The paper reviews the current position of the Milan Approach in the family therapy field. Over the past 20 years this approach has made a major contribution to the development of family therapy theory and practice in the U.K. However, the ideas have been modified in order to fit different client groups in a range of settings; until today, the Milan, or Post-Milan approach is an amalgam of the original concepts and new techniques. This paper describes the development of this approach and highlights the following topics as central to current thinking: language, power, narrative, family resilience, externalising, focusing on change, and solution focused approaches. Several techniques of the Post-Milan approach are demonstrated in a discussion of one case treated by the author.

Keywords: Systemic; Milan; family therapy; externalisation

Reading this paper

Maybe it was spending so many Sundays of my childhood sitting in church listening to sermons that clinched it. It gives a young boy plenty of time to doodle and plenty of time to think, and one of the ways I could express my frustration was to challenge, with my inner voice, the preacher’s proclamations from the pulpit. So now, today, I am left with an active distrust of monologues and ideologies. ‘Why should it be like that?…Who says that’s the way things are?…How do you know?’ These are all questions that pop into my head when I hear someone explain the way things are. And this clearly has advantages and disadvantages. One advantage is that as a family therapist, I am keen to create space for many different points of view, but my dilemma arises when I come to write an article like this. I can only produce a monologue based upon my own ideology and, as a result, I simply cannot take my own ideas too seriously.

What I do take very seriously, however, is the process of dialogue. My own ideas become more interesting to me when I see them making some impact on another person and, then, I become interested in the way I am influenced by that other person. So I would like to remind the reader that I am only talking about ‘half-truths’ in this paper.

Without your reactions, questions, disagreements, these ideas will go nowhere.

The comments from the pre-publication review of this paper reminded me that readers will be referring back to a variety of ‘authorities’ to judge the value of these ideas. Some of you will be referring back to research evidence, others to the correct lineage of therapeutic thinking, and others will choose to make favourable or unfavourable comparisons with your own schools of therapy. And that is fine, but this paper is limited because it is only a monologue. The ideas must not stand alone, they must be placed in your context, and each reader will need to supply some imaginary dialogue if we are going to edge a bit closer to helpful practice.

Time to reflect

To mark the 25th anniversary of the Milan Approach, two of the original Milan team, Luigi Boscolo and Gianfranco Cecchin, organised an ‘event’ at one of the lake resorts in Northern Italy in October 1997. The three days were crowded, as one might expect, with birthday celebrations and good food; but there were also presentations by individuals and groups from all over the world, and it was
an occasion when one could reflect upon the ways the original Milan Systemic Therapy has evolved and been applied to many different contexts over the years. Therapeutic work was being done in an enormous range of settings, including clinics, hospitals, schools, refugee centres, police departments, primary care settings to name a few. What came across most clearly to me was that there are huge variations now in the therapeutic techniques used. Over time, the Milan Family Therapy techniques have inevitably been influenced through their interaction with other approaches, such as cognitive behavioural, brief problem focused, feminist therapies, solution focused therapy, narrative and linguistic approaches.

While the theory and practice of the therapeutic techniques have become more diverse, it was also clear that the services themselves had all been conceived and designed on the basis of what I would call ‘enduring systemic principles’. For example, each seemed to take careful account of the meanings that a new service would have for other agencies in the wider system. Each looked at the type of feedback that would pass between the new service and the older agencies, and each endeavoured to ask the grounding question, ‘In what way does a new service contribute to the process of change that is going on in the wider system?’.

So, given this chance to stop and think, after 25 years, about all the new developments as well as the enduring systemic principles, it seems an apt moment to commit some of my thoughts to paper. When the Milan Approach arrived in Britain, about 1979–80, I was one of a group of enthusiasts, including my colleagues Ros Draper and Caroline Lindsey, who worked to develop the model by setting up a training course at the Tavistock Clinic in London. I have remained active in the field since that time, so I can offer my own views about what has happened to the Milan Approach over the years.

**Laying the foundations**

Originally, the Milan Approach was one amongst several family therapy methods being used. What distinguished it from the other methods was its effort to transform contemporary systemic ideas—mainly those of biologist/anthropologist Gregory Bateson, and the strategic therapist, Paul Watzlawick—into a model for observing patterns of family interaction and techniques for making therapeutic interventions (Bateson, 1974; Watzlawick, 1974). For example, the idea that a system, as defined by Bateson, is ‘any unit structured on feedback’ led to the emphasis on observing feedback loops between family members, and subsequently the ‘circular questioning’ technique of interviewing whereby the therapist structures each question on the basis of feedback from the previous question.

Whereas other approaches to family therapy placed the emphasis on poor communication, or incorrect problem solving strategies (Strategic family therapy), or unhealthy structures, such as weak hierarchies or inappropriate alliances (Structural family therapy), the Milan Approach initially proposed that pathological behaviour was the result of individuals being isolated or vilified in the power struggles to maintain particular family relationships. Symptomatic behaviour was seen in two ways: as a reaction to this isolation and as a means by which a family member could ‘strike back’ against those family relationships that were excluding and hurtful. Therapy attempted to offer insight into the struggle for the control of family relationships, often over several generations; and it attempted to counter the family’s resistance to change with powerful rituals, homework tasks and paradoxical prescriptions.

The four members of the Milan team, who were psychiatrists and psychoanalysts, published their seminal paper in 1980 (Selvini et al., 1980), in which they described the three techniques of hypothesising, circularity, and neutrality, and for some years these techniques, along with the emphasis on team working and the presentation of powerful interventions, have been the hallmarks of the Milan Approach and have been practised and developed by various clinical teams in Britain.

**Changes afoot**

But several things happened around the mid-1980s that challenged the prevailing ideology and changed the Milan Approach forever (see Campbell, Draper, & Huffington, 1991). The first was the impact of constructivism and social constructionism, which led to the view that the therapist was not tracking down a ‘truth’ about family relationships or underlying dynamic processes, but rather she was constructing many ‘truths’ through the interactive conversation with the family. Hypothesising, instead of being seen as a chance to speculate ‘what was really going on’, became an opportunity to discuss a range of ideas in order to stimulate the therapist’s ability to engage in an interactive and therapeutic conversation.

As a philosophical position, constructivism, which proposes the observer sees the world through the lens of her own constructs, raised many hackles when it was introduced into the family therapy field, because it re-kindled the age-old debate about what really exists in the absence of an observer. But social constructionism, which shifts the emphasis from the individual to the way constructs are created through interaction, arrived soon after to shift the debate away from philosophical arguments toward issues that are much more relevant to family therapy (see Burr, 1995). For example, family therapists find social constructionism a very powerful tool because it encourages them to see clinical ‘realities’ such as diagnostic labels, concepts of ‘self’, and family roles as the products of social interaction across many levels from the cultural and societal down to the familial and individual.

In a parallel development, the traditional view of the
family as an interacting or cybernetic system being observed ‘out there’ by the therapist was replaced by what family therapists call ‘second-order cybernetics’ (von Foerster, 1974). That is, the observer, or in this case the therapist, is a part of the very system she is observing. The therapist then has to hypothesise about the family as a ‘family-being-observed-by-a-therapist-in-family-therapy’.

What does this mean in practice? I think this development protects therapists from drowning in too much content. These ideas are tools that enable therapists to keep sight of the process going on between them and the clients. It also emphasises that all the ‘realities’ that the therapy turns up are socially constructed, i.e. they are relative to the context, temporary, and negotiated through social, conversational process. The important point, it seems to me, is this: if ‘realities’ are seen in this light, it is easier for therapists and their families to appreciate that new realities, or constructs, can also be created through this same conversational process.

It is worth saying at this point that family therapists tend to be great pragmatists. Many of us are drawn to the drama and intensity of family meetings, because of the opportunity to make things happen. Families are exceedingly complicated, and it is problematic to theorise about such a complex process of change. As a result family therapy theory tends to lag behind the development of technique which ‘seems to be helpful’. For many of us, a theoretical explanation is not as compelling as the question, ‘Did the family find this helpful?’ Therefore, I think readers may get more out of this paper if they temporarily adopt a pragmatic frame of mind.

Revisiting neutrality

The second impact comes from the clinical cases of child abuse, and the reconsideration of the position of women in cases of marital violence. For example, as child protection cases became more prominent in the 1980s, therapists were forced to re-examine their therapeutic neutrality, because they were operating in a domain that demanded action by professionals to protect children from real injuries. It was clear that taking a neutral position about abusive behaviour in the family was tantamount to condoning the continuation of that behaviour. This clarified the point that a therapist must, as a supporter of the values of this society, give precedence to the safety of family members. If and when family members are safe, the therapist begins working in a different domain, in which the therapist can take a more ‘neutral’ position toward the family’s values and behaviour (see Campbell et al., 1991, pp. 43–53).

Neutrality is a term that has led to much misunderstanding in the family therapy field. However, today, therapists would recognise that no therapist can be ‘neutral’ in the formal sense of the word. Rather, therapeutic neutrality refers to the attempt to appreciate that all points of view in a family discussion are valid within some particular context. A neutral therapist tries to withhold judgement, and instead arouse their own curiosity about what particular context would validate the things the family member is saying. The influence of post-modern thinking and its invitation to re-examine the process by which we have arrived at our basic assumptions has also hit the family therapists hard. Various writers and therapists challenged the male-oriented, Western, concepts that were commonly used to describe family behaviour (Luepnitz, 1988) and now we are more aware that our culture, race, gender, and sexual orientation influence the way we give meaning to the problems families bring to us. We hold deep-seated assumptions that we are only beginning to understand as we interact with families from cultures other than our own. The aim is to appreciate and understand the meaning of family behaviour for each family in their own specific context. This is not easy to do, as the pull of our own underlying assumptions draws us away from understanding the family’s own context; and I think the best we can do as therapists is to continue to reflect and talk about our own biases and assumptions, particularly those about normative and pathological behaviour. If we can move away from the view that some ways of being are better than others, we are more likely to be responsive to groups who have traditionally fallen beyond the pale of normative behaviour, such as families of different races, cultures, or sexual orientation.

Applications of systemic thinking

The final impact on the Milan Approach has been the gradual expansion of the systemic canon beyond the practice of family therapy, where it had been nurtured, to work with individuals, couples and organisations; and the inevitable cross-fertilisation with other ways of thinking that occurs over time. The range of ideas and techniques has pulled therapists in so many different directions that a new ‘umbrella’ term was needed to loosely connect these new techniques and family therapists have coined the term ‘Post-Milan’ therapy to contrast with the earlier, perhaps more coherent, Milan Approach. Also various clinicians said they did not want to be limited by the label ‘family therapist’ since the family unit was only one part of the larger system they were trying to understand, and, thus, the ‘systemic therapist’ was born. The systemic therapist, circa 1999 (or should I say the systemic therapist for the new millennium?), will certainly pay allegiance to the core systemic concepts of context, difference, feedback, patterns of interaction, meaning and change, but he or she will also incorporate a broader range of techniques and certainly be working in a broader range of settings.

I now want to turn to a brief description of the newer ideas and techniques that are currently being practised by systemic therapists, and I will cover the following topics: language, power, narrative, family resilience, externalising, focusing on change, and solution focused approaches. I appreciate that a paper of this length only
provides an introduction to these topics, so I have included a few references for readers who want further discussion.

**Language**

If it is true that sentences are the only things that are true (Rorty, 1989), then therapists should pay careful attention to the way realities are created through language. Many systemic therapists are interested in the social process by which certain meanings get attached to certain words. We hear things like: ‘He’s lazy’, ‘She’s depressed’, ‘He’s violent’, but the words have particular meanings to each relationship and each family. ‘Depressed’ may mean in one family about unavailable mother–child relationships going back many generations; whereas in another family the same word means a temporary setback for an individual in a stormy marriage. The point is that the words people use have meanings that are always attached to some relationship between that person and A. N. Other. But family relationships are embedded within the wider discourses in society. The recent attention given to the link between anorexia nervosa and society’s preoccupation with thinness is just one example. The branch of British psychology pursuing discourse analysis is influential in offering family therapists tools for analysing the processes by which individuals interact to build social discourses but are at the same time influenced by those discourses (Potter, 1996).

A distinction between therapeutic approaches may be helpful to illustrate the way language is understood: a humanist or psychodynamic approach utilises a concept of self, which suggests there is a coherent and bounded sense of a ‘me’ that will act in a consistent way across many contexts because the ‘me’ is influenced by a core, inner self. Many systemic therapists take a different view. They would say we are constantly recreating our sense of self through interaction with others and with language, and the sense we all have of a coherent ‘me’ is actually due to the fact that we interact repeatedly with familiar people and linguistic concepts. Language enters this debate by offering, through social discourse, new concepts that allow the use of resources to overcome the problems. It is as though the personal resources, however weak or unavailable they may initially appear, do lie buried beneath the dominant story of failure. The task of the therapist is to seek out and, for example, the way social discourse has modified certain concepts over the years; linguistic concepts such as ‘an attractive woman’, ‘man’s work’, ‘worthy of love’, ‘dutiful wife’, ‘protective husband’ are the only raw materials we have available to construct a sense of who we are, yet these building blocks are in a continuous state of evolution.

**Power**

So much of the family therapist’s work is about the exercise of power and influence over family relationships, that it is natural the therapists should be attracted to writings on this subject. The French philosopher, Foucault (1980), describes how knowledge and truth in any field, such as psychiatry, create a dominant story and a subjugated or alternative story that is frequently not heard within society; Gilligan, an American psychologist, has studied the loss of ‘voice’ for women in society by describing the changes that take place in girls’ self-confidence as they reach puberty (Gilligan, 1993); and White and Epston (White, 1989; White & Epston, 1990) from Australia have developed a therapeutic approach based on the way individuals create narratives about themselves based on a dominant story about unworthiness and failure, which subjugates other stories about being more worthy and successful.

This is played out in the following way. At the higher levels, societal discourses expressed through such things as political debate, advertising, and magazines create a notion of ‘how to be’ in society, and this is reinforced in its own unique way through family interactions. Because parents have much more power than children in family settings, their values will predominate, and may not give space to the less powerful, alternative values of children. Children are offered only certain concepts of how to be. Typical examples might be: ‘make your parents proud of you’ or ‘always stand up for your beliefs’. When such concepts have also helped family members survive in the world and become the source of power in family negotiations, they are unlikely to be cast aside when confronted with a child who does not conform to these concepts. It is more likely that children in these situations grow up with a story of ‘who they are’ that is based on a failure to fit into the family values.

**Narrative therapy**

What is referred to as narrative therapy is a growing influence in the Post-Milan world of family therapy (see Gergen & Gergen, 1983; White & Epston, 1990). This approach assumes individuals construct stories about themselves that include their problems or mental illness and, above all, a story or script that does not allow the use of resources to overcome the problems. It is as though the narrative does not contain a story of this person as a well-functioning family member. The therapist assumes that personal resources, however weak or unavailable they may initially appear, do lie buried beneath the dominant story of failure. The task of the therapist is to seek out small examples of these hidden resources and to build on them. This can be achieved by understanding the process by which these resources have been subjugated by various events and relationships, and then gradually building an alternative narrative containing the new resources.

This work is very popular with both therapists and families because it builds on people’s struggle to overcome their obstacles however small their efforts may seem to be. Small efforts are rewarded with interest and understanding, tasks are set between sessions to provide further examples of using resources, and a network of family members and others can be enlisted to facilitate the process of an individual creating a new narrative for
Therapy Matters: The Milan Systemic Approach

Externalising the problem

One of the techniques associated with the narrative approach is ‘externalising the problem’. This is not a defence mechanism in the psychodynamic sense, but an active intervention on the part of the therapist to help the client: (1) embody the problem they see before them—i.e. give it human characteristics, such as a shape, a colour and, crucially, a will of its own; (2) locate it outside the self—somewhere ‘out there’, and then; (3) plan a strategy for counteracting the ways in which the problem tries to make the client miserable. This is a very creative process, first devised by White with encopretic children to help them use their resources to defeat the power of the ‘sneaky poo’ that sneaks up on children to soil their pants and make them unhappy and humiliated (White, 1989). Readers may find similarities with psychoanalytic concepts of split-off parts of the self, or Gestalt techniques such as talking to parts of one’s own experience which are embodied and ‘placed’ in an empty chair. However, the externalising process of White and Epston is unique as a fully elaborated therapeutic process.

A therapist with whom I have been doing ‘live’ supervision recently saw a very depressed couple who had virtually stopped communicating, each enclosed in their own silent world. After a number of sessions in which we tried to identify sources of their despair, we felt we had not shifted their perspective and decided to externalise this process. The therapist said the impasse between them was not the result of either one or another’s behaviour but it was almost as though some force came between them and made them both feel hopeless about changing their relationship. She moved a chair between them to locate this force and, together, they decided it should be called ‘the demon’. Freed from the tight, encapsulated thinking that, ‘it either has to be him or me’, the couple could unite against their common enemy, the demon. They visibly relaxed, became more animated and talked of things they could do to improve their relationship. At one point, the wife slapped the chair where the demon was meant to be and said, ‘I have to tell this demon I want to have my husband back’.

The solution-focused approaches

If the Milan and Post-Milan family therapy movements are characterised by seeing the whole family as a system and targeting interactive patterns as the source of understanding and intervention, another therapeutic approach, which has different origins, and is characterised by focusing on the clients’ problem solving strategy, is making important contributions to the field (Hoyt, 1994). Known as the solution focused approach, its origins trace back to the Brief Problem Focused Therapy Project in Palo Alto, California in the 1960s and 1970s. But more recently practitioners such as de Shazer (1982) in America, and George, Iveson and Ratner (1990) in the U.K. have posed the question, ‘Why deal at all with the problem saturated thinking of clients and other professionals? Why not concentrate on the way clients solve problems and try to generalise the successful strategies to other areas of the clients’ lives?’

The interviewing techniques that are used tend to place clients in a context of either a real situation in the present, or imaginary situations in the future, in which they have been successful in some fashion or are no longer burdened by their problem. The solution behaviour is discussed and supported and gradually becomes amplified. Small changes are monitored until they build the momentum for larger changes and many of these therapists utilise between-session tasks, also carefully monitored, to keep the therapeutic process alive. This is a similar process as that employed in the narrative approach, but here there is less emphasis on tracking the development of the narrative and establishing the new narrative with the support of relationships in the family.

A case illustration

In order to illustrate the way some of these ideas can be put into practice and demonstrate how family therapists may combine different approaches within the same case, I want to describe some work I have done recently with a family. From my perspective, looking back, I can see that my work falls into four stages, each of which utilised one of the different approaches within the broadening spectrum of family therapy.

Paul, aged 9, was referred because he developed acute anxiety states about his mother’s safety when the two of them were separated. This led to continuous phone calls to check that she was alright and to agreements about the precise time mother would return home from her work as a librarian. For example, if she agreed to arrive from work at 5.00 p.m., Paul would begin to watch for her a few minutes before 5.00, and if she were a minute late, he would collapse in a state of anxiety and hyperventilation. Paul was the eldest of two children with a sister, 7, in a family that had gone through a painful divorce several...
years earlier. The children lived with their mother but frequently saw their father, and both parents had new partners of their own.

**Stage 1: Letting the family tell their story**
The whole family was invited to the first session, and I wanted to simply let them talk about what they were feeling. There was a lot of tension between mother and father who sat at opposite sides of the room. As we talked about the divorce, the family became very tearful and the children moved to sit on their parents’ laps. It seemed as though divorce had only happened yesterday. It also struck me that Paul was very resentful about the new partners. He didn’t like it when he was with this parent and the other partner tried to be friendly, as though the partner wanted this new unit ‘to be like a family’.

I was purposely trying not to think too much but rather to empathise with what the different family members were going through and to share enough of this to reassure them that I would try to respect and hold in mind their experiences while we were working together. (This piece of my work with this family is not described in conceptual terms. It is more ‘from the heart’ if you will, and I put it this way because many Milan therapists—and I certainly include myself—have, in the past, been over-enamoured with systemic formulations and interviewing techniques. This was necessary at the time to develop a new model but, more recently, these therapists are more explicit about integrating their empathy and personal responses into their therapeutic work.)

**Stage 2: Exploring systemic hypotheses**
I organised my thoughts around two hypotheses: Paul had been a central lynchpin between his parents, in this close-knit, affectionate family, and he was losing some of the closeness to each parent, as well as the powerful role of being a ‘switchboard’ in the family. But adding the systemic perspective, i.e. to see how others contribute to the problem behaviour, I surmised that the parents felt personally uncertain about moving to the next stage of their lives, so it may have been difficult to give the children clear messages about the new partners: and I also sensed that they felt terrible about inflicting so much pain on their children through the divorce, and perhaps there was an embargo on angry and blaming feelings that usually accompany divorce. One could see how the problem behaviour might be experienced by the family as a way of holding things back from further development, and diverting feelings of anger or despair into more acceptable feelings of concern and closeness.

This stage of the work led us into the exploration of these themes. I explained to the family that I thought it would be helpful to first have some understanding of what is going on for all of them, in order to give some possible meaning to why the family was in this predicament. I had some ideas I wanted to discuss with them, but this wasn’t all we would do to tackle the problem. I also wanted to work directly with them to help Paul get this behaviour under control so he could also get on with his life.

**Stage 3: Externalising the problem**
After several sessions, the father said he could not come to the next few meetings because of work commitments, so I used this as the opportunity to shift my focus and work with Paul and his mother alone. My intention was to describe a pattern and purpose in Paul’s behaviour and to give it a name that he could identify, and to which we could both refer during our future conversations. He chose to call it his ‘worry’. The next step was to describe the ‘worry’ as an external force outside himself—a powerful force with a life of its own which, for its own reasons, lands on him from time to time causing him to worry about his parents’ safety. Paul liked this discussion and got involved drawing a picture of ‘worry’ as a red cloud. But before I could elicit his resistance to worry, I needed to draw out examples from his own life of fighting back against forces intended to defeat him. In the first session Paul had said he was very keen on football and an avid Tottenham Hotspur supporter, so I explored this area to find examples of how he would fight back on the football pitch if someone took the ball away from him.

Once this was clearly established, I worked with Paul and his mother to identify a series of strategies he could use to fight back against worry and keep it at bay for a brief period each day. We went through each day of the week to identify when and how the worry landed on him. For example, on Monday Paul went directly from school to stay with a neighbour until his mother came home from work at 5.00 p.m. His usual pattern was to walk into the neighbour’s house and go straight to the telephone to call his mother. We externalised this process by saying ‘worry’ was waiting for him at the neighbour’s front door and landed on his shoulder the moment he walked in, which caused him to rush to the telephone. He agreed that he could try to keep worry at bay by forestalling the phone call to his mother for 1 minute by taking off his coat and speaking briefly to the neighbour when he first came into the house, but after 60 seconds he was to go straight to the telephone to contact his mother as usual.

In the context of systemic family work, it was possible, in this case, to enlist the support of Paul’s parents, and even the neighbour, to help him keep worry at bay by both respecting his attempts to resist it, and also his need to let it control him and guide his actions. The adults knew about Paul’s weekly strategy and were aware of the need to support his efforts but not to expect too much too soon and not to take any of the initiative away from Paul—he was engaged in his own personal struggle with worry and would slowly overcome it in his way and in his time.

Together, Paul, his mother and I designed a weekly plan in which Paul would keep worry at bay for 1 minute each day. The circumstances were different each day, i.e. some days he would be with his father, others alone at home.
with his sister, so we had to be creative about the best strategies for each situation and the best way to involve others to support his plan. I found doing this detailed work over several sessions certainly clarified Paul’s strategy but, also, the slow, methodical discussion of worry in all its week-long manifestations seemed to have the effect of exposing its mystery and loosening its grip on Paul. As our sessions continued, Paul lost some interest in these strategies, almost as though he was getting bored with the process and wanted to think about other things. This also coincided with his success with the strategies and the gradual expansion from 1 minute to 2 and 3 minutes during which he could keep worry at bay.

After four sessions dedicated to this work both Paul and his mother felt there had been considerable improvement. The problem was not so controlling of their lives and they felt they could carry on with the weekly plans on their own. Toward the end of this period, Paul decided he would be able to go on a week-long school trip to Wales. We discussed how he would deal with ‘worry’, who may become more powerful when Paul is so far from home, and the family discussed their own strategies which included asking his grandfather to buy him a pager for the trip!

Stage 4: Individual work in the family context
The final stage of my work was initiated by Paul himself. At the beginning of the fifth session, mother said Paul wanted to have a meeting with me on his own. He had always been reticent, and cautious during the meetings with other family members, and I was very curious to know what he wanted to talk about on his own, so I agreed to end the family meeting early so he could have half a session with me. When we were alone he launched straight into a story. One evening several years earlier he answered the telephone to hear a female voice crying and saying ‘I’m having an affair.’ This left Paul very confused about whether this was a prank or a true story, and if it were true, ‘I’m having an affair.’ This left Paul very confused about whether this was a prank or a true story, and if it were true, what it was about, who was this woman, and what would it mean to him about his own explanation for why his parents split up?

Two issues interested me particularly as Paul and I unravelled his story. One was the deep sense of hurt and outrage that his father might have been having an affair. Paul sounded to me like a jilted lover, and it made me wonder if he had some idea that his close relationship with his mother was like an affair that excluded his father. (Some therapists would describe this as a hypothesis about oedipal rivalry.) I have found with other children that it is very difficult to come to terms with a divorce when children are entwined with adult relationships that they do not understand, and probably doubly difficult if they are underground, secret relationships. I discussed this theme by first asking him for his own explanation as to why his parents split up, and then adding my own thoughts that children often have two explanations: one is ‘sensible’, and the second one, which is more weird and confusing, in which they think they are partly responsible for the break-up. He agreed that he was very confused and we continued to talk about how he had always fitted in between his parents.

The second issue became more clear to me when I asked myself why Paul wanted to have this session private from his mother. In terms of the previous hypothesis, one could speculate that he wanted to retain a secret relationship with his mother, but I was struck by his reply to me when I asked him if he saw his mother as a fragile person. He immediately said, ‘Yes’, with a look of recognition that I had not seen on his face before, and this led me to explore the hypothesis that Paul was deeply worried about whether his mother would survive the break-up. Many of the things that were on his mind might hurt her further. This struck a chord with Paul and we discussed this at some length. I tried to empathise with his dilemma that on one hand he might like his mother to have a new partner for support in her life, but on the other hand, that means a new man intrudes into his relationship with his mother.

After a second session divided between the family meeting and time for Paul on his own, mother suggested things had improved and they didn’t feel they needed further meetings, but Paul wanted to know if he could have a final session with just him and his father. During this meeting, I was struck by the way Paul explained how badly he felt about staying in his father’s house and about his partner, and by the way his father patiently and reasonably listened to the catalogue of complaints. Something didn’t seem right but I couldn’t put my finger on it. It finally occurred to me that this process seemed to mask more dangerous, angry feelings about the break-up and we spent most of the session talking about how difficult it was to see any of these feelings of anger and sadness, and perhaps Paul wanted to try to be strong by building up power and control in his life and the life of his parents.

We said good-bye after this session. I told them to contact me again if they thought further meetings would be helpful, and I have not heard from them in 6 months since that last meeting.

Evaluating outcomes
The evidence to support family therapy’s claim to be an effective form of treatment is patchy. Outcome studies pose methodological problems; because there are so many intervening variables in a family’s on-going life, which can affect change in beliefs and behaviour, it is difficult to pin down the variables that may be related to therapy. Also, as family therapy researchers become more interested in the family’s own construction of meaning rather than the observation of an external, observing ‘scientist’, they lead research toward qualitative studies, which, at this time, do not have the professional status nor funding that quantitative, empirical studies enjoy. Nevertheless, there is a growing number of researchers who are trying to investigate the interactive processes within family therapy.
and interested readers are referred to the key review papers by Friedlander et al. (1994) and Diamond et al. (1996).

There are a number of research projects that have supported the claim for family therapy as the treatment of choice for specific problems. In Britain, Russell et al. (1987), at the Maudsley Hospital, were able to demonstrate that family therapy was the preferred method of treatment for younger anorexic patients, and Lask and Matthew (1979), in an albeit small sample, were able to demonstrate the efficacy of family therapy in the treatment of childhood asthma. In the U.S.A. where more research studies have been conducted, recent reviews of research (see Special Issue, Journal of Marital and Family Therapy, 1995), have found that moderately conduct disordered adolescents and their families are most helped by outpatient family therapy and as the degree of disturbance increases, family therapy alone becomes less effective (Chamberlain & Rosicky, 1995). Liddle and Dakov (1995) found that family based approaches were significantly effective in engaging and retaining adolescents and their families in treatment and reducing drug abuse.

In general, research studies have been limited to relatively small samples of specific clinical problems and, given methodological limitations, some positive findings are emerging. Many clinicians, including myself, would see family therapy as a treatment of choice for young people (up to the age of leaving home) living in a family setting whose problems and/or symptoms are within the moderate range. As symptoms become more severe, more intensive forms of treatment are required, such as inpatient treatment or drug treatment, and in these cases family therapy has been found to be an effective adjunct to other treatments. Within adult mental health there is a growing interest in the systemic approach. Clients with serious enduring disabilities will inevitably be involved in a network of family and professional relationships. This can present problems for clients when, for example, they leave one set of relationships (such as the family) and establish new ones in a different setting (such as a hostel). In complex cases involving a network of carers, family therapy per se may not be recommended, but the systemic thinking that underpins family therapy work is indispensable in understanding the workings of the professional network.

Conclusion

Today, distinctions between different schools of family therapy are more difficult to make because the field has matured and there are more ideas and techniques to choose from. In addition, the very questions that seemed to be worth fighting over in the past, such as, ‘Can a therapist ever be neutral?’ or ‘Do families need insight for lasting change?’ have themselves been de-constructed, and therapists are now more interested to examine the assumptions underlying the questions or to turn to the family and involve them in a dialogue about such questions.

I have tried in this paper to clarify the areas in which the Milan Approach has developed its original thinking and those areas in which it has stepped aside for newer models within the field. But the field has moved on, and now I think systemic therapists should turn their attention to making new distinctions: those are the distinctions between psychological and non-psychological approaches to human problems. It is incumbent upon all of us to let go of some of the parochial debates we have had over the recent years and think about the conversations we can create amongst people who have very different views about creating services to solve current mental health problems.

References


