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Contrasting four major family therapy paradigms: implications for family therapy training

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Four major paradigms of family therapy are contrasted: affective-experiential, structural, strategic and Milan. The differences are defined according to the way in which therapists think and behave in relation to their premises about change, and they are discussed under the following headings: historical roots and understanding of symptom formation; therapists' stance and techniques used in change; focus, goals and locus of change; and time perspective in change. Some suggestions are made with regard to training family therapists based on the differences that emerge when contrasting these models of family therapy.

Introduction

Beginning family therapists may find the task of deciding which family therapy 'school' to follow a bewildering experience, given the number of choices that are now available. Opting prematurely for a unitary model has the drawback of reducing the *breadth* of their knowledge (Lebow, 1984), whereas choosing an integrative approach too early may lead to a lack of *depth* and *clarity* in their understanding of family therapy (Liddle, 1982). It is my belief that the pitfalls could be avoided if training family therapists assimilated a *number* of therapy models. They would then be in a better position to decide which paradigm suits them if they choose to become 'specializers'. If they choose to become 'integrators', this process will be enhanced by their more in-depth knowledge of the various 'ingredients'.

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Previous attempts have been made to contrast various family therapy models, i.e. structural versus strategic (Fraser, 1982), strategic versus Milan (MacKinnon, 1983), structural versus Milan (Minuchin *et al.*, 1983). Although useful, these comparisons contrast only two models at a time, and none includes an affective model. The aim of this paper is first to define and contrast criteria from four family therapy paradigms (including affective) and then to describe a format for training beginning family therapists using these criteria as a basis (see Appendix).

Contrasting the four family paradigms of family therapy

It is not the aim of this paper to show one paradigm as being better than the other, indeed there is no evidence that this is so (Gurman and Kniskern, 1981), but rather to highlight their differences and similarities. The four models chosen, i.e. affective-experiential, structural, strategic and Milan, will be discussed under the following headings: historical roots and understanding of symptom formation; therapists' stance and techniques used in change; focus, goals and locus of change; and time perspective in change.

It is not in the scope of this paper to give a full account of each paradigm with examples, etc. This can be obtained from the extensive reference list which is also intended to function as a bibliography for a training workshop.

Historical roots and understanding of symptom formation

Affective-experiential family therapy

The affective-experiential group are not a unitary school of family therapy but are representatives of the 'humanistic growth potential' movement that emerged in the U.S.A. in the sixties. Satir (1972, 1982) is probably the most well-known representative of this group, and could be considered as a prototype of this 'school'.* Other representatives are Gestalt family therapy (Kempler, 1973; Kaplan and Kaplan, 1978), transactional analysis family therapy (Erskine, 1982) and transactional analysis-Gestalt combinations (McClendon and Kadis, 1983). Satir has drawn on ego psychology, psychodrama,

* Whitaker and Keith's (1981) Symbolic-experiential therapy has much in common with this 'school', but is more complex and abstract and, therefore, more difficult to teach to beginners, hence it has been omitted from this paper.

Gestalt therapy and transactional analysis for her inspiration and knowledge (Satir, 1982; p. 25).

Symptoms are thought to arise in families where the *self-esteem* of the individual members is not mutually enhanced, and where important *affects* such as anger, resentment, warmth and concern are not communicated in a clear and direct manner. Destructive communication patterns reduce self-esteem, which in turn leads to further destructive communication, etc. (Satir, 1972). Problems can also arise when parents project their own 'unfinished business' that they have internalized from their past onto their spouses or children. In this sense, these therapists see a dynamic interplay between the intrapsychic and interpersonal domains (Kaplan and Kaplan, 1978; Erskine, 1982).

Structural family therapy

Minuchin (1974, 1978) broke away from traditional psychodynamic ways of understanding families when he devised the structural approach to family therapy. In the mid 60s, Haley left the Mental Research Institute in Palo Alto (hereafter called MRI) to join Minuchin in Philadelphia and worked with him for the next ten years. The mutual influence of Haley's strategic ideas and Minuchin's structural views on each other's work is very evident (see later).

Structural family therapists believe that problems emerge in families when their boundaries (that define structures) are not clear and when they have hierarchical problems, with cross-generational coalitions and alliances. Families with diffuse boundaries are said to be enmeshed and those with rigid boundaries disengaged (Minuchin *et al.*, 1967; Minuchin, 1974, 1978). Structural family therapists (given that they make allowances for cultural differences) have a fairly fixed and clear idea of what a 'healthy' structural map of a family 'should' look like, i.e. clear flexible boundaries between the parental subsystem, the child subsystem and the outside world.

Strategic therapy

These therapists are strategic in the sense that they take the responsibility for defining what happens during treatment and design specific strategies to create change in the family system (Haley, 1973). This 'school' can be divided into two major subgroups: Haley's structural-strategic group (Haley, 1973, 1980, 1984) and the MRI

group (Watzlawick *et al.*, 1974; Fisch *et al.*, 1982). Although these two groups have much in common, they also have fundamental differences (Hoffman, 1981; MacKinnon, 1983). They share common roots with Bateson in that both Haley and Weakland (who is part of the MRI group) were part of the Bateson research project in Palo Alto in the fifties (Bateson *et al.*, 1956). Both Haley and the MRI group were profoundly influenced by Milton Erickson who could be considered 'the father' of strategic therapy [see Haley (1973)]. Haley, however, broke away from Bateson's notion of circularity and non-hierarchical relationships and joined Minuchin in 1966 in Philadelphia, having more affinity with Minuchin's structural and hierarchical ideas. Ten years later, Haley left Minuchin and moved to Maryland to start his own family therapy institute where he continued with Madanes to explore strategic therapy in an hierarchical framework (Madanes, 1981). The MRI group retained Bateson's ideas of circularity, particularly in their understanding of the recursive relationship between problem and solution interaction.

Haley sees problems as arising in families where there are incongruent and confused hierarchies. Symptomatic members are often triangulated in cross-generational coalitions that reinforce and contribute to the confused hierarchies (Haley, 1980). The MRI group differ from the hierarchical view of symptom formation. They see symptoms arising out of faulty interactional patterns where the very efforts that family members make to correct problems, create and perpetuate problems, i.e. they see attempted solutions as the problem (Watzlawick *et al.*, 1974).

Milan approach

The Milan approach is associated with a group of psychoanalytically trained psychiatrists—Selvini Palazzoli, Boscola, Cecchin and Prata—based in Milan, Italy (Selvini Palazzoli *et al.*, 1978, 1980; Tomm, 1984*a*, *b*; Campbell and Draper, 1985). Tomm (1984*a*), in his historical review, describes four periods in the Milan team's developments. The first period, including a psychoanalytic approach, began in 1967 and ended in 1971 when they began to study the works of Watzlawick and colleagues from the MRI group in Palo Alto. The second period culminated in their book *Paradox and Counter-paradox* (Selvini Palazzoli *et al.*, 1978), which has much in common with the strategic 'school'. The third period began in 1975 when they began to study Bateson (1972) in depth. Like Bateson, they were interested in how different

levels of meaning in a system were related to one another in a circular fashion and disagreed with the notion of hierarchy. They were more interested in pattern and information than structure and form. Their clinical application of these ideas is well represented in their paper 'Hypothesising—neutrality—circularity' (Selvini Palazzoli *et al.*, 1980).

The Milan group see pathology arising out of systems that operate on the basis on *epistemological errors*, i.e. the family members fail to see the circular connections to their behaviour, have a linear view of problems, see themselves having unilateral control over one another and believe that there is an objective reality, e.g. 'I am correct, you are wrong' (see Dell, 1985; p. 4). These families are informationally closed and have fixed 'beliefs'. Maturana and Varela (1980) are emerging as an important source of inspiration in the evolving field of Milan-type therapy. They believe that individuals are *structure-determined* and that they can only change in as much as their structure allows. Thus, there cannot be *instructive interaction*, i.e. we cannot make people change, we can only create perturbations that may stimulate change in their system. See Dell (1985) and Hoffman (1985) for a fuller elaboration of these views. Thus, Bateson and Maturana share a common disagreement with the notions of hierarchy and power in the change process of systems. From these views, the Milan team have derived the therapist stance of neutrality (see later).

Therapists stance and techniques

Affective-experiential therapy

These therapists become involved in a therapeutic *encounter* with family members, encouraging mutually open, honest and direct expression of emotions. The therapist's *self-disclosure* has four main functions. (1) To model open and honest communication of feelings. (2) To demonstrate that 'we're all part of the human race', thus reducing the hierarchy between therapist and family members. (3) To enhance the level of empathy in the therapeutic context. (4) To give feedback on how the individual's behaviour affects the therapist and family members. These therapists aim to create a context of trust and acceptance, a safe place where people will be prepared to take *risks* in revealing and sharing their innermost vulnerable feelings which are often masked by more distancing and defensive behaviours. This sharing of 'real' emotions strengthens the emotional bonds in the family (Greenberg and

Johnson, 1985). Affective-experiential therapists are active and charismatic yet are careful not to undermine the client's autonomy and *self-healing potential*, i.e. they are facilitative rather than instructive (Satir, 1972; p. 13). These therapists have a strong belief in the innate potential of each human being: 'I regard people as miracles, and the life within them as sacred' (Satir, 1972; p. 40). Affective-experiential therapists encourage *learning through action*, e.g. family sculpting is a useful technique for exploring and dealing with interpersonal boundary issues (Duhl *et al.*, 1973). The Gestalt 'two chair' technique is a useful way of helping family members 're-own' their 'unfinished business' that is often 'projected onto' other family members (McClendon and Kadis, 1983). They encourage physical contact between family members, and embrace and hold family members themselves. They encourage people to *experiment* with new behaviours, with the hope that something new and useful will arise. Affective-experiential therapists see change occurring when family members develop an *awareness of self* in the context of the 'I-thou' relationship (Kaplan and Kaplan, 1978).

Structural family therapy

Structural family therapists, like the affective-experiential ones, believe that they need to 'get into' the family in order to diagnose and implement change, a process they call *joining* (Minuchin, 1974; Minuchin and Fishman, 1981).

> Like an anthropologist, the therapist joins the culture with which he is dealing . . . He experiences the pressures of the family system. At the same time he observes the system . . . unlike the anthropologist, the therapist is bent on changing the culture he joins (Minuchin, 1974; p. 124).

The initial joining is facilitated by the therapist's process of *accommodation*, i.e. acceptance of the family's values and rules (Minuchin, 1974; p. 123). It is the *joining that makes restructuring possible* by creating a context of trust and faith in the therapist as a leader and director of the change process (Minuchin and Fishman, 1981; p. 32). As Minuchin says, 'joining is the glue that holds the therapeutic system together' (Minuchin and Fishman, 1981; p. 32).

The therapist uses him/herself to probe the family system in order to test its flexibility and understand its structure. Minuchin (1974; Minuchin and Fishman, 1981) has devised many techniques to restructure the family. Structural family therapists get the family

members to enact transactional patterns rather than describe them. They disrupt functional coalitions and form alliances with one family member against the other. They will keep one member 'down' while 'building up' another. They encourage action, e.g. by changing seats, to emphasize restructuring and to clarify individual and subsystem family boundaries. They escalate stress and attempt to unbalance the system, especially when families are rigid and 'stuck'. They set tasks for the family to do, to be enacted in the session and to be done at home. These are then evaluated at the next session. They manipulate affect by 'putting on' a mood that is symmetrical or complementary to the family's mood. The influence of Haley is seen, especially in the way symptoms are utilized, e.g. relabelling of, exageration of and prescription of symptoms (Minuchin, 1974; p. 153; Minuchin and Fishman, 1981; p. 244).

Strategic family therapy

Structural-strategic and MRI therapists take an objective stance, that is *'meta' to the family system*, i.e. they do not join with the family, nor do they stress the use of affect or 'use of self'. They avoid challenging the family 'defences' and try to effect change *out of the awareness* of the family members (Haley, 1973). Like the structural family therapists, both groups of strategic therapists make use of 'power tactics' in establishing 'control' over the symptomatic behaviour. The MRI group are more *covert* in doing this and often appear laid back. They adopt a 'Judo-like' stance, using the patient's momentum and 'energy' to promote change. This is done by use of 'paradoxical' techniques such as reframing, positive connotation and prescribing the symptom (Watzlawick *et al.*, 1974). As Hoffman has stated, 'They go one down to go one up' (Hoffman, 1985; p. 382). The Haley group tend to be more *overt* in the use of power, being more active and directive as exemplified in Haley's *Ordeal Therapy* (Haley, 1984).

Both groups function in the spirit of Erickson in that they use strategies such as reframing, prescribing and encouraging the symptom, etc., in order to change the symptom. [See Haley (1980), Madanes (1981) and Watzlawick *et al.* (1974).] In the Haley model, strategic interventions are mostly in the service of disrupting pathological coalitions and hierarchies, whereas in the MRI model, strategic interventions are more in the service of disrupting pathological interactional patterns, particularly those related to the problem-solution context. They attempt to shift the family from first-

order attempts at change, i.e. 'cosmetic' changes, to a second-order level of change that involves a change in the fundamental 'rules' and patterns of the family (Watzlawick *et al.*, 1974).

A team behind a one-way mirror is frequently used by both groups of strategic therapists to help plan strategies. They may also become involved in the interventions (Papp, 1980).

Milan therapy

These therapists adopt the stance of *neutrality* (Selvini Palazzoli *et al.*, 1980; Tomm, 1984*b*) in that they remain neutral to how or whether the family should change and avoid taking responsibility for change. They believe that the family members know best and are able to find their *own* unique solutions. They do not take sides or attach 'blame' to anyone and are non-judgemental. Like the affective-experiential therapists, they have an innate belief in the family's 'self-healing' potential (Bateson, 1972). Unlike the structural and strategic therapists, Milan-systemic therapists do not take an instructive or directive stance (Dell, 1986). They are 'low-key' and avoid being charismatic.

They work with a team who take a 'meta' (objective) position behind a one-way mirror, and are thus able to help the therapist retain his/her neutrality and to develop *hypotheses* (Selvini Palazzoli, 1980; Tomm, 1986). Each hypothesis arises out of information obtained from the system, verbally and non-verbally, and acts as a guide to the therapist in obtaining new information, which is then used to further enhance and change the hypothesis, which is always seen to be an evolving and changing one.

The technique of *circular questioning* is used to elicit information about the interrelatedness of the components of the system, which includes the therapist, team, family, referral source, other helping agencies, etc. (Tomm, 1986). These questions elicit new information that is useful for the therapist *as well* as for the family. It has been found recently that certain forms of questioning may be sufficient to promote change without resorting to major interventions (Tomm, 1987).

They do at times, though, deliver an intervention at the end of the session that involves reframing the symptom. They differ from the MRI group in that their questions, hypotheses and interventions involve the symptom *and* the wider system, whereas the MRI group restrict these processes to the narrower problem-solution context. The Milan group also prescribe tasks and rituals at times but are not

concerned if these are not done (Tomm, 1984*b*) which is in marked contrast to the structural and strategic therapists who may insist that the 'homework' is done (Haley, 1984).

Focus goals and locus of change

Affective-experiential therapists

These therapists focus mostly on the nuclear family and, at times, the extended family, but seldom include other components of the wider system. They frequently do individual work in the family sessions. Their goals are not just symptom removal, but rather personal and family growth. These therapists see the locus of change as being more *in* the therapy sessions than outside.

Structural family therapists

These therapists focus mainly on the nuclear family and, at times, the extended family, but they do not stress the wider system. Their goals are to change the family structure and, therefore, family functioning. They see most change occurring *in* the therapy sessions, but will set tasks to enable some change to occur outside.

Strategic family therapists

Both the MRI and Haley structural-strategic therapists concentrate on the nuclear and, at times, the extended family, but do not stress the wider system. The Haley structural-strategic therapists generally do not see individuals or couples on their own, unless for strategic reasons, but the MRI group commonly see individuals or couples in order to treat the family, often without seeing the other members at all (Weakland, 1983).

The goals of the MRI and Haley groups are *symptom removal only* (broader change is inevitable as well, given the connectedness of the symptom and the system). The MRI group would see themselves planting the 'seeds' of second-order change in the therapy session, but would expect the therapeutic effects to develop *outside* the session, as would the structural-strategic therapists, who would also expect change to occur in-session, given that they also work structurally.

Milan systemic therapy

This group focus on the wider system and not just the nuclear and extended family. They may spend as much or more time with the network of professional helpers as with the family itself. They see

family therapy as only *one* way of intervening in a system (Cecchin, 1986). If these therapists have any goals at all, it is *not* to have a goal—which is in keeping with their belief in the family's self-healing potential and its capacity to make its own choices. These therapists see the locus of change as being more *outside* the therapy sessions and, like the MRI group, see the 'seeds of change' as being 'planted' during the session.

Time perspective in change

Affective-experiential therapy

These therapists see change occurring in a *continuous* stepwise fashion. The therapist 'stands' firmly behind the family members so that they do not 'slip back' and 'lose ground'. They, therefore, prefer regular and frequent sessions, usually once per week, until the family is able to maintain its own progress. At times, they will have time-extended marathon sessions, in order to give greater intensity and continuity to their work. These therapists work in the 'here and now' but are interested in past history in as much as they believe that the past influences people's 'belief systems', which then influences their current interaction (Erskine, 1982). Hence, their approach is to deal with the 'there and then' in the 'here and now'.

Structural family therapy

These therapists also adopt a *continuous* framework for change and will work closely with the family until such time as the family members are able to maintain their new structure. These therapists attach little importance to past history and work essentially in the 'here and now'. Sessions are usually one per week until restructuring has occurred.

Strategic family therapy

Both strategic groups emphasize *discontinuous* second-order change, i.e. they see change occurring in 'leaps' rather than in a stepwise fashion. Their work is brief-focused therapy, and hence they would see the family about once a week for six to ten sessions only. Haley's structural-strategic group will, at times, see change as operating in a continuous way which is in keeping with the structural elements in their approach. Neither of the strategic groups put any emphasis on the past and work only in the 'here and now'.

Milan therapy

Like the MRI group, these therapists expect change to occur in a *discontinuous* manner and hence are happy to see the family only once per month. This lengthy time interval also gives the family time to find its own unique solutions. The number of therapy sessions vary with each case and can range from one to twenty. These therapists, unlike the others, will often terminate therapy 'prematurely', before obvious change has occurred (Tomm, 1984*b*). Therapists see past, present and future as interlinked, and their circular questions often address and link these different time frames (Penn, 1985).

Description of family training workshop

The workshop/seminar format to be described makes use of two major principles designed to enhance the learning experience. They are (1) learning through difference and (2) learning through experience and action.

Learning through difference

When an issue to be understood is compared to something different, it often takes on a clearer meaning. This view is stated by Bateson (1972) when he says, 'information is a difference'. This is especially so when the information to be gained is relative to something else and not absolute, as is often the case with human behaviour. Thus, the directive and active stance of the structural therapist can best be understood in relation to the more indirect and passive stance of the Milan therapist; continuous change can be understood in relation to discontinuous change; teamwork can be understood and evaluated in relation to single therapist work, etc. Contrasting not only 'sharpens' and 'brings forth' the information to be learned, but also 'sets the stage' for lively debate between proponents for and against a certain technique or belief.

Learning through experience and action

The value of learning through experience and action is well known. Techniques like rôle-playing with video feedback have become part of most family therapy training programmes but have only been

described in a few instances (Churven, 1977; Wingarten, 1979). Having trainees simulate being 'family members', 'therapists', 'supervisors', etc., has many advantages, e.g.

(1) It gives them first-hand knowledge about being a 'family member' and hence increases their empathy for 'real' family members.
(2) It enables new trainees to practise their skills without the fear of failing or harming their patients.
(3) They can experiment with new ideas that they may be reluctant to try on 'real' families.
(4) They are able to benefit from the feedback of the 'family members', something that is difficult to get from 'real' families.
(5) In general, I have found that rôle-playing enhances trainees' self-awareness and confidence and also tends to help the training group as a whole develop a close and trusting working realtionship.

There are potential drawbacks in simulated family therapy exercises, e.g.

(1) A blurring can occur between the rôle taken on by an individual and the *actual* character traits that could lead to situations where personal conflicts inherent in 'real' working relationships become enacted in the rôle-play.
(2) Rôles can be carried over to their real-life situations, in much the same way as an actor in a 'soap opera' is seen to have those characteristics off the television.

These difficulties can be obviated by careful and sensitive facilitation by the seminar leader and by taking care that the rôle players 'de-rôle' after each session, i.e. they 'break-loose' their identification with the character they were playing by making an open declaration such as 'I am not Johnny the rebellious drug addict, but David, a responsible clinical psychologist', etc. In general, the advantages of rôle-playing far outweigh the disadvantages, and it allows trainees to understand the differences between the different paradigms from first-hand experience.

Various ways of using simulated family therapy

How training workshops are organized and structured will depend on the size and the needs of the training group. Some trainers may prefer to limit the number of paradigms to be contrasted to only two or three.

If all four models of family therapy are to be assimilated and contrasted successfully, the author would suggest (from experience) that a minimum of two hours per week over a two-year period would be required to do justice to this task. Simulations are, at times, best done in small groups with an appointed observer. The small groups then often meet as a large group at the end of the exercise to report on their perceptions and experiences. At other times, the task may best be carried out in a large group format with a central rôle-play that is observed by the rest of the group. In some cases, there may be multiple levels of simulation and observation, for example, a simulated 'family' is seen by a simulated 'therapist' who is assisted by a simulated 'team'. Observations can be made at all of these levels of interaction. These exercises can be videotaped for analysis and discussion at the same or subsequent workshops.

In my experience, it is best for the first paradigm to be learned *in toto*, using the criteria defined above as a basis. Relevant reading should be done prior to each workshop and should be integrated into clinical discussions. Once one model has been fairly well assimilated, the second one can be learned and contrasted with the first, the third with the second and first, and the fourth with the third, second and first. During the learning process, much of the simulation is done 'piecemeal' in the sense that the exercise might involve rôle-playing of only one or two criteria at a time, e.g. practising joining, experimenting with reframing, trying out a neutral stance, etc. These 'mini' exercises are important when trying to learn the components of each paradigm, but it is also important to play out some complete sessions to help the student obtain a full 'Gestalt' of each model.

Towards the end of the training programme, a 'family' should be selected to be interviewed in all four family therapy paradigms. They are given a basic 'script' about the family dynamics, personality types and typical patterns of interaction, and are then encouraged to improvise around this scenario. The family members and the family script should be kept as constant as possible to enable the same people to experience the different approaches first hand. Four different 'therapists' are selected to represent each paradigm. A 'supervisor' is appointed to help the therapist remain true to the models of family therapy that they are using. Four different family assessments are done on the same 'family', spaced one week apart to try and keep the boundaries between each paradigm clear. The rich material produced from these interviews is best exploited by videotaping and then discussing at subsequent workshops. A further option is to edit the

tapes in such a way that the criteria for each paradigm follow each other in sequence, thus making contrasting immediately possible.

Conclusion

It is hoped the the method of training beginning family therapists by contrasting specific criteria described above will help them gain a broad yet deep knowledge of family therapy. Most importantly, it is hoped that by experiencing these paradigms first hand as 'patient' and 'therapist', trainees would be able to gain insight into their own strengths and weaknesses and hence be more able to decide which model or models of therapy they are best suited to, either as 'specializers' or 'integrators' in their future learning.

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APPENDIX. *Criteria for contrasting four major family therapy paradigms*

	Affective-experiential	Structural	Strategic		Milan
			Haley	MRI	
Roots	Modified psychodynamics. Human potential movement	Minuchin; Haley—to some extent	Erickson; Bateson—to some extent	Erickson; Bateson—to some extent	Bateson; MRI—to some extent
Symptom formation	Inadequate or inappropriate communication of important affects. Projection of disowned conflicts onto others. Low self-esteem. Lack of awareness of self/other	Pathological family structure and disturbed boundaries	Pathological hierarchies and cross-generational coalitions	Attempted solutions become problems	Fixed family beliefs. Linear view of problem
Therapist stance	Use of self in the service of encountering and enhancing 'I-thou' relationship. Active, directive, charismatic, facilitating. Recognize family's self-healing potential	Use of self in the service of joining and restructuring. Active, directive; charismatic, instructive	Little overt use of self except when working in structural mode. Active, directive, charismatic, instructive	No overt use of self. Passive, non-directive. Go one down to be one up. Covertly instructive	Neutral stance, no overt use of self. Passive, non-directive. Non-instructive. Recognize family's self-healing potential
Special techniques	Rôle-play, enactment and experimenting, to encourage emotional contact	Joining. Restructuring techniques, e.g. unbalancing, stimulating, transactions, enactments, etc.	Restructuring techniques at times	No restructuring techniques	Neutrality, hypothesizing and circular questioning
			Symptoms—focused 'paradoxical' techniques, e.g. positive connotation, reframing, prescribing symptom, etc. (both Haley and MRI)		*System*—focused 'paradoxical' interventions

APPENDIX. (*cont.*)

	Affective-experiential	Structural	Strategic		Milan
			Haley	MRI	
Focus of therapy	Nuclear family. At times extended family. 'Individual therapy' in family context	Nuclear family. At times extended family	Nuclear family. At times extended family (both Haley and MRI)	'Family therapy' with individuals and couples	Ecosystem
Goals of therapy	Family and individual growth	Change family structure and therefore functioning	Symptom removal (both Haley and MRI)		Systemic change
Locus of change	Mostly in session	Mostly in session	In and out of session	Mostly out of session	Mostly out of session
Time frame	Continuous change	Continuous change	Continuous and discontinuous change	Discontinuous change	Discontinuous change
	Sessions one per week	Sessions one per week.	Sessions usually one per week		Sessions usually one per month.
	No. of sessions flexible, (can vary from four to forty).	Contract six to ten sessions	Contract six to ten sessions (both Haley and MRI)		No. of sessions flexible (can vary from one to twenty).
	There and then in the here and now	Here and now	Here and now	Here and now	Past-present-future recursively linked