifying the slightest negative comments. The therapist joined the parents around their concern for Eric's self-esteem. Suggestions were given on what they could say to Eric and his sister Amy about coming to family therapy. A beginning partnership emerged when the therapist and parents discussed a potential plan to ensure that no family member would feel pathologized during a family session.

**First Session with All Family Members.** Subsequent sessions with all family members would solidify the therapist's initial therapeutic parental alliance as well as join with Eric and Amy. The first family session began with a discussion about positive family and individual experiences, punctuating emotional connections between the children and their parents. Allen set the emotional tone in the session, displaying a highly articulate, controlled and precise interactional style. He assumed the role of spokesperson and responded to all of the therapist's initial questions about Eric. Sue sat quietly, deferring to her husband. Although not directly critical of his wife, Allen seemed to be subtly blaming her for Eric's problems. Consequently, the therapist intervened in a respectful manner to ensure that Sue had equal time to talk. The therapist wanted the parents to come together as a team to feel confident that their concerns about Eric were developmentally valid. This was important because parental ambivalence about the validity of the problem would weaken the therapeutic system when intensity increased later in treatment.

The therapist affirmed the parents' expert knowledge of Eric's strengths and limitations. Parental theories linking the etiology of Eric's problems to self- or other-blame were re-directed. Rather, the parents' attention was focused on the kinds of support children need to achieve the normal milestones of social-emotional development. The fact that some children need more support than others was emphasized. The use of a normative developmental framework based on objective milestones helped them and Eric not to feel blamed, but optimistic, in helping Eric master his developmental dilemmas. The therapist summarized, "*Eric's loss of control clearly makes him suffer and also hurts his relationships with you and his sister. However, I do not believe this is simply a matter of will power. Maybe he's trying to tell you that he is in over his head right now and needs your help with trying to cope with some very big feelings. We need to learn more about how he is processing things emotionally, what is getting in the way of his ability to effectively cope with his fears, disappointments, and frustrations, and how you and his sister can help him*."

Eric presented initially as shy and cautious, but soon felt safe to talk about how badly he feels when "*anger gets me*." Since he was already showing a natural predilection toward "externalizing the problem," a technique described by White (1989), the therapist capitalized on it. Eric engaged in a relatively detailed conversation about the impact of his very big feelings on himself and his parents, sister,

teacher, and peers. Amy described how Eric's anger annoys her, but was also able to empathize with him. Eric then responded to a game of guessing where and when his anger did not "win" (e.g., during rough and tumble sports). Now he could eagerly accept the therapist's invitation to have a "*competition with anger*" using his parents as "coaches." Reasons for winning or losing would be recorded in his weekly journal. The goal of this task was to empower Eric to elicit parental support in understanding how his internal reactions combine with situational family, peer, or teacher interactions to trigger temper outbursts or to master them.

The session concluded with a brief orientation about treatment. Although most mental- health professions mandate informed consent in their ethics code, this is too often treated as a pro forma activity by therapists rather than an essential element of forming a therapeutic system. A treatment system constitutes a new social system. The expectations and procedures may not be well- known. Explaining what the treatment entails significantly advances establishing collaborative alliances.

Positive relationships with family members prove essential, but inadequate alone, to sustain engagement in the absence of a clear and motivating treatment focus. Stage 2 places a major emphasis on the exploration and assessment of a child within a family context.

**Stage Two: Establishing A Meaningful Therapeutic Focus**

A meaningful therapeutic focus derives from a well-grounded assessment of an individual child in the context of family, based on multiple perspectives, and developed in partnership with both the child and the family. A therapist elicits detailed descriptions of a child's presenting symptoms and their impact on functioning across major social contexts, such as family, school, peer group, and community. Resources are also identified. Information about individual or family strengths and vulnerabilities are incorporated into broader clinical themes that make sense to the family. This process helps to provide a vehicle for moving toward change.

**Sessions Two through Four (All Family Members) and Five (Parents and Eric's Teacher).**

Eric's multi-dimensional assessment was based on standardized questionnaire data, observed family interaction, Eric's journal of "encounters with temper," observations of Eric's play within sessions, and discussions with the parents, Amy, Eric, and Eric's teacher about situations that trigger Eric's tantrums. This assessment clarified an anxiety component related to the symptoms. For example, his tantrums occurred most frequently around transitions from one activity to another and in contexts where there was high sensory stimulation, particularly of the verbal kind. Other anxiety-related symptoms, such as compulsions, had appeared in the months prior to the parents seeking treatment, but they had not been linked together with the tantrums.

Viewing Eric as anxious and easily overwhelmed provided a new perception of his presenting problems. This perception opened up constructive dialogues between the parents, between the parents and both of their children, and between the parents and Eric's teacher. All had unwittingly been placing Eric

in too many situations requiring flexibility, his greatest weakness. They examined the number, type, and intensity of demands for flexibility being made on Eric. Accompanying his mother on her numerous errands frequently interrupted his staying home or playing in the neighborhood each afternoon. At school, numerous demands for shifting gears, such as moving from one activity to another in the classroom, and, most significantly, stresses on the playground overextended his capacity for flexibility. Since Eric already felt he had little control over events in his life, these demands proved too much. This type of problem-solving dialogue is often overlooked when gross family interactions are examined out of the context of individual-level child data.

Examination of recurring family interactions added importantly to understanding other sources of tension and anxiety for all family members and their subsequent reciprocal responses. Emotional connections between Eric and his mother, as well as within the couple, were marked by insecurity and distance. Allen became stiff and fidgety whenever Sue spoke, as if he half-expected her to misspeak or diverge into a tangent. Sue talked hesitatingly, frequently looking at Allen, attempting to correct herself based on whatever she read into his facial expressions. When his parents were conversing, Eric would quickly disengage and retreat into playing with toys in the room. Amy would also withdraw and do her homework. In subsequent sessions Amy negotiated a contract with the therapist that she would come to sessions on an "as-needed" basis because of her heavy homework load and extracurricular activities. Perhaps she, too, needed time away from the parental tension.

The therapist playfully highlighted this negative interactional pattern in a family session when the father reprimanded Eric for leaving the family circle. The father had also just given an irritated glance at his wife when it looked as though she might comment on the action. The therapist brought the focus back to the parents saying, "*I think Eric has the right idea, this conversation is way too heavy for someone his size to bear. Is there something that you're trying to help Sue get out that could be useful here*?" Sue haltingly pointed out that Allen is more adept with words and that she often has trouble expressing her words fast enough because she views herself as a slow thinker. The therapist changed the perception of this self-deprecating comment by first acknowledging Sue's observation of differences between her and Allen's processing styles. The therapist then questioned whether Sue's tendency to reflect on what she is going to say might be considered by some to be a real strength. The notion of individual differences and the importance of accepting and learning to work with them within the family (as opposed to labeling them as deficits) emerged as a theme that was played out repeatedly in this family's treatment.

By making overt this one interactional pattern between the parents, critical family history emerged as well as important information about Sue's 20-year struggle with her own emotional health and self-esteem. Allen made an effort to steer the conversation back to Eric, but the therapist briefly blocked this in the interest of stretching the family's tolerance for conflict and negative emotions, as well

as to promote elevating Sue's status within the parental relationship. Sue's description of her difficulties and Allen's efforts to deflect it represented a recurring parental pattern of minimizing serious issues.

Sue spoke of her mother as being critical and intrusive while describing her father as distant. The similarity with her current family was noted in order to create an opening for Sue to acknowledge her disappointments and to begin to talk with Allen about their relationship. As Sue began to talk more openly, Allen revealed how Sue's dependency burdened him. He related that Sue frequently went to bed and slept when challenges arose and how she called him to come home to care for the children. This set of interactions maintained Eric's insecurity in his relationship with his mother. Sue acknowledged this and described her frequent bouts of low energy, crying spells, and gloomy moods. The therapist wondered aloud about the presence of clinical depression. Sue seemed surprised to hear that the condition, which she had learned to live with over the years, might not result from character flaws, but instead might respond to treatment. She indicated that, in previous therapy, medication had been discussed, but the therapist had never given a diagnosis or suggested that learning more effective coping skills might help her.

Both Sue and Allen seemed to relax once this "secret" emerged. Allen began advocating that Sue obtain an evaluation for depression and enter treatment for it. The therapist took great care to avoid implying that Sue's depression was "the" cause of Eric's difficulties. Instead, the therapist highlighted the importance of both parents being able to work together from a position of strength to help Eric learn to cope with his big feelings. In a sense, Sue needed to learn to handle her own big feelings. Sue followed through with a brief series of individual therapy sessions, resulting in an increased sense of empowerment for her and a more active, positive role in the family. This intervention served three process goals. One, it began a re-structuring of the family organization by promoting a stronger, more functional parental alliance. Two, this intervention challenged the family's avoidant style for handling conflict and negative emotions. In the interest of protecting one another from the feared harmful impact of disappointment and hurt feelings, honest appraisals and straight talk about individual experience had become nearly impossible for all family members. Consequently, effective problem-resolution was curtailed. Three, this intervention began to call attention to the need to appreciate individual differences such as temperament, perceptions, coping styles, and emotional needs.

By the end of the fifth session, a more complete case formulation, with clear goals and objectives, was in place. In contemporary SFT, case formulations operate as enhanced problem- definitions, which establish therapeutic focus. They provide a summative activity wherein information about presenting symptoms, child and family strengths, and child and family development become integrated into a meaningful story. An effective problem definition or therapeutic focus offers clarity and galvanizes children and their families into action. It links the symptoms and what must be done to address them to the next step in the child and family's development.

Following the initial five sessions, the parents began to view Eric's tantrums as an expression of his being overwhelmed by sensations and feelings too big for him to handle. They learned the two reasons Eric's coping skills were underdeveloped. One stems from his constitutional sensitivity and proneness to anxiety. Consequently, he often begins an interaction with his parents, Amy, or others already highly aroused. To learn greater self-control and self-regulation, he needs his parents and teacher to provide more early warnings and orientation for upcoming transitions, as well as help with visualizing what he can do that is fun within the next activity. When prevention fails, and Eric becomes overwhelmed, he needs containment and soothing, rather than threats and other power-based responses. The parents also realized that, when they do not work together and overwhelm him with their own tension and anxiety, his effective coping strategies decrease. The parents must, therefore, find ways to become more supportive of one another and more tolerant of their own individual differences. In particular, father needs to stop rescuing mother, and she should remain more involved in the parenting role, exercising greater assertive parenting tactics with both children.

The case formulation clarifies both what the child needs to learn and what family structures will support this learning, and then links these understandings to the presenting problems. This opens the door to the third stage of treatment in which the focus turns primarily to problem-resolution, re-alignment of family relationships, and increasing emotional capacities.

**Stage Three: Creating Key Growth-Promoting Interpersonal Experiences**

To foster problem-resolution and development, the therapist uses oneself and organizes family relationships to create or stimulate key interpersonal experiences designed to provide intensive practice of emerging, but weak, coping skills. Both therapy sessions and family life at home become emotionally based learning laboratories for child and parents. Interventions follow the assumption that emotional skills are best learned experientially or from the inside out. Thus the SFT therapist must remain highly attuned to emotional and interactional process. Two major elements appear crucial for making interactions become more growth-promoting -- emotional challenge and emotional support. Both seem essential in proper proportions for interactional experiences to promote growth or change, rather than a repetition of an accustomed pattern. The therapist varies or adjusts the levels of intensity associated with the emotional challenge and the accompanying support. Here many of the techniques associated with the SFT model generally come into play, including boundary making, raising intensity, enactments, and punctuation of interactional process (Minuchin & Fishman, 1981).

**Sixth Session with Eric and Parents.** A spontaneous enactment of Eric's problem in handling disappointment and discomfort occurred during the sixth session. Eric loudly demanded to go home midway through the session, proclaiming that he was bored and was missing his favorite television show. Sue attempted to empathize with him when Allen motioned emphatically to her that he would handle it. Allen sternly told Eric to "cool it" and promised to stop by the ice cream store on the way home from the

session if he behaved. Eric immediately calmed and smiled. At this moment, however, the therapist blocked the full implementation of this resolution by turning to Sue and asking, "*Do you think Eric could settle down without any bribes*?" This brought Sue back into the interaction, increasing the tension in every dyadic and triadic relationship in the room, particularly between the therapist and Allen, Sue and Allen, and the parents and Eric. Now both Eric and the family were presented with a slightly different, but significant emotional challenge that needed resolution. Sue responded to the therapist's challenge haltingly, "*I really don't know what Eric can handle anymore*." She then glanced protectively at Allen's reddened face signifying he had felt criticized. He defensively responded that at least his directive had proven effective. The therapist supported Allen, indicating that he probably would have proceeded in the same way. However, the therapist then proposed that treatment sessions offer a safe place to question old methods and to experiment with new strategies.

This one conflictual interaction between Eric and his parents supplied rich material for an intense, constructive dialogue between the parents and the therapist for another forty minutes. The therapist focused the parents on both Eric's internal processes and family interactional processes, asking "*What do you think triggered his reaction just now*?" After entertaining the parents' guesses ranging from "*a short attention span"* to *"just being difficult*," the therapist highlighted recent conversation that may have made Eric anxious. Specifically Sue had initiated discussion about the impact of Allen's unavailability the day before when she called him at work to ask for help in handling one of Eric's volatile tantrums. Allen bristled, and Sue pouted. Then Eric was ready to leave. Both parents agreed with the therapist's observations. This led to a reflective examination about other tantrums and potential links to daily routines or interactions in the home. For the family, this enactment engendered a deep appreciation of the power of anxiety as a force leading to Eric's demanding, explosive behavior. It also helped to provide a rationale as to why bribing Eric with an ice cream cone might short-circuit efforts to master this anxiety, as well as block an opportunity for them to demonstrate their abilities to handle and resolve conflict.

As often happens with child- and adolescent-focused clinical problems, Eric's family shows a parallel difficulty in handling the same class of emotions as Eric. His family as a whole or as individuals do not tolerate tension and discomfort. Interactions are shut down before a natural resolution of issues occurs. Fear and anxiety govern interactions. When disappointment and anxiety challenge Eric, he, in turn, confronts his family. Family members display an inability to support his efforts to master these powerful feelings because they themselves feel uncomfortable with them. By terminating conflict prematurely, the parents miss an opportunity to probe beneath the surface of Eric's demands and suppress hypothesizing about the possible triggers of his behavior. Eric misses an opportunity to become more aware of his intentions, a critical process in learning to self-regulate.

In the enactment described above, the therapist intended to extend the dynamic tension in family relationships longer than the family would naturally tolerate in order to kindle these opportunities to

engage in critical thinking. The possibility of promoting discovery of new ways for working with these feelings could arise. Growth and development derives from struggles with mild to moderate levels of emotional tension. The family's learning this throughout therapy helps to contain some of the anxiety associated with attempting new behavior. Interventions such as the one described with Eric and his family constitute "core" emotional challenges because they cut across multiple system levels. They possess the potential to alter both the family structure and dynamic as well as the child's internal structure and dynamic. Therapy with Eric and his family involved numerous similar experiences, based on the assumption that a significant level of daily practice proves necessary to incorporate both new internal structures and new family structures.

Work with a variety of subsystems in the family often becomes important in order to provide growth-promoting experiences of sufficient intensity. In the early days of SFT and other models of family therapy, a mistaken belief prevailed that children and adolescents greatly benefited primarily from the indirect effects of change at the larger family-system level. This represented a trickle-down theory of change. In contemporary SFT, it is believed that work at one subsystem level cannot be omitted or replaced by work at another level. Meaningful change expected in a child or adolescent's coping skills requires specific interventions directed at these specific processes.

**Seventh and Eighth Sessions (Eric and Parents).** The parents and therapist mutually decided to use family play in the seventh session to observe how Eric processed different emotions and coped with overwhelming negative emotions. Eric gravitated toward toy soldiers and policemen, with overarching play themes generally involving the good guys trying to restrain the bad guys. The bad guys kept escaping from their jails. Rather than interpreting the symbolism in the play, the therapist utilized it to show the parents how Eric could incorporate new ideas and emotions into his play. The therapist wondered aloud whether the bad guys' intentions had been misunderstood by the good guys. Eric guessed, "Maybe the bad guys were really trying to save the townspeople from something they couldn't see." The therapist helped Eric to further elaborate on this idea, stretching his ability to entertain a broader range about other people's (and perhaps his own) intents or motivations. Developmentally this skill is assumed to be a prerequisite for increasing the capacity to represent emotions at an abstract level and to mentally engage in problem-solving difficult situations (Greenspan, 1992).

Sue and Allen also joined Eric's play and helped him to hypothesize about the intensity and intent of his play characters' emotions. Eric was delighted to have his parents connect with him within an arena in which he felt so competent -- the world of play and imagination. The parents were urged to spend some time each day engaged in fantasy play. One objective of this task was to increase the number of interactions at home in which Eric and his parents experienced sustained emotional connections around non-threatening, yet emotional, themes.

During the eighth session, family play concentrated on increasing awareness of family member's emotion-regulation styles. Together the family drew a cardboard "emotion scale," using different colors to symbolize varying degrees of emotional intensity. When the scale registered "red," indicating high emotional intensity, each individual described what he or she could do, both autonomously and/or with the help of another, to bring it down to an "even keel yellow." In this and future sessions, the emotion scale was utilized to help family members modulate arousal, to hypothesize about the intentions of self and others, and to communicate about it during discussions of emotionally charged home situations. The parents utilized the scale at home to defuse potentially explosive situations and to become more adept at reading each other's and their children's intents or motivations.

Over the next several sessions, the therapist and parents designed and implemented behavioral interventions to assist Eric in containing explosions and to ensure that his tantrums would no longer work to avoid uncomfortable situations. The parents kept negative consequences or punishments for the behavior at a minimum, and instead waited them out. Eric identified "safety zones" on each floor of the house where he could go whenever he felt that he would explode. He chose tight, dark, and quiet places such as under the sofa or within closets.

Through continued subsystem work, both Eric and his family practiced the types of growth-promoting interactional experiences outlined above for approximately one month. Gradual changes occurred both in the ways the family operated and in Eric's presenting symptoms. Stage Four began with the accomplishment of agreed-upon goals.

**Stage Four: Solidify Changes and Terminate**

Although the therapist continually helps family members to integrate different themes generated during treatment, this task becomes more central in Stage Four. Families need a clear conceptual understanding of how their actions produce desired outcomes to solidify changes, especially when relapses occur. The therapist wants to know how the family will right themselves when one member slips. Here family members take the lead roles, and the therapist serves as a partner or guide. Changes must generalize beyond the therapy context and be sustained long after treatment ends.

**Subsequent Sessions with Eric and Parents.** For Eric and his family, Stage Four began with a small crisis. Symptoms that had significantly improved suddenly escalated. Until the relapse, Tommy's volatile tantrums decreased from fifteen to sixteen per week to two or less, with recovery time shortened from over an hour to less than ten minutes. As in this case, a relapse presents rich opportunities for linking various strands of the therapy and for solidifying changes. In the session following the relapse, the parents and therapist reviewed possible changes either at home or within school that could have played a role in Eric's relapse. Here the parents took a leadership role. These previously conflicted parents worked more as partners, requiring only mild support, readily drawing on a more elaborated case formulation which they had developed over the course of the therapy.

Sue confidently suggested that interactions with a new child in Eric's class could be stressing him. The therapist asked her to pursue this hunch with Eric. Initially, Eric rebuffed her inquiries, leaving Allen poised to shut down this avenue (albeit with less impatience than previously) and to open another. The therapist quickly recommended that Sue find another way to open the dialogue with her son. In contrast to her previous style of backing away from challenge, she moved forward, kneeled on the floor beside Eric and joined him briefly in his play. With this level of support and engagement, Eric talked about his difficulties with a new child in his class. He felt jealous because his friends expressed more interest in the new child than in playing with him. Allen now teamed with Sue and Eric to problem-solve the situation. All three family members explored the emotional signals behind the problem behavior, examined changes within the social context, and then worked together to develop solutions. The therapist reviewed his observations of the family's approach to this new challenge, highlighting how little he needed to help. The family then identified what made their problem-solving successful. In this way, the family used an opportunity to internalize a method for self-reflection, an essential process for self-correction.

Before treatment ended, the family was invited to reflect on their vulnerabilities and to think ahead to preventive strategies for the future. The family also reviewed each family member's progress throughout treatment and identified coping resources for future challenges. These types of dialogues helped to solidify therapy themes related to conflict tolerance, acceptance of individual differences, and emotional expressiveness that had emerged in various forms throughout the treatment.

**Post-Treatment.** In a follow-up visit nine months later, Eric showed further decreases in tantrums and continued growth in social-emotional competencies. For example, Eric was now engaging in sports activities that he always admired, but was too anxious to try. He was now better able to verbalize his worries and to request support when needed. The parents had grown closer and more secure with one another, as had Eric and his mother. A more relaxed, tolerant attitude about negative emotions and conflict pervaded throughout the family. The treatment consisted of eighteen sessions total over the course of ten months.

**Supporting Research**

A strong commitment to both family-process and treatment-outcome research has continued ever since the first approximations of the model began to emerge in the early 1960s at the Wiltwyck School for Boys. Empirical studies using SFT-inspired approaches over the last thirty-five years have made major contributions to the larger body of research establishing family-based treatment in general as viable and efficacious for a variety of child and adolescent disorders (Diamond, Serrano, Dickey, & Sonis, 1996). Liddle (2000) in MDFT, Diamond et al. (in press) in ABFT, and Henggeler et al. (1998) in MST are currently generating the strongest empirical support for many of the core constructs and practices of SFT in their three integrative, highly specified research-based models.

The SFT model represents the product of a quasi-experimental process, bearing some resemblance to the inductive step-wise manner Kazdin (1994) recommended for treatment development studies**.** For example, Minuchin and his colleagues began their work with only a few sketchy concepts derived from sociology and anthropology. They let their systematic observations of families in therapy guide model development. Their early adoption of one-way mirrors, and then of videotape recordings of clinical sessions to document family and therapeutic processes, reflects the value placed on keeping theory grounded in concrete, observable phenomena. Observational methodology has always held a central position in research related to SFT, relying on various family tasks or assignments to evoke interactional behaviors which could be coded for pattern.

As with the therapy, studies related to SFT since Wiltwyck have tended to be "population-centered." With social context as central to this model, most of the initial studies during the first twenty-five years were more focused on understanding specific groups of families and charting the interactional landscape around specific problem areas than on the documentation of treatment outcomes. The population studied at Wiltwyck included behaviorally disordered children and adolescents living in families described as "the ghetto-living, urban, minority group member, who is experiencing poverty, discrimination, fear, crowdedness, and street-living" (Minuchin, et al., 1967, p. 22). A total of eleven families comprised the treatment group. Early outcome studies in SFT, as was true for much of the treatment field in the 1960s and 1970s (Gurman & Kniskern, 1981), tended to have very small samples and did not involve control groups. These researchers relied primarily on pre- and post-measures of change in child symptoms and family interactional patterns.

Despite the methodological limitations of the early studies, the results proved very encouraging regarding the model's potential for effectiveness. For example, seven of eleven families followed at Wiltwyck showed improvement in interactional flexibility and quality of the communication process at the end of six months of family intervention (Minuchin, et al., 1967). This study of under-organized, unstable families solidified the conviction "that families need some kind of structure, some form of hierarchy, and some degree of differentiation between subsystems" (Colapinto, 1991, p. 419). The thrust

of the simple, early study at Wiltwyck has been validated by current, more sophisticated research with this population (see comprehensive reviews by Henggeler, Borduin, & Mann, 1992; Tolan, Cromwell, & Brasswell, 1986).

Controlled research based on the MST model developed by Henggeler and colleagues (1998) has built upon and significantly extended the early exploratory empirical work begun by Minuchin at Wiltwyck. In this SFT-informed model, closely supervised community-based practitioners available twenty-four hours per day provide treatment within the homes and communities over a period of four to six months, with interventions guided by a highly specified treatment manual. Henggeler (1999) and colleagues have published eight randomized clinical trials comparing MST with other models for intervening with seriously troubled, delinquent youth. They consistently demonstrated success in reducing delinquent behavior, drug use, and out-of-home placements (such as incarceration and hospitalization). Current MST studies spotlight treatment retention, cost effectiveness, and quality assurance.

Ecosystemic Structural Home-Based Family Therapy (ESSFT; Lindblad-Goldberg et al., 1998), also a home-based expansion of the model begun at Wiltwyck, was developed to serve a population of children and adolescents with a broad spectrum of severe mental health disorders who are considered to be at high risk for out-of-home placement. Eight months of treatment is provided by co-therapy teams, with interventions including family therapy, community linking, 24 hour crisis availability, family support services, and respite care. Therapists receive 3 years of intensive training in the model and 3 hours of weekly supervision. A seven-year study of ESSFT treatment outcomes targeting 1,968 diverse families across more than 40 different community agencies showed significant reductions both in presenting symptoms (from both the child and parents' perspectives) and in the use of out-of-home placement (Dore, 1996). Significant positive changes were also observed in family functioning and the child or adolescent's psychosocial functioning. These changes were maintained up to one year post-treatment. Both this variant of SFT and the variant, MST, significantly expand the emphasis on treating the family within the ecology of the community.

Another early research area by Minuchin and his colleagues at the Philadelphia Child Guidance Center dealt with middle-class families with children showing psychosomatic conditions. On both physiological and interactional measures, the special vulnerabilities of some children with chronic illness correlated with certain over-organized family patterns, such as enmeshment, rigidity, over-protectiveness, and absence of conflict resolution. SFT proved effective in treating families with diabetic children who showed frequent, medically unexplained emergency hospitalizations for acidosis, and children who experienced intractable asthma and relied heavily on steroids (Minuchin, Baker, Rosman, Liebman, Milman, & Todd, 1975). In summarizing the results of treating fifty-three cases of anorexia nervosa, Minuchin, Rosman, and Baker (1978) reported a ninety percent improvement rate, with the positive

effects maintained at follow-up intervals of up to two years. In more recent well-designed studies comparing individual therapy and a modified, integrative version of SFT with young anorexic girls, researchers have replicated these early findings (Dare, Eisler, Russell, & Szmukler, 1990; Russell, Szmukler, Dare, & Eisler, 1987).

During this same time-period, Stanton and Todd (1982) began applying SFT to the treatment of heroin addicts receiving methadone and their families. In one of the earliest controlled studies of SFT, they compared this treatment model with a family placebo condition and individual therapy. Those in the SFT treatment condition showed significant symptom reduction, with the level of positive change doubling that achieved in the other two conditions; these positive effects persisted at six and twelve-month follow-ups. Numerous subsequent studies with substance-involved adolescents using family-based treatment have replicated and expanded these findings (e.g. Friedman, 1989; Henggeler, Borduin, Melton, Mann, & Smith, 1991; Lewis, Piercy, Sprenkle, & Trepper, 1990). These studies also highlighted the power of the model in fostering engagement with treatment. For example, compared to a rate of forty-nine to fifty percent for peer groups, family treatments resulted in attrition rates of eleven to thirty percent. Szapocznik et al. (1988) increased the attendance of substance-involved youth at first sessions by forty percent using a strategy derived from SFT.

Liddle's research using Multi-Dimensional Family Therapy (2000) includes some of the most rigorous testing of core SFT constructs with this clinical population. In addition to a focus on family interactions, MDFT incorporates an emphasis on individual developmental themes and family affect. Three randomized trials have established the model's efficacy with adolescent substance-abusers (Liddle, Dakof, Parker, Diamond, Barrett, & Tejeda, in press). Process studies have also received a major emphasis in Liddle and colleagues' research agenda, including a focus on the relationship between in-session patterns of change and resolution of parent-child conflict (Diamond & Liddle, 1999) and strategies for improving poor therapist-adolescent alliances (Diamond, Liddle, Hogue, & Dakof, in press).

Although SFT has been applied to the treatment of a wide range of child and adolescent disorders, there are fewer family-based treatment outcome studies reported in the literature targeting childhood internalizing disorders such as anxiety and depression. In one well-designed study Szapocznik et al. (1989) compared SFT with psychodynamic therapy and a non-treatment control condition for Hispanic school-age boys presenting with a variety of problems typically seen in an outpatient setting. About half of the boys displayed behavior problems, with the rest evidencing anxiety and adjustment difficulties. While equivalent in their effectiveness at reducing levels of behavioral and emotional symptoms and increasing general social-emotional adaptation, the two treatment conditions significantly differed in their impacts on family functioning. The families of the boys receiving psychodynamic therapy deteriorated in functioning during the treatment and at one-year follow-up. In contrast, the

families of the boys receiving SFT showed improved family functioning which was maintained through the one-year follow-up.

Studies are currently underway by Diamond and colleagues (Diamond & Siqueland, 1998; Diamond et al., in press) using an SFT-derived model--Attachment-Based Family Therapy--with depressed adolescents. The model highlights reduction of blame in the family, improving communication and problem-solving skills, fostering authoritative parenting styles, and strengthening family social supports. Early results are promising. For example, significant reductions in depressive symptoms were reported by the treatment group, as compared to wait-listed patients, in a randomized pilot study of thirty-two, mostly African-American, clinically depressed adolescents (Diamond, 1998).

In sum, SFT has proven to be an influential and effective treatment model for children and adolescents who present with a wide variety of clinical problems. The developers of several strong research-based treatment models (e.g. Multi-Dimensional Family Therapy, Multi-Systemic Therapy, Attachment-Based Family Therapy, and Bio-Behavioral Family Therapy) have incorporated core concepts and intervention strategies from SFT and rigorously tested them with specifically defined clinical populations. This complements the focus in contemporary family-therapy-treatment outcomes research, which has shifted from comparative studies of different broad-based family therapy models to testing more integrated, highly specified versions of family-focused approaches. The current trend toward greater specification and operationalization of the goals and methods of treatment throughout the field of psychotherapy (see Roth & Fonagy, 1996) can only help to strengthen the model and make it more effective and more teachable. As is evident in the integrative effort of this chapter, SFT will unlikely maintain the status quo, even in reference to itself. Instead, its proponents will continue to develop, re-organize and respond to the endless challenges and circles of feedback, influencing while being influenced.

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