

Structural Family Therapy¹

DEFINITION

Structural family therapy is a model of treatment based on systems theory that was developed primarily at the Philadelphia Child Guidance Clinic, under the leadership of Salvador Minuchin, over the last 15 years. The model's distinctive features are its emphasis on structural change as the main goal of therapy, which acquires preeminence over the details of individual change, and the attention paid to the therapist as an active agent in the process of restructuring the family.

HISTORICAL DEVELOPMENT

Structural family therapy was the child of necessity, or so the student may conclude in tracing the origins of the movement back to the early 1960s, to the time when Salvador Minuchin was doing therapy, training, and research at the Wiltwyck School for Boys in New York. Admittedly, our historical account does not need to start precisely there, but the development of a treatment model—no less than the development of an individual or a family—can only be told by introducing a certain punctuation and discarding alternative ones.

It would be possible to choose a more distant point in time and focus on Minuchin's experience in the newborn Israel, where *families* from all over the world converged carrying their bits of common purpose and their lots of regional idiosyncrasies, and found a unique opportunity to live the combination of cultural universals and cultural specifics. Or, reaching further back, one could think of Minuchin's childhood as the son of a Jewish family in the rural Argentina of the 1920s, and wonder about the influence of this early exposure to alternative cultures—different rules, different truths—on his conception of human nature. Any of these periods in the life of the creator of structural family therapy could be justified as a starting point for an account of his creation. The experiences provided by both are congruent with philosophical viewpoints deeply rooted in the architecture of the model; for instance, that we are more human than otherwise, that we share a common range of potentialities which each of us displays differentially as a function of his or her specific context.

But the Wiltwyck experience stands out as a powerful catalyst of conceptual production because of a peculiar combination of circumstances. First of all, the population at Wiltwyck consisted of delinquent boys from disorganized, multi-problem, poor families. Traditional psychotherapeutic techniques, largely developed to fulfill the demands of verbally articulate, middle-class patients besieged by intrapsychic conflicts, did not appear to have a significant impact on these youngsters. Improvements achieved through the use of these and other techniques in the residential setting of the school

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tended to disappear as soon as the child returned to his family (Minuchin, 1961). The serious concerns associated with delinquency, both from the point of view of society and of the delinquent individual himself, necessarily stimulated the quest for alternative approaches.

The second circumstance was the timing of the Wiltwyck experience: it coincided with the consolidation of an idea that emerged in the 1950s—the idea of changing families as a therapeutic enterprise (Haley, 1971). By the early 60s, family therapy thinking had become persuasive enough to catch the eye of Minuchin and his colleagues in their anxious search for more effective ways of dealing with juvenile delinquency. Finally a third fortunate circumstance was the presence at Wiltwyck of Braulio Montalvo, whom Minuchin would later recognize as his most influential teacher (Minuchin, 1974, p.vii).

The enthusiastic group shifted the focus of attention from the intrapsychic world of the delinquent adolescent to the dynamic patterns of the family. Special techniques for the diagnosis and treatment of low socioeconomic families were developed (Minuchin & Montalvo, 1966, 1967), as well as some of the concepts that would become cornerstones in the model exposed a decade later.

Approaching delinquency as a family issue proved more helpful than defining it as a problem of the individual; but it should not be inferred that Minuchin and his collaborators discovered the panacea for juvenile delinquency. Rather, they experienced the limitations of therapeutic power, the fact that psychotherapy does not have the answers to poverty and other social problems (Malcolm, 1978, p. 70).

Nowadays *Families of the Slums* (Minuchin, Montalvo, Guerny, Rosman & Schumer, 1967), the book that summarizes the experience at Wiltwyck, will more likely be found in the Sociology section of the bookstore than in the Psychotherapy section. But the modalities of intervention developed at Wiltwyck, and even the awareness of the limitations of therapy brought about by their application, have served as an inspirational paradigm for others. Harry Aponte, a disciple of Minuchin, has worked on the concept of bringing organization to the underorganized family through the mobilization of family and network resources (Aponte, 1976b).

From the point of view of the historical development of Minuchin's model, the major contribution of Wiltwyck has been the provision of a nurturing and stimulating environment. The model spent its childhood in an atmosphere of permissiveness, with little risk of being crushed by conventional criticism. Looking retrospectively, Minuchin acknowledges that working in "a no man's land of poor families," inaccessible to traditional forms of psychotherapy~ guaranteed the tolerance of the psychiatric establishment—which had not accepted Nathan Ackerman's approach to *middle-class* families (Malcolm, 1978, p. 84).

The possibility to test the model with a wider cross-section of families came in 1965, when Minuchin was appointed Director of the Philadelphia Child Guidance Clinic. The facility was at the time struggling to emerge from a severe institutional crisis—and, as Minuchin himself likes to remind us, the Chinese ideogram for "crisis" is made of "danger" and "opportunity." In this case the opportunity was there to implement a systemic approach in the treatment of a wide variety of mental health problems, and also to attract other system thinkers to a promising new pole of development for family therapy. Braulio Montalvo also moved from New York, and Jay Haley was summoned from the West Coast.

Haley's own conceptual framework differs in significant aspects from that of Minuchin, but undoubtedly the ideas of both men contributed a lot to the growth and strengthening of each other's models, sometimes through the borrowing of concepts and techniques, and many times by providing the contrasting pictures against which the respective positions each became better defined. Together with Montalvo, Haley was a key factor in the intensive training program that Minuchin wanted and had implemented at Child Guidance Clinic. The format of the program, with its emphasis on live supervision and videotape analysis, facilitated the discussion and refinement of theoretical concepts and has been a continuous primary influence on the shaping of the model. The preface to *Families and Family Therapy* (Minuchin, 1974) acknowledges the seminal value of the author's association with Haley and Montalvo.

While Minuchin continued his innovative work in Philadelphia, the clinical and research data originating in different strains of family therapy continued to accumulate, up to a point in which alternative and competitive theoretical renderings became possible. The growing drive for a systemic way of looking at behavior and behavior change had to differentiate itself from the attempts to absorb family dynamics into a more or less expanded version of psychoanalysis (Minuchin, 1969, pp. 179—187). A first basic formulation of Minuchin's own brand of family therapy was almost at hand and it only needed a second catalyst, a context comparable to Wiltwyck.

The context was provided by the association of Philadelphia Child Guidance Clinic with the Children's Hospital of Philadelphia, which brought Minuchin to the field of psychosomatic conditions. The project started as a challenge, in many ways similar to the one posed by the delinquent boys of Wiltwyck. Once again the therapist had to operate under the pressures of running time. The urgency, of a social nature at Wiltwyck, was a medical one at Philadelphia. The patients who first forced a new turn of the screw in the shaping of Minuchin's model were diabetic children with an unusually high number of emergency hospitalizations for acidosis. Their conditions could not be explained medically and would not respond to classical individual psychotherapy, which focused on improving the patient's ability to handle his or her own stress. Only when the stress was understood and treated in the context of the family could the problem be solved (Baker, Minuchin, Milman, Liebman & Todd, 1975). Minuchin's team accumulated clinical and research evidence of the connection between certain family characteristics and the extreme vulnerability of this group of patients. The same characteristics—enmeshment, over protectiveness, rigidity, lack of conflict resolution—were also observed in the families of asthmatic children who presented severe, recurrent attacks and/or a heavy dependence on steroids (Liebman, Minuchin & Baker, 1974; Minuchin, Baker, Rosman, Liebman, Milman & Todd, 1975; Liebman, Minuchin, Baker & Rosman, 1976, 1977, pp. 153—171).

The therapeutic paradigm that began to evolve focused on a push for clearer boundaries, increased flexibility in family transactions, the actualization of hidden family conflicts and the modification of the (usually overinvolved) role of the patient in them. The need to enact dysfunctional transactions in the session—prescribed by the model so that they could be observed and corrected—led therapists to deliberately provoke family crises (Minuchin & Barcai, 1969, pp. 199-220), in contrast with the supportive, shielding role prescribed by more traditional approaches. If the under organized families of juvenile delinquents invited the exploration of new routes, the hovering overconcerned families of psychosomatic children led to the articulation of a first version of structural

family therapy.

In an early advance of a new conceptual model derived from the principles of general systems theory (Minuchin, 1970), the clinical material chosen as illustration is a case of anorexia nervosa. Although Minuchin's involvement with this condition was practically simultaneous with his work with diabetics and asthmatics, anorexia nervosa provided a special opportunity because in this case the implementation of the model aims at eliminating the disease itself, while in the other two cases it can not go beyond the prevention of its exacerbation. In both diabetes and asthma, the emotional link is the triggering of a somatic episode, but it operates on a basic preexistent physiological vulnerability—a metabolic disorder, an allergy. Thus, the terms “psychosomatic diabetic” and “psychosomatic asthmatic” do not imply an emotional etiology for any of the two conditions. In anorexia nervosa, on the other hand, the role of such vulnerability is small or inexistent. Emotional factors can be held entirely responsible for the condition, and then the therapeutic potential of the model can be more fully assessed. Clinical and research experience with anorexia is the most widely documented of the model's application (for instance Liebman, Minuchin & Baker, 1974a, 1974b; Minuchin, Baker, Liebman, Milman, Rosman & Todd, 1973; Rosman, Minuchin & Liebman, 1975; Rosman, Minuchin, Liebman & Baker, 1976, 1977, pp. 341—348).

During the first half of the 1970s, with the Philadelphia clinic already established as a leading training center for family therapists, Minuchin continued his work with psychosomatics. In 1972 he invited Bernice Rosman, who had worked with him at Wiltwyck and coauthored *Families of the Slums*, to join the clinic as Director of Research. Minuchin, Rosman, and the pediatrician Lester Baker became the core of a clinical and research team that culminated its work 6 years later with the publication of *Psychosomatic Families* (Minuchin, Rosman & Baker, 1978).

Also in 1972 Minuchin published the first systematic formulation of his model, in an article entitled, precisely, “Structural Family Therapy” (Minuchin, 1972). Many of the basic principles of the current model are already present in this article: the characterization of therapy as a transitional event, where the therapist's function is to help the family reach a new stage; the emphasis on present reality as opposed to history; the displacement of the locus of pathology from the individual to the system of transactions, from the symptom to the family's reaction to it; the understanding of diagnosis as a constructed reality; the attention paid to the points of entry that each family system offers to the therapist; the therapeutic strategy focused on a realignment of the structural relationships within the family, on a change of rules that will allow the system to maximize its potential for conflict resolution and individual growth.

During this same period of time, the clinical experience supporting the model went far beyond the psychosomatic field. Under Minuchin's leadership, the techniques and concepts of structural family therapy were being applied by the clinic's staff and trainees to school phobias, adolescent runaways, drug addictions and the whole range of problems typically brought for treatment to a child clinic. The model was finally reaching all sorts of families from all socioeconomic levels and with a variety of presenting problems.

In 1974 Minuchin presented structural family therapy in book form (Minuchin, 1974) and the Philadelphia Child Guidance Clinic moved to a modern and larger building complex together with Children's Hospital. A process of fast expansion started: the availability of

services and staff increased dramatically and a totally new organizational context developed. The visibility of Philadelphia Child Guidance Clinic, which reached international renown, brought a new challenge to the model in the form of increasing and not always positive attention from the psychiatric establishment. In 1975 Minuchin chose to step down from his administrative duties and to concentrate on the teaching of his methods and ideas to younger generations, at the specially created Family Therapy Training Center.

This move signaled the beginning of the latest stage in the development of the model, a period of theoretical creation driven by the need to develop a didactically powerful body of systemic concepts consistent with the richness of clinical data. The current status of structural family therapy (Minuchin & Fishman, 1981) is characterized by an emphasis on training and theoretical issues. In the delivery of training, increasing attention is being paid to the therapist's epistemology—concepts, perspectives, goals, attitudes—as a “set” that conditions the learning of techniques. In the development of theory, the trend is to refine the early systemic concepts that served as foundations of the model, by looking into ideas developed by systems thinkers in other fields.

TENETS OF THE MODEL

Structural family therapy is primarily a way of thinking about and operating in three related areas: the family, the presenting problem, and the process of change.

The Family

The family is conceptualized as a living open system. In every system the parts are functionally interdependent in ways dictated by the supraindividual functions of the whole. In a system AB, A's passivity is read as a response to B's initiative (interdependence), while the pattern passivity! initiative is one of the ways in which the system carries on its function (for example, the provision of a nurturing environment for A and B). The set of rules regulating the interactions among members of the system is its structure.

As an *open* system the family is subjected to and impinges on the surrounding environment. This implies that family members are not the only architects of their family shape; relevant rules may be imposed by the immediate group of reference or by the culture in the broader sense. When we recognize that Mr. Brown's distant relationship to Jimmy is related to Mrs. Brown's overinvolvement with Jimmy, we are witnessing an idiosyncratic family arrangement but also the regulating effects of a society that encourages mothers to be closer to children and fathers to keep more distance.

Finally, as a *living* system the family is in constant transformation: transactional rules evolve over time as each family group negotiates the particular arrangements that are more economical and effective for any given period in its life as a system. This evolution, as any other, is regulated by the interplay of homeostasis and change.

Homeostasis designates the patterns of transactions that assure the stability of the system, the maintenance of its basic characteristics as they can be described at a certain point in time; homeostatic processes tend to keep the status quo (Jackson, 1957, 1965). The two-way process that links A's passivity to B's initiative serves a homeostatic

purpose for the system AB, as do father's distance, mother's proximity and Jimmy's eventual symptomatology for the Browns. When viewed from the perspective of homeostasis, individual behaviors interlock like the pieces in a puzzle, a quality that is usually referred to as *complementarity*.

Change, on the other hand, is the reaccommodation that the living system undergoes in order to adjust to a different set of environmental circumstances or to an intrinsic developmental need. A's passivity and B's initiative may be effectively complementary for a given period in the life of AB, but a change to a different complementarity will be in order if B becomes incapacitated. Jimmy and his parents may need to change if a second child is born. Marriage, births, entrance to school, the onset of adolescence, going to college or to a job are examples of developmental milestones in the life of most families; loss of a job, a sudden death, a promotion, a move to a different city, a divorce, a pregnant adolescent are special events that affect the journey of some families. Whether universal or idiosyncratic, these impacts call for changes in patterns, and in some cases—for example when children are added to a couple—dramatically increase the complexity of the system by introducing differentiation. The spouse subsystem coexists with parent-child subsystems and eventually a sibling subsystem, and rules need to be developed to define who participates with whom and in what kind of situations, and who are excluded from those situations. Such definitions are called *boundaries*; they may prescribe, for instance, that children should not participate in adults' arguments, or that the oldest son has the privilege of spending certain moments alone with his father, or that the adolescent daughter has more rights to privacy than her younger siblings.

In the last analysis homeostasis and change are matters of perspective. If one follows the family process over a brief period of time, chances are that one will witness the homeostatic mechanisms at work and the system in relative equilibrium; moments of crisis in which the status quo is questioned and rules are challenged are a relative exception in the life of a system, and when crises become the rule, they may be playing a role in the maintenance of homeostasis. Now if one steps back so as to visualize a more extended period, the evolvment of different successive system configurations becomes apparent and the process of change comes to the foreground. But by moving further back and encompassing the entire life cycle of a system, one discovers homeostasis again: the series of smooth transitions and sudden recommendations of which change is made presents itself as a constant attempt to maintain equilibrium or to recover it. Like the donkey that progresses as it reaches for the carrot that will always be out of reach, like the monkeys that turned into humans by struggling to survive as monkeys, like the aristocrats in Lampedusa's *Il Gattopardo* who wanted to change everything so that nothing would change, families fall for the bait that is the paradox of evolution: they need to accommodate in order to remain the same, and accommodation moves them into something different.

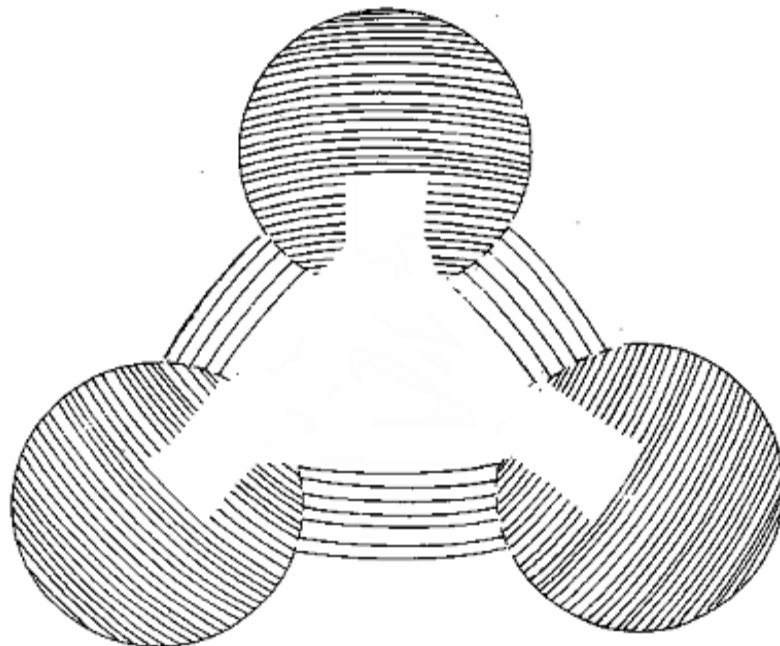
This ongoing process can be arrested. The family can fail to respond to a new demand from the environment or from its own development: it will not substitute new rules of transactions for the ones that have been patterning its functioning. AB find it impossible to let go of the passivity/initiative pattern even if B is now incapacitated Jimmy and mother find it impossible to let go of a tight relationship that was developmentally appropriate when Jimmy was 2 but not now that he is 18. Maybe Jimmy started showing trouble in school when he was 12, but the family insisted on the same structure with mother monitoring all communications around Jimmy and the school, so that Jimmy was

protected from father's anger and father from his own disappointment.

When families get stagnated in their development their transactional patterns become stereotyped. Homeostatic mechanisms exacerbate as the system holds tightly to a rigid script. Any movement threatening a departure from the status quo is swiftly corrected. If father grows tougher on Jimmy, mother will intercede and father will withdraw. Intergenerational coalitions that subvert natural hierarchies (for example, mother and son against father), triangular patterns where parents use a child as a battleground, and other dysfunctional arrangements serve the purpose of avoiding the onset of open conflict within the system. *Conflict avoidance*, then, guarantees a certain sense of equilibrium but at the same time prevents growth and differentiation, which are the offspring of conflict resolution. The higher levels of conflict avoidance are found in *enmeshed* families— where the extreme sense of closeness, belonging, and loyalty minimize the chances of disagreement—and, at the other end of the continuum, in *disengaged* families, where the same effect is produced by excessive distance and a false sense of independence.

In their efforts to keep a precarious balance, family members stick to myths that are very narrow definitions of themselves as a whole and as individuals— constructed realities made by the interlocking of limited facets of the respective selves, which leave most of the system's potentials unused. When these families come to therapy they typically present themselves

as a poor version of what they really are. See Figure 1. The white area in the center of the figure represents the myth: "I am this way and can only be this way, and the same is true for him and for her, and we can not relate in any other way than our way," while the shaded area contains the available but as yet not utilized alternatives.



The presenting problem

Structural family therapy conceptualizes the problem behavior as a partial aspect of the family structure of transactions. The complaint, for instance, that Jimmy is undisciplined and aggressive, needs to be put in perspective by relating it to the context of Jimmy's family.

For one thing, the therapist has to find out the position and function of the problem behavior: When does Jimmy turn aggressive? What happens immediately before? How do others react to his misbehavior? Is Jimmy more undisciplined toward mother than toward father? Do father and mother agree on how to handle him? What is the homeostatic benefit from the sequential patterns in which the problem behavior is imbedded? The individual problem is seen as a complement of other behaviors, a part of the status quo, a token of the system's dysfunction; in short, the system as it is supports the symptom.

The therapist also has to diagnose the structure of the system's *perceptions* in connection with the presenting problem. Who is more concerned about Jimmy's lack of discipline? Does everybody concur that he is aggressive? That his behavior is the most troublesome problem in the family? Which are the other, more positive facets in Jimmy's self that go unnoticed? Is the family exaggerating in labeling as "aggressive" a child that maybe is just more exuberant than his siblings? Is the family failing to accommodate their perceptions and expectations to the fact that Jimmy is now 18 years old? Does the system draw a homeostatic gain from perceiving Jimmy primarily as a symptomatic child? An axiom of structural family therapy, illustrated by Figure 1, is that a vast area of Jimmy's self is out of sight for both his relatives and himself, and that there is a systemic support for this blindness.

So the interactional network knitted around the motive of complaint is the real "presenting problem" for the structural family therapist. The key element in this view is the concept of systemic *support*. The model does *not* claim a direct causal line between system and problem behavior; the emphasis is on maintenance rather than on causation. Certainly, sometimes one observes families and listens to their stories and can almost see the pathways leading from transactional structure to symptomatology. But even in these cases the model warns us that we are dealing with current transactions and current memories, as they are organized *now*, after the problem has crystallized. Thus, instead of a simplistic, one-way causal connection the model postulates an ongoing process of mutual accommodation between the system's rules and the individual's predispositions and vulnerabilities. Maybe Jimmy was born with a "strong temperament" *and* to a system that needed to pay special attention to his temper tantrums, to highlight his negative facets while ignoring the positive ones. Within this context Jimmy learned about his identity and about the benefits of being perceived as an aggressive child. By the time he was 9, Jimmy was an expert participant in a mutually escalating game of defiance and punishment. These mechanisms—selective attention, deviance amplification, labeling, counter escalation—are some of the ways in which a system may contribute to the etiology of a "problem." Jimmy's cousin Fred was born at about the same time and with the same "strong temperament," but he is now a class leader and a junior tennis champ.

Discussions around etiological history, in any case, are largely academic from the perspective of structural family therapy, whose interest is focused on the *current* supportive relation between system and problem behavior. The model shares with other systemic approaches the radical idea that knowledge of the origins of a problem is largely irrelevant for the process of therapeutic change (Minuchin & Fishman, 1979). The identification of etiological sequences may be helpful in *preventing* problems from happening to families, but once they have happened and are eventually brought to therapy, history has already occurred and can not be undone. An elaborate understanding of the problem history may in fact hinder the therapist's operation by

encouraging an excessive focus on what appears as *not* modifiable.

The Process of Therapeutic Change

Consistent with its basic tenet that the problems brought to therapy are ultimately dysfunctions of the family structure, the model looks for a therapeutic solution in the modification of such structure. This usually requires changes in the relative positions of family members: more proximity may be necessary between husband and wife, more distance between mother and son. Hierarchical relations and coalitions are frequently in need of a redefinition. New alternative rules for transacting must be explored: mother, for instance, may be required to abstain from intervening automatically whenever an interaction between her husband and her son reaches a certain pitch, while father and son should not automatically abort an argument just because it upsets Morn. Frozen conflicts have to be acknowledged and dealt with so that they can be solved—and the natural road to growth reopened.

Therapeutic change is then the process of helping the family to outgrow its stereotyped patterns~ of which the presenting problem is a part. This process transpires within a special context, the *therapeutic system which offers* a unique chance to challenge the rules of the family. The privileged position of the therapist allows him to request from the family members different behaviors and to invite different perceptiOn5~ thus altering their interaction and perspective. The family then has an opportunity to experience transactional patterns that have not been allowed under its prevailing homeostatic rules. The system's limits are probed and pushed, its narrow self~definitiOn5 are questioned; in the process, the family's capacity to tolerate and handle stress or conflict increases, and its perceived reality becomes richer, more complex.

In looking for materials to build this expansion of the family's reality -alternative behaviors, attitudes, perceptions, affinities, expectations- the structural family therapist has one primary source from which to draw: the family itself. The model contends that beyond the systemic constraints that keep the family functioning at an inadequate level there exists an as yet underutilized pool of potential resources. (See Figure 1, the shaded areas.) Releasing these resources so that the system can change, and changing the system so that the resources can be released, are simultaneous processes that require the restructuring input of the therapist. His role will be discussed at some length in the following section.

APPLICATION OF THE MODEL TO THERAPY

In discussing the practical applications of structural family therapy, the first point to be made is that the model is not just a cluster of techniques with specific indications, but rather a consistent way of thinking and operating~ derived from the basic tenet that human problems can only be understood and treated in context. As such, the model is in principle applicable to any human system in need of change.

The family, however, presents some unique characteristics that make it a comparatively accessible and rewarding field of application, it is a natural group with a history and a future, whose members tend to remain associated even under circumstances that would be lethal for the fate of other human groups —such as high levels of ongoing conflict, extreme negative feelings and ultimate dysfunctionality—_and can then be expected (more than as members of other groups) to endure the challenges of therapy. Families

usually have the motivation to invest time, money, energy and affect for the sake of one of their members, and they also offer a prospect of continuity for the changes initiated during therapy.

In actual practice structural family therapy has been mostly applied to—and has grown from families where a son or daughter is the identified patient. This context offers some additional advantages, in that cultural expectations define the family as a most relevant environment for a child, and the parents as directly responsible for his or her well-being. The extent of the bias, if any, built into the model's current formulations by virtue of the specifics of child psychotherapy will only be measurable upon extensive application of structural family therapy to "adult" problems.

There are no specific requirements that families and/or problems should meet for the model to be applicable. True, the family needs to be motivated and resourceful, but a systemic understanding implies that any family can be motivated and no family is resource less—or the point of meeting the therapist would never have been reached. Similarly, the problem must be a "transactional" one, but this according to system thinking is a matter of how the problem is defined, described or framed. In addition to the work with low socioeconomic families, delinquency and psychosomatic illness (already mentioned in connection with' the historical development of the model), the literature on structural family therapy includes case material from many different origins. School related problems (Aponte, 1976; Berger, 1974; Moskowitz, 1976), drug abuse (Stanton, 1978; Stanton & Todd, 1979; Stanton, Todd, Heard, Kirschner, Kleiman, Mowatt, Riley, Scott & Van Deusen, 1978), mental retardation (Fish-man, Scott & Betoff, 1977), specific symptoms such as elective mutism (Rosenberg & Lindblad, 1978) and encopresis (Andolfi, 1978) are some examples; although not a complete list, they give an idea of the variety of clinical contexts to which the model has been applied.

While it is difficult to imagine a family problem that could *not* be approached from structural family therapy, there are however certain contexts, of a different sort, that limit the applicability of the model. Hospitalization of the identified patient, for instance, hinders the efforts to restructure the family because of the unnatural isolation of a key member, the confirmation of the family's definition of the problem and the naturalization of a crucial source of energy for family change. By artificially removing stress from the family's reality, hospitalization tends to facilitate and reinforce the operation of homeostatic mechanisms; the resulting therapeutic system is one in which the therapist's power to effectively challenge stereotyped transactional rules is greatly diminished. A similar constraint is typically associated with medication, and in general with any condition that appeases crisis and takes the motivation for change away from the system.

Another crucial variable in determining the applicability of structural family therapy is the therapist's acceptance of the *goals* set by the model for the therapeutic enterprise, and of the *function* prescribed for him or her. These are areas in which structural family therapy departs considerably from some other approaches, as will be described in the following discussion.

Goals and Function of Therapy

The basic goal of structural family therapy is the restructuralization of the family's system of transactional rules, such that the interaccional reality of the family becomes more

flexible, with an expanded availability of alternative ways of dealing with each other. By releasing family members from their stereotyped positions and functions, this restructuralization enables the system to mobilize its underutilized resources and to improve its ability to cope with stress and conflict. Once the constricting set of rules is outgrown, individual dysfunctional behaviors, including those described as the presenting problem, lose their support in the system and become unnecessary from the point of view of homeostasis. When the family achieves self-sufficiency in sustaining these changes without the challenging support of the therapist, therapy comes to an end.

This statement of goals may appear as too ambitious an objective; after all, the “presenting problem” was perhaps originally characterized as one aspect in the behavior of one out of seven family members. But from the model’s point of view, the structural relationship between system and problem behavior is not just a farfetched conceptual connection: it is an observable phenomenon. Whenever the “problem” is enacted in a session, the structure of related transactions is set in motion with the regularity of a clock-work. Again, the presenting problem ultimately *is* the structure of relationships, and each occurrence of the problem behavior or symptom provides a metaphor for the system. Changing one of the terms in this equation implies changing the other—not as a prerequisite but as a co variation. In structural family therapy it is not necessary to postpone consideration of the original complaint in order to pursue structural change. On the contrary it is possible, and frequently inescapable, to weave the fabric of the one with the threads of the other.

The therapist’s function is to assist the family in achieving the necessary restructuralization. The position prescribed for him by the model is similar to that of a midwife helping in a difficult delivery. Once change is born and thriving the therapist must withdraw and resist the temptation to “overwork” his temporary association with the family by taking over the rearing of the baby. Some therapists are specially vulnerable to this temptation because of the tradition in psychotherapy that calls for a complete, ultimate “cure” of the client—an improbable goal whose equivalent can not be found in other health disciplines (an internist will hardly tell a patient that he or she will never need a doctor again). The concept of an ultimate cure is unthinkable in structural family therapy, which emphasizes constant growth and change as an essential feature of the family system. Hence, the structural family therapist is encouraged to limit his participation to the minimum that is necessary to set in motion the family’s natural healing resources.

It certainly may happen that as a result of the therapist’s intervention the family is helped not only to change but also to metachange—that in addition to the overcoming of its current crisis, the family will also improve its ability to deal with future events without external help. This high level of achievement is of course desirable, but that does not mean that other more modest accomplishments are valueless. A restructuralization that allows Danny to go back to school while his father takes care of mother’s depression and emptiness may be a perfectly legitimate outcome, even if the family comes back 4 years later, when Jenny runs into adolescent trouble. From the point of view of structural family therapy, this prospect is more sensible, natural and economic than the protracted presence of a therapist accompanying the family for years, unable to separate because of his need to make sure that things are developing in a satisfactory way.

In yet another sense, the therapist's role as prescribed by structural family therapy runs contrary to psychotherapy tradition. Much of the confessor-like behavior encouraged by other approaches is here regarded as therapeutically irrelevant—and mostly counter indicated. The therapist is not there primarily to listen to and answer sympathetically his clients' fantasies, secrets, fears, and wishes, but to assist in the development of a natural human context that can and should provide that kind of listening. He is not there to provide extensive one-to-one reparative \ experience for this and that family member, but rather to operate an intensive "tune-up" of the natural healing system.

By limiting the duration and depth of the therapist's incursion into the family system, the model places restrictions upon his curiosity and desire to be helpful, and ultimately upon his power to control events. This loss of control on the part of the therapist is an inevitable consequence of the broadening of his scope (Minuchin, 1970).

Therapist's Role

The therapist's role, as prescribed by this model, includes an element of paradox. The therapist is asked to support while challenging, to attack while encouraging, to sustain while undermining. A crucial conceptual distinction is necessary here to protect the therapist from confusion or hypocrisy: he is requested to be *for* the people in need of help, *against* the system of transactions that cripple them.

The first task for the structural family therapist is to enter the system that is in need of change and to establish a working relationship. This requires a certain degree of accommodation to the system's rules—but not up to a point in which the therapist's leverage to promote change is lost. Too much challenge to the system's rules at the entry stage would lead to the therapist's dismissal; too much accommodation would void his input by absorbing it into homeostasis. The therapist has to find the right equation of accommodation/challenge for each particular family through a process of probing, advancing, and withdrawing that guides his entrance and at the same time gives him clues about the family structure.

So the structural family therapist is actively engaged in a dance with the family right from the beginning of their contact. There is little room in this model for neutral listening or floating attention. The therapist approaches the family with a series of initial hypotheses built on the basis of minimal intake information, and proceeds to test, expand, and correct those hypotheses as he joins the family. His attention is selectively oriented toward process and away from content; he is more interested in how people relate than in what they have to say, and he listens to content mostly as a way of capturing the language of the family, the \, metaphors that will later help him catch the ears of his clients. As processes and themes unravel, the therapist's selective attention privileges some of them and discards the others. A map of the family begins to emerge in him—a map depicting positions, alliances, hierarchies, complementary patterns.

Soon the dancer turns into stage director, creating scenarios where problems are played according to different scripts. The embedding of the symptom in family transactions is explored and highlighted. Family members are invited to talk to each other, or excluded from participation. Distances and positions are prescribed, alternative arrangements tried. The therapist-director uses whatever knowledge he is gaining about the actors to create situations that will uncover hidden resources or confirm suggested limitations. He is looking for the specific ways in which this system is keeping its homeostasis, so that he can disrupt them and force a new equilibrium at a higher level of complexity. But he is also searching for the system's strengths that will indicate possible

directions for his challenge. The stage director is out to make trouble for the cast.

While the model prescribes activity, initiative, and directiveness, it also warns against centrality. The therapist is supposed to organize a scenario and start the action, but then to sit back as a spectator for a while. If he becomes too central the system can not fully display its limitations and potentialities; the therapist himself gets trapped in a stereotyped position where he will most probably be absorbed by homeostasis. He needs to be mobile, to constantly redefine his position, displacing himself from one role to another, from one alliance to another, from one challenge to the next—while at the same time maintaining a focus, a thread, a relevant theme connecting all of his moves together and to the presenting problem. In this the structural family therapist resembles a camera director in a television studio, who decides to air the close-up “take” from one of the cameras. Far from indulging in self-praise for the beauty of the achieved picture, he is already planning the next -knowing also that from time to time the total picture will be needed as a reminder to the audience of what it is all about.

In short, the role of the therapist is to move around within the system, blocking existing stereotyped patterns of transactions and fostering the development of more flexible ones. While constantly negotiating the immunological mechanism/isms of the family organism in order to be accepted, he behaves as a strange body to which the organism has to accommodate by changing and growing.

PRIMARY TECHNIQUES

Over the course of the years structural family therapists have developed and adapted a variety of techniques, to help themselves carry out their function as prescribed by the model. They can be classified, according to their main purpose, into (a) those that are primarily used in the formation of the therapeutic system, and (b) the larger group of techniques more directly aimed at provoking disequilibrium and change.

(a) Joining Techniques

Joining is the process of “coupling” that occurs between the therapist and the family, and which leads to the formation of the therapeutic system. In joining, the therapist becomes accepted as such by the family, and remains in that position for the duration of treatment; although the joining process is more evident during the initial phase of therapy, the maintenance of a working relationship to the family is one of the constant features in the therapist’s job.

Much of the success in joining depends on the therapist’s ability to listen, his capacity for empathy, his genuine interest in his client’s dramas, his sensitivity to feedback. But this does not exclude a need for technique in joining. The therapist’s empathy, for instance, needs to be disciplined so that it does not hinder his ability to keep a certain distance and to operate in the direction of change. Contrary to a rather common misunderstanding, joining is not just the process of being accepted by the family; it is being accepted *as a therapist*, with a quota of leadership. Sometimes a trainee is described as “good at joining, but not at pushing for change”; in these cases, what in fact happens is that the trainee is *not* joining well. He is accepted by the family, yes, but at the expense of relinquishing his role and being swallowed by the homeostatic rules of the system. Excessive accommodation is not good joining.

Maintenance is one of the techniques used in joining. The therapist lets himself be organized by the basic rules that regulate the transactional process in the specific family system. If a four-generation family presents a rigid hierarchical structure, the therapist may find it advisable to approach the great-grandmother first and then to proceed downward. In so doing, the therapist may be resisting his first empathic wish—perhaps to rescue the identified patient from verbal abuse—but by respecting the rules of the system he will stand a better chance to generate a therapeutic impact.

However, in order to avoid total surrender the therapist needs to perform his maintenance operations in a way that does not leave him powerless; he does *not* want to follow the family rule that Kathy should be verbally abused whenever somebody remembers one of her misdoings. As with any other joining technique, maintenance entails an element of challenge to the system. The therapist can for instance approach the great-grandmother respectfully but he will say: “I am very concerned because I see all of you struggling to help, but you are not being helpful to each other.” While the rule “great-grandma first” is being respected at one level, at a different level the therapist is positioning himself one up in relation to the entire system, including grandmother. He is joining the rules to his own advantage.

While maintenance concentrates on process, the technique of *tracking* consists of an accommodation of the therapist to the *content* of speech. In tracking, the therapist follows the subjects offered by family members like a needle follows the record groove. This not only enables him to join the family culture, but also to become acquainted with idiosyncratic idioms and metaphors that he will later use to endow his directive statements with additional power—by phrasing them in ways that have a special meaning for the family or for specific members.

At times the therapist will find it necessary to establish a closer relation with a certain member, usually one that positions himself or is positioned by the family in the periphery of the system. This may be done through verbal interventions or through *mimesis*, a nonverbal response where the therapist adopts the other person’s mood, tone of voice or posture, or imitates his or her behavior -crosses his legs, takes his jacket off, lights a cigarette. In most of the occasions the therapist is not aware of the mimetic gesture itself but only of his disposition to get closer to the mimicked member. In other cases however, mimesis is consciously used as a technique: for instance, the therapist wants to join the system via the children and accordingly decides to sit on the floor with them and suck his thumb.

(b) Techniques for Disequilibrium

The second, larger group of techniques encompasses all interventions aimed at changing the system. Some of them, like enactment and boundary-making, are primarily employed in the *creation* of a different sequence of events, while others like reframing, punctuation~ and unbalancing tend to foster a different *perception* of reality.

Reframing is putting the presenting problem in a perspective that is both different from what the family brings and more workable. Typically this involves changing the definition of the original complaint, from a problem of one to a problem of many. In a consultation (Minuchin, 1980) with the family of a 5-year-old girl who is described by her parents as “uncontrollable,” Salvador Minuchin waits silently for a couple of minutes as the girl circles noisily around the room and the mother tries to persuade her to behave, and then

he asks the mother: "Is this how you two run your lives together?" If the consultant had asked something like "Is this the way *she* behaves usually?" he would be confirming the family's definition of the problem as "located" in the child; by making it a matter of two persons, the consultant is beginning to reframe the problem within a structural perspective.

In the quoted example the consultant is feeding into the system his own reading of an ongoing transaction. Sometimes a structural family therapist uses information provided by the family as the building materials for his frame. Minutes later in the same session, the mother comments: "But we try to make her do it," and the father replies "I make her do it." Minuchin highlights then this brief interchange by commenting on the differences that the family is presenting: mother can not make her do it, father can. The initial "reality" described just in terms of the girl's "uncontrollability" begins to be replaced by a more complex version involving an ineffective mother, an undisciplined child, and maybe an authoritarian father.

The consultant is reframing in terms of *complementarity*, a typical variety of the reframing technique, in which any given individual's behavior is presented as contingent on somebody else's behavior. The daughter's uncontrollability is related to her mother's ineffectiveness which is maintained by father's taking over— which, on the other hand, is triggered by mother's ineffectiveness in controlling the daughter. Another example of reframing through complementarity is the question "Who makes you feel depressed?" addressed to a man who claims to be "the" problem in the family because of his depression.

As with all other techniques employed in structural family therapy, reframing is based on an underlying attitude on the part of the therapist. He needs to be actively looking for structural patterns if he is going to find them and use them in his own communications with the family. Whether he will read the 5-year-old's misbehavior as a function of her own "uncontrollability" or of a complementary pattern, depends on his perspective. Also, his field of observation is so vast that he can not help but be selective in his perception; whether he picks up that "I make her do it" or lets it pass by, unnoticed amidst the flow of communication, depends on whether his selective attention is focused on structure or not. As with joining, as with unbalancing, reframing requires from the therapist a "set" without which the technique can not be mastered.

The reframing attitude guides the structural family therapist in his search of structural embeddings for "individual" problems. In one case involving a young drug addict, the therapist took advantage of the sister's casual reference to the handling of money to focus on the family's generosity toward the patient and the infantile position in which he was being kept. In another case, involving a depressed adolescent who invariably arrived late at his day treatment program, the therapist's reframing interventions led to the unveiling of a pattern of overinvolvement between mother and son: she was actually substituting for his alarm-clock. In an attempt to help him she instead was preventing him from developing a sense of responsibility.

The intended effect of reframing is to render the situation more workable. Once the problem is redefined in terms of complementarity -for instance, the participation of every family member in the therapeutic effort acquires a special meaning for them. When they are described as mutually contributing to each other's failures, they are also given the key to the solution. Complementarity is not necessarily pathological; it is a fact of life, and it can adopt the form of family members helping each other to change. Within such a

frame, the therapist can request from the family members the enactment of alternative transactions.

Enactment is the actualization of transactional patterns under the control of the therapist. This technique allows the therapist to observe how family members mutually regulate their behaviors, and to determine the place of the problem behavior within the sequence of transactions. Enactment is also the vehicle through which the therapist introduces disruption in the existent patterns, probing the system's ability to accommodate to different rules and ultimately forcing the experimentation of alternative, more functional rules. Change is expected to occur as a result of dealing with the problems, rather than talking about them.

In the case of the uncontrollable girl, the consultant, after having reframed the problem to include mother's ineffectiveness and father's hinted authoritarianism, sets up an enactment that will challenge that "reality" and test the family's possibilities of operating according to a different set of assumptions. He asks the mother whether she feels comfortable with the situation as it is—the grown ups trying to talk while the two little girls run in circles screaming and demanding everybody's attention. When mother replies that she feels tense, the therapist invites her to organize the situation in a way that will feel more comfortable, and finishes his request with a "Make it happen" that will be the motto for the following sequence.

The purpose of this enactment is multileveled. At the higher, more ambitious level, the therapist wants to facilitate an experience of success for the mother, and the experience of a successful mother for the rest of the family. But even if mother should fail to "make it happen" the enactment will at least fulfill a lower-level goal: it will provide the therapist with an understanding of the dysfunctional pattern and of the more accessible routes to its correction.

In our specific example, the mother begins to voice orders in quick succession, overlapping her own commands and hence handicapping her own chances of being obeyed. The children seem deaf to what she has to say, moving around the room and only sporadically doing what they are being asked to do. The consultant takes special care to highlight those mini-successes, but at the same time he keeps reminding the mother that she wanted something done and "It is not happening—make it happen." When father, following the family rule, attempts to add his authority to mother's, the consultant blocks his intervention. The goal of the enactment is to see that mother "makes it happen" by herself; for the same reason, the consultant ignores mother's innumerable violations to practically every principle of effective parenting. To correct her, to teach her how to do it would defeat the purpose of the enactment.

The consultant keeps the enactment going on until the mother eventually succeeds in organizing the girls to play by themselves in a corner of the room, and then the adults can resume their talk. The experience can later be used as a lever in challenging the family's definition of their reality.

If mother had not succeeded, the consultant would have had to follow a different course—typically one that would take her failure as a starting point for another reframing. Sometimes the structural family therapist organizes an enactment with the purpose of helping people to *fail*. A classical example is provided by the parents of an anorectic patient who undermine each other in their competing efforts to feed her. In this situation the therapist may want to have the parents take turns in implementing their

respective tactics and styles, with the agenda that they should both fail and then be reunited in their common defeat and anger toward their daughter—now seen as strong and rebellious rather than weak and hopeless.

Whether it is aimed at success or at failure, enactment is always intended to provide a different experience of reality. The family members' explanations for their own and each other's behaviors, their notions about their respective positions and functions within the family, their ideas about what their problems are and how they can contribute to a solution, their mutual attitudes are typically brought in-to question by these transactional micro-experiences orchestrated by the therapist.

Enactments may be dramatic, as in an anorectic's lunch (Rosman, Minuchin & Liebman, 1977, pp. 166—169), or they can be almost unnoticeably launched by the therapist with a simple "Talk to your son about your concerns, I don't know that he understands your position." If this request is addressed to a father that tends to talk to his son through his wife, and if mother is kept out of the transaction by the therapist, the structural effects on behavior and perception may be powerful, even if the ensuing conversation turns out to be dull. The real power of enactment does not reside in the emotionality of the situation but rather in the very fact that family members are being directed to behave differently in relation to each other. By prescribing and monitoring transactions the therapist assumes control of a crucial area—the rules that regulate who should interact with whom, about what, when and for how long.

Boundary making is a special case of enactment, in which the therapist defines areas of interaction that he rules open to certain members but closed to others. When Minuchin prevents the husband from "helping" his wife to discipline the girls, he is indicating that such specific transaction is for the mother and daughters to negotiate, and that father has nothing to do at this point; this specific way of making boundaries is also called *blocking*. Other instances of boundary making consist of prescriptions of physical movements: a son is asked to leave his chair (in between his parents) and go to another chair on the opposite side of the room, so that he is not "caught in the middle"; a grandmother is brought next to the therapist and far from her daughter and granddaughters who have been requested to talk; the therapist himself stands up and uses his body to interrupt visual contact between father and son, and so forth.

Boundary making is a restructuring maneuver because it changes the rules of the game. Detouring mechanisms and other conflict avoidance patterns are disrupted by this intervention; underutilized skills are allowed and even forced to manifest themselves. The mother of the 5 year old is put in the position of accomplishing something without her husband's help; husband and wife can and must face each other without their son acting as a buffer; mother and daughter continue talking because grandma's intervention, which usually puts a period to their transactions, is now being blocked; father and son can not distract one another through eye contact.

As powerful as the creation of specific events in the session may be, their impact depends to a large extent on how the therapist punctuates those events for the family.

Punctuation is a universal characteristic of human interaction. No transactional event can be described in the same terms by different participants, because their perspectives and emotional involvements are different. A husband will say that he needs to lock himself in the studio to escape his wife's nagging; she will say that she can not help protesting about his aloofness. They are linked by the same pattern, but when describing

it they begin and finish their sentences at different points and with different emphases.

The therapist can put this universal to work for the purposes of therapeutic change. In structural family therapy punctuation is the selective description of a transaction in accordance with the therapist's goals. In our example of enactment, the consultant organized a situation in which the mother was *finally* successful, but it was the consultant himself who made the success "final." Everybody—the mother included—expected at that point that the relative peace achieved would not last, but the consultant hastened to put a period by declaring the mother successful and moving to a different subject before the girls could misbehave again. If he had not done so, if he had kept the situation open, the usual pattern in which the girls demanded mother's attention and mother became incompetent would have repeated itself and the entire experience would have been labeled a failure. Because of the facts of punctuation, the difference between success and failure may be no more than 45 seconds and an alert therapist.

Later in the same session the consultant asked the parents to talk without allowing interruptions from their daughter. The specific prescription was that father should make sure that his wife paid attention only to him and not to the girl. Given this context for the enactment, whenever mother was distracted by the girl the therapist could blame *father* for the failure—a different punctuation from what would have resulted if the consultant had just asked mother to avoid being distracted.

A variety of punctuation is *intensity*, a technique that consists of emphasizing the importance of a given event in the session or a given message from the therapist, with the purpose of focusing the family's attention and energy on a designated area. Usually the therapist magnifies something that the family ignores or takes for granted, as another way of challenging the reality of the system. Intensity is achieved sometimes through repetition: one therapist put the same question about 80 times to a patient who had decided to move out of his parents' home and did not do so: "Why didn't you move?" Other times the therapist creates intensity through emotionally charged interventions ("It is important that you all listen, because your sister can die"), or confrontation ("What your father did just now is very disrespectful"). In a general sense, the structural family therapist is always monitoring the intensity of the therapeutic process, so that the level of stress imposed on the system does not become either unbearable or too comfortable.

Unbalancing is a term that could be used to encompass most of the therapist's activity since the basic strategy that permeates structural family therapy is to create disequilibrium. In a more restricted sense, however, unbalancing is the technique where the weight of the therapist's authority is used to break a stalemate by supporting one of the terms in a conflict. Toward the end of the consultation with the family of the "uncontrollable" girl, Minuchin and the couple discuss the wife's idea that her husband is too harsh on the girls:

Minuchin: Why does she think that you are such a tough person? Because I think she feels that you are very tough, and she needs to be flexible because you are so rigid. I don't see you at all as rigid, I see you actually quite flexible. How is that your wife feels that you are rigid, and not understanding?

Husband: I don't know, a lot of times I lose my temper I guess, right? That's probably why.

Wife: Yeah.

Minuchin: So what? So does she. I have seen you playing with your daughter here and I think you are soft and flexible, and that you were playing in a rather nice and accepting way. You were not authoritarian, you had initiative, your play engaged her. . . . That is what I saw. So why is that she sees you only as rigid

and authoritarian, and she needs to defend the little girls from your (*punches father's knee*)? I don't see you that way at all.

Husband: I don't know, like I say, the only thing I can think of, really, is because I lose my temper with them.

Wife: Yes, he does have a short fuse.

Minuchin: So what? So do you.

Wife: No, I don't.

Minuchin: Oh you don't. Okay, but that doesn't mean that you are authoritarian, and that doesn't mean that you are not understanding. Your play with your daughter here was full with warmth and you entered very nicely, and as a matter of fact she enjoyed the way in which you entered to play. So, some way or other your wife has a strange image of you and your ability to understand and be flexible. Can you talk with her, how is that she sees that she needs to be supportive and defending of your daughter? I think she is protecting the girls from your short fuse, or something like that. Talk with her about that, because I think she is wrong.

Wife: That's basically what it is, I'm afraid of you really losing your temper on them, because I know how bad it is, and they are little, and if you really hit them with a temper you could really hurt them; and I don't want that, so that's why I go the other way, to show them that everybody in the house doesn't have that short fuse.

Husband. Yes, but I think when you do that, that just makes it a little worse because that makes her think that she has somebody backing her, you know what I mean?

Minuchin (shakes husband's hand): This is very clever, and this is absolutely correct, and I think that you should say it again because your wife does not understand that point.

In this sequence the consultant unbalances the couple through his support of the husband. His focus organizes him to disregard the wife's reasons, which may seem unfair at first sight. But it is in the nature of unbalancing to be unfair. The therapist unbalances when he needs to punctuate reality in terms of right and wrong, victim and villain, actor and reactor, in spite of his knowing that all the comings and goings in the family are regulated by homeostasis, and that each person obliges with his and her own contribution; because the therapist also knows that an equitable distribution of guilt's and errors would only confirm the existing equilibrium and neutralize change potentialities.

While unbalancing is admittedly and necessarily unfair, it is not arbitrary. Diagnostic considerations dictate the direction of the unbalancing. In the case of our example, the consultant chooses to support the husband rather than the wife because in so doing he is challenging a myth that *both* spouses share: initially the husband agrees to his wife's depiction of him, and it is only through the intensity of the consultant's message that he begins to challenge it. At different points in the same session, the consultant supports the *wife* as a competent mother and questions the idea of her unremitting inefficiency—again, a myth defended not only by her husband but by herself as well. In the last analysis unbalancing—like the entire structural approach—is a challenge to the system rather than an attack on any member.

CASE EXAMPLE

The Murphy family is composed of father (Joe), 33 years old; mother (Connie), 30; Jenny, 7; and Kevin, 4. On the telephone, the mother stated that Kevin is very aggressive, throws toys at his sister and screams for no apparent motive. Last week he

pushed Jenny and caused her to injure her eye. Mother's sister Pat, 28 years old, who lives in the same apartment building and is a school teacher, has always thought Kevin to be hyperactive, and some time ago she arranged for a neurological examination. The test found nothing wrong with Kevin. The Murphys own a small grocery store where both work.

When the family (including Pat) enters the room for the first interview, Kevin and Jenny (who has a patch on her right eye) go directly to the toys; the therapist follows them and starts his joining by inquiring about Jenny's condition. He finds out that the lesion is not serious and also that Pat intervenes frequently in his dialogue with the children—adding to or correcting the information provided by Jenny and Kevin. It turns out that Kevin pushed Jenny while playing, and then Jenny hit a counter corner. As the therapist stands up from the floor and sits on a chair, the children quickly organize themselves to play; Kevin does not—and will not—shows any of the typical signs of hyperactivity. The therapist proceeds then to explore the family structure and to reframe the problem.

Therapist: So you had a scare.

Mother: Yes. Thank God she is going to be okay, but I still—I don't know, it is scary, the things that can happen, and I—(*Looks at Pat*).

Pat: Yes, well, I was the one who started this I guess, so maybe I should say something. (*Mother nods.*) You know, I had been noticing, like Kevin was always too active, and I wondered whether I should say something, but then Connie came up with the same thing and—

Therapist: Connie? What did you come up with?

Mother: Like she said, he was always difficult, but then he started to give more and more trouble and it got to a point—he is impossible. One minute he can be playing and the next thing you know he is yelling and he will not stop. I don't know, the doctor says he doesn't need any medicine but I—

Therapist: You can't control him, eh? (*After some exploration, Jenny has started to build a tower with blocks; Kevin follows her leadership.*)

Pat: He is really uncontrollable when it comes to it.

Therapist: So Connie and Pat find Kevin difficult. How about you, Joe?

Father: I don't know, he does get on his mother's nerves, but he doesn't give me any trouble.

Pat: Well but you—you are different.

Father: Yeah, maybe, but. . . well, I don't know.

Therapist: You think you are different?

Pat: He is more patient.

Therapist: Are you?

Father: I don't know, she says that but... (*therapist signals that he should talk to Pat*).

You say that I don't pay them enough attention.

Pat: It's not that. (*To therapist :*) I feel it's easier for Joe because he can tune himself off, like when Kevin is hyper.

Therapist (to mother:) What do you think?

Mother: Pardon?

Therapist: Your sister is saying something about your husband.

Mother: Is it easier for him? Yes, in a way I think it is easier. Like, the kids can be playing rough and it is like okay with him, he doesn't care, he says kids are kids. But I can not see them going on like that, someone has to stop them, or everybody gets crazy.

Therapist: Everybody or just you?

Mother: Everybody. You know, Mr. Murphy here has his temper too.

Therapist: Then you stop them, eh? You mean you need to help him to keep his patience? Are you making things easier for him?

Mother: I guess, yes, I guess I am.

Therapist: That must be a hell of a lot of work. Is your sister helpful?

Mother: What do you mean?

Therapist: I mean, it must be very difficult to protect your husband's patience if he has a temper. Does your sister help you with that?

Mother: Well, she helps with the kids, they listen to her—that helps, a lot.

Therapist: That helps with Jenny but not with Kevin, because you two together can not cope with him, right? It takes your husband's temper to control Kevin?

Mother: Well yes, when it gets real bad he is the only one.

Therapist: And I bet Kevin knows that. Kevin? Your daddy is tough? Is he tougher than mommy? (*Kevin nods and goes back to his play with Jenny.*) So you have a nice arrangement here. You two take care of Joe's patience and Joe only intervenes when it is really necessary. Only that then (*to father*), maybe sometimes Kevin has to get tougher if he wants you rather than Connie or Pat?

During this sequence the therapist has had a chance to assess the extent of Pat's involvement in the life of the Murphys. He is not challenging her interferences; rather, he is accepting the rules of communication of the family. At the same time, the therapist has been reframing the problem, from a complaint about Kevin into a situation involving at least four people. Now the therapist is ready to initiate his challenge to the family's arrangement.

He sets the stage for an enactment by asking the parents to bring Jenny to talk with the grown-ups but to leave Kevin playing. At this point he thinks that Jenny also has a function in keeping Kevin busy, and that the separation of the children will trigger Kevin's "hyperactivity." When Kevin, as expected, begins to protest loudly about the unfair discrimination, the therapist asks mother to protect Joe's patience.

Mother: You stay there playing for a while, Kevin, the doctor wants to talk to Jenny.

Kevin: No! (Stands up and moves toward his mother.) -

Mother: No Kevin, I told you to stay there, you can not come here now.

Pat (to Kevin): It is only for a while.

Kevin: Is he going to see her eye?

Pat: No, I don't think so. (Looks at the therapist who looks at the ceiling. Kevin leans on Pat.)

Mother (to the therapist): Is it okay if he stays here?

Therapist: I don't know. (*To father:*) Is it okay that he should disobey your wife? She just told him to stay there.

Father: Yeah, but that is it, you see, they keep doing it. Connie and Pat, they do it all the time.

Therapist: Tell that to your wife.

Father: But I tell her, I tell you, don't I?

Father and mother now initiate a rather low-key discussion about what should be done when Kevin does not respond to their requests, with father espousing a more stern position and mother advocating for more understanding. Pat alternates between trying—not too forcefully—to send Kevin back to the toys, and listening to the couple's dialogue. Jenny watches silently. After a minute or two the therapist interrupts the sequence and steps up the challenge.

Therapist: You are not going to get anywhere, because you are asking your wife to send Kevin back but she can't do it.

Father: Yes I know. Well, I wasn't—

Therapist: But you know why? You know why your wife can't do it? Because she does not have Kevin right now, Pat does.

Father: How do you mean? -

Pat: He means I'm stealing your son, like we used to say—

Therapist: No, you are not stealing anything, you are trying to help. But you are not being helpful, because all the time that you take care of Kevin they ~don't have to agree. You see, they can't finish this argument, they don't need to, because you are protecting them from Kevin, and Kevin from them.

Pat: But I am not keeping him.

Therapist: Oh yes you are, by being so available. I'll tell you what, I'll ask you to take a rest.

The therapist then invites Pat to move her chair next to him and spend the next minutes observing her relatives. So Pat is being defined as a well-meant, helpful person—which she most probably is—but the boundaries are being set all the same.

The therapist is also punctuating the triadic relationship by placing the emphasis of his description on Pat's helpfulness toward the Murphys. The same transaction could alternatively have been described as the Murphys helping Pat to feel useful, or as the two women forming a coalition against Joe, or as Connie being the middle woman between her husband's and her sister's demands, and so on. In fact these different versions of the same reality are equally true and will eventually be emphasized in later sessions. At this point however, the therapist chooses the angle that seems to be less threatening for Pat, because he has assessed the power held by the sister in the family.

The rest of the first session is employed in discussing the differences in personality between Jenny and Kevin, and other issues where the children are the focus of attention. Father is asked to "interview" the children for the therapist, in a move that anticipates the direction of the unbalancing that will be initiated in the second interview. At the end of the session Pat is invited to share her observations with the family.

The Murphys were in treatment for a total of 18 weekly sessions. The early scene where father and mother fruitlessly disagreed while Kevin clung to Pat could be used as an illustration for different stages of the treatment—provided the scene was photographed from many different angles and with many different lenses, so that it could render a variety of themes. The first therapeutic goal was to make room for an unobstructed relationship between father and Kevin. They should be able to establish their own rules, without interference from mother or Pat. This objective was made difficult by the myth that father was unable, either because of his temper or his indifference, to sustain such a relationship. The therapist had to unbalance by pushing father to exercise his rights and obligations, challenging mother's opinion and maintaining Pat as a nonparticipant observer.

As father gained in assertiveness he began to bring his own challenges into the picture. He insisted that Kevin should go to nursery school, and successfully refuted his wife's objections. (Kevin had been spending most of his days with mother at the store, a small place that constrained his activity, and where Jenny's accident occurred.) The complaints about Kevin's behavior gradually disappeared and, simultaneously, Pat began to lose interest in the sessions and even missed some. The therapist decided to temporarily excuse the children from attending the sessions and to shift the focus toward her.

Pat, the younger of the two sisters, was single and divided her life mostly between her job as a teacher and the Murphys. She and Connie talked a lot, mostly about the children and probably about Mr. Murphy as well. Pat was also the family's favorite babysitter. With father assuming a new role in the family, the pattern of coalitions underwent a change: mother moved closer to her husband and away from her sister. Pat began to feel depressed and to withdraw even from the children, which brought about a reversal in the sisters' relationship. While before Pat had been the knowledgeable teacher and Connie the troubled mother, now Connie was being the fulfilled family woman and Pat the lonely single. Connie grew solicitous about Pat, which only helped to increase Pat's feelings of depression and inadequacy.

The therapist introduced his own framing in this arrangement by pointing out that Connie was being intrusive; Pat had a right to her own privacy, including the right to feel depressed and lonely without interference. Connie could indicate that she would be available if Pat needed company or advice—but she should not impose herself on her sister...At Pat's own request, the therapist held a couple of individual sessions with her alone.

The content of these two sessions is not nearly as important as the fact that they took place, reinforcing the message of differentiation. Following them—and although the subject had not been discussed between Pat and the therapist—Pat announced in a somewhat solemn manner her “resignation” as the Murphy's babysitter. The Murphys, particularly Connie, were distressed at the possibility that Pat could be acting out of a feeling of rejection; the therapist supported Pat in her stand that she was just making what she thought was a good decision for her.

The last sessions, in which the children were again included, were devoted to monitoring the adjustment of the Murphy family to the new set of rules. At that point Kevin was doing well in nursery school—after a somewhat difficult start— while at home he did not present any problem that his parents could not handle. The parents had reopened a discussion about the future of their grocery store, an issue on which they had conflicting points of view. Dealing with the conflict had been impossible before because of her fears of making him feel incompetent and his fears of upsetting her; now, from their new perceptions of each other, a conflict-solving approach was possible. Finally, Pat's private life remained wrapped in a mystery that the therapist had to respect—because his restructuring intervention had come to an end.

However, 8 months later the therapist called for a follow-up and, according to Mrs. Murphy, the only news worth mentioning was that Pat was dating somebody whom she—Connie—did not like at all. “But,” Mrs. Murphy hastened to add, “Joe keeps telling me it's her life and it's none of my business. And I tell him if I don't like the guy, I'm sorry, I don't like him, and that's none of *his* business either.”

EVALUATION

Treatment models tend to resist evaluation, not only because of the methodological difficulties that plague the definition and control of relevant variables, but mainly because of the decisive effect of value judgments on the selection and interpretation of data. Outcome criteria, which are crucial in assessing the efficacy of treatment; ultimately reflect the ethical choices of a culture or subculture; “empirical evidence” is just a relative truth (Colapinto, 1979).

Structural family therapy enjoys in this respect a comparatively enviable status, because one of its areas of application— psychosomatic illness— facilitates the formulation of “objective” criteria for the evaluation of outcome. Symptom remission is a more precise indicator when the issue is labile diabetes than when we are talking about a depressive reaction. In the first case it is possible to count the number of hospitalizations, while in the second, one has to rely more on subjective reports.

Minuchin and his collaborators have periodically published their research findings in the field of psychosomatics (see, for instance, Baker, Minuchin, Milman, Liebman & Todd, 1975; Liebman, Minuchin & Baker, 1974c; Minuchin, Baker, Rosman, Liebman, Milman & Todd, 1975; Rosman, Minuchin, Liebman & Baker, 1976, 1977). The most complete report (Rosman, Minuchin, Liebman & Baker, 1978) summarizes information on 20 cases of labile diabetes, 53 cases of anorexia and 17 cases of intractable asthma.

In the case of labile diabetes (operationally defined as severe, relapsing ketoacidosis, chronic acetonuria and/or extreme instability in diabetic control), 88% of the subjects (aged 10 to 18 years) recovered— this meaning that no hospital admissions for ketoacidosis occurred after treatment, and/or that diabetic control stabilized within normal limits. The remaining 12% showed moderate improvement: some symptomatology persisted after treatment but there was a marked reduction in the number of hospital admissions, and/or a more stable diabetic control. The diabetic group was in therapy for periods ranging from 3 to 15 months, with a median of 8 months, and was followed up for 2 to 9 years, with a median of 4½ years.

Of the 53 anorectics (aged 9 to 21 and with a median weight loss of 30%o), 86% achieved normal eating patterns and a body weight stabilized within normal limits; 4% gained weight but continued suffering of the effects of the illness (borderline weight, obesity, occasional vomiting), and 10% showed little or no change or relapsed. Treatment lasted between 2 and 16 months—with a median of 6—and follow up was done between 1½ and 7 years, with a median of 2½ years.

Finally, the 17 asthmatics (suffering severe attacks with regular steroid therapy, or an intractable condition with steroid dependency), aged 7 to 17 years, achieved recovery (little or no school days lost, moderate attacks with occasional or regular use of bronchodilator only) in 82% of the cases. An additional 12% improved moderately (weeks of school lost, prolonged and severe attacks and some use of steroids but with symptomatic improvement), and the remaining 6% stayed unimproved (more than 50% school loss with need for special schooling, persistent symptoms and dependency on regular steroid therapy). Duration of treatment was between 2 and 22 months with a median of 8, and follow up was done between 1 and 7 years later, with a median of 3.

Psychosocial assessment of the 90 cases, based on the degree of adjustment to family, school or work, and social and peer relationships, showed results that paralleled these data.

The systematic and sustained application of the model in the Philadelphia Child Guidance Clinic over the last 15 years—in which thousands of families were served— provides an additional, although admittedly indirect, indication of its validity. The same applies to the sustained-enrollment in the training programs offered at the Clinic by the Family Therapy Training Center. In addition to workshops and other continuous education activities, the Center offers an 8-month extern program where an average of 40 family therapists are trained each year, and 3 summer practica that provide an intensive experience to another 70 professionals. The intensive use of live supervision and

videotapes encourages and facilitates the evaluation of treatment process.

SUMMARY

Structural family therapy is a model of treatment primarily characterized by its emphasis on structural change and on the therapist as an active agent of change. Its origins can be traced back to Salvador Minuchin's work with delinquent boys from poor families at the Wiltwyck School in the early 1960s; its consolidation coincided with Minuchin's tenure at the Philadelphia Child Guidance Clinic, where he was appointed Director in 1965. The successful application of the model to the treatment of psychosomatic conditions, documented through research, was primarily responsible for the interest aroused by Minuchin's approach; but structural family therapy can be and has been applied to the entire range of emotional disorders.

The model conceptualizes the family as a living open system whose members are interdependent and which undergoes transformation of an evolutionary nature. Family process is regulated by the multilevel interplay of homeostasis and change, and it can be arrested—in which case the family fails to adjust its rules to changing environmental or intrinsic demands, and homeostasis becomes dominant. Intergenerational coalitions, triangulations, conflict avoidance and lack of growth and differentiation characterize these families, which then come to therapy as caricatures of themselves.

The problem behavior is seen as a partial aspect of this family stagnation; the diagnostic endeavor consists of assessing the transactional and perceptual structure that is supporting (rather than "causing") the symptom. Accordingly, therapeutic change depends on the modification of the family structure: positional changes, increases and reductions in distances, redefinition of hierarchical relations, exploration of new alternative rules, and conflict resolution are required so that the natural road to growth can be reopened. A special context, the therapeutic system, is created to this effect, where the therapist pushes the system limits in a quest for its potential strengths and underutilized resources.

The therapist's function is to assist the family in its restructuring, and his participation is subject to boundaries both in terms of depth and time. His role is paradoxical—he needs to find the right equation of accommodation and challenge—and at different moments of his encounter with the family it can be compared to the job of a dancer, a stage director, a camera director and a strange body in the family organism. The model provides him with techniques for the formation of the therapeutic system and for the creation of disequilibrium and change: joining techniques such as maintenance, tracking and mimesis, and disequilibrating techniques such as reframing, enactment, boundary making, punctuation, and unbalancing.

Structural family therapy has been directly validated through research in the fields of psychosomatics, and indirectly through its application to thousands of families presenting all sorts of different problems. The sustained demand for training from mental health practitioners provides another indirect measure of the model's validity.

ANNOTATED SUGGESTED READINGS

Minuchin, S., Montalvo, B., Guerney, B. G., Rosman, B. L., & Schumer, F. *Families of the slums*. New York: Basic Books, 1967.

This book summarizes the experience at Wiltwyck. It is a report on a research focused on the structure and

dynamics of poor and disorganized families with more than one delinquent child, and it includes some of the early instruments developed by the group to assess family interaction.

Minuchin, S. *Families and family therapy*. Cambridge, MA: Harvard University Press, 1974. This is the first systematic presentation of structural family therapy. It discusses the basic concepts in the model and their implications for therapy, with the help of excerpts and transcriptions from interviews with normal and problem families.

Minuchin, S., Rosman, B., & Baker, L. *Psychosomatic families: Anorexia nervosa in context*. Cambridge, MA: Harvard University Press, 1978. Presents the specifics of psychosomatic disorders, including the characterization of the psychosomatic family, the treatment program and the outcome, with a special emphasis on anorexia nervosa. It also includes long excerpts from family sessions.

Minuchin, S., & Fishman, H. C. *Family therapy techniques*. Cambridge, MA: Harvard University Press, 1981. An updated account of the model that draws from the experience accumulated in the course of several years of teaching at the Family Therapy Training Center. Emphasis is on the analysis of techniques and the theoretical and philosophical rationale behind the techniques.

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