

# Child-Focused Family Therapy: Behavioural Family Therapy Versus Brief Family Therapy

William J. Smith,\*\* Thomas V. Sayger\*\*\* and Steven A. Szykula\*\*\*\*

---

*We examined the effectiveness of behavioural family therapy (following the treatment agenda outlined in Fleischman, Horne and Arthur, 1983) and brief family therapy (following the procedures outlined in Fisch, Weakland and Segal, 1985), in the treatment of child psychological disorders. The parents of the 49 children referred to the outpatient unit of a children's hospital completed the Child Behavior Checklist (CBCL) (Achenbach and Edelbrock, 1983). Three scales of the CBCL were examined to assess the effectiveness of the two therapeutic approaches pre- to post-treatment. Significant pre- and post-treatment differences were found for behavioural family therapy on the Internalizing, Externalizing, and Sum T scales and for brief family therapy on the Internalizing and Sum T scales. Sum T scales represent the sum of scores across all sub-scales of the CBCL. Neither treatment was found to be more effective than the other.*

---

## INTRODUCTION

A combination of a coercive parent–child relationship and weak parental attachment has been shown to result in problematic child behaviours in addition to ineffective social skills and peer rejection (Horne, Glaser, Sayger and Wright, 1992). The purpose of the present study was to examine the effectiveness of two approaches, behavioural family therapy and brief family therapy, in the treatment of child behavioural disorders. Forty-nine children and their families were referred to an outpatient psychiatric unit of a children's hospital for various psychological problems. The Child Behavior Checklist (Achenbach and Edelbrock, 1983) was completed by the parents of children referred for treatment. The children's diagnoses comprised: oppositional defiant disorder, attention deficit hyperactivity disorder, overanxious disorder, conduct disorder, functional enuresis, and functional encopresis.

## Behavioural Family Therapy

Behavioural family therapy, along with the social learning approach, is a systematic way of assessing a family's interactions, developing intervention strategies and then evaluating change (Horne, 1991). This approach emphasises the functional analysis of behaviour and includes the observation of behaviour, acquiring a baseline assessment of the rate and frequency of its occurrence,

and identifying its consequences. These consequences are then modified to change the behaviour.

Behavioural family therapy assumes that problems occur as a result of the decay of positive reinforcement control, and are preserved by reciprocal aversive control. This perspective views families as systems of interbehaving people, and asserts that the behaviour of the child is reinforced and maintained by environmental factors (Sayger and Horne, 1993). Behavioural methods teach family members life skills to help them address problems as they occur. Most behaviourally-oriented theories adhere to the belief that a child's behavioural problems are related to parental variables (Evans, Okifuji, Engler, Bromley and Tishelman, 1993).

Behaviour therapists employ strategies such as 'time outs', token economies, social skills training, and setting limits. Child behaviour therapy is replete with effective techniques but the relationship between client and therapist is of paramount importance (Motta and Lynch, 1990). A key component is helping parents acquire skills to address behaviour problems in the home after the cessation of treatment. Effective parents have the ability to perceive accurately their child's capabilities and thus have realistic expectations of their children. In addition, competent parents have effective problem-solving abilities and a number of child-rearing skills at their disposal. Clinicians are encouraged to help families establish a social support network, which may help to promote prosocial behaviour in children while helping parents cope with the stress of parenting. One study found that mothers who saw their children as having acting-out problems and who reported having little social support, experienced very little prosocial mother–child contact (Szykula, Mas, Turner, Crowley, and Sayger, 1991).

Several studies address the efficacy of social learning family therapy as applied to families with aggressive and conduct disordered children. The results indicate that

---

\*\*University of Memphis

\*\*\* Associate Professor and Director of Training in Counseling Psychology, The University of Memphis, Room 100, Ball Education Building, Memphis, TN 38152; sayger.tom@coe.memphis.edu

\*\*\*\*Comprehensive Psychological Services, Salt Lake City, UT.

families reported a decrease in antisocial behaviour and an increase in prosocial behaviour as well as corresponding increases in the family's level of cohesion and decreases in family conflict (Sayger et al., 1993; Sayger, Horne, Walker, and Passmore, 1988; Szykula, Sayger, Morris and Sudweeks, 1987). The social learning approach was shown to be effective in the amelioration of family strife and in diminishing the negative behaviours of aggressive boys. Glaser, Sayger and Horne (1993) state that there is a link between relationship characteristics (e.g. cohesion, expressiveness, control, conflict) in the family home environment and family violence. Thus, it was concluded that engaging a parent in individual therapy would not be as effective in helping to mediate family problems as would a systemic approach addressing family dynamics which would involve all family members.

### **Brief Family Therapy**

The Mental Research Institute (MRI) school of brief family therapy characterises problems as malicious cyclic patterns which are oftentimes well-intentioned solutions to discerned difficulties (Fraser, 1995; Thomas, 1992). According to Fraser (1995), problems are not viewed as a function of some deviation in the arrangement of family, personality, ego, or any other construct. In the clinical setting it is important to focus on the specific problem and not to engage in promoting insight. The primary objective of brief family therapy is change, which involves the modification of continuous interactional patterns.

The brief family therapy approach of Fisch, Weakland and Segal (1985) begins with a telephone assessment. When parents call to make an appointment for their child, the clinician requests an initial session with the family. It is seen as important for the clinician to exercise control early in the therapy process. After assessing the family, the clinician determines whether the family would benefit from a direct approach or a paradoxical strategy. The clinician employs techniques such as reframing or using paradoxical intention which entails the deliberate direction to a family member to engage in the problematic behaviour, which sometimes results in the extinction of the behaviour. In order to minimise resistance, it is imperative that the clinician avoid making statements that are antithetical to the parents' perspective.

According to Watzlawick (1988), brief therapy may involve first and/or second order change. First-order change is change within a system, with the accompanying rules and structure of the system staying the same (i.e. a short-term solution to address an immediate problem). Second-order change requires alteration in the existing family structure and rules. The goal of brief therapy is the resolution of the presenting problem via second order change. Some first order changes may occur as part of the normal developmental process (e.g. when a teenager seeks greater independence she/he may defy her/his parents by breaking a curfew). Second order change reflects the alteration of the recursive relation-

ship cycle, thus when the teenager breaks curfew the parents see this as a need for greater independence and communicate with the child on areas in which the teenager can take more responsibility. Thus, the pattern of the relationship has been altered for a longer term.

Jackson's perspective on brief therapy (as cited in Thomas, 1992) stresses the role of the therapist as crucial to the therapeutic process. The therapist questions each family member and carefully observes the interactional patterns of the family. The primary directive techniques consist of 'quid pro quo', relabelling, and prescribing the symptom. In the quid pro quo process, the clinician questions each family member to ascertain what each needs from the other and what each wishes to give to the other. In this respect, family members negotiate with one another to establish new rules for their relationship. Relabelling consists of the elucidation of the positive aspects of a symptom. The therapist asserts that the act of arguing may be construed as caring, in that individuals generally only quarrel with those they feel connected to emotionally. The technique of prescribing the symptom entails encouragement to continue interacting in the same manner. For example, the therapist directs the arguing family to increase their arguing in order to more fully demonstrate their caring for one another. Typically, the family desires to show that the therapist is wrong and thus will decrease their arguments. This will eventually result in improved family relationships. Obviously, this technique should be employed cautiously and with sensitivity.

### **Similarities, Differences and Effectiveness with Children**

As explicated earlier, brief therapy addresses the presenting problem, does not have insight as a goal, and is not geared towards teaching parents future coping skills. In contrast, Sayger (1992) recommended a social learning behavioural approach which would provide parents with insight and knowledge regarding systemic explanations of the problematic behaviour of their children as well as furnishing parents with skills to lessen future difficulties.

The collaborative nature of formulating treatments is common to both brief family therapy (Watzlawick, 1988) and behavioural family therapy (Sayger, 1992). However, unlike behavioural family therapy, collaboration in the form of disclosing and explaining techniques in advance does not occur in brief family therapy. Behavioural family therapy looks at the 'figural' facets of the problem which encompasses the familiar approach of stimulus-response-consequence analysis and intervention; while brief family therapy looks at the contextual 'ground' of the problem and includes each family members' interactional pattern and needs.

In order to address the effectiveness of behavioural family therapy and brief family therapy, the following research questions were posed in this current study: (a) Is behavioural family therapy effective in the resolution of child behaviour problems? (b) Is brief family therapy effective in the resolution of child behaviour

problems? (c) Is one approach more effective than the other?

## METHOD

### Sample

Forty-nine children referred to an outpatient psychiatric unit of a children's hospital were randomly assigned to two treatment groups and three therapists. The first group consisted of 28 children, who completed behavioural family therapy following the treatment agenda outlined in Fleischman, Horne and Arthur (1983), including sessions on specific topics such as setting up for success, self-control, discipline, reinforcement, communication, generalisation, and maintenance. The second group, consisting of 21 children, completed brief family therapy following the procedures outlined in Fisch et al. (1985). No family dropped out of the treatment protocol and all families completed all required sessions.

Due to random assignment, each group presented with a similar range of behaviour problems. This was a true random assignment to treatment and therapist. The behavioural family therapy and brief family therapy groups did not differ significantly ( $p > .05$ ) on age of child (behavioural family therapy Mean = 8.04 years (SD = 2.97); brief family therapy Mean = 9.54 years (SD = 3.78)), gender (behavioural family therapy = 67% male; brief family therapy = 59% male); socioeconomic status (Hollingshead, 1957): behavioural family therapy Mean = 39.11 (SD = 13.67), brief family therapy Mean = 38.48 (SD = 13.79)); number of sessions attended (behavioural family therapy Mean = 6.5 (SD = 4.63), brief family therapy Mean = 8.9 (SD = 4.51)); or general severity of problems (as measured by therapist ratings on the Sayger-Szykula Case Severity Index [see Szykula et al., 1991] and by pre-treatment CBCL scores). These scores were derived from the Hollingshead Four Factor Index of Social Position (Hollingshead, 1957).

Additionally, twelve children from the behavioural family therapy group and nine children from the brief family therapy group met the DSM-IV criteria for Attention-Deficit and Disruptive Behavior Disorders (i.e. conduct disorder, attention-deficit/hyperactivity disorder, oppositional defiant disorder), seven from the behavioural family therapy group and six from the brief family therapy group met the criteria for Generalized Anxiety Disorder (i.e. overanxious disorder of childhood), two from each group met the criteria for Adjustment Disorders, two from each group met the criteria for Elimination Disorders (i.e. Encopresis, Enuresis), one from each group met the criteria for Dysthymia, one from each group met the criteria for Sleep Disorder, and one from the behavioural family therapy group met the criteria for Gender Identity Disorder.

### Therapists and Treatment Fidelity

The therapy was administered by two males completing their predoctoral internships and a male supervising

psychologist. The supervising psychologist had eight years of clinical experience in using behaviour therapy and four years using brief therapy. Each intern possessed at least four years of clinical experience and six months of supervision in behaviour and brief family therapy prior to the beginning of the study. The two interns each had one year of clinical experience with supervision in each therapy model, but were more familiar with behaviour therapy through previous educational experiences. To insure treatment fidelity as much as possible, all therapists were supervised one hour each week during the course of the study to evaluate their adherence to the treatment models.

Both interns and the psychologist employed manualised versions of the therapeutic approach in question; thus, a viable attempt was made to give each approach an equal opportunity to succeed. Treatment fidelity was assessed by randomly selecting three audiotaped sessions from each of the three therapists to be reviewed by a psychologist knowledgeable about both treatments, but blind to the treatment conditions represented on the tapes. The psychologist accurately classified each tape. As described previously, clients were randomly assigned to treatment group. To test for group equivalence, t-tests for independent samples (adjusted for unequal Ns) were conducted on several variables and yielded no significant differences between groups ( $p > .05$ ). The variables included age of the child, socioeconomic status, number of sessions attended, and pre-treatment severity level.

### Assessment Protocol

The parents independently completed pre-treatment measures or were administered the pre-treatment measures by the assigned therapist during the intake interview. The post-treatment measures were collected within two weeks of completion of treatment by an undergraduate research assistant unaware of the treatment condition. The post-treatment data were collected in the client's home, while the pre-treatment data were collected in the clinician's office.

### Instrument

The instrument used in the present study was the Child Behavior Checklist (CBCL; Achenbach and Edelbrock, 1983). The CBCL has been shown to have high test-retest reliability as well as high content and construct validity (Achenbach and Edelbrock, 1983). The CBCL contains 118 items addressing behaviour problems, in addition to items reporting a child's school performance (which includes the child's performance and participation in organisations, social relationships, games, and sports). The Child Behavior Profile is used to score the CBCL, which has separate standardised editions for each gender within various age groups. Three scales (Externalizing, Internalizing, Sum T) were examined to assess the effectiveness of the two therapeutic approaches. For example, the Internalizing scale measures such behaviours as depression, anxiety, and social withdrawal.

The Externalizing scale measures such behaviours as aggressiveness, delinquency, and hyperactivity. The Sum T scale is the overall assessment of both Internalizing and Externalizing scales. The scores were reported in T-score form (Mean = 50, SD = 10).

## RESULTS

An initial analysis using independent t-tests was conducted to determine the individual effectiveness of each treatment in reducing problematic child behaviours. Table 1 presents the results of the t-tests to determine the effectiveness of each family therapy approach and includes means, standard deviations, and levels of significance on the dependent variables from pre- to post-test.

Results of the t-tests showed that for behavioural family therapy, significant differences were reported for Internalizing and Externalizing, while the Sum T behaviour scales of the CBCL approached significance ( $N = 28$ ,  $df = 27$ ,  $p < .05$ ). For brief family therapy, significant differences were found for Internalizing, and Sum T behaviour scales of the CBCL ( $N = 21$ ,  $df = 20$ ,  $p \leq .05$ ). The Externalizing scale was not significant for brief family therapy ( $p = .086$ ).

A second question explored in the current study was whether brief family therapy or behavioural family therapy were differentially effective in reducing child behaviour problems. A multiple analysis of covariance (MANCOVA) was conducted to assess the comparative effectiveness of behavioural family therapy and brief family therapy as well as the effectiveness within treatments from pre to post-measurement. The MANCOVA, which controlled for pre-test differences between samples, showed that neither treatment was more effective than

the other ( $df 1,44$ , Wilks F value .990,  $p = .936$ ) in reducing problematic child behaviours. Participant satisfaction was assessed using a consumer satisfaction survey using a seven-point Likert scale where 1 = considerably dissatisfied and 7 = greatly satisfied. Satisfaction scores for the Behavioural group showed a mean of 6.11 ( $SD = 1.25$ ) and for the Brief group a mean of 5.27 ( $SD = 1.72$ ).

## DISCUSSION

The present study demonstrates the effectiveness of both behavioural and brief family therapy in the resolution of child behaviour problems. The results indicate a significant change in the behaviour of children pre to post-test for both behavioural and brief family therapy approaches as they relate to the changes in the Internalizing and Sum T scales. In addition, behavioural family therapy demonstrated significance with respect to changes in the Externalising (e.g. aggression, delinquency, hyperactivity) scale. The results are consistent with those of Sayger et al. (1993) and Sayger et al. (1988) which report a reduction in family problems and problematic behaviour of aggressive boys who participated in social learning family therapy. Eighty-six percent of the behavioural group changed, 77% of the brief group (100% of the behavioural group had behaviour change but not all changed diagnoses, 82% of the brief group had behaviour change but not all changed diagnoses).

There may be some variation in success attributable to psychological disorder (e.g. disruptive behaviour disorders may be more amenable to behavioural family therapy than depressive disorders); even though a post-hoc review of clients in this particular study showed no significant difference in types of disorders which were

Table 1. Results of t-tests for Pre-to-Post Assessments on the CBCL for Behavioural Family Therapy ( $N = 28$ ) and Brief Family Therapy ( $N = 21$ )

Treatment Variable	Means		t-value	p
	Pre	Post		
Behavioural Family Therapy				
Internalizing	68.39 (8.14)*	62.07 (9.91)	3.26	.003
Externalizing	70.25 (10.49)	62.54 (11.94)	2.69	.012
Sum T	70.11 (10.93)	64.71 (11.39)	2.02	.053
Strategic Family Therapy				
Internalizing	66.05 (11.17)	60.52 (11.00)	3.23	.004
Externalizing	65.48 (10.68)	62.67 (10.85)	1.81	.086
Sum T	69.00 (10.64)	63.29 (13.14)	3.29	.004

\* Standard Deviations are in parentheses.

clinically changed. It should also be noted that 100% of the behavioural family therapy group and 67% of the brief family therapy group met their treatment goals as established by their therapist.

Post-hoc analyses to explore the results more closely revealed that the effectiveness of both therapeutic approaches did not seem to be specific to any one diagnostic category. Those in the Brief therapy group showing significant changes were equally divided among the diagnostic categories of Disruptive Behaviour, Anxiety, Sleep, and Elimination Disorders. Those in the Behavioural therapy group showing significant changes were equally divided among the diagnostic categories of Disruptive Behaviour, Anxiety, Dysthymic, and Sleep Disorders. Additionally, when looking only at internalising scores, 71% of the brief group and 79% of the behavioural showed improvement, while for the externalising scales 71% of the brief and 86% of the behavioural group showed improvement.

The lack of significance of change in the externalising scale for the brief therapy group may have several explanations. First, the instrument used to assess these behaviours may have been less sensitive to the changes expected in brief therapy (i.e. second-order change). Second, because brief therapy focuses less on skill development than the behavioural approach does, the treatment's impact may take longer to register; thus, external changes may not be seen as rapidly. A long-term follow-up may provide a more adequate answer to the impact of the brief approach on externalising behaviours. Third, assessment was self-rated, thus parents may have felt more positive about their child's behaviour, but had not fully noticed actual changes in behaviours.

The implications of the present study underscore the apparent effectiveness of the two therapeutic approaches and support the continued use of both behavioural family therapy and brief family therapy in the remediation of behavioural disorders of children. However, the long-term impact of these two approaches remains unclear. Follow-up studies for behavioural family therapy have shown some ability to maintain treatment gains (Sayger et al., 1988; Steinberg, Sayger, and Szykula, 1997). Few follow-up studies have been conducted on brief family therapy; however, this does not mean that long-term gains might not be maintained. Another limitation to the study is that the two predoctoral students lacked clinical experience in both approaches. It can be argued that the longer one practises a specific therapeutic modality, the more proficient one becomes in that modality. A particular limitation of the current study is its small sample size which did not allow for exploring the impact of therapy on specific child psychiatric disorders.

Practising family therapists should continue to examine their clinical effectiveness. It appears that both approaches can be effective and the choice of which to implement with a given family or child may rest on the clinical judgment, comfort, and preference of the clinician.

Families generally seemed to be satisfied with whichever approach they received; thus, the clinician's skills at establishing a positive working relationship and developing client confidence in their clinical abilities may play key roles in treatment effectiveness and outcome.

Further research is recommended to examine specific disorders of children and the effectiveness of behavioural family therapy and brief family therapy in their amelioration. In conclusion, it is important to recognise that this study is a preliminary investigation and future research in this domain is encouraged.

## References

- Achenbach, T. M., and Edelbrock, C., 1983. *The Manual for the Achenbach Child Behavior Checklist*, Burlington, VT, University of Vermont.
- American Psychiatric Association, 1994. *The Diagnostic and Statistical Manual of Mental Disorders*, 4th edn. Washington, DC, Author.
- Evans, I. A., Okifuji, A., Engler, L., Bromley, K. and Tishelman, A., 1993. Home-school Communication in the Treatment of Childhood Behavior Problems, *Child and Family Behavior Therapy*, 15, 37-59.
- Fisch, R., Weakland, J. H. and Segal, L., 1985. *The Tactics of Change: Doing Therapy Briefly*, San Francisco, Jossey-Bass.
- Fleischman, M. J., Horne, A. M. and Arthur, J. L., 1983. *Troubled Families: A Treatment Program*, Champaign, IL, Research Press.
- Fraser, J. S., 1995. Process, Problems, and Solutions in Brief Therapy, *Journal of Marital and Family Therapy*, 21, 265-279.
- Glaser, B. A., Sayger, T. V. and Horne, A. M., 1993. Three Types of Family Environment Scale Profiles: Functional, Distressed, and Abusive Families, *Journal of Family Violence*, 8, 303-311.
- Horne, A. M., 1991. Social Learning Family Therapy. In A. M. Horne and J. L. Passmore (Eds), *Family Counseling and Therapy*, 2nd edn. Itasca, IL, Peacock.
- Horne, A. M., Glaser, B. A., Sayger, T. V. and Wright, L. B., 1992. Behavior Disordered Children: Home and School Interventions, *Contemporary Education*, 64, 10-15.
- Motta, R. and Lynch, C., 1990. Therapeutic Techniques vs. Therapeutic Relationships in Child Behavior Therapy, *Psychological Reports*, 67, 315-322.
- Sayger, T. V., 1992. Children with Conduct Problems and their Families: Discovering the Sources for Change, *The Family Psychologist*, Winter, 35-36.
- Sayger, T. V. and Horne, A. M., 1993. Family Counseling with Children: Attending to the Children in our Midst, *Family Counseling and Therapy*, 1, 6, 1-14.
- Sayger, T. V., Horne, A. M. and Glaser, B. A., 1993. Marital Satisfaction and Social Learning Family Therapy for Child Conduct Problems: Generalization of Treatment Effects, *Journal of Marital and Family Therapy*, 19, 393-402.
- Sayger, T. V., Horne, A. M., Walker, J. M. and Passmore, J. L., 1988. Social Learning Family Therapy with Aggressive Children: Treatment Outcome and Maintenance, *Journal of Family Psychology*, 1, 261-285.
- Steinberg, E. A., Sayger, T. V. and Szykula, S. A., 1997. The Effects of Strategic and Behavioral Family Therapies on Child Behavior and Depression, *Contemporary Family Therapy: The International Journal*, 19, 537-551.
- Szykula, S. A., Mas, C. H., Turner, C. W., Crowley, J., and Sayger, T. V., 1991. Maternal Social Support and Prosocial Mother-child Interactions, *Journal of Family Psychology*, 5, 82-92.
- Szykula, S. A., Sayger, T. V., Morris, S. B., and Sudweeks, C., 1987. Child-focused Behavior and Strategic Therapies: Outcome Comparisons, *Psychotherapy: Theory, Research, Practice and Training*, 24, 3S: 546-551.
- Thomas, M. B., 1992. *An Introduction to Marital and Family Therapy: Counseling toward Healthier Family Systems across the Lifespan*, NY, Macmillan.
- Watzlawick, P., 1988. *Ultra-solutions. How to Fail most Successfully*, NY, Norton.