

## Extended Dialogue About Significant Developments

# Manualising Systemic Family Therapy: The Leeds Manual

Stephen Allison, Amaryll Perlesz and Helen Pote  
(with contributions from Peter Stratton and David Cottrell, LFTRC)

Steve Allison and Amaryll Perlesz review a systemic family therapy manual developed at the Leeds Family Therapy and Research Centre. Responding to the critique, Helen Pote gives an account of the manual's history, and its reception in the UK.

## Steve Allison Opens the Discussion

Therapists are working with families to understand the patterns ... (Manual: 12).

The process of systemic family therapy is hard to describe and this can present a problem for outcome studies. As researchers, we need to know exactly what a therapy team has done in order to reproduce the program ourselves. This is where a therapy manual can help. It makes the process more consistent and provides a description of what happens at each step of the therapy. However, few comprehensive manuals have been written for systemic family therapy teams seeing clients in the 'real world'. The *Systemic Family Therapy Manual* from Pote and her colleagues fills this gap. The Manual offers 'guidelines for the implementation of systemic family therapy, so that therapists can offer a unified version of therapy, with some flexibility to express their own creativity'. (Manual: 6). Family therapy teams can adopt the Manual as a guide and still have considerable flexibility in how they tailor their program.

The Manual contains a remarkable synthesis of techniques from the Milan, narrative and solution focused schools. Many of the great discoveries of systemic family therapy are here. In fact, there is almost an embarrassment of riches. From the research point of view, family therapy teams may need to work quite hard to adapt the Manual for their own outcome studies. There could be considerable debate in teams about their preferred mix of interventions. A good deal of variation would be possible and this would need to be clearly documented with the Adherence Protocol. How successful is this synthesis? Well, the authors have designed their model to be evaluated in outcome studies. They are seeking an evidence-based answer to the

question of how well therapy works, and frame it in terms of effectiveness and measurable outcomes.

There is always a slightly edgy feeling, like fingernails scraping across a blackboard, in using empiricism to measure the benefits of social constructivism: it has been likened to Godzilla meeting Bambi. The tough methods of cost effectiveness have been applied successfully to the complex ecology of lived experience. However Godzilla's huge footprints are sometimes all that has remained as evidence of the encounter! Some styles of therapy have tried to do justice to both meaning and measurement. Cognitive therapy has been crafted carefully to pass the empirical test. The Manual has some elements that may replicate this success. It contains reasonably detailed accounts of a wide variety of interventions. It also has a clear model of change that has more than a hint of the 'cognitive' about it.

Family struggles are seen as arising from 'unhelpful attributions'. Attributions are the ways that people explain things to themselves and others. The authors point towards the negative consequences of explanations such as blaming individuals for family problems; seeing difficulties as permanent, intrinsic and uncontrollable; viewing motivation



left:  
**Stephen Allison**  
centre:  
**Amaryll Perlesz**  
right:  
**Helen Pote**

**Steve Allison** is Senior Psychiatrist, Southern Child and Adolescent Mental Health Services, c/- Flinders Medical Centre, Bedford Park, SA, 5041, Australia. Email: Steve.Allison@flinders.edu.au

**Amaryll Perlesz** is Senior Lecturer in Family Therapy, The Bouverie Centre, La Trobe University, Melbourne, Australia.

**Helen Pote** is a Lecturer in Clinical Psychology, Department of Psychology, Royal Holloway & Bedford New College, Egham, Surrey, TW20 0EX, The United Kingdom.

as sinister rather than well-meaning; and finding no hope in the future. These unhelpful attributions lead families into an impasse that brings them to therapy.

The *Manual's* model of change assumes that systemic family therapy works by helping family members understand the linkages between their unhelpful attributions and their struggles. In this sense it is essentially a cognitive model. Pote and her colleagues focus on certain 'misunderstandings' about relationships that could be crucial in problem formation and resolution. Systemic family therapy is viewed as a pragmatic series of methods that change the relationship misunderstandings associated with negative feelings and behaviours. Circular questioning, team reflections, externalising conversations and a solution focus open up more adaptive ways of understanding, and improve family interactions.

The Leeds Family Therapy and Research Centre, which developed the *Manual*, has pioneered this mixing of cognitive and systemic ideas. They helped introduce attribution theory to family therapy over a decade ago (Stratton et al., 1988). They looked for causal statements in narratives to see how people understood family problems. These explanations were thought to underlie the family's ability (or lack of ability) to cope with adversity. Given the Leeds model of family change, attribution theory could become the unifying theme in the *Manual*. Modifying attributions is a primary goal of the Leeds model. The theme could be carried through the guiding principles, session goals, case examples and adherence protocol. This could enable a more systematic evaluation of this theoretically interesting model of change.

A drawback of using attribution theory as the theoretical basis is that it is quite complex. There are simpler strategies in cognitive and behavioural family therapy. Structured problem solving is a good example (Falloon et al., 1993; Falloon, 2000). This method aims to teach families how to reduce stress through a step-by-step behavioural approach. The six-step method is a remarkably robust and works well with families. The framework is relatively easily for families to learn and use at home for themselves. The evidence suggests that structured problem solving is quite effective in helping family members cope with a wide range of mental health problems (Falloon et al., 1993; Falloon, 2000).

In a way, Falloon's simple model is tough competition for the *Manual*, which presents a very complex model suitable for highly trained therapists. A complicated model would need to be *much* more effective than a simple one to be really impressive. In public mental health services, there are severe limitations on funding and hence on the amount of therapy available. There needs to be substantial evidence for the superiority of the more complex model for it to become the basis for training and practice.

The evidence suggests that families might gain as much benefit from structured problem solving as from systemic family therapy. Miller, Duncan & Hubble (1997: 29) have suggested that the specific therapeutic technique has a small effect when compared with all the other factors in the system such the resilience of client, the resources of social

environment, the quality of the therapy relationship and the power of hope.

These were the considerations I had in mind when the Editors asked our team to use the *Manual* for a year. Would it find a place in our work? Over the year we used it as a resource in a public mental health service for small groups of trainees who were learning about family therapy. The trainees had considerable experience in mental health, but were new to family therapy. They were working in hospital and community child mental teams, often doing assessments and crisis intervention with families. Using the *Manual* in training highlighted some of its pluses and minuses.

To begin with, the Leeds model is clearly not designed for crisis intervention. There is a small section on risk assessment but not much information about handling suicidal or violent behaviour. It assumes a reasonably sedate treatment course, with 'initial', 'middle' and 'ending' phases. This measured pace would be more suitable for entrenched patterns that take some time to change.

The resolute focus on the family rather than the individual was also unhelpful at times when a family member was acutely depressed or psychotic. Here the mental health system required a diagnosis and an individual risk assessment. In these circumstances, trainees were involved in practices proscribed in systemic family therapy such as an advice giving, linear thinking, pathologising narratives and a focusing on the individual. The trainees had to live with the incompatible demands of systemic therapy and the mental health system. On the other hand, the contrasting viewpoints were useful. The *Manual* offered a more progressive and optimistic outlook. This fitted into the broader context of a mental health system that is gradually accommodating to these ideas.

The trainees found a useful overview of the systemic approach in the *Manual*. The basic model was clear and trainees began to use accessible techniques such as externalising conversations. The highlight of their term was working with the experienced family therapy teams in the service. These were the sorts of teams that the authors had in mind when they wrote the *Manual*. The trainees followed families through their sessions with the teams and this kind of work gained their interest and respect. They recognised the special qualities of systemic family therapy and the *Manual* was a good guide for the journey.

Writing this review has crystallised a couple of impressions. The first is that new trainees needed a simple model of family therapy to help them survive the rigours of everyday practice. This is where the easy-to-teach, versatile model of structured problem solving was handy. With this in place, the trainees had the freedom to build a more complex model for themselves. The *Manual* provided an excellent way of doing this. The trainees could adopt new techniques on a pragmatic basis according to their circumstances. The mix of systemic and cognitive ideas in the Leeds model of change was stimulating. Attribution theory linked nicely with the trainees' previous work in individual therapy. It gave a theoretically attractive model, which led

to some interesting reflections about the basis for change in family therapy.

### Amaryll Perlesz Continues

I take off my hat to the Leeds University team. It is no easy task to describe in 47 pages a complex, systemic way of working and, in doing so, to provide a useful set of guidelines and a therapist checklist for working through the phases of therapy. Although the authors claim that the Manual is principally designed as a research tool, they also view the Manual's function as being to guide therapeutic work in a clinic setting (again principally for experienced family therapists). They suggest a less formal function of the Manual as a framework for supervision of skill development in trainee family therapists.

For those readers who may be interested in using the Manual — and I would encourage them to do so — it is concisely and clearly written, and a useful guide to 'good systemic practice'. Anybody reading it will critically say: 'You haven't thought of this or that!' — because this is the very nature of complex systemic practice. However, simply being forced to think about the omissions will assist therapists to be self-reflective, and thereby more open to changes and modifications in their own work. Moreover, being able to articulate one's practice so clearly will assist trainers in their skills development work with less experienced therapists.

The Manual covers the guiding principles of sound systemic practice; it outlines a model for therapeutic change; it summarises and gives examples of key interventions such as circular questioning and reflecting teams; it offers practical details on how to deal with the therapeutic setting. There are comprehensive guidelines to the conducting of initial, middle and end sessions, with a check list for each of these phases (there are particularly helpful sections here on the kind of information that therapists often 'forget' to collect). Assessment of risk, work in child protection, and wider networks are covered in a section on 'indirect work'; and there is a thoughtful section at the end of the Manual on 'proscribed practices' where therapists are invited to look more closely at some of the 'naughty', non-systemic things we all do — without banning these practices outright, the Manual reminds therapists to notice when they 'lapse' into these ways, and either justify them, or rectify them! Finally, the clear reminder to write back to referrers should cause a few red faces, and the 'record sheet' for recording sessions will be very useful in training group live supervision.

I should perhaps locate myself, and my biases, as an experienced family therapist who — by the time this review makes it into print — will have worked with families in a publicly funded, clinic setting for twenty years, and will have participated in the training of twenty cohorts of family therapists during that time. As a sideline I am interested in family therapy research, so a manual that could assist in outcome studies has particular appeal. I should also admit that it is almost twelve months since we received a copy of the manual, and since that time I imagine it has

undergone review with suitable additions and modifications. I would like to engage with the authors around its continuing development, because I believe it shows great promise as a training tool, although I suspect it has less immediate application as a research tool.

Why not then begin with the research angle? If the *Manual* were to be used as a research tool across varied settings there would need to be further guidelines on its application to ensure reliability, validity and replicability of findings. The only guidelines here are that the *Manual* be used in conjunction with an accompanying 'adherence protocol'. But there is no clear indication of what this 'adherence protocol' actually is. If the authors are referring to the therapists' checklists at the end of each therapy phase (or their goals for each of these phases), the latter would need to be set out in a format useable for research purposes. This could easily be done by revisiting the goals or the checklists (and changing their wording slightly) and adding a Likert-type scale for each item, which could be self-rated by the therapist. However, we are all aware how notoriously unreliable self-ratings are. Alternative guidelines and suitable criteria for observer-ratings are absent in the *Manual*. I would be interested to know how the *Manual* has been used for research purposes, and would be happy to do some replication studies here in Melbourne.

Ironically, I think the Manual's strength lies in its training function (which was not its primary purpose). And here I'd like to engage the authors around some of the material that *could* be included. I've italicised 'could', because I understand a manual of this sort needs to be manageable in size, and there could be endless legitimate inclusions. But I add them here in case the authors themselves, the reviewers, or potential users might be interested in such modifications. They are not in any priority order.

The writing of the *Manual* is unfortunately 'heterosexist' in orientation and there are no examples used of gay/lesbian families, nor is there reference to the need for a tolerance of sexual diversity in the section on 'Cultural Context'.

Although 'safety' and 'child protection issues' are dealt with in the section on 'Indirect Work', these issues are of *direct* importance in the everyday dialogue of therapy, and should therefore be given prominence in the therapists' checklists. Moreover, there need to be more direct hints on how to work with sexual abuse, family violence — either between partners or by adolescents to their parents — extreme conflict, involuntary clients, severe disability, psychiatric illness etc., which are bread and butter work in public clinics. Perhaps the examples could be more representative of this more difficult public sector work.

For instance, there is nothing at all on 'family sensitive practice' and dealing with carers who have been inadvertently abused and neglected by the system. In this light too, although referrers and the wider network have received some attention, many therapies in these clinic settings involve a complex range of social control agencies — forensic, juvenile justice, child protection, mental health and disability systems — and more explicit guidelines need to

be brought into the body of the text and the checklists, rather than including them almost as an addendum in the 'indirect work' section.

The *Manual's* origins are unashamedly Milan systemic, yet they also profess to be informed by post-Milan and narrative ideas. Given that the guiding principles cover areas such as narratives and language, constructivism, social constructionism, the cultural context, power, co-constructed therapy, and self-reflexivity, one would have expected much greater attention to techniques important to postmodern therapies. There is little attention paid to therapeutic letter writing or to the exploration of dominant sociopolitical contexts that constrain individuals; the *Manual* deals mainly with their 'family-based' belief systems. There is brief mention of 'unique outcomes,' externalising, and miracle questions, but nothing at all on 'Just therapy', dealing with poverty and social injustice, 'co-researching' and the use of clients' wisdoms about their own survival and recovery.

There is no mention of 'co-therapy' in the room. Since the *Manual* is aimed at practitioners working in clinic settings — where co-therapy is an important aspect of daily practice — one would have thought it a useful addition. There are many traps for the unwary co-therapist, yet it is a useful luxury to have a fellow professional in the room, and we have found it to also be a rewarding experience in a training context.

More complex to include, but perhaps no less necessary, might be a section on single-session therapy (SST). The efficacy of SST is unquestionably high, and given that it is a useful tool to control waiting lists in the public sector, guidelines to SST practice would greatly enhance the *Manual*.

Students often ask questions about confidentiality within the whole system (and secrets), particularly when bits of families are seen, and only some of the many agencies involved are giving the therapy team information. Although there is brief mention of this in the *Manual*, perhaps more could be made of it.

I look forward to hearing from the authors if and how they have modified the *Manual* over the last year or so, and to begin to engage in a dialogue on how we can use it in a similar manner in our individual settings. I'd particularly encourage trainers in family therapy to get their hands on a copy, because it could save them many hours of work in imparting some of the basics to their students.

### **Helen Pote Responds (with contributions from Peter Stratton & David Cottrell, LFTRC)**

We very much want to thank both contributors for their time and thoughtfulness in using and reviewing our manual. Reading the enthusiastic responses of both teams was very encouraging. Much of this enthusiasm seems to lead to a desire to include more (not less) material in the manual itself. This was very much a tension for us, too, and led us to think again about our aims in developing the manual and the process by which it was developed.

### ***Aims and Purpose of the Manual***

The initial purpose of the research was to develop 'a' manual (not 'the' manual), for systemic family therapy that could be used for family therapy outcome research. However our motivations as trainers, clinicians and researchers were more complicated. We wanted a description of the process of family therapy, which was prescriptive enough to achieve the main purpose of the manual as a research tool, yet we also wanted such a document to be palatable to working systemic therapists. We wanted to capture the essence of their work, without ignoring the richness and diversity of their ideas and practice. In this lies the dilemma of developing a research tool suitable for the rigours of quantitative outcome research within a theoretical field that is increasingly postmodern. It involves allowing flexibility whilst requiring sameness — a difficult balance.

These dual aims for the *Manual*, research and practice, and the inherent tension in such duality, are we think reflected in the reviewers' thoughts about it — such as Amaryll wondering if the *Manual* suits training rather than research purposes and Steve highlighting the need to do justice to both meaning and measurement in the development of the *Manual*.

We think the tension has benefit and that the duality is one of the *Manual's* strengths. It reflects its richness as a resource. It also means that the *Manual* will continue to evolve and cannot remain static. We will return to the future of the *Manual* later, but first it seems appropriate to take a step back and think about its development.

### ***Process of Developing the Manual***

The *Manual* was developed from a year-long research project. It began by looking at the variety of ideas and practices of therapists working within the clinics at the Leeds Family Therapy and Research Centre. Some had worked in LFTRC since 1979 while others had joined more recently, bringing different experience and training. We interviewed therapists about what they thought were the important components of their practice, theoretical and technical, and analysed their individual and collective narratives. This was followed by the development of an observational rating scale, which was used to measure therapists' practice, using videos of therapy sessions.

The findings from these observations were interesting, and showed overall that therapists were very sensitive to their activities in therapy. Therapy goals and therapist interventions were consistent between therapist self-descriptions and observational ratings. The observational ratings also added other specific details about the process of family therapy at a much more micro-analytic level. Observations highlighted how therapists gradually increased their focus on family solutions and successes, across the course of therapy. In addition we found an increasing use of circularity in therapist's language and questioning, once they had connected with the family, and gained initial descriptions of the family's concerns. We then used a variety of quantita-

tive and qualitative analysis methods to integrate the self-report and observational data, looking at common systemic themes and practices to form the main body of the Manual.

In terms of what we saw in practice in our own local context, it is fair to say that the team use fewer narrative and externalising techniques than other teams, and have not practised co-therapy since 1983. This is not to say that we do not value those ideas, just that they were not prominent enough in the observations of practice to be included as core and fully shared practice.

We were pleased Amaryll raised the issue of adherence as this was a prominent part of the final stages of the Manual project. We felt that previous attempts at adherence measures in family therapy had been basic, and limited by their reliance on the self-report of therapists. We therefore developed an observational adherence measure that can be used alongside the Manual. It is rated by the family therapy team (or independent observers) and can be used together with therapists' self report. This increases the diversity of views on adherence and increases the strength of the adherence ratings.

Throughout this research process we were enthusiastic about the possibility and utility of a systemic manual. However, it was important to hold onto the hypothesis that such a task might not be achievable. Acknowledging the possible impossibility of the task of manualising systemic therapy was helpful as it enabled us to immerse ourselves in the variety of systemic ideas and practices and value these in their own right without trying to force them into synthesis. However we do feel we were able to achieve some unity, across the diverse field that is systemic family therapy. We were pleased Steve also recognised this unity in the finished Manual. Such unity, however, inevitably has some costs.

Two of the main costs are that some aspects of practice are omitted and some may be over-generalized. To some extent, the fact that the Manual was the result of a research process, grounded in therapists' accounts and observations of therapy, helped with the decisions about what to leave in, what to leave out, what to keep general and what to make specific. Indeed during the research phase we did restrict the Manual to practices that we could speak about from substantial experience, and as observational researchers we were limited by what we saw. However it wasn't quite that simple: many debates and dilemmas remained about what to include and how specific to be to meet our aims.

#### ***What to Include?***

In developing the Manual, working as a team and consulting to clinics around the UK were crucial in helping us with this debate. It guarded against reductionism and idiosyncrasies in the development of the Manual and helped us make decisions about content and form. Feedback from the U.K. context highlighted that therapists working from a range of systemic models (Milan, structural, narrative, constructivist and social constructionism) welcomed the generic systemic

ideas in the Manual, feeling that it captured their guiding principles. However a few therapists did feel that the Manual did not capture some important technical elements of their practice. The reviewers' comments seemed to echo this feedback. In the current review we were surprised (and pleased) by the recognition of the Manual's systemic themes, particularly as the reviewers came from such diverse organisational and cultural contexts, but we recognised their call for inclusion of practices such as crisis intervention, co-therapy and post modern techniques.

We also recognised the considerable debate which Steve imagined could happen in teams about their preferred mix of interventions from the Manual. Amaryll suggests that personal adaptations to the Manual will assist therapists in being self-reflective and open to change. We feel that such a process also enables therapists to monitor their own therapy process and their own outcomes. As discussed, such debate and reflection characterised the research process and we are glad to see similar dilemmas continuing into practice.

Of course we could simply update the Manual and incorporate these ideas to develop a 'second generation' version of the Manual. This would change the traditional research base and aims of the Manual but perhaps increase its utility. However given the discussion above, perhaps the aim should be multiple, context specific manuals, a process that Howard Liddle has referred to as therapists developing their own 'personal manuals' for practice. The outcome research process may then look much more akin to the progress research outlined by William Pinsof, with multiple mini outcome measurements tailored to the reality of therapy in the 'real world'.

Despite this context specific aim, we have begun to think that some aspects of systemic family therapy need more emphasis in the Manual, for example cultural sensitivity, working with abuse and protection. It might be important for these things to be positioned in the Manual as central to the work rather than supporting the direct clinical work or being context specific.

#### ***How General?***

In the development of the Manual we questioned whether it was too generalist and whether manuals have to be school specific. The essential factor seemed to be whether the systemic models of change would be too different across the modes of family therapy we were trying to describe. In many ways we felt that they were not, that there were common ideas shared across many schools, and hence we were able to develop a more generic model of change which excluded rather fewer systemic therapy orientations than we first thought.

Steve comments on the cognitive flavour of the model of change discussed in the Manual, and suggests unifying the Manual through the theme of attribution theory. It is true that the work of LFTRC has been strongly influenced by the contributions of its Director, Peter Stratton, whose work in attributions in family and organisational systems is well known (Stratton et al., 1998). It is a test of the observational

research process that this flavour came through. Although Peter is in the process of developing an approach to systemic therapy based in the attributional research, we felt that it would limit the usability of the Manual if the attributional approach were too explicit. However, the fact that LFTRC has combined attribution and attachment theories throughout its history undoubtedly underpins what we would see as the cognitive-relational style in which we apply systemic practice.

### **Where do we Go from Here?**

The Manual has two obvious applications as the reviewers point out — as a research or training tool, or both.

### **Training**

Amaryll feels that the Manual may be more useful as a training tool with less immediate impact as a research tool. She begins a useful dialogue on how the Manual may need to develop for training in her context, raising issues such as cultural and sexual diversity, co-therapy and a range of post-modern techniques. As discussed, the Manual does have an observational adherence protocol and hence it does show promise as a research tool. This protocol was not publicly available when Amaryll and Steve started their work with the Manual. In response to this review and similar comments from other users, we have added the draft adherence protocol to the Manual website. However, in practice it is fair to say that the Manual has been taken up much more readily by therapists, trainers and trainees in the U.K. for training purposes rather than for outcome monitoring.

Trainees (in clinical psychology and family therapy) give very positive feedback on the utility of the Manual in developing their systemic skills, though they acknowledge that a background in systemic theory is essential in order to use the Manual. The adherence protocol has also been used successfully to monitor trainee skills development. However, one strong objective at the outset of the development of the Manual was that it should not become a cookbook for novice or expert therapists. We are mindful that the adherence protocol is a measure of adherence and not competence. Development of the Manual as a training tool would require further attention to the measurement of competence as a whole, rather than individual skills or competencies. This review, along with other feedback, is encouraging us to develop the Manual in this direction. In the process we will bring within direct focus issues such as working with wider systems, various forms of violence and abuse and chronic physical and psychiatric conditions. These would be central in a general training context but would have been too specialised for a generic research Manual.

### **Therapy Outcome Research**

Steve points out that the Manual faces stiff competition from other therapeutic modalities. We agree to some extent, but feel that the outcome research comparing the utility of systemic family therapy and cognitive therapy models remains sparse. Developing further research opportunities was one of our motivations in developing the Manual. Good outcome

research clearly specifies the therapy being used, and this specification usually comes in the form of a manual. We felt that the systemic manuals that existed did not describe the sort of systemic practice or philosophies that underpinned our work. Indeed some therapists would argue that the practices and philosophies we describe are still incongruent with manualisation and current outcome research philosophies and practices. We disagree. We feel we have developed a manual useful for research and would love to use the Manual in therapeutic outcome trials, to assess whether the therapy we have described is helpful to those who consume it.

Unfortunately lack of funding has prevented the systemic family therapy outlined in the Manual taking this test. However, positive findings from research into the efficacy of other models of family therapy suggest Steve is being perhaps a little pessimistic (Miller et al., 2000; Sandberg et al., 1997). An important next step for systemic family therapy outcome research will be to use manuals in conjunction with outcome measures that facilitate measurement of second order change suitable across systemic and cognitive therapy models. We hope we can play some part in this process.

We very much want to share the Manual with others to facilitate its continued use and debate about its content. Readers can download the Manual and the Adherence Protocol from <http://www.psyc.leeds.ac.uk/research/lftrc>. A web discussion group is available for you to send further thoughts.

### **References**

- Falloon, I., Laporta, M., Fadden, G. & Graham-Hole, V., 1993. *Managing Stress in Families: Cognitive and Behavioural Strategies for Enhancing Coping Skills*, London, Routledge.
- Falloon, I., 2000. Problem Solving as a Core Strategy in the Prevention of Schizophrenia and Other Mental Health Disorders, *Australian and New Zealand Journal of Psychiatry*, 34, Supplement: 185–190.
- Miller, R. B., Johnson, L. N., Sandberg, J. G., Stringer-Siebold, T. A. & Gfeller-Strouts, L., 2000. An Addendum to the 1997 Outcome Research Chart, *American Journal of Family Therapy*, 28: 347–354.
- Miller, S., Duncan, B. & Hubble, M., 1997. *Escape from Babel: Toward a Unifying Language for Psychotherapy Practice*, NY, Norton.
- Pote, H., Stratton, P., Cottrell, D., Boston, P., Shapiro, D. & Hanks, H., 1999. *Systemic Family Therapy Manual*, Leeds, Leeds Family Therapy and Research Centre; University of Leeds, UK. Find a copy at <http://www.psyc.leeds.ac.uk/research/lftrc>
- Pote, H., Stratton, P., Cottrell, D., Boston, P. & Shapiro, D., 1999. *Systemic Family Therapy Manual Therapist Adherence Protocol*, Leeds, Leeds Family Therapy and Research Centre; University of Leeds, UK.
- Sandberg, J., Johnson, L., Dermer, S., Gfeller-Strouts, L., Siebold, J., Stringer-Siebold, T., Hutchings, J., Andrews, R. & Miller, R. B., 1997. Demonstrated Efficacy of Models of Marriage and Family Therapy: An Update of Gurman, Kniskern & Pinsof's Chart, *American Journal of Family Therapy*, 25: 121–137.
- Stratton, P., Munton, A., Hanks, H., Heard, D. & Davidson, C., 1988. *The Leeds Attributional Coding System Manual*, Leeds Family Therapy and Research Centre; Leeds University. 