

Thematic review of family therapy journals in 2004

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In this paper the principal English-language family therapy journals published in 2004 are reviewed under the following headings: evidence-based practice, common factors in effective therapy, innovations in family therapy, innovations in couples therapy, training, gender, diversity, international developments, terrorism, and historical transitions.

Introduction

In 2004 many developments in a broad range of areas were covered in the family therapy journals. In this review, reference will be made to particularly significant papers and also to less significant but representative articles in the areas of evidence-based practice, common factors in effective therapy, innovations in family therapy, innovations in couples therapy, training, gender, diversity, international developments, terrorism, and historical transitions.

Evidence-based practice

There is increasing pressure for all practitioners within the health service to engage in evidence-based practice (EBP). EBP, which originated in mainstream medicine, refers to the process of using research results to make clinical decisions about the assessment and treatment of patients and clients. Patterson *et al.* (2004), in the *Journal of Marital and Family Therapy* (JMFT), offered a very useful five-step introduction for systemic practitioners to the ideas of EBP. First, convert your need for information in the clinical decision-making process into an answerable question. Second, search relevant databases for the relevant research results. Third, appraise the validity, impact and applicability of the research by checking if the study was

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well conducted, what the effect size was for the treatment investigated, and what the costs and benefits of using the treatment are. Fourth, integrate the research results with your clinical expertise, the client's circumstances including available social support and financial resources, and the values and preferences of yourself and your client. Finally, evaluate the effectiveness and efficiency of your treatment decisions to inform future practice. Patterson *et al.* show how trainees in family therapy programmes can be coached in becoming better 'consumers' of research findings and use research to inform their clinical practice. In an appendix to the article, lists of useful resources and websites which support EBP are given.

In the 2004 family therapy journals there were two comprehensive reviews which are ideal for informing EBP in the areas of substance abuse and relationship distress.

EBP and substance abuse

Stanton (2004) reviewed results from nineteen outcome studies, involving 1,501 cases, within ten different clinical approaches to helping alcohol or drug abusers engage in treatment. For adults with alcohol problems Community Reinforcement with Family Training is the best option with an engagement rate of 71%. For adolescent substance abusers the best options are Intensive Parent and Youth Attendance Intervention and Strategic, Structural Systems Engagement which have engagement rates of 87 to 89%. These highly effective programmes entail home- and office-based sessions and involve coaching family members in skills to promote treatment engagement, and addressing issues that enhance alcohol and substance abusers' motivation to engage in treatment.

EBP and relationship distress

Twenty treatment outcome studies were reviewed by Byrne *et al.* (2004) on the efficacy of marital therapy for couple distress. They concluded that behavioural couples therapy, integrative couples therapy, emotionally focused couples therapy and insight-oriented marital therapy are all effective in the short and long term for a proportion of couples, and that the occasional finding of the superiority of non-behavioural interventions requires replication.

Common factors

In JMFT there was a special section on the common factors debate. Two positions were presented. Sprenkle and Blow (2004a, 2004b) proposed that greater attention should be paid to conceptualizing and researching common factors that underpin all therapy models, and teaching skills associated with these common factors in family therapy training programmes. Sexton, in contrast, argued that specific therapy models should be developed for specific problems, and on family therapy training programmes it is these problem-specific models that should be taught (Sexton and Ridley, 2004; Sexton *et al.*, 2004). This important dialogue was articulated in a series of four sequentially written papers. Details of each of the two positions deserve elaboration.

The common factors position

Sprenkle and Blow (2004a, 2004b) argued that a set of common factors and mechanisms of change underpin most forms of successful psychotherapy in general, and marital and family therapy in particular, regardless of the theoretical orientations of the therapists or the specific therapeutic techniques employed. For this reason, they propose that these common factors should be given more attention in our field, which has tended to emphasize the differences rather than the similarities between various models of systemic practice. The main common factors for which there is some empirical evidence (albeit largely from studies of individual psychotherapy) fall into the following categories:

- the therapeutic relationship;
- client factors;
- therapist factors;
- expectancy and hope;
- non-specific treatment variables common to all forms of psychotherapy;
- common factors unique to systemic practice.

The most important client factors are motivation to engage in treatment and readiness to change. Factors common to most good therapists are the fact that they are well adjusted themselves; they match their activity level and style to clients' expectations and

preferences; they find new, creative ways to formulate and reframe clients' problems; and they offer clients credible rationales for learning new adaptive skills for resolving problems. Along with eliciting hope and the expectation of improvement, the main non-specific factors common to most forms of psychotherapy are helping clients develop more adaptive behaviour patterns (behavioural regulation); helping clients develop more adaptive ways of thinking about their problems (cognitive mastery); and helping clients regulate their emotions and to make adaptive emotional connections with themselves, their family members and the therapist (emotional experiencing). There is also a developmental sequence common to most forms of psychotherapy in which interventions that support clients (such as reassurance) precede interventions that promote learning to see problems in new ways (such as reframing), and these in turn precede interventions that promote new forms of behaviour. Three common factors are unique to all forms of systemic therapy, but differentiate it from individual approaches to psychotherapy. These are: conceptualizing problems as occurring within patterns of relationships; actively involving the family and social network of the identified patient in therapy; and developing a therapeutic alliance, not just with the identified patient, but also with members of their family and social network. Sprenkle and Blow hope that their delineation of common factors will accelerate the process of integration of models and practices within the field and reduce inter-model rivalry. They also proposed that research should focus more on 'How do therapists make common factors happen in any therapy model?' and less on 'Which is the best therapy model?'. Finally they argued that as we come to understand more about common factors, training will focus not on teaching general therapeutic models (e.g. narrative, structural, Bowen), but on coaching trainees in specific practices associated with particular common factors. Thus trainers will teach therapists skills for matching their style to clients' expectations; engaging with clients and their networks; enhancing clients' motivation to change; pacing therapy to match clients' readiness to change; deepening the therapeutic alliance; creatively finding new ways to look at problems; selecting from a range of techniques to help clients find new ways of thinking about their situations; selecting from a range of interventions when helping clients develop more adaptive patterns of interaction; and selecting from a range of techniques when helping clients develop more adaptive emotional connections.

The specific models position

Sexton argued that Sprenkle and Blow's common factors position fails to take account of the limited nature of available data and the need to match specific interventions to specific client problems (Sexton and Ridley, 2004; Sexton *et al.*, 2004). The common factors argument is based on the failure of meta-analyses to find differences between the outcome of different schools of therapy across a range of schools and problems, and the observation that common factors across different therapies and problems are correlated with outcome. What the common factors proponents do not take into account are the research findings which show that for specific manualized family therapy protocols developed for specific problems, families that have the best outcomes receive therapy from therapists who adhere most closely to the manualized protocols. Thus, for example, in the case of adolescent conduct problems, therapists who help parents work together to set limits and deepen their relationships with their adolescents according to a therapy manual for this sort of problem will help the youngster develop more prosocial behaviour. It would be of little use, where adolescents' main problem is antisocial behaviour, to help parents support their adolescents to eat a healthy diet (a goal common in the manualized treatment of adolescent anorexics) or to face separations from parents with greater courage (a goal common in the manualized treatment of separation anxiety). Sexton proposed the development of a series of comprehensive complex process-based change models for specific problems as an alternative to the limitations of the common factors approach. Sexton agrees that there are common 'change mechanisms' but these can be understood only within the context of specific models of practice for addressing particular problems within which they are activated. These mechanisms include: redefining the problem; resolving therapeutic impasses; maintaining a strong therapeutic alliance; reducing negativity within sessions; improving clients' interactional and behavioural competency with respect to clients' specific problems; and adhering to the problem-specific model of therapy being practised. Thus the challenge for researchers and trainers is to develop, research and teach certain models of practice which articulate specific procedures for therapists to follow when helping clients to resolve particular problems. In doing so therapists will facilitate the occurrence of common change processes. Sexton's position would lead to research programmes which try to identify 'What works for whom?' and training

programmes in which trainees learn specific manualized protocols for treating marital distress, adult depression, adolescent anorexia, childhood conduct problems and so on.

There is clearly room for taking a 'both/and' rather than an 'either/or' position in the common factors vs. specific models debate, although it is probably of value for the field to have the two positions clearly articulated in the first instance, and both Sprenkle and Blow, and Sexton have done a fine job in this respect.

Innovations in family therapy

In 2004 the journals contained many thoughtful papers on creative approaches to clinical practice with families and children. For example, Arad's (2004) paper – 'If your mother were an animal, what animal would she be?' – outlines an interesting approach to eliciting children's perceptions of parents; and in two articles Gallagher (2004a, 2004b) provided sound guidance on working with parents victimized by their children. There was also a welcome smattering of papers on important service delivery issues, particularly using family–community links in the delivery of family therapy services, and making family therapy more accessible.

Using family–community links in family therapy

Coffey (2004) described the integration of ecosystemic family therapy with systems of mental health care services for children and families in nine innovative pilot projects in Massachusetts. Rojano (2004) outlined an approach to the practice of community family therapy for treating low-income, urban families. Within this approach clients strive for personal and family growth, accessing community resources and increased community involvement. Therapists in a parallel manner strive for personal growth, collaboration with community resources for professional support and community development. McKay *et al.* (2004) described the Chicago HIV prevention and Adolescent Mental Health Project (CHAMP) which is a family-based HIV-preventive intervention. CHAMP was developed, delivered and overseen by a partnership, consisting of parents, school staff, community-based agencies and university-based researchers. A preliminary evaluation of the programme showed that it improved family communication and decision-making and reduced adolescent HIV risk.

Making family therapy more accessible

Fuller (2004) in the *Australian and New Zealand Journal of Family Therapy* (ANZJFT) described a model of home-based family therapy for families experiencing psychiatric crises. The model involves using specific engagement strategies, problem-solving to manage crises, and practices to address safety issues. Miller and Slive (2004) in *JMFT* outlined the development of a walk-in family therapy service. The service operates from a systemic, collaborative, consumer-oriented perspective. In follow-up telephone interviews with forty-three clients three to six months after treatment, 67% indicated improvement, and 43% found their single session sufficient to address their concerns. Bischoff (2004; Bischoff *et al.*, 2004) discussed the application of behavioural telehealth methods to the delivery of marriage and family therapy. The advantages and disadvantages of the following methods were considered: telephone, e-mail, internet chat rooms in which clients type their messages, internet-aided audio conversations, internet-aided video-audio discussions, videophone, and video-conferencing. Some of these methods are being used in the campus marital and family therapy clinic at the University of Nebraska to provide a service to rural communities that do not have access to regular clinical services.

Innovations in couples therapy

Innovations in couples therapy were covered in most journals in 2004. There were informative clinical papers on using discursive practices to address blame in couples therapy (Sinclair and Monk, 2004), blamer softening events in emotionally focused couples therapy (Bradley and Furrow, 2004), working with impasses in couple therapy (Scheinkman and Fishbane, 2004), emotionally focused therapy for business-owning couples (Danes and Morgan, 2004), and solution-focused premarital counselling (Murray and Murray, 2004). There were also important research-oriented papers including the evaluation of the efficacy of couples-based interventions for panic disorder with agoraphobia (Byrne *et al.*, 2004); using research literature on close relationships as a resource for couples therapy (Hendrick, 2004); the association between playfulness and enthusiasm in everyday life and the use of humour and affection during marital conflict resolution (Driver and Gottman, 2004); and the coding of attachment behaviour in couples (Wampler *et al.*, 2004). Four themes that exemplify the way in which couples therapy is currently developing are briefly summarized below.

Therapeutic relationship in couples therapy

A series of papers in *Family Process* (FP) addressed aspects of the therapeutic alliance in couple therapy. Knobloch-Fedders *et al.* (2004) in a study of eighty couples found that family-of-origin distress and marital distress, but not individual symptoms, affected the quality of the therapeutic alliance in couples therapy. Symonds and Horvath (2004) in a study of forty-seven couples found that the correlation between the therapeutic alliance and outcome was significantly stronger when the partners agreed about the strength of the alliance, when the male partner's alliance was stronger than the female's, and when the strength of both partners' alliance increased as therapy progressed. Garfield (2004) in light of relevant research proposed that in couples therapy the alliance can be strengthened by establishing a 'meta-alliance' with the couple around their loyalty conflicts in therapy; avoiding splits and disruptions; and prioritizing marital distress over individual symptoms as a therapeutic focus. The therapeutic alliance may also be strengthened by helping couples to balance their relational power differences in therapy and addressing their concerns about the impact of the therapist's gender on the therapy process. Where clients have high levels of family-of-origin distress, this may lead to a weakening of the therapeutic alliance later in therapy. Thus the therapeutic alliance can be strengthened by addressing the relevance of family-of-origin distress to therapeutic impasses in couples therapy. On the same theme, Flaskas (2004) in the ANZJFT reviewed multiple conceptualization of therapeutic relationships within the field of marital and family therapy, and her paper offers a useful overview of these key issues: the adoption of collaborative style; adopting positions of curiosity and not-knowing; listening and witnessing; practices of transparency and the therapist's use of self; and addressing therapeutic impasses and failures.

Couples with psychological and physical disorders

Snyder and Whisman (2004) in JMFT outlined directions for training and practice in treating distressed couples in which one or both partners have psychological or physical disorders, a paper which draws on their recent textbook on this topic. In such cases they recommend comprehensive individual and systemic assessment. They also recommend matching treatment to client needs and argue that treatment should address both couple distress and specific disorders from which partners suffer. They recommend that therapists adopt an

EBP approach and take account of the biomedical and psychosocial treatment outcome literature on 'what works for whom' in designing treatments for distressed couples with physical and psychological disorders. Finally, they recommend that therapists conceptualize the assessment and treatment process in a way that integrates multiple theoretical perspectives.

Domestic violence

Stith *et al.* (2004) reported a study of the comparative effectiveness of two solution-focused treatment programmes for couples who chose to stay together after mild-to-moderate domestic violence had occurred. Forty-two couples were randomly assigned to either individual couple or multi-couple group treatment and there were nine couples in the control group. Six months after treatment the participants in the multi-couple treatment programme had the best outcome in terms of reduction in domestic violence and improvement in marital satisfaction. Male violence recidivism rates were 25% for the multi-couple group, 43% for the individual couple group and 66% for the comparison group. Rivett and Rees (2004) provide an interesting account of systemic group work with violent men (see also commentary by Vetere and Cooper, 2004).

Infidelity

Gordon *et al.* (2004) in a replicated case study investigation of an integrative treatment for couples recovering from an affair found the twenty-six-session programme to be effective for four out of six couples. In the first stage of the programme therapists assessed the impact of the affair on couple functioning, addressed immediate crises such as suicidality or violence, contained partners' volatile emotions, and helped partners negotiate safe guidelines for interacting outside of therapy sessions. In the second stage, individual, couple and broader systemic and contextual factors that contributed to the development of the affair were explored to help the couple develop a shared understanding of how the affair occurred. In the third stage of treatment the focus was on forgiveness and moving on.

Training

Training was a common theme in the journals in 2004. There was a special section including four papers on the topic in the *Journal of*

Systemic Therapies (JST). These covered training clients to negotiate informed consent (Paez and Britton, 2004), supervising written case studies (Chenail, 2004), changes in the supervision relationship when working with complex cases (Bacigalupe and Abbott, 2004), and trainee learning styles (Aggett, 2004). In other journals Naden *et al.* (2004) explored the tensions and synergies experienced by students on the Seattle Pacific University Family Therapy Programme in which postmodern narrative therapy and modernist Bowen family systems theory are both taught; and Aguirre (2004) offered a personal account of the challenges she faced as a bilingual Latina when training in a predominantly English-speaking marital and family therapy programme. Three particularly important training papers, summarized below, were published in 2004 on approved supervisors, psychiatry training and training therapists to work with children.

AAMFT approved supervisors survey

Lee *et al.* (2004) reported a survey of American Association of Marital and Family Therapy (AAMFT) approved supervisors in the JMFT. Thirteen per cent or 2,046 of AAMFT's clinical members are approved supervisors. Currently the majority of approved supervisors are Caucasian (92%), married (80%), female (55%), and over 45 years old (87%). About half are qualified to doctoral level, have practised for about twenty years and 59% have supervised for about ten years. The majority use live, video-recording and audio-recording supervision methods.

Family therapy and psychiatry training

Heru (2004) in *Families, Systems, and Health* (FS&H) outlined the basic skills for working with families that psychiatrists in inpatient settings must acquire to meet the core competency requirements of the Accreditation Council for Graduate Medical Education in the USA. These include: understanding how family functioning influences psychiatric illness and recovery patterns; how this knowledge may be integrated into biopsychosocial formulations and treatment plans for specific cases; and how to develop collaborative working alliances with families. Heru proposed that these skills should be taught and assessed during psychiatry residents' second year of training.

Training family therapists to work with children

Sori and Sprenkle (2004) in JMFT reported a Delphi study on training family therapists to work with children. The expert panel in this study believed that children should participate in family therapy sessions except when parents are discussing sex or sensitive issues. Child-focused courses should cover developmental issues, techniques for engaging children, child and family theoretical issues, play therapy, treatment of child disorders, and specific child and family problems including divorce and abuse.

Gender

In ANZJFT there were two important papers on lesbian parenting. Perlesz and McNair (2004) in a study of 151 Australian lesbian parents found that despite the constraints and challenges of living within a heteronormative and homophobic society and dealing with discrimination and legal, political and social non-legitimation, the group of lesbian parents they studied expressed great pride in raising well-adjusted and happy children. They also described their families as thoughtfully planned, proud, accepting and celebratory of diversity and difference, flexible in gender roles, and as having interesting, supportive, extended kinship networks that included a wide range of positive role models for their children. On the other hand, Malley and Tasker (2004) highlight the relative lack of attention given to gay and lesbian issues by the family therapy training courses. In Telford's (2004) paper on therapy with lesbian couples, she argued that to be effective and ethical, therapists must be aware of their own views, fears and assumptions about homosexuality, and the ways that society, including the world of therapy, still subjugates same-sex relationships. In the *Journal of Feminist Family Therapy* (JFFT), Mittal and Wieling (2004) reported on a focus group and web-based survey in which they found that a significant relationship between therapist ethnicity and how they practised feminist family therapy. Participants' majority or minority status was a significant factor in how they interacted with clients.

Diversity

Conducting marital and family therapy with clients from ethnically diverse cultures was a central theme in the family therapy journals in 2004.

Research and culturally sensitive practice

There were special sections in two issues of JMFT on the implications of research with ethnically diverse families for developing culturally sensitive models of marital and family therapy. Turner *et al.* (2004b) focused on planning, conducting and disseminating culturally sensitive marital and family therapy research with ethnically diverse cultural groups. Murry and Brody (2004) described how they used findings from a decade of research in rural African American communities to design a culturally sensitive family-based prevention programme. Szapoznick's team at the University of Miami Centre for Family Studies outlined how over three decades they have conducted basic research, and developed and evaluated culturally sensitive structural/strategic family therapy models for working with poor, inner-city Hispanic and African American families (Muir *et al.*, 2004). Burton *et al.* (2004) reported on the use of ethnographic methods to provide a model for understanding family issues relevant to therapy with African American oppressed minority families. Asai and Olson (2004) described how they developed a culturally sensitive adaptation of the Premarital Personal and Relationship Evaluation Inventory with 849 Japanese premarital couples. Turner *et al.* (2004a) outlined the chief findings from their ethnographic interview study of African American families facing serious illness and death. They showed how health care providers, including family therapists, have often hindered more than helped these families. Collectively these papers highlight how basic research with ethnic groups can inform the development of culturally sensitive, clinical practice models. Two papers in the *Journal of Family Therapy* (Burck, 2004; Karamat Ali, 2004) address the issue of bilingualism and its implications for clinical practice.

Multicultural clinical practices

In many journals there were useful papers on specific clinical practice issues relevant to working with culturally diverse ethnic groups. What follows are some examples. Kim *et al.* (2004) conducted a content analysis of the relevant treatment literature to discover the most common expert recommendations for family therapy with Asian Americans and to examine their application to Korean Americans. The following specific guidelines were generated: assess support systems, assess immigration history, establish professional credibility, provide role induction, facilitate 'saving face', accept somatic complaints, be present/problem focused, be directive, respect family

structure, be nonconfrontational, and provide positive reframes. Lee and Mjelde-Mossey (2004) described a solution-focused approach to working with East Asian elders and their families in situations where older family members endorse traditional values and children endorse Western values. Solution-focused therapy with these families facilitates harmony, despite this cultural dissonance, by empowering family members to draw on personal strengths in which multiple worldviews and values of individual members are recognized, incorporated and negotiated. Orathinkal and Vansteenwegen (2004) in ANZJFT presented an approach to working with Melanesian families (from Papua New Guinea and the Solomon Islands) which takes into consideration Melanesian worldviews, values and social systems, and is grounded in a traditional 'mediation–reconciliation ritual' model of solving family or couple conflicts. The model is particularly suited to working with families in which domestic violence has occurred, which is a frequent problem in Melanesian families. Lidchi *et al.* (2004) in ANZJFT described using family biograms with families forcibly displaced in Colombia. Biograms map changes over time, including the experiences leading up to the family's flight, the consequences of that flight, and the meaning the family gives to its changed situation, as well as the family's resources for re-establishing itself in a new culture. Common themes may be extrapolated from biograms, and these qualitative research findings may be used to help agencies plan larger scale interventions.

Multicultural issues in training

With the increased demand to conduct marital and family therapy with culturally diverse groups, it is essential that training programmes prioritize multicultural issues. Inman *et al.* (2004) in a study of student and faculty perceptions of the integration of multicultural issues into USA-accredited family therapy programmes found a distinct pattern of strengths and weaknesses. On the positive side most programmes had integrated multicultural issues into the academic course curriculum and arranged for trainees to have supervised clinical practice with culturally diverse clients. In contrast, few programmes reported that at least 30% of staff and students were from ethnic minorities; or had staff members who prioritized multicultural research; or included an evaluation of multicultural issues in their examination procedures; or had distinct multicultural resource centres.

International developments

Family therapy and systemic practice is finding a foothold throughout the world and this is reflected in coverage of international developments in family therapy journals in 2004.

Systemic medicine around the world

Two issues of FS&H focused on systemic health interventions across countries and cultures in Germany, Finland, Canada, Vietnam, Australia, Uganda, Belgium and Brazil. While not strictly family therapy, these projects represent systemic practice in the broadest sense, and reflect innovative attempts to introduce a psychosocial dimension into areas where traditionally biomedical practices dominated. Fritzsche *et al.* (2004) reported on the development and evaluation of a programme to enhance psychosocial primary care skills for general practitioners in their treatment of somatizing patients in Germany. Although psychosocial primary care has been established in Germany since 1994, the treatment of somatizing patients is still a major challenge for GPs. Larivaara *et al.* (2004) described some innovative systemic family medicine projects in Finland, where family-oriented primary care has been established since the 1980s. McElheran *et al.* (2004) outlined a shared mental health care model, in which psychiatrists and mental health clinicians collaborated with family physicians in the diagnosis, assessment and treatment of people with mental health problems in family physicians' offices. This Canadian project was jointly run by the Calgary Health Region and the Alberta Mental Health Board and was supported by a federal-provincial initiative into new primary care service delivery models. Schirmer *et al.* (2004) described a needs assessment and service plan for behavioural medicine curriculum development in Vietnam. Winefield and Chur-Hansen (2004) outlined the integration of psychologists into primary mental health care in Australia. Sliep *et al.* (2004) showed how narrative theatre – an approach based on narrative therapy and forum theatre – has been used to address domestic violence in a refugee camp in Northern Uganda. Sluzki (2004), through a detailed family case example involving psychotic symptoms and family conflict, illustrated how to use systemic consultation to address acculturation-related problems with a Moroccan immigrant family in Belgium. Rasera *et al.* (2004) described a support group for people with HIV/AIDS in Brazil. Collectively these papers illustrate the internationalization of systemic practice within medicine.

Hong Kong

A special issue of the *International Journal of Narrative Therapy and Community Work* was devoted to narrative work in Hong Kong. Kin-yin (2004) and Wai-fong (2004) reflected on the history of Hong Kong and the waves of immigration and emigration that have shaped that society. Chi-kwan (2004a) through an exploration of personal narrative conveyed some of the complex themes that contribute to the construction of Chinese Hong Kong identity. Siu-wai (2004) described creative narrative work with a group of young women suffering from chronic mental health problems. Man-kwong (2004) showed how young people can be helped to address substance use through narrative therapy involving the metaphor of the migration of identity and externalizing conversation. On-kee (2004) outlined his use of narrative practices in child protection social work. Chi-kwan (2004b) reflected on work with a 12-year-old girl with diabetes. Cheuk-wai (2004) described a group she facilitated with young women who had experienced sexual abuse. This collection of papers illustrates creative ways in which narrative practices have been used to address complex problems in an oriental culture.

Terrorism

There was a special section on psychosocial issues and terrorism in FS&H which focused predominantly on the outcome of the 11 September terrorist attack on the World Trade Center (often referred to as 9/11). Miller and Heldring (2004) reviewed twenty-nine research studies of the psychological impact of 9/11. She found that in the twelve-month period following 9/11 the rates of post-traumatic stress disorder (PTSD) varied from 7.5 to 40% depending upon proximity to the attack. Rates of depression were as high as 60% among New York office workers. Women, children, adults in midlife, and divorced or separated people were at greater risk for developing symptoms. Actively seeking social support was associated with resilience. In a report on the ongoing national US longitudinal investigation of the impact of 9/11, Silver (2004) noted that people right across the USA who only saw the attack on the World Trade Center on television were adversely affected, and that prior mental health problems and the use of avoidant coping strategies were associated with greater risk of PTSD symptoms. A strong argument was made in two papers (Heldring, 2004; Melnyk, 2004) for primary care providers to

incorporate evidence from research reviews such as Miller and Heldring's (2004) into their clinical services by training primary care workers in effective assessment and intervention skills for addressing mental health problems such as PTSD and depression. Hamilton (2004) described how 9/11 prompted the Red Cross to develop strategic initiatives to increase volunteer capacity, develop collaboration between agencies, and increase training for mental health professionals' EBP for post-trauma problems. Vogel *et al.* (2004) showed how psychiatry and emergency medical service teams collaborated in providing psychoeducation and support for emergency medical services staff and their families to help them deal with stress associated with emergency work in New York following 9/11. Barnett (2004) argued that while protecting the physical assets of the USA has been a high priority, the need to protect psychological assets led to the National Resilience Development Act being introduced into Congress. This may lead to funding for psychosocial clinical and research services associated with terrorist attacks. While none of the papers in this special section of FS&H are about family therapy in the narrow sense, they do highlight how a broad systemic practice framework has been useful in conceptualizing and addressing some of the challenges posed by terrorism.

Historical transitions

A number of significant historical transitions in the field of marital and family therapy were reported in the journals in 2004.

Gianfranco Cecchin (1932–2004) died on 2 February 2004 at 3 a.m. in a car accident. Eulogies, obituaries and tributes ranging in style from the formal to the irreverent were published in many journals (Anderson, 2004; Bertrando, 2004; Cade, 2004; Linares, 2004; Ray, 2004a; Sluzki, 2004b; Stewart, 2004; Storm, 2004; Tomm, 2004). Gianfranco will be missed by us all. The good news is that his last book will be available shortly – *Power Struggles: Managing Escalations in Psychotherapy* – which is being co-written with Wendal Ray and Gerry Lane.

Margaret Singer, known best for her work on processes in families with a member diagnosed with schizophrenia, and her board membership of FP, also died recently. Lyman Wynne (2004) wrote a moving obituary for her in FP.

Margaret Topham (1927–2004), a founding figure in Austrian family therapy, died in 2004. Her achievements have been remembered in obituaries by Jim Carwley, Ann Stark and Mike Locke

(Tributes to Margaret Topham, 2004) and Max Cornwell (2004). She was the first Australian family therapist in full-time private practice, the first person to introduce family therapy to the Australian media, and an influential and gifted therapist.

Gregory Bateson's hundredth birthday was honoured by Evan Imber-Black in a special issue of FP in 2004. She described him as 'a somewhat reluctant founding father of family therapy' (Imber-Black, 2004).

Mental Research Institute. There was a special section in JST on the MRI, offering up-to-date information on the family therapy centre that emerged directly from Bateson's work (Ray, 2004b). Richard Fisch's (2004) paper 'So what have you done lately?' is particularly informative. While there have been some minor modifications to the MRI method, MRI therapists are still doing 'more of the same'. Despite the MRI's theoretical tenet that this usually makes everything worse, paradoxically it is continuing to make everything better!

Twenty-five Years of ANZJFT. The year 2004 marked the twenty-fifth anniversary of ANZJFT which was founded in 1979 by Brian Stagoll, Moshe Lang, Graham Martin and Michael White.

Conclusion

In light of this thematic review it is clear that 2004 was an important year for family therapy. There was a welcome move towards EBP. With respect to couples and family therapy, innovations in practice and training continued apace. There was increasing sensitivity to gender and cultural diversity within the field, and an increasing internationalization of systemic practice. This was also a year in which we lost or remembered some of the great family therapy pioneers.

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