

Family therapy: the rest of the picture

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The specialist literature on family therapy naturally tends to focus only on the special features of what is a much larger body of skills and knowledge. To redress the balance this paper outlines the rest of the picture in various ways. About 90 separable component parts of family therapy are described. Some implications of this analysis are identified.

Introduction

If a speciality like family therapy were a subject to be photographed, and all the articles and books about family therapy were the photographs, the pictures would be mostly of one part of the subject only—like ‘mug-shots’ of the kind used in passports or criminal identification files. Like the faces photographed, *not one family therapy article or book is exactly like another*. The functions of ‘mug-shots’ and specialist literature are similar—the refined identification and differentiation of knowledge at the core of a specialist field. This is what interests the readers and members of that field. The rest of the picture is of fundamental importance, but it is almost the same in every instance and so familiar to the readership that it is taken for granted, as we do with what lies below the shoulders of a ‘mug-shot’ and gets left out. The rest of a speciality’s picture may be so basic that it is not even exclusive to that one speciality. So the editor of the specialist literature naturally cuts out and publishes only the ‘mug-shot’ part of submitted articles.

The family therapy literature is full of fascinating ‘mug-shots’. The ‘faces’ in the picture are the characteristic theories and interventions of the various schools of family therapy. There is no doubt that exploring these is a valid and productive exercise—as is evident even from a broad summary of our rich field (such as Barker, 1986). However, for both

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those in and outside the field, I think there is value in bringing in the rest of the picture. That is the aim of this paper. If family therapy is basically a systems approach (as described by Barker and others), then the interest in the rest of the family therapy system should come naturally to us. And it is appropriately a family therapy specialist journal that includes the rest of the picture.

The paper falls into the following sections, all of which are presented in outline only:

- (1) some broad basic statements or theorems about our field;
- (2) the full picture of the making of a family therapist;
- (3) the full generalized picture of family therapy's components; and
- (4) some implications.

The ubiquitous system

Dare (1979) stated that family therapy is unique in having no special subject matter apart from the mundane business of family life that all humans experience. Haley (1970) described family therapy in terms of the process the developing therapist goes through. His experience was that before working with some 200 family therapy cases, trainees do not see how broadly the new family/systems approach applies, but afterwards they cannot see anything (even prescribing pills) except within that framework. From these statements, it follows (for family therapists) that:

1. Humans, including helping professionals, always exist and function in systems, but they may or may not know it. (From this starting point, we can develop further basic theorems for family therapy, as follows).
2. The functions of a family include task-tackling, problem-solving, communication, co-operation, conflict, conflict-resolution, support etc.
3. An individual or other sub-system in a family system—or involved by it—may affect positively or negatively that system's functioning. (Without going into it further here, I think there would be general agreement amongst family therapists as to what ultimately constitutes positive and negative functioning in this respect, though there may be some debate about the means of achieving positive change.)
4. Whether the effects of what they do are positive or negative, therapists may not know they are doing it, or they may think they know it.
5. If they think they know it, they may be right or wrong about the effect they are actually having.

6. A family therapist's skill is to produce positive effects on families' functioning, eliminating the negative (Arlen and Mercer, 1945).

7. Family therapists should not only *think* they know how to produce positive effects, but also get validation so that they *know* that they know it. If this is achieved, we could describe them as skilled in systems work with families.

8. The aim of family therapy training is to develop this skill and knowledge.

Family therapists specialise in one kind of human system—families. But if we are dealing with the mundane and the ubiquitous, family systems are not the only kind of system we all function in. We can count in other systems such as peer groups, schools, committees, work and recreational settings. And increasingly family therapists are aware that families and professionals are themselves sub-systems of larger systems.

Although systems are ubiquitous, they do not all have the same properties. Someone who is skilled in systems work with one kind may not be with another. Yet, for open systems (like human ones) it is in the nature of a systems approach that one system cannot be isolated from the many others that impinge on it. There should also be some congruency in the aims and methods from one system to another. So, all the above theorems are potentially equally applicable to other fields—for example, organizational work (Miller, 1976). Taking this broader picture of our field is often denoted by the term 'a family/systems approach'.

The making of a family therapist

Haley considered only the last phase of the making of a family therapist—the last 200 cases. But we can extrapolate the rest of the picture from what he described. Thus, the full career would be as follows:

1. Lay-person

Through childhood and after, like everyone else, people destined to be family therapists take part in ubiquitous family/systems functioning, but may not be aware of this as such; yet they may naturally have a positive or negative influence on that functioning.

2. Preliminary steps

Interest, design, circumstance, luck and 'psycho-pathology' lead such people to the helping professions.

3. Joins helping profession

Now such people choose a life where they will increasingly take a professional part in family/systems functioning, as well as continuing to do so personally.

4. Basic training

Professionals in training may still be unaware of their inevitable and powerful role in family/systems functioning—indeed some kinds of professional training seem designed to *decrease* any natural awareness. However, newly enrolled professionals have to learn something about relationships with clients or patients, referral and discharge, engaging in interviews, problem-definition, ‘contracting’ to do appropriate work, and many other basic skills (see below).

5. First base

At some point (presumably at the end of basic professional training) workers will be effective enough in basic skills to conduct the appropriate form of case-work for their discipline. If it is effective, this casework will—by definition—go with mild or moderately positive influences on family/system functioning, though the workers may still be largely unaware of these systems skills as such. Many workers may have no interest or motivation to go further, or at least not further towards family therapy, but some choose to develop in that direction.

6. Training in family therapy

We know that the best way to learn family therapy is in a setting that is committed to it. Ideally, there should be a wide range of families and their problems as well as therapists, interventions or even kinds of family therapy, as long as the trainee can utilise the rich diet.

7. Fully fledged

Around the 200th case, if we follow Haley’s (1970) description, the family therapist reaches that state of awareness of the ubiquity of family/systems functioning and the skill of producing thoroughly positive effects where appropriate.

To summarize so far: our full picture includes some basic theorems and the earlier stages in the making of a family therapist. Family therapy shares its subject matter of family/systems functioning with all humans, and its general aims of promoting positive functioning with other ways

of working. It also shares basic skills with all helping professions from whose ranks family therapists step forward. This leads into describing the fuller picture of family therapy itself as a way of working.

Family therapy's component parts

Though its various schools have different faces, family therapy is usually talked of as a monolithic entity. For example, members of audiences find 'it' impressive but decide they could not do 'it' in their own setting. 'It' is indeed a powerful method of working with people and a wide range of problems. But the monolith can be seen to be an assembly of a number of components. All kinds of family therapy have these components in some form or other and they also include those basic aspects that other forms of professional help and therapy may take for granted. Although the components in this whole picture of family therapy may be utterly familiar to us—and, in our practice, we immediately recognize when one of the items is missing—the task of itemizing the obvious can take more trouble than might be expected. Before continuing, readers might like to attempt their own list. The aim here is to describe the components of a generalized stereotype of family therapy as a way of working. The following list—about 90 components altogether—has been developed and refined in discussion and workshops; so it has some validity, although it could be constructed differently. The stereotyped picture may need adjusting for it to fit the actual picture. I have indicated several points where I think the stereotype needs up-dating or amendment.

1. Basics

We take for granted the fact that family therapists are fairly mature human beings—maturity not necessarily being a function of age here. They should have a good grasp of the language and culture in which they work, or what they need to do if not. They have the following basic professional and case management skills: acceptable experience; qualification and position in one of the caring professions; skills in organizing time/diary/priorities; setting up meetings; giving proper notice and information before a meeting for clients to prepare for it; introducing and interviewing at the meeting; taking enough basic history to provide adequate basic formulation; negotiating some sort of contract with clients; liaison and referral with other agencies directly and by use of phone and letters; closing cases; the management of records and filing systems; and of confidentiality and other ethical matters.

Adequate desk, office and secretarial facilities are also needed. Especially important is the simple authority and organizational support for appointments and meetings in general—that is, there is some holding system or ‘cover’ for incoming calls and emergencies to prevent unwarranted intrusion into carefully set up commitments, whatever they may be.

2. Basic support

In addition (even if the work is not family therapy), time and personnel are routinely available for satisfactory supervision and/or alternative support. Alternative support would preferably be with colleagues in the same work setting, but could include study days, courses, etc. So study leave may be essential for many. Satisfactory in-house support is only possible if at least a core group of staff (and their supportive line managers) can withstand excessive staff turnover, whether the turnover is by choice, by edict of management or by natural consequence of trainee status of colleagues.

3. The family as case

Although referrals are usually of problematic individuals and the case or statutory order held in the individual’s name, it is the family, or nearest substitute for the family, that is considered to be the case.

4. One key-worker per case

Generally, each family case is taken on by one worker (but also see below) who will be responsible in person for the direct contact throughout the work. This means that practical and other issues around holidays and other leave are dealt with satisfactorily.

5. Autonomy

Whether by being in private practice, by virtue of the employing agency’s remit and structure, or by personal endeavour, the therapist—or the immediate therapeutic team—has considerable autonomy requiring equivalent self-confidence. Some professions are free to operate with remarkably little accountability. The stereotyped family therapist has the image of someone with the envied charisma and mystical powers of a magician. But actually they only require the quite

ordinary freedom to decide what to say and do there and then, to start with a family or not, and at any point to finish. More basically still, the therapist has some overall control over the work-load. In fact, freedom and power are relative—agency requirements on workers may seem to slow down decision-making, but usually they confer much greater power to the worker than the stereotyped family therapist has.

6. Motivation

A family therapist uses autonomy to assess the quantity and quality of motivation for work in both family and therapist. Within reason, family therapists expect families to come to them—they are the ones who want help with their problems.

7. Premises

So, premises are designed to accommodate this work routinely, with comfortable reception, waiting and interview facilities. And there is that prominent technology of family therapy: one-way screens, sound relay, videos, intercoms, and so on. Beside this stereotype is the fact that most family therapists choose to or have to do most of their work without the technology; and they are not found only in select premises.

8. Boundaries

Attention is paid to basic boundaries from the first point of referral—who and what business belongs to the sessions. Increasingly a family-systems worker is aware of the business that belongs elsewhere—between the family and other systems and agencies (Dimmock and Dungworth, 1985; Dale *et al.*, 1986).

9. Framework

There is some kind of coherent problem-solving/systems frame of work. This framework or theory will incorporate functions such as communication, interaction, relationship and roles. Because it is dealing with families and the most intimate business therein, it will also include an understanding of family and individual life cycle or maturational tasks and some variety of more sophisticated interactional framework, possibly drawing from the field of intra-personal or psychodynamic theory. There is conflict within family therapy over values and

theoretical frameworks which accompanies debate over aims and methods. But our purpose here is to outline only common aspects.

10. Aim

In contrast with workers whose remit is to support, care for, educate, adjust to, monitor, comment on, interpret, mollify or ameliorate problems—all of which may be valid and necessary for someone to do for all human beings—a family therapist adopts an optimistic problem-solving attitude. Even ‘the symptom’ is seen as a positive attempt at problem-solving and is valued as such. There is a central driving belief that families can change by being empowered through the co-operative work of family therapy. These aims go as far as taking the stance that, if therapists are not solving problems, then they are perpetuating them and families are eminently capable of doing this themselves. It is the client family that has the problem to solve, a fact that family therapists remember more often than many other helpers. Thus there are relatively fewer and less frequent sessions, the family usually being set tasks as homework between interviews, with an active drive towards completing the work in order to close the case. If necessary, steps may be taken to provoke anxiety or a crisis, possibly by withdrawing rather than by playing a part in supporting the situation. (To many caring professionals, some of these aims are the most unpalatable components of family therapy. In the past there was some comfort in the debate about directive versus reflective family therapists. But giving directives now seems to be part of the stereotype (Barker, 1986) with little room for the less direct approach. (I would argue that the directive approach will eventually give ground again, but there is not room here.)

11. Training system

There is a specific (not generic) training system to produce such therapists and methods. A variety of new methods have been associated with family therapy training, such as role play, video, live supervision, adult and self-learning methods. Live supervision has clearly become the central feature of all kinds of family therapy training (Whiffen and Byng-Hall, 1982). Perhaps it is because live sharing of work is linked with training, where there may be a fair number of people around a one-way screen, that the stereotype of the team is of a large group. Otherwise it is not clear why large numbers are apparently more desirable than small

numbers (Speed, 1987). Increasingly a family therapy training session will address the struggle over competing sets of values that workers face with the client family and from within the field of family therapy. However, many of these issues should also have been addressed in any helping professional's basic training.

12. Breaks

As part of live screening, one or more breaks are taken during an interview. This goes with team discussion before and after the interview. Communicating with the therapist by phone or ear-bug is a lesser form of break.

13. Conjoint families

The core of family therapy's stereotype is meeting the whole family, doing this conjointly, and knowing why and how to do the work entailed—that is, skilled systems work. It is particularly characteristic that the initial assessment meeting is set up as a conjoint one. Although the interview may go ahead with family members missing, their absence may well become the key issue focused on. Members of the extended family and other outsiders may be included. Confusing this important stereotype is the increasing recognition that, once a worker knows the value of conjoint family meetings, non-conjoint work has a renewed validity and place.

14. Live team? or: no help needed?

Live supervision of *trainees* is part of family therapy, actual and stereotyped. Barker (1986) discusses live consultation under the heading of training. Whiffen and Byng-Hall (1982) make 'closing the [supervision] gap' their theme. Their contributing authors, however, vary in their emphasis on whether a live team is an integral part of *the method itself*. A number indicate that the supervising training team becomes part of the therapeutic force; this led Clark (1982) to ask whether training in family therapy is meant to produce a 'fighter pilot' or a member of a 'bomber crew' since the training would not be the same for both. Many briefly imply that live teams are a good thing in general. A few explicitly aim to produce entirely independent practitioners. Very few explicitly state that a live team is integral to the method apart from

its training function—prominent among these is the Milan group (Boscolo and Cecchin, 1982). The impression is that for the stereotyped family therapist, ‘fully fledged’ tends to mean ‘no help needed’. (I contradict this stereotype later.)

15. Formulation and intervention

The family’s problems and the therapist’s interventions are construed within some kind of systems and interactional formulation. A systems approach does not, however, result in interventions all over the place—a key issue in a key part of the system is usually focused and thoroughly worked on and through in the expectation that the other parts will fall into place. (This does not necessarily mean that there is only the one key issue or only one way of working it through.) Finally, the stereotype is generally that interventions are highly accomplished, clever, snazzy, tricky and even unethical. To the family therapist these would be simply aspects of the method’s ‘therapeutic’ power in the cause of empowering families. Sometimes it seems that nothing is too much for family therapy’s powers. But quite limiting indications and contra-indications are also described (Barker, 1986). (The stereotype of family therapy does not include follow-up and research—locally for each case or by major statistical research.)

Implications

Family therapy is a special, complex, powerful and sophisticated way of working. This makes it an effective match for the complexity of human life and problems. It has been useful to have a monolithic image and name with the appearance of an impermeable boundary around family therapy separating what is part of it from what is not. Towards the end of the list of components are those we would take as particularly characteristic of family therapy—conjoint family meetings, systems framework and interventions etc. But listing all the necessary features and identifying them separately demonstrates the following:

1. The strength of the method is especially due to the large number of components that have been integrated into the one force.
2. If we manage to dispense with our monolithic thinking, it is possible to consider many of the 90 components as useful methods in their own right, without necessarily implying the others. Though many components need care and thought to set up, few need major special training. For example, if they have been missing, any of the ways

described that protect a worker from distraction or disorganization should increase the quality of the work. Live consultation is possible with only one or two colleagues, without any special technology, and with other kinds of work than conjoint families. (Incidentally, these facts make it possible for live consultation to be a routine, not a rare once-a-week part of work. Paradoxically, this can turn out to be a highly economic investment of staff.) And breaks are not inseparably linked to live consultation—an individual worker (and the clients) can benefit by openly taking a break alone. Even the technological components can be explored separately—it is interesting, for example, to use sound relay without vision, or vice versa.

3. The strength is partly due to a thorough foundation in basics that should be, but often is not, present in all helping agencies and other methods too. In other words, some of the benefits of taking on family therapy lie in the incidental improvement of basic functions rather than in adopting its specialist features.

4. The most surprising finding is this. Although family therapy is a unique combination of these features, and some are quite characteristic of this method and not others, not one is its sole property. Taking the most characteristic components, for example: other methods (e.g. 'intermediate treatment' or group psychotherapy) entail working with conjoint groups of people; and meeting families is not necessarily family therapy—even if it is conjointly—for example, when the family doctor visits a sick patient. Certainly the 'face' of family therapy in the literature has unique, though disputed, varieties of systems theoretical framework and focused interactional intervention and work. But fields other than family therapy can claim their own variety of the same general categories of component (Miller, 1976). The fact that only the combination is unique to family therapy, not the separate components, explains why we have come to talk of it as if it were a monolith.

5. It is worth asking which components are the most essential as opposed to characteristic or unique. For example, if it was your own family being referred, you might choose maturity of the worker, conjoint family meeting, or live consultation as more essential components than others. In addition, some features are inherently essential before the more sophisticated components can work—at the most basic level, you cannot do family therapy unless you are able to keep appointments reliably!

6. If all its components can be found in other methods, then we should respect this fact and not think family therapy has absolutely cornered the market. There is a semi-permeable boundary around family therapy.

There *is* something special about the combined assembly of components, and there is no alternative for any new field but to band together monolithically with a suitable rallying banner raised high in distinction to other methods. But if, once established, we want to relate to those outside the field we need the more discriminating language of its components, especially since it turns out that most if not all those components should be familiar to the outsiders. Rather than be critical of a trainee, a professional or an agency because they are not doing 'it', we would get further by identifying those items they already have, should have, could do immediately, could do with a bit of planning, are perhaps not appropriate at all for that person or agency, and those well nigh impossible to achieve.

This process might be a useful part of any out-house course, workshop or text-book, preventing the common syndrome of participants or readers being overwhelmingly impressed until they get back to their work place. It is certainly not surprising that the indiscriminate attempt to sell the complete 90-component monolith as if it was a single simple item is often doomed to failure and frustration. The fear of opening up the monolith is in the loss of quality control over what gets called family therapy. But that name will not be used or abused when it is the components that are being looked at.

Inter-agency discussion of the components may usefully uncover misunderstandings. For example, the busy social work manager's belief that anything called 'therapy' involves years of intensive time for each case with little to show for it at the end in social work terms may mean that there is absolutely no place for it in that manager's department. Discussing the components will clarify that generally the reverse is true for this 'therapy'. It will also clarify how many of the components are, should or could be found in social work—indeed, as a family-systems method, family therapy's natural parents should have been social work. And some components may need to be adapted before fitting into local social work services—for example, compared with family therapy's stereotype, there are some different aims for that agency, different kinds of motivation in its clients, poorer premises, and greater (statutory) power but rather less freedom to decide for themselves for the workers. Other agencies have different patterns of strengths and weaknesses in the list of family therapy components.

7. The list of components draws attention to family therapy as a way of working. The face of family therapy shown in the literature is usually its characteristic theories and special kinds of intervention abstracted from any particular setting and offered for general consumption. The

component list shows it more as a practical structure for working with people. Of course, in its early stages a new field must rely heavily on abstracted communications among its members and for spreading the word to outsiders. But, now that it is established, we can emphasize family therapy's elements as a structure within which to work, not just a theoretical schooling to be inserted into the worker. This should be no surprise to those with a family-systems approach who know that no man can be an island, not even a master family therapist! In other words, the list is another way of showing that a systems approach to families requires that we consider the system operating around the worker and other agencies too, not to mention the other systems around the family. Following on from this, four areas need to be reviewed (though space prevents doing so here.)

8. As a systems way of working with its inherent need for constant high-quality feedback, live consultation is surely a vital component of the method itself, not just one of its training methods. Preferably, we should be working as, and learning how to be, part of bomber crews, not just fighter pilots. Although the isolated pioneers in the field had to operate without help, no one need do so now. Our leaders should not be surprised when they find they gain rather than lose in the process of subordinating themselves to the team system—live or otherwise (Byng-Hall, 1982; Palazzoli, 1985). The routine use of live consultation, linked to team review and personal supervision, can enrich every aspect of work and learning.

9. A question arises over the nature of learning and training in family therapy. There is no doubt that the subject matter and the method are of the highest complexity. But (a) if what we are working with is mundane and ubiquitous at the same time as being highly complex; (b) if the method is a development of our universal personal experience of human systems as well as what should be part of our ordinary basic professional training; and (c) if the method itself is a structure for work to occur within as much as it is a special theoretical construct, then learning such an approach must be practice based primarily and only secondarily learnt through abstract forms of learning. Cognitive functioning is very active during practice-based work and learning, engaged there in the specific complexities of a real situation. Apart from an initial demonstration of what the full method looks like for those who do not know, abstract theoretical concepts, research or descriptions of other people's practice are best fed into, and digested by, the work-based structure *after the event*, pegging what has been learnt into place and enriching further practice. For the fine details of this kind of work, there

can be grave problems if a good *description* is used as if it is also the best *prescription* for what to do. And validation of skilled systems work—defined as producing positive effects on a systems functioning—is not necessarily the same as ticking off an abstract check-list of skills performed.

10. If family therapy is accepted as being a multi-component force which cannot be entirely confined to one profession or agency, the way we use terminology needs to be reviewed. In particular the word ‘therapy’ has a wide and mystifying variety of uses, tends to support the monolithic view, and excludes workers who, while they may be competent in every one of its components separately and together, might never be able to see themselves as ‘therapists’. Since it is not possible (even if it was desirable) to change the name of family therapy, moving quickly into the language of its component parts should help here.

One common meaning of ‘therapy’ in family therapy is to designate that a family engages and co-operates in meeting as a family and in the close interactional work that the family therapist considers will be good for them. For therapists who consider this a *sine qua non*, family therapy will be contra-indicated for a family who will not co-operate (for example, see Ainley, 1984, p. 102). But it is a pity if family therapists or others throw out all family therapy’s other components, and a ubiquitously valid systems approach, just because parts of one or two components are missing with some families.

11. Another difficulty that arises from the term ‘therapy’s’ monolithic and medical associations is a research model that is suitable for the more concrete world of physical disease and treatment, but is problematic when we are dealing with human conditions that are outside the realm of ‘bioscience’ (Taylor, 1982). The present analysis of family therapy surely confirms the need to stop lingering with the bioscientific and develop a more appropriate mode of research for this field. We had better research, not how ‘it’ works, but how ‘we’ work.

Conclusion

Taking a wide-angle lens to family therapy has given us a full portrait that includes the rest of the picture. The finer features of sophisticated theory and practice may have lost the focus they had in the ‘mug-shot’. Below the shoulders we find that our subject—family/systems functioning and working with it—is mundane and ubiquitous as expected. But the familiarity has apparently bred a contempt for identifying these usually unremarked parts of our body of practice. The

basic theorems could apply to any work with human systems; and the skills gained during basic professional training are equally basic for family therapy. Family therapy may exercise these limbs more than other kinds of work, so that part of its relative muscle is built up by using what every helping profession should have. Identifying all the component parts shows just how many different limbs and muscles there are. As general categories, none of these is unique to family therapy. But again family therapy can take credit for exercising many of them fully and developing its own characteristic variety of some of the features.

Family therapy's identity is secure enough to stand the conversion from monolith to multi-component force, and from isolated to related field of work—related to other systems methods, to other professional work and methods, and related to human life in general. Alternatively, if this unique combination of components produces such a powerful, broadly based and widely acceptable way of working, the full picture confirms that we should have the greatest expectations for our field. Recently a theoretical aspect of this theme has been developed by authors exploring their academic fields in relationship to family therapy (Carpenter, 1988).

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