



Title	Milan systemic family therapy: a review of 10 empirical investigations
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Publication date	1991
Publication information	Carr, Alan. "Milan Systemic Family Therapy: A Review of 10 Empirical Investigations." Wiley-Blackwell, 1991. https://doi.org/10.1046/j..1991.00425.x .
Publisher	Wiley-Blackwell
Item record/more information	http://hdl.handle.net/10197/5464
Publisher's statement	This is the author's version of the following article: Milan Systemic Family Therapy: A review of 10 empirical investigations. (1991). Journal of Family Therapy 13 which has been published in final form at http://dx.doi.org/10.1046/j..1991.00425.x
Publisher's version (DOI)	10.1046/j..1991.00425.x

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Carr, A. (1991). Milan Systemic Family Therapy: A review of 10 empirical investigations. *Journal of Family Therapy*, 13, 237-264.

MILAN SYSTEMIC FAMILY THERAPY: A REVIEW OF 10 EMPIRICAL INVESTIGATIONS

ABSTRACT

Ten empirical investigations of Milan Family Therapy (MFT) are reviewed in this paper. The studies include both single group and comparative group outcome trials; investigations of therapeutic process; clinical audit and consumer satisfaction surveys. Substantive findings and methodological issues are discussed in the light of family therapy and individual psychotherapy research generally.

INTRODUCTION

Within the field of family therapy and systems-consultation the impact of the Milan Approach has been widespread (Campbell & Draper, 1985; Jones, 1988). Despite this, little empirical research on the effectiveness of Milan Family Therapy (MFT) or the processes underpinning systemic and symptomatic change which arise from it has been conducted. While literature reviews and meta-analyses of family therapy as a generic form of intervention abound, to date, no comprehensive review of extant empirical research on MFT has been published in a major family therapy journal or handbook (Gurman & Kniskern, 1978, 1981; Gurman, Kniskern & Pinsof, 1986; Hazelrigg et al, 1987; Markus et al, 1990; Shoham-Salomon & Bice-Broussard, 1990). To remedy this situation the present review was conducted.

METHOD

A detailed manual literature search was conducted covering all major English language family therapy journals and edited handbooks published between 1975 and 1990. Major British and North American psychotherapy, clinical psychology and psychiatry journals were also examined. Finally a letter requesting both published and unpublished manuscripts describing empirical investigations of family intervention, including MFT was placed in a variety of widely read periodicals and newsletters, e.g. the Newsletter of the Association for Child Psychiatry and Psychology, the Bulletin of the Royal College of Psychiatry, The Psychologist, Context and Social Work Today. The letter was placed in these periodicals as part of a broader review of empirical research on family intervention generally in the UK and Ireland.

OVERVIEW OF 10 STUDIES

Only 10 studies were identified which met minimal methodological requirements. Four were comparative group outcome studies (Green & Hegert, 1989a, 1989b; Simpson, 1989; Bennun, 1986; Bennun, 1988). Two were process studies (Bennun, 1989; Vostanis et al, 1990). One was a single group outcome study (Manor, 1989, 1990, 1990). Two were consumer surveys (Fitzpatrick et al, 1990; Mashal et al, 1989) and one was, a clinical audit of a series of consecutive patients (Allman et al., 1989).

A summary of the main characteristics of the 10 studies is set out in Table 18.1. Most have been conducted in the past five years. Four features of these studies bear on their ecological validity and deserve mention. First, the studies come from four different countries. Second, in all cases identified patients sought treatment rather than being solicited as recruits for an analogue study. Third, identified patients included both adults and children. Fourth, all of the studies were conducted in regular outpatient centres.

Table 18.1. Context and design of 10 MFT studies

No	First Author	Year of Pub	Country of study	Design	N per gp	Symptom	System
1	Green	1989	USA	CO	MFT-11 ST-11	Adult PD Childhood PD Relationship P	Difficult cases with chronic problems. Mixed ethnicity. Mixed SES. MFT consultation offered by senior staff to junior colleagues at private institute.
2	Simpson	1989	UK	CO	MFT-45 ST-42	Childhood PD	Cases with home, school & community based chronic problems. Mixed SES. Referred by GPs to NHS Child Psychiatry OPC.
3	Bennan	1988	UK	CO	MFT-6 ST-6	Alcohol Problems	Mean history of alcohol problems of 9 years. All from two parent intact two generational families. 8 men & 4 women with a mean age of 43y. Referred from various sources to NHS OPC.
4	Bennan	1986	UK	CO	MFT-10 ST-10	Alcohol Problems Depression Childhood PD	Difficult cases with chronic problems. Mixed SES. Referred from various sources to NHS OPC.
5	Bennan	1989	UK	P	MFT+ ST-35	Alcohol Problems Depression Childhood PD	Difficult cases with chronic problems. Mixed SES. Referred from various sources to NHS OPC.
6	Vostanis	1990	UK	P	MFT-12	Childhood PD	Mixed Cases. Referred by GPs to NHS Child Psychiatry OPC.
7	Manor	1989	UK	SO	MFT-45	Childhood PD Child abuse	Difficult cases with chronic problems. Mixed ethnicity. Low SES. Referred by Social Workers to Social Services Family Therapy Clinic
8	Fitzpatrick	1989	Ireland	CS	MFT-24 ST-26	Childhood PD	Mixed cases. Mixed SES. Referred from various sources to a General Hospital Child Psychiatry OPC containing a family therapy training programme.
9	Mashal	1989	Canada	CS	MFT-19	Early adulthood PD	Difficult cases. Average age of children was 21. Mixed ethnicity. Mixed SES. Referred from various sources to General Hospital Psychiatry OPC
10	Altman	1989	UK	CA	MFT-50	Adult PD	Difficult cases with previous history of therapy. Separation-individuation was key issue for most. Mixed SES. Referred by GPs to NHS OPC.

NOTE: NHS OPC = National Health Service Out Patient Clinic. CO = Comparative outcome study. P = Process study. SO = Single group outcome study. CS = Consumer survey. CA = Clinical Audit. MFT = Milan Family therapy. ST = Standard therapy.

Table 18.2. Methodological characteristics of 10 MFT studies

Design Feature	Study Number									
	1	2	3	4	5	6	7	8	9	10
Comparison group	1	1	1	1	0	0	0	1	0	0
Controlled assignment to groups	1	1	1	1	0	0	0	0	0	0
Groups comparable on baseline variables	1	1	1	0	0	0	0	1	0	0
Diagnostic homogeneity	0	0	1	0	0	0	0	0	0	0
Pre-treatment assessment	1	1	1	1	0	1	1	0	0	0
Post-treatment assessment	1	1	1	1	1	1	1	0	0	0
Follow-up assessment (>3 months)	1	1	1	1	0	0	1	1	1	1
Client ratings	1	1	1	1	1	0	0	1	1	0
Therapist ratings	1	1	0	0	0	0	1	1	0	1
Researcher ratings	1	1	0	0	0	1	0	0	1	0
Symptom assessed	1	1	1	1	1	0	0	1	1	1
System assessed	1	1	1	1	1	1	1	0	1	1
Deterioration assessed	1	1	1	1	1	0	1	0	1	1
Engagement in further treatment assessed	0	1	0	1	0	0	0	1	1	1
Appropriate statistical analysis	1	1	1	1	1	1	1	1	1	1
Experienced therapists used for all treatments	1	1	1	1	1	1	1	0	1	1
Treatments equally valued by therapists	1	1	1	1	1	1	1	1	1	1
Quality control of treatment	0	0	0	0	0	0	0	0	0	0
Data on concurrent treatment given	1	0	0	1	0	0	0	0	0	1
Total	16	16	14	14	8	7	9	9	10	10

Note: 1=design feature is present. 0= design feature is absent.

A summary of the methodological features of the 10 studies is set out in Table 18.2. From this table it may be concluded that the four comparative group outcome studies were methodologically quite robust. The single group outcome study and the process studies were slightly less methodologically sophisticated. Finally the consumer survey's were less robust than the other types of investigations. Conclusions may be drawn from the first four studies with considerable confidence. Only tentative generalisations may be made on the basis of the findings from the remainder of the studies.

Detailed methodological criticisms of each study will not be given. Rather, in the case of each study, readers may refer to the methodological profile for that study contained in Table 18.2. However, for each study one or two noteworthy methodological strengths and important methodological refinements that could be introduced in future research are given under the heading *Comments*. A fuller consideration of methodological issues in family therapy research generally is available in Gurman and Kniskern's 1978 and 1981 papers.

REVIEW OF 10 STUDIES

STUDY 1. Green, R. & Herget, M. (1989a; 1989b)

Design. In this comparative outcome study, eleven therapists were asked to select 2 ongoing family therapy cases matched for difficulty. One case was randomly selected from each pair to participate in a Milan-systemic consultation to help resolve a therapeutic impasse. The remaining cases served as a comparison group. Therapists who submitted families to the study worked in a variety of clinics in California and used a variety of models of family therapy. The consultations all occurred at the Redwood Centre. The model of consultation used, drew on the ideas and practices of the original Milan Team but was more frankly goal directed than the position taken by Boscolo and Cecchin when the original Milan team split up (Boscolo et al, 1987; Cecchin, 1987; Selvin-Palazzoli et al., 1989). In the majority of cases the end-of-consultation-interventions involved framing the persistence or resolution of the family's presenting problem as a dilemma. The pro's and con's of persistence or resolution for each member of the family was typically specified. Paradoxical prescriptions were rarely used by this team. Assessment occurred before consultation, one month following consultation, and at 3 year follow-up. The follow-up assessment was conducted by phone. 11 families per group were followed up at one month and 8 families per group were followed up at 3 years.

Measures. Kiresuk's (1968) Goal Attainment Scale (GAS) was the principal measure used to assess movement towards the three main

therapeutic goals identified by each family during a preliminary independent research interview. Secondary measures included family and therapist ratings of improvement on 5 point scales a month after consultation and Moos'(1981) Family Environment Scale. This was completed by literate family members before the consultation and one month later. On each occasion family members' scores were averaged to obtain a family score on this questionnaire.

Results. On the GAS, average movement towards Goal #1 and for a composite of Goals #1 + #2+ #3 was significantly greater for families who received MFT at one month and 3 years follow up. At post-therapy and follow-up effect sizes for principal goals and composite goal scores ranged between $d = 0.82$ and $d = 1.29$. That is, the average MFT client showed more improvement than between 79% and 90% of clients in the control group after treatment and at follow up on principal goal and composite goal attainment indices.(These treatment effects were very large by psychotherapy research standards, where most meta-analyses of psychotherapies yield d values of about 0.7. Rosenthal, (1984) has classified d values less than 0.2 as small; d values between 0.2 and 0.8 as moderate; and greater than 0.8 as large.)

MFT and ST groups did not differ on baseline measures, i.e. the Family Environment Scales or problem chronicity. On the GAS, for those families receiving MFT, 54% made moderate or good progress towards Goals #1+ #2+ #3 after 1 month and 88% made moderate or good progress after 3 years. For ST families the figures were 36% at one month and 63% at 3 years. On both therapist and client rating scales MFT families were rated as making significantly more progress towards goals than ST families after 1 month. Changes on the Family Environment Scales were not significant for either the MFT or ST group.

Comments. Green's study shows that a 2 hour MFT consultation enhanced the immediate and long term outcome of a variety of forms of family therapy with difficult cases where a therapeutic impasse was hampering progress.

A key strength of the study was the use of a robust individualized method for assessing change in symptomatology, i.e. the GAS. It is disappointing that a more sensitive measure of systemic change was not included in the assessment battery. Studies by Bennun (1986) and Vostanis et al (1990) reviewed below suggest that Shapiro's (1961) Personal Questionnaire and the Expressed Emotion Scales (Vaughan & Leff, 1976) are highly sensitive to systemic changes. These might fruitfully have been included in Green's study. The Family Environment Scale which was used in Green's study as an index of systemic change has one main drawback. It is one of the many family assessment instruments which, like the psychometric personality

inventories on which it is modelled, taps perceptions of relatively enduring aspects of family functioning.

STUDY 2. Simpson, L., (1989)

Design. In this comparative outcome study 118 referrals to Royal Edinburgh Hospital for Sick Children's Department of Child and Family Psychiatry were randomly allocated to MFT or ST. MFT was conducted following the description and guidelines set out in early Milan publications (Selvini-Palazzoli et al., 1978, 1980). ST comprised standard individually oriented child assessment and therapy coupled with parental counselling. MFT was carried out by 2 psychiatrists and 2 social workers. ST was carried out by a traditional multidisciplinary child psychiatry team. 74% of recruited families participated in treatment, 45 in MFT and 42 in ST. 2 families dropped out of the study before the end of treatment and two dropped out between the end of treatment and 6 month follow up. Families were assessed before and after treatment and at 6 month follow-up. Therapists were also interviewed. An independent researcher carried out these assessments using instruments listed below.

Measures. The following assessment battery was administered: a semi-structured family interview which inquired about the symptom, the family system and the family's involvement in treatment; Rutter's (1970) A & B scales which obtain ratings of parent and teacher perceptions of behaviour problems in school-going children or Richman's (1982) Behaviour Checklist in the case of preschoolers; visual analogue scales assessing the family's perception of symptom severity and family system functioning; and a stressful life event inventory. For each case, a record of the nature and duration of the therapy was obtained from each therapist using a standardised form.

Results. MFT & ST groups did not differ on baseline or demographic variables with one exception. The MFT group had more severe symptomatology as rated by Rutter's Teachers Questionnaire. After treatment and at six month follow up MFT & ST groups did not differ on any absolute indices of problem severity, family functioning, satisfaction with treatment or involvement in further treatment. Both MFT and ST alleviated symptoms in about 3/4 of cases, and overall families were satisfied with such treatment.

MFT led to slightly greater improvement in family functioning than ST. In MFT symptomatic and systemic improvement were associated. This was not the case for ST. MFT was briefer than ST. The average duration of MFT was 3 sessions and for ST it was 5 sessions. Fewer failed appointments occurred with MFT. However, MFT was not less manpower intensive since in this study a full four person team consulted to each family at each appointment.

Comments. The central finding of this study is that in a child psychiatry setting MFT on the one hand and traditional individual child therapy with parent counselling on the other led to similar levels of symptomatic change. However, MFT differed from the more traditional approach in that it led to improvement in perceived family functioning and this correlated with symptomatic improvement.

In MFT this greater perceived change in family functioning associated with symptomatic improvement may have been due to families adopting the beliefs of their therapists, i.e. that for symptomatic improvement to occur concurrent systemic change is essential. Alternatively it may have been due not only to a change in the family's beliefs but also to a change in family behaviour. Unfortunately independent observations of family behaviour were not obtained in Simpson's study, so this question remains to be answered in further research.

The brevity of MFT and the reduced number of failed appointments may have been due to the increased efficiency with which teams offer clinical service when they share a common clinical model. This unity of commitment is by definition absent in traditional multidisciplinary child psychiatry teams where eclecticism predominates.

The strengths of this study include the use of large groups, the use of an extensive assessment battery which included a stressful life events scale, and the use of the service offered by a multidisciplinary child psychiatry team as a comparison group. It is disappointing that no attempt was made to specify precisely how the formulations and family intervention of the MFT and ST teams differed since both were clearly engaged in differing forms of family work.

STUDY 3. Bennun, I. (1988)

Design. In this comparative outcome study 16 families each containing a person with alcohol problems were randomly assigned to either MFT or ST. MFT conformed to the model outlined in the writings of the original Milan group (Selvini-Palazzoli, 1978,1980). ST was behaviourally based problem solving therapy. MFT on average lasted for 8 sessions and ST lasted for 9 sessions. MFT was conducted by IB and a team. 5 other therapists treated the ST group. Community mental health clinic and a specialist alcohol unit served as a base for the therapy. Assessments were conducted before and after therapy and at 6 months follow up. 4 families dropped out of the study.

Measures. Three self-report questionnaires were used to assess symptomatology and marital and family functioning at each evaluation point in the study: Stockwell's (1983) Severity of Alcohol Dependence Questionnaire (SADQ), Olson's (1983) Family Satisfaction

Rating and Kimmel's (1974) Marital Adjustment Test(MAT). All three instruments are reliable and valid standardized self-report inventories.

Results. MFT & ST groups were comparable on baseline measures of alcohol dependence and marital and family satisfaction. After treatment and at follow up both MFT and ST groups showed no difference in symptomatology or system functioning on the 3 dependent measures. Overall both groups showed significant improvement in symptomatology and system functioning. Despite this clients were still in the mild dependency range of the SADQ and the distressed range of the MAT. Improvement in marital satisfaction occurred more rapidly with ST, possibly because spouses hope that treatment would be effective was effected more immediately by the problem solving approach.

Comments. Both MFT and behavioural problem solving therapies had very similar effects on clients' perceptions of drinking patterns and family functioning in this study of problem drinkers from intact families.

The use of problem-solving therapy, an intervention of proven effectiveness with problem drinkers, as a comparison treatment against which to assess MFT is a key strength in the design of this study. The notable weaknesses are the small group sizes and the absence of observational measures.

STUDY 4. Bennun, I. (1986)

Design. In this comparative outcome study 27 families were randomly allocated to MFT or ST, the definitions of which were similar to those given in the Bennun (1988) study just reviewed. The families presented with a range of difficulties including alcoholism, depression, eating disorders, agoraphobia and childhood and adolescent emotional and conduct problems. Treatment ranged from 7-10 sessions and was conducted by experienced therapists. Therapy was provided in NHS Community Psychiatry outpatient clinics. Families were assessed before treatment, midway through treatment, after treatment, and at 6 month follow-up. 25% of the sample dropped out before the end of treatment. A six month telephone follow-up was carried out with 13 (65%) of the families who completed therapy.

Measures. Systemic changes were measured using the Sharpiro's (1961) Personal Questionnaire (PQ). Statements about the relationship between the symptom and the family system were drawn up with each family at intake and the families beliefs about changes in these statements rated before and after therapy and midway through treatment. Symptomatic change was assessed using symptom specific measures appropriate to the presenting problem. These included Stockwell's (1983) Severity of Alcohol Dependence Questionnaire;

Beck's (1967) Depression Inventory; Mark's (1979) Fear Questionnaire; tantrum frequency; weight; frequency of asthma attacks; and number of therapist scheduled tasks completed. These measures were used before and after therapy and mid way through treatment. Change in families' levels of concern about the presenting problem was assessed by interview after therapy. Satisfaction with treatment was assessed on a 5 point scale after therapy. Symptomatic recurrence was assessed by telephone interview six months after therapy.

Results. Both groups showed significant positive systemic change as assessed by the PQ over the course of therapy. However the MFT group showed significantly more systemic change than the ST group. All families in both treatment groups showed moderate or good symptomatic improvement immediately after therapy. There were no marked differences between the MFT & ST groups on indices of problem severity after treatment. 20% of MFT families and 50% of ST families reported no change in their initial concerns after therapy. The mean rating of satisfaction with therapy for both groups of families was 1.6 on a 5 point scale, indicating that both groups of families were highly satisfied with the therapy received. Of 7 MFT families followed up at 6 months 5 (75%) were asymptomatic, 2 (25%) reported occasional recurrences and none reported seeking further treatment. Of 6 ST families followed up at 6 months 2 (33%) were asymptomatic, 3 (50%) reported occasional recurrences and 1 (17%) sought 3 further sessions of family therapy.

Comments. This study shows that in the short term both MFT and ST led to moderate or good symptomatic improvement, improved systemic functioning and a high level of therapeutic satisfaction. However, MFT led to greater improvement in family systems functioning, a greater decrease in concern over the presenting problem and better symptomatic improvement at follow-up compared to ST.

The most noteworthy feature of the study is the use of a robust individualized measure of systemic functioning, i.e. the PQ. It is unfortunate that some equivalent measure of symptomatic status such as the GAS was not also used so that the correlation or covariation of symptomatology and systemic functioning over the course of treatment could be statistically analysed.

STUDY 5. Bennun, I. (1989)

Design. This single group process study is based on perceptions of the therapist furnished by members of thirty five families who participated the two Bennun studies just reviewed (Bennun, 1986, 1988). In 23 families an adult was symptomatic and in 12 the focus for concern was a childhood problem. There were 35 fathers; 35 mothers and 27 literate identified patients over the age of 13. Of these 10 were

fathers, 13 were mothers and 4 were children. Half of the families included in this study had received MFT and half had received ST. Therapy lasted between 7 & 10 sessions. At the beginning of session 2 literate family members complete the therapist rating scale described below. At the end of therapy, patients completed assessments of satisfaction with treatment-outcome and symptomatic status on the instruments described in the next section. The correlation between family members perceptions of the therapist and outcome were calculated for the whole sample and for the subsample of cases who had alcohol problems. Both analyses yielded similar results.

Measures. Clients' perceptions of the therapist were assessed with Schindler's (1983) Therapist Rating Scale. This is a 29 item schedule on which patients rate the therapist for 3 main sets of characteristics: positive regard/interest; competency/experience; activity/direct guidance. Satisfaction with treatment-outcome was assessed on a 5 point scale. For the 18 patients with alcohol problems Stockwell's (1983) Severity of Alcohol Dependence Questionnaire was used to assess symptomatic change.

Results. The perceptions of the therapist held by the father of a family had a much stronger association with therapeutic outcome than those of the mother, except when the mother was the identified patient. If fathers perceived the therapist as competent and active in providing direct guidance then therapy was more likely to be successful. The more divergent the views of the mother and the father of the therapist, the more likely therapy was to be unsuccessful. Clients' perceptions of therapists were unrelated to the form of therapy they received, i.e. MFT or problem solving therapy.

Comments. The centrality of the role of father's perceptions of the therapeutic process in determining outcome suggests that the notion of family hierarchy being based on generational status alone without reference to gender may be erroneous. This point has been central to feminist analyses of family therapy (e.g. Goldner, 1990). From a clinical perspective these findings suggest that engaging fathers early in the therapeutic process through the adoption of a competent and directive style should be a priority. The impact on outcome of fathers' perceptions of the therapeutic process in the later stages of therapy is an important question for further research. Does therapy lead to a more equal distribution of influence within the family as it progresses or does it reinforce the status quo?

That divergent parental opinions concerning the therapeutic process is associated with poor outcome suggests that therapists should avoid escalating conflict and disagreement between parents concerning their views of the therapeutic situation without facilitating the resolution of this conflict in the early stages of therapy. The impact on outcome of

divergent parental opinions in the later stages of therapy remains open for investigation.

Few service based studies and surveys of consumer views of therapy use standardized instruments to assess clients perceptions of therapists. The use of such a measure is the study's main strength. Its main weaknesses are that client perception were only measured at one point in the therapeutic process and no assessment of therapist behaviour was made so as to determine the precise behavioural correlates (from an outsider's perspective).

STUDY 6. Vostanis, P., Burnham, J., & Harris, Q. (1990)

Design. In this process study Expressed Emotion (EE) (Vaughan & Leff, 1976) was rated from unedited videotapes of the first, second and last sessions of the therapies of 12 families attending the Charles Burns Clinic in Birmingham. In 6 of the cases therapy was conducted by JB and QH was the therapist in the remaining 6 cases. During data collection, therapists were blind to the nature of the study. The clients were families with children who presented with conduct, emotional or relationship difficulties, 80% of whom were referred by the GP. Therapy lasted between 2 & 8 sessions.

Measures. EE comprises 5 subscales: emotional overinvolvement (EOI), critical comments, warmth, hostility and positive comments. A range of scores were obtained from rated videotapes for the first three of these scales. For the final two scales in most cases a score of nil was obtained.

Results. Both over-involvement and critical comments showed a significant reduction over the course of the first two sessions. Warmth did not increase significantly between the first and second session but did show an overall increase between the first and last session.

Comments. High EE scores in the families of schizophrenics have been associated with a high relapse rate for this disorder. It has been shown that behavioural, psychoeducational and supportive family interventions can lower EE and reduce this relapse rate (Berkowitz, 1988). Vostanis's study shows that MFT can reduce EE, albeit in a different population. An important question for further research is how changes in the family belief system facilitated by MFT lead to changes in the emotional climate of the family as assessed by the EE scale. What follows are some detailed hypotheses, based on attribution theory (Forsterling, 1988), which deserve investigation.

Parents who attribute their children's symptoms to illness (or 'being sick') probably respond with a high level of emotional overinvolvement. Those who attribute their children's problem behaviour to disobedience (or 'being bad') probably respond with a high

level of critical comments. MFT helps parents to see their child's symptomatic behaviour as part of a wider pattern of family interactions rather than as an intrinsic 'sick' or 'bad' characteristic of the child. This new way of construing the child's symptoms may empower the parents to explore new ways of alleviating the child's symptoms. Vostanis study suggests that this de-labelling or reframing process occurs early in MFT. Once the parent has consolidated the belief that the child's symptomatic behaviour is a function of the situation in which he finds himself and not an entrenched personal characteristic, it becomes possible for the parent to express warmth towards the child. Vostanis' study suggests that this process occurs later in therapy.

The key feature of this study is the use of a well validated observational measure of systemic functioning. It is unfortunate that parental attributional beliefs concerning the source of the index patients symptomatology were not assessed so as to test the more detailed hypotheses set out in the previous paragraph. It would also have been useful if some index of symptomatic change was included so that the covariation in symptomatology and systemic functioning over the course of therapy could have been documented.

STUDY 7. Manor, O. (1989, 1990a, 1990b)

Design. A cohort of 46 cases who received MFT informed services at Rownham's Centre for Families and Children were followed up in this single group outcome study. MFT theory and technique were used at Rownham's within the context of a range of social work services including family assessment, family treatment and consultation to social workers who had reached a therapeutic impasse in working with multiproblem families. In 19 cases referred children were placed at Rownham's Residential Unit for a brief period as an adjunct to outpatient MFT services. The average length of contact with the centre was about 7 months. The majority of cases were referred by social workers, and in most instances referrers were included in at least one MFT consultation. Data were gathered before and after treatment and at six month follow-up. It was not possible to follow up 4 families post-treatment and a further 2 cases were lost at 6 month follow up.

Measures. Referring social workers perceptions of the referred cases were assessed by a questionnaire, which was administered before treatment, after therapy and at 6 month follow-up. The questionnaire solicited data on presenting problems, current and previous family structure and functioning, and involvement with other services. Two principal outcome measures were also assessed by the questionnaire: perceived risk and perceived complexity. Both variables were assessed on four point scales. Risk referred to the social worker's perception that a member of the family, usually a child, was at risk of injury,

disablement or death. Complexity referred to the social worker's perception of the complexity of the family situation in terms of the number of people or agencies involved with the presenting problem and their related patterns of social interaction.

Results. Outpatient MFT along with the use of adjunctive residential facilities as necessary was associated with a significant overall reduction in the referring social worker's ratings of the risk and complexity of referred cases. Risk reduction was associated specifically with the placement of a child in a residential unit temporarily while MFT occurred. The reduction in a social worker's perception of case complexity was specifically associated with the family's participation in MFT. Despite the differential effects of MFT and residential placement on perceived risk and complexity there was a significant positive correlation between the two variables. High risk families were perceived by social workers as complex. Low risk families were seen as less complex.

Comments. The following hypotheses which specify the processes which link MFT and residential placement to the reduction of perceived complexity and risk deserve further investigation. Residential placement probably reduced perceived risk in this study by containing the children of dysfunctional families while the parents of these families and the referring social workers had an opportunity to explore new ways of dealing with their family problems in MFT. MFT itself probably reduced the perceived complexity in two ways. First, it may have helped the referring social worker develop a more coherent systemic hypothesis within which to conceptualize the role of various agencies in the problem determined system. Second, this hypothesis may have provided a framework from which to negotiate the inclusion or exclusion of involved agencies in problem resolving system.

The outstanding features of this study is its focus on perceptions of referrers rather than those of family members and the identification of perceived risk and complexity as meaningful variables in this type of research. Allowing for the usual limitation of single group outcome studies (noted in Table 18.2) the principal shortcoming of this work is the indeterminate reliability and validity of the perceived risk and complexity measures. The refinement of these measures is an important task for the future.

STUDY 8. Fitzpatrick, C., NicDhonnaill, C., & Power, A. (1989)

Design. Of 68 families followed up in this consumer survey, 50 agreed to participate. 24 families had received MFT and 26 had received ST. MFT was offered by trainees on a 2 year Family Therapy Training Programme at the Department of Child Psychiatry in the Mater Hospital, Dublin. Experienced systemic therapists offered trainees live

supervision using a one-way screen and telephone. The model of MFT employed drew on both the early ideas of the Milan team (Selvini-Palazzoli et al, 1978, 1980) and on Cecchin's later developments (Cecchin, 1987). ST, which was offered by a multidisciplinary child psychiatry team from the same hospital, involved individual assessment and treatment of the child and concurrent parent counselling. The MFT and ST groups were cohorts referred independently to either the Family Therapy Training Programme or the Child Psychiatry team from separate sections of the hospital's overall catchment area. Semi-structured family interviews were conducted 12-18 months after treatment by independent researchers. Each family's main therapist also completed a questionnaire. The families contained children under 18 most of whom were referred because of neurotic or conduct problems. Most were referred by the GP or the school. In most cases MFT and ST lasted for 2-6 sessions. MFT and ST groups were comparable on demographic variables.

Results. There was more frequent disagreement between therapist and family about the referral problem remaining a central focus of therapy in the MFT group than in the ST group. In the MFT group 42% of families said that their therapists disagreed with them about this matter. In the ST group disagreement occurred in only 16% of cases. Otherwise families opinions concerning the experience of MFT and ST and its effect on both symptom and system were comparable. In the case of both treatments about 3/4 of families reported sustained symptomatic improvement.

Comments. An important question arising from this study is the client's perceptions of the conditions under which disagreement between therapists and clients concerning the focus of therapy in MFT is perceived as useful in facilitating change. In MFT clients are offered a reframing of their presenting problems in systemic terms. If this difference is too small, the therapist's reframing of the situation will be assimilated into the clients original belief system without any alteration to it. If the difference is too large, the therapist's reframing will be rejected as irrelevant, outlandish or non-empathic. Reframings that are too similar or too different from the clients original belief system concerning the presenting problem will not facilitate therapeutic change. The difference between the client's original view of the problem and the therapists reframing of it must be sufficient to facilitate a therapeutic change in the client's belief system and related behaviour and feelings. The precise parameters of this difference from the client's perspective is a key question for future research in this area.

STUDY 9. Mashal, M., Feldman, R., & Sigal, J. (1989)

Design. In this consumer survey 76 individuals from 17 families who had received MFT at the Family therapy Department of the Jewish General Hospital were interviewed by telephone using a semi-standardized 12 item interview. The degree of psychopathology shown by family members and families as a whole was independently and reliably rated by two clinicians on the basis of information available in the case notes. MFT in this study was probably based on the early writing of the original Milan team (Selvini-Palazzoli et al., 1978, 1980). The average age of children in the families was 22 years, so the central lifecycle issue was 'leaving home' or individuation. All were difficult cases where previous therapy had been unsuccessful. Families attended for about 10 sessions on a monthly basis.

Results. Patients were more likely to view MFT as leading to positive personal and family change than parents. Just over 3/4 of patients describe MFT as effective but MFT was considered to be effective by just over 1/2 of parents. Almost 1/2 of all family members disliked MFT. For parents, this dislike was tied to a negative attitude towards the team behind the screen. For fathers, the long delay between sessions and the overall length of treatment also contributed to their dissatisfaction. Negative attitudes to MFT were not associated with videotaping consultations. Families who disliked MFT, particularly those containing a severely symptomatic member, sought other forms of further treatment.

Comments. A strength of this study is its empirical focus on factors that detract from client satisfaction. However, half of the families in this study found the use of a team and screen satisfying and also were satisfied with the way in which the schedule of therapeutic consultations was established. It is unfortunate that way in which the therapists managed these tasks successfully was not investigated in further detail. This is an important area for further research.

STUDY 10. Allman, P., Sharpe, M., & Bloch, S. (1989)

Design. In this clinical audit the case notes of the first 50 patients seen at the Warneford Hospital Family Clinic were reviewed by the clinical team using a standardized review form. Patients were adults (17-65 yrs) with histories of previous psychiatric intervention and 20% received concurrent pharmacological treatment during MFT. Most were single, living with their parents and had a diagnosis of neurosis. MFT lasted, on average, 4-5 sessions.

Results. In this study 2/3 of cases showed symptomatic improvement and 1/2 showed positive systemic change. Separation from family of origin was the most common systemic problem in a group of predominantly neurotic adults. The most common end-of

session-intervention (EOSI) was to show non-specific positive respect for the family and to offer hope. Less common was the direct offering of an alternative view of the problem (in the form of a partial or complete systemic hypothesis). It was rare for the team to use paradox or ritual prescription. Because of small cell frequencies crosstabulations of diagnostic categories, systemic themes and frequencies of various EOSIs were not reliably interpretable.

Comments. An important feature of this study was the attempt made to quantify the family issues upon which systemic hypotheses were based and the characteristics of EOSIs. However, frequency counts of EOSI characteristics is not a research method which holds much promise. More important is the patterning of EOSI characteristics and types over the course of therapy and the exploration of the relationship of these patterns of interventions to case type and outcome. For example it is of little use to the clinicians who conducted this audit to know that positive connotation was used frequently and ritual prescription rarely. Most clinicians would wish to know at what point during the course of therapy with a particular type of case was it useful to couple positive connotation with ritual prescription.

DISCUSSION

1. Symptomatic Change. A summary of the data on the therapeutic outcome for clients who have received MFT is contained in Table 18.3. MFT leads to symptomatic improvement in about 2/3 - 3/4 of cases. Deterioration occurs in under 1/10 of cases which have received MFT. MFT is helpful with a range of cases from routine adult and child psychiatric referrals to very difficult social work cases or chronic adult psychiatry cases. MFT is as effective in facilitating symptomatic change as problem focused family therapy and is sometimes more effective in facilitating positive systemic changes than problem focused therapy.

These data on symptomatic outcome and deterioration for MFT are comparable to outcome data for other forms of family therapy (e.g. Gurman & Kniskern, 1981; Gurman Kniskern and Pinsof, 1986, Hazelrigg et al, 1987, Markus et al, 1990) individual adult therapy (Garfield, 1981; Parloff et al, 1986) and individual child therapy (Kazdin, 1988).

2. Systemic Change. About 1/2 of cases show positive systemic change as a result of MFT. Improvement in marital and family functioning noted after therapy is sustained at 6 month follow-up and possibly longer. This finding is consistent across a variety of standardized and unstandardized self-report measures of systemic functioning.

Table 18.3. Ratings of outcome after MFT from 9 studies

	Study Number									
	1	2	3	4	6	7	8	9	10	
Symptomatic improvement after treatment										
Client	-	74	SI	80	-	-	-	-	-	-
Therapist	-	73	-	-	-	-	-	-	-	-
Researcher	54	-	-	-	-	-	-	-	-	-
Symptomatic improvement at follow-up										
Client	-	84	SI	100	-	-	71	67†	-	-
Therapist	-	-	-	-	-	70*	-	-	-	68
Researcher	88	-	-	-	-	-	-	-	-	-
Systemic improvement after treatment										
Client	0	CI	SI	CI	-	-	-	-	-	-
Therapist	-	-	-	-	-	70*	-	-	-	-
Researcher	-	-	-	-	SI	-	-	-	-	-
Systemic improvement at follow-up										
Client	-	CI	SI	-	-	-	-	73†	52	-
Therapist	-	-	-	-	-	-	-	-	-	-
Researcher	-	-	-	-	-	70*	-	-	-	-
Drop-out rate	28	30	25	25	-	13	26	22	-	-
Deterioration	-	7	-	0	-	-	-	6†	10	-
Sought further therapy	-	24	-	-	-	-	33	62	28	-

NOTE: CI = Comparative and significant improvement relative to control group.
 SI = Significant improvement relative to pre-therapy status. *This is a 'perceived risk' rating.
 †These scores have been averaged from mothers', fathers' and patients' responses.

Over the course of MFT family members observe changes in the frequency with which symptom related patterns of family interaction occur (as measured by the PQ). Parental criticism and over-involvement (as measured by the EE scale) decrease rapidly over the course of MFT and parental warmth towards the problem child increases more gradually as MFT progresses.

3. The Process of Engagement. The father's perceptions of the therapist in early sessions are more important than the mother's in determining the outcome of MFT. MFT is more likely to be effective where father's view the therapist as directive and competent, at least in the early sessions of therapy. More general reviews of the family therapy literature have yielded similar findings to these. Failure to

engage the father in therapy correlates with therapeutic dropout and poor outcome (Gurman & Kniskern, 1978). The technical skills of family therapy alone are insufficient for effective treatment. The therapist must also have developed relationship building skills (humour, warmth etc.) and structuring skills which give family therapy sessions focus and direction (Gurman & Kniskern, 1981).

4. Treatment Duration. A notable feature of MFT is its brevity. In this review, most treatments lasted between 5 and 10 sessions. This brevity of treatment, however, is not unique to MFT. In general reviews of family therapy, it has been concluded that effective outcome is usually yielded by treatments that last between 10 and 20 sessions (e.g. Gurman & Kniskern, 1981). In adult psychotherapy 15% of patients show measurable improvement before the first appointment, 50% of patients are measurably improved by 8 sessions and this figure rises to 75% after 26 sessions (Howard et al, 1986). In reviews of individual child therapy average duration of treatment has been estimated at about 10 sessions (Kazdin, 1988, Chapter 3).

5. Consumer's Views. About half of client's dislike MFT and this dissatisfaction is in part linked to specific aspects of MFT practice, i.e. screens, teams and the scheduling of therapy. Such ambivalence is not unique to MFT, or indeed to psychotherapy. Over 50% of clients in a cohort that had received structural or strategic family therapy at the Family Institute in Cardiff described treatment as 'uncomfortable' but despite this 89% viewed therapy as helpful (Frude & Dowling, 1980). 68% of Sigurd Reimers (1989) cohort found their initial contact with his Structural Family Therapy Clinic uncomfortable, but 84% said they would return for further therapy. The concerns about the use of screens and teams in family therapy identified in this review are in line with those described by Howe (1989) and must be a stimulus for MFT practitioners to explore ways in which the technology of MFT can be used to empower clients rather than arouse dissatisfaction. A spate of recent papers have described such pioneering explorations (Pimpernell & Treacher, 1990; Birch, 1990; Hoffman, 1990; Anderson, 1990; Cade, 1990)

6. Consultation and Co-ordination. MFT consultation to cases where therapists and families have reached a therapeutic impasse leads to greater short and long term symptomatic change, than the absence of such consultation. MFT (along with adjunctive residential containment of children at risk where necessary) leads to a reduction in the referring worker's perception of case complexity and risk. MFT probably reduces case complexity. Residential containment probably reduces risk.

7. Measurement of Symptoms and Systems. In future outcome research the use of goal attainment scaling to assess

symptomatic change and the use of the Sharpiro's personal questionnaire to assess systemic change is recommended. In future process research this review suggests that the use of the EE scales and client perception of therapist scales would be fruitful. Of particular interest would be the investigation of the differences on these measures between cases that show improvement and deterioration. Also of interest would be changes on these measures in relation to the occurrence of "critical therapeutic moments" or "highly valued micro-interventions".

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