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Family Therapy: A Structural Approach

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It is hard to describe family therapy without also thinking about social work. Both share common ground at the conceptual and practice levels. Each encompasses a way of looking at the individual in context, scrutinizing the relationship between behavior and environment, between part and whole. Family theory and social work reject a passive problem-solving stance and instead support active empowerment of people by tapping their existing resources, uncovering new ones, and creating a viable context for change.

This chapter will describe some of the central concepts of this perspective, using structural family therapy as a model. The structural approach is but one of many "schools" of family therapy.* In the same way that the individual reflects only a part of the family, this model represents just a partial image of family theory. Structural family therapy was chosen to represent family therapy because, as Hoffman (1981) points out, "Minuchin has a clear method and a theory consistent with that method" (p. 262). The effectiveness of the structural approach has been investigated with a number of clinical populations, particularly psychosomatics and substance abusers (Minuchin, Rosman, & Baker, 1978; Stanton, Todd, et al., 1982). I believe that these measurable results support

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* The "schools" of family therapy are well represented in Gurman and Kniskern's (1981) *Handbook of Family Therapy* and in Piercy & Sprenkle's (1986) *Family Therapy Sourcebook*.

and explain the clinical relevance of a family therapy perspective. In addition, it is the approach that I know best, and I have remained comfortable with my bias in favor of it.

THE CONCEPT OF THE PERSON AND THE HUMAN EXPERIENCE

Without a doubt, Western society, more than any other in the world, emphasizes the importance of the individual. Our cultural stereotypes are rich with images that seem to call for individualism at any cost. The context of human drama becomes a mere backdrop to highlight the triumph of the person over circumstance, a view constantly reinforced by virtually every medium. Yet even the Lone Ranger had Tonto—and without the bad guys, there would be no good guys.

From a family therapist's perspective, individual behavior can only be understood within its relational context. Man and his fellow creatures are "looked upon as inseparable from their environments" (Haley, 1971, p. 1). Although this premise may sound simple and even obvious, it is by no means easy to apply. Co-responsibility—the idea that all parties in a social system contribute to a shared reality—is a difficult concept to grasp. The following story illustrates how foreign this perspective is to the Western mind, or at least to the Western tourist:

An American woman was driving her car in China. While stopped at a corner, she was suddenly struck by a man on a bicycle, causing both man and bike to go tumbling. Fortunately, the man was unhurt, but the car and bicycle each sustained damages. A policeman was summoned to assess the damages. After carefully looking over the vehicles and hearing the story, he proceeded to write out two tickets: One ticket was issued to the hapless bike rider for being "90% at fault." The second went to the woman who had been sitting, stopped in her car, for being "10% at fault." The American was furious and demanded to know how she could be found "at fault" since 1) she was at a complete stop and 2) the bike rider had run into her. The policeman heard her complaint and then patiently explained that had she not been in China, there would have been no accident at all.*

When watching and listening to each person's story, family therapists borrow the eyes and ears of the Chinese policeman. Power in a system, or the "relative influence of each member on the outcome of an activity" (Aponte, 1976b, p. 434), is shared, but not in equal proportions. This is particularly true in cases of abuse, rape, or incest, in which power is

* My thanks to Jorge Colapinto for relating this story

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unevenly distributed and is supported in this arrangement by a larger social and political context (Taggart, 1985). This concept is a departure from traditional reductionistic positions. Speculating about internal forces is one thing; accounting for contextual organizers, particularly if they include the observer, is another. Examining events in context changes how we think about aberrant behavior—and what we do about it.

Although family therapists understand that people are part of increasingly larger systems, they do not believe that individuals are reduced to being helpless cogs in the machine of life. A key to the systems position is in recognizing that individuals and their larger social system counterparts are nonsummative (Speer, 1970). It is the human equivalent of two plus two equaling nine. People are viewed as active participants of a mutually constructed reality and are always more than what they seem.

The emotions of pain, sorrow, love, and joy are still very much a part of the human experience. It is not only people's "internal" system that determines emotions and behaviors, but also—and largely—the dynamic interplay of their responses to other people and situations. This is vividly true for children, who are born with specific genetic and temperamental predispositions; this "raw material" is shaped by and shapes the lives and forces around them. The longitudinal research of Thomas and Chess (1984) makes the cumulative impact of these forces clear. If the "fit" between individuals, their capacities, their motivations, and their styles of behaving are consonant with the environment, "optimal development is possible" (Thomas & Chess, 1984, p. 8).

Context affects everyone, even therapists. As the process of change begins, the therapist is inexorably pulled to "fit" the family and its context.

The Therapist as System Member

Principle of Least Effort . . . a system will try to adapt to its environment or will try to change the environment to suit its needs, whichever is easier.—Stuart Umpleby (1984, p. 32)

Like Schweitzer treating the sick, therapists like to believe they are immune. Edgar Levenson, a psychiatrist who applied structuralism to psychoanalysis, points out, "It is an epistemological fallacy to think that we can stand outside of what we observe, or observe without distortion what is alien to our own experience" (Levenson, 1972, p. 8).

Levenson's point makes apparent the difficulty of embracing a systemic view of human beings, namely, we cannot look at others without also looking at ourselves. If clients are acting crazy when they are with us, then, from this perspective, there is a reasonable chance that we might

have something to do with it. Likewise, if someone is "acting out" in a family, one can safely assume that it is part of a larger drama of which we, the family, and other systems are a part. Ernst von Glasersfeld (1980), a radical constructivist, points to the universal aspect of this interactive process between environment and organism—namely, survival:

In order to remain among the survivors, an organism has to get by the constraints which the environment poses. It has to squeeze by the bars of constraints. . . . The environment does not determine *how* that may be achieved. Anyone who by any means manages to get by the constraints, survives. (p. 90)

Family therapists agree that the business of surviving changes the organism. In social environments, this change is circular. That is, as a person changes to meet contextual demands, the context also changes to absorb new input. Each affects the other in always subtle and sometimes dramatic fashion as the dance of reciprocity shapes its participants in the mutual struggle for survival.

Over 30 years ago, this discovery—that we all contribute to interpersonal problems—provided a sobering yet hopeful beacon to family therapy's early pioneers. In the knowledge of our contribution, also lies the hope that we can likewise participate in the resolution of problems. Either way, we are touched by the process.

HISTORICAL PERSPECTIVE

The early years of family therapy have been described as every thing from a "kaleidoscope" (Kaslow, 1980) to a "guerrilla war" (Guerin, 1976). It was most likely a little of both, and much more.

Broderick and Schrader's (1981) historical account of marriage and family therapy is the most comprehensive. Of particular note for social workers is the authors' recognition of the social work movement and their comment that although social work has been "inextricably woven" with the history of marriage and family therapy, social workers have been, in turns, "the most daring pioneers and the most passive Johnny come lately's in the whole parade of professionals" (p. 6).

The idea of looking at behavior in the context of the family began sometime in the late 1940s and early 1950s. According to Guerin (1976), the impetus for the movement stemmed from those who were frustrated by the limitations of traditional psychiatry with schizophrenics and their families and with the problems of juvenile delinquency. According to Guerin, research provided the umbrella under which new theories could be tested. Ironically, "for unexplained reasons a number of therapists began to deal with whole families in the 1950s, often without knowing

that anyone else was doing so" (Haley, 1971, p. 2). This isolation may have contributed to the delay of family therapy's acceptance and to the formation of "schools" that were formed around some of the early pioneers.

Throughout the 1960s and 1970s, these schools did little to promote dialogue and cross-fertilization. However, as Bill Vaughn once said: "It's never safe to be nostalgic about something until you're absolutely certain there's no chance of its coming back" (Gardner & Gardner-Reese, 1975, p. 191). Perhaps that is why family therapy is now showing hopeful signs that it is ready for both nostalgia concerning its origins and dialogue about its future.*

Despite these diverse beginnings, however, the field of family therapy began to jell by the early 1960s, about the time Salvador Minuchin began writing about his work at the Wiltwyck School for Boys in New York, a school for delinquent boys from poor, disorganized, multiproblem families (Colapinto, 1982).

The Development of Structural Family Therapy

During the 1950s and early 1960s, therapists had found that certain clinical populations seemed to repel traditional psychotherapy methods with unnerving consistency. Inner-city delinquent children, like those who filled the halls of the Wiltwyck school, were particularly troublesome. It was there Minuchin found that he needed a model of change that worked.

In 1966, when Minuchin's work was first published, political and social forces also seemed ripe for change (Malcolm, 1978). The "Great Society" became national testimony to the end of Social Darwinism. People were ready to experiment, to try new things. Medicare was introduced; communes were started; long hair, short skirts, drugs, and strange music were "in." There was a prevailing belief that changing the environment could, in fact, change people. Money, programs, and politicians poured into "the community." It was empowerment on a grand scale. Social workers were delighted. President Kennedy's "If you are not part of the solution, you are part of the problem" speech became the guiding principle of social policy. Systems thinking was everywhere, or so it seemed.

In the case of structural family therapy, however, Colapinto (1982) has noted the confluence of three factors: the difficult population with which Minuchin was working; timing; and the collaboration with Braulio Montalvo, a man whom Minuchin said "has the rare capacity to receive an idea and then give it back enlarged" (Minuchin, 1974, p. vii), that

* See Olson (1970) for another historical account of the family therapy movement.

set the stage for the evolution of structural family therapy. Commenting on his own family therapy work, Minuchin said:

We must be doing something wrong, I thought. At this point I read an article by Don Jackson or Virginia Satir or somebody, and I said to my colleagues, "Let's begin to see families," and we did. It was a great adventure. We didn't know anything. And since we didn't know anything, we invented everything. We broke through a wall in our treatment room and put in a one-way mirror and began to observe one another and to build a theory out of nothing. (Malcolm, 1978, p. 84)

The one-way mirror was to become a symbol of the new therapy's brazenness. Theory and therapist were pushed to unify the abstract with the concrete. In fact, Minuchin's early works and those of the other founding parents could have easily been dismissed as yet another "fad." However, the times were right and research results eventually supported the new theory. A move to Philadelphia and the challenge of working with psychosomatic children presented an opportunity to make structural family therapy and family theory more legitimate.

The Child Guidance Years

In 1965, Minuchin was appointed Director of the Philadelphia Child Guidance Clinic. Montalvo followed Minuchin to Philadelphia and was later joined by Bernice Rosman, another Wiltwyck colleague. In 1967, Jay Haley (a communications expert) came from California, where he had worked with Gregory Bateson and the team from the Mental Research Institute.*

The 1960s also were a time for a commitment to the community, and in 1969 the Clinic received a grant to train members of Philadelphia minority groups (who had no formal education or experience as psychotherapists) to become family therapists. The two-year program used innovative teaching methods, including the use of one-way mirrors, videotapes, and intensive live supervision of family sessions, to create highly competent therapists (Montalvo, 1973). All 24 of the program graduates returned to work within the community. (However, the graduates never had the opportunity to share their expertise with successive

* The work of Gregory Bateson and his colleagues at the Mental Research Institute (MRI) was a seminal contribution to the field. A comprehensive overview of the MRI group can be found in Bodin (1981). Further readings by members of the present and former MRI staff are suggested as excellent sourcebooks. For example, see Bateson (1972); Bateson, Jackson, Haley, & Weakland (1956); Haley (1963, 1973); Jackson, (1957); Satir (1967); Watzlawick, Beavin, & Jackson (1967); Watzlawick, Weakland, & Fisch (1974).

trainees: Economic policies changed and there were fewer grants for this type of program. The model had to prove successful in other applications to remain credible.)

Structural Theory Comes of Age

Research for the model was provided by the clinic's affiliation with Children's Hospital of Philadelphia. Diabetic children who had an unusually high number of hospitalizations for acidosis (a stress-related condition) were not improving with traditional forms of therapy. Minuchin and his team began to see a correlation between certain family characteristics (such as enmeshment, overprotectiveness, rigidity, and lack of conflict resolution) and the reasons for recurrent hospitalization (Baker, Minuchin, Milman, Liebman, & Todd, 1975).

This study also provided the key to working with another challenging patient group—anorectics. Unlike other disorders that bring children to hospitals (such as diabetes or asthma), anorexia has no physical etiology, and therefore the effectiveness of therapy (as opposed to medical treatment) can be more readily measured in terms of a "cure."^{*}

As the application of the theory grew, so did the Child Guidance Clinic. It stretched the boundaries of traditional outpatient and inpatient work by incorporating the structural approach into all facets of programming, including the construction of two residential apartments, fully equipped to hospitalize entire families.

KEY THEORETICAL CONCEPTS

*There is no such thing as an individual, there are only fragments of families.—Carl Whitaker^{**}*

One can say that a person's problems are a result of present relationships, or past relationships, or both. Regardless of the source of the difficulties, one must still decide what to do about them.

For example, a therapist can believe that the source of Charley Shore's Bipolar depression is genetic, predisposed, and historic. If interventions are designed to address these sources, the therapist will talk to Charley individually, attempt to resolve intrapsychic conflicts, and perhaps prescribe medication. If, on the other hand, the therapist can make a

^{*} The most complete record of the research and clinical work on anorexia from a structural approach can be found in Minuchin, Rosman, and Baker (1978).

^{**} (Carl Whitaker, staff seminar, Philadelphia Child Guidance Clinic, March, 1983.) Whitaker's work has had a tremendous impact on the field of family therapy. An excellent overview of his work can be found in Neill & Kniskern (1982).

distinction between the source of the problem and the source of the solution, he or she greatly increases problem-solving possibilities. In our example, this means recognizing that Charley's depression occurs in a context that affects not only him, but his wife, his daughter, his son, and so on. It follows that if the depression affects them, they can also affect the depression. It is possible to challenge Charley's illness by helping him change, but the probability of success is lowered by ignoring the roles of the rest of the family.

A systems position does not ignore the individual, the past, or even the need for medication. It simply puts these issues into a useful, nonblaming therapeutic context, in which all the opportunities for change can be incorporated. Critics of family therapy have charged that biological issues are overlooked or often discounted by the model. A family systems based paradigm does not preclude components in the genetic or physical substrata. One cannot cure mental retardation or other disabling or limiting aspects of certain diseases. From a systems perspective, these are all part of the "fit" between the individual and his or her environment. Family therapists who ignore these "givens" are simply doing bad family therapy. The family and present circumstances are, however, always looked to first, as a primary context in which behaviors are manifested, maintained, and changed.

The Family as a System

A family is a living, open system composed of individuals who are connected in specific ways that mutually affect one another.* Families evolve patterns of transacting that are both economical and effective for that particular group of people (Minuchin, 1972). These accustomed ways of relating are interdependent and complementary and are necessary for carrying out system functions. The rules that regulate family interactions are known as the family's *structure* (Colapinto, 1982, p. 116).

These rules can be either explicit or implicit. Explicit rules—bedtimes, curfews, no stray socks in the living room—come to mind when one is thinking of how families work. Implicit rules, on the other hand, can only be observed in action. In other words, in order to know that there is a rule in a particular family about who is responsible for nurturance, one must repeatedly observe that in that family, when the child cries, it is the mother who picks it up. These rules or structures emerge over time and are content-specific for each family but universal at the level

* Jane Jorgenson (1986) has researched how families define the concept of "family." Definitions ranged from strictly blood relatives to inclusion of non-blood-related people who were treated as if they were related. Also see Minuchin, P. (1985) for an excellent integration of the individual development from a systems perspective.

of family functioning. Other universals of family functioning are growth, change, and maintenance of stability.

Growth

Because the family is a living, open system, it influences and is influenced by a myriad of circumstances both inside and outside of its membership. From the viewpoint of structural family therapy, this means that the family's continuous evolution as a system and its members' evolution as individuals will tend to move in the direction of growth and increased complexity. We know, for example, from sensory deprivation experiments, that people's inner stability depends on stimulation (Allport, 1960). In families, these necessary stimuli come not only from internal sources (e.g., the developmental changes that each member experiences), but also from external forces such as community, culture, work, and attitudes about sex roles and race. Each factor impacts the family in different degrees at different times. The family absorbs societal change as it percolates down and then in time returns the favor, changing itself and society in the process.

Regulation, rules, and change

In the same way that permeable membranes allow organisms to regulate the constant in-and-out flow of energy between themselves and their surroundings, semipermeable boundaries between the family and the outside world modulate changes (i.e., "stimuli," such as births, deaths, marriages, divorce, and death) imposed by the exigencies of life (Katz & Kahn, 1966/1969). Through a process of feedback, this in-and-out flow of information alters family structure, rules, and roles as the system adapts to change.

Homeostasis, which in the context of family therapy means the tendency for social systems to "seek a steady state" (Dell, 1982, p. 27), ensures the stability of the system over time (Jackson, 1957; 1965). If the family were to change with every new bit of information, it would cease to be a system and would instead be a jumble of disconnected parts. On the other hand, not responding to new information would result in *entropy*—that is, undifferentiation or "a gray, random sameness without movement or change" (Hoffman, 1981, p. 340). Without change, growth cannot occur, and without growth the system will cease to be functional or, in the case of families, will have an increased probability of becoming symptomatic.

Change and homeostasis become interchangeable forces—figure and ground in dynamic balance—pushing and protecting the family throughout the life cycle. Health of the family members is measured by their ability to successfully adapt to their environment. To the extent that

people can choose how and when to respond and not simply "react," they will experience greater mastery over their circumstances. Health and choice, then, are inseparable (Dubos, 1978).

Complementarity of functioning in patterns and roles ensures the internal stability of the system and helps to counterbalance the stress associated with change. That is, the component parts co-evolve an "organized coherent system," in which all parts of the system fit together (Dell, 1982, p. 31). To the degree that Charley is distant and underresponsible, Nancy is proximate and overresponsible.* This complementary unity unfolds in sequences of behavior and thinking that can range from seconds to generations (Breunlin & Schwartz, 1986). Put together, these sequences "reveal a fundamental pattern of oscillation, or cyclical change, among the various parts as the influence of each element temporarily moves into ascendancy in response to inputs from the larger environment and then is overcome by the opposite" (Jordan, 1985, p. 167).

Here again, "the ability to respond fluidly to changing conditions by temporarily drawing on one side of a polarity within the system is the key to successful adaptation of that system" (Jordan, 1985, p. 167). In the Shore family, for example, Nancy's proximity to Michael as an infant was appropriate and necessary: Michael was sick; she was a nurse as well as a mother; Rena was busy with the extended family; and Charley was at work. As Michael grew older, this arrangement needed to shift, and a different complementarity was called for.

When a system must change structurally to meet new needs, the system becomes stressed and temporarily loses its equilibrium. However, such disequilibrium ideally leads to a healthier adjustment and further development—in other words, greater differentiation and complexity. Some people may feel disloyal to their families at these transition points; moreover, as family members attempt to differentiate themselves, some may be pressured to resume old roles as the uncertainty of change calls for the familiarity of old patterns (Boszormenyi-Nagy & Spark, 1973).

According to the structural approach, subsystems are the way in which "the family system differentiates and carries out its functions" (Minuchin, 1974, p. 52). One can begin at any transition point in the life cycle to illustrate the shift in family roles and rules. Birth, marriage, death, and adolescence, as well as unemployment, divorce, or a move, all embody these changes. However, we most clearly see subsystem development when a child is born and husband and wife also become mother and father. According to Minuchin (1974):

Subsystems can be formed by generation, by sex, by interest, or by function. Each individual belongs to different subsystems, in which he has different levels of power and where he learns differentiated

* The concepts of overresponsibility and underresponsibility have been diligently explored and developed in work with alcoholics and their families by Bepko and Krestan (1985).

skills. A man can be a son, nephew, older brother, younger brother, husband, father and so on. In different subsystems, he enters into different complementary relationships. (p. 52)

The composition of the subsystem is not as important as the clarity of the boundaries. For example, Rena could only be parented effectively by Charley and Nancy to the degree that they worked together and to the extent that Gram and Aunt Flo did not interfere with parental decisions.

Boundaries

Boundaries are the subsystem rules that determine who participates in which situations, when, and how (Minuchin, 1974). Expanding on Minuchin's work, Wood and Talmon (1983; Wood, 1985) distinguish two types of boundaries: 1) interpersonal boundaries, or "proximity" (Wood & Talmon, 1983, p. 351); 2) boundaries that reflect who participates in certain subsystem roles—that is, intergenerational boundaries or "generational hierarchy" (Wood, 1985, p. 489).^{*} Each of these boundaries has affective consequences for family members as they negotiate subsystem membership. Examples of such negotiations include one parent's telling a child to be quiet while the other parent is on the phone, an older sibling's increased privileges, or an injunction to the children to stop interfering with husband-wife time. These kinds of boundaries affect family members' internal experience and their experience of others. Just as specialized cells in the body have to be free from interference to function effectively, so, too, do familial subsystems need clear boundaries (Kerr, 1981).

Boundaries can be conceptualized along a continuum of permeability, ranging from *enmeshed* (diffuse) at the one end to *disengaged* (rigid) at the other. Most families fall somewhere in the middle of the continuum and may, at different points in the life cycle, temporarily operate near either end (see Figure 1).

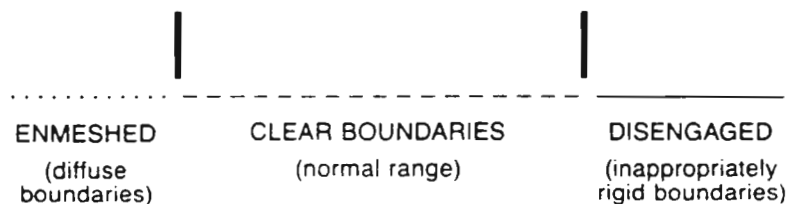


Figure 1. Diagram from *Families and Family Therapy* (p. 54) by S. Minuchin, 1974, Cambridge, MA: Harvard University Press. Copyright 1974 by S. Minuchin. Adapted by permission.

^{*} My thanks to Betsy Wood for clarification of this point.

"Enmeshed" and "disengaged" are not family types that connote either health or pathology; instead, they are styles of interaction for a particular family group, at a particular time, mitigated by culture and context. For example, if one listened to a family's interactions shortly after the birth of a new child, one would hear sounds that reflected a healthy over-involvement in the baby's life. Later, when the children leave home, interactions would reflect more distance.*

As the family attempts to cope with internal or environmental change, boundaries may collapse, leading to greater proximity among family members, or they may become underorganized as the family attempts to find problem-solving pathways within the existing family structure (Aponte, 1976b).

Problems can occur when boundaries remain unclear or when a family consistently operates at either extreme of the boundary continuum. Repeatedly enmeshed interactions will heighten a family member's sense of belonging. However, this is often paired with a reduced sense of independence and differentiation.** For example, children who grow up in an enmeshed subsystem can be discouraged from risk-taking and from pursuing peer membership outside the family. Conversely, members in a disengaged system may have an exaggerated sense of independence, but do not experience adequate nurturance. Michael's "loner" status at school can be seen as a byproduct of both an enmeshed mother-son dyad and a disengaged father-son dyad. Not only is he physically and emotionally close to his mother and distant from his father, but also, because his parents cannot operate as an effective unit, he is denied the systemic permission needed for him to move beyond the family limits. Within and between the various systems, a cycle of self-fulfilling prophecies develops. For example, to the extent that Michael is marked as "different," he remains wired to the family. Likewise, to the degree he orbits in close proximity to his family, he will remain "different."

In order for Michael to successfully move out into his peer group, two things would need to change. First, there would need to be more proximity and agreement between Nancy and Charley. Second, there would need to be more distance between Nancy and Michael and more proximity between father and son.

Symptoms

What is it about the Shores that prevents their growth and development? The Shores' family development has been arrested. Despite the

* Two primary sourcebooks on family development from a systems perspective are Carter and McGoldrick (1980) and Walsh (1982).

** Murray Bowen's work at the National Institute of Mental Health during the mid-1950s with schizophrenics and their families led to his development of family systems theory and concepts that are now a part of the family therapy vocabulary. Kerr (1981) provides an informative historical and theoretical overview of Bowen's work. (Also see Bowen, 1966)

constant pressure of new circumstances, the Shores have clung to a structural artifact—adaptive at an earlier stage of family life, outdated in its current one. When Thomas and Chess (1984) refer to a poor fit or "dissonance between the individual and the environment" (p. 8), they could be referring to the Shores' current inability to find an organizational shape that will get them out of the developmental woods. In family therapy terms, this is what is known as being "stuck."

Another way to examine why families get stuck is to explore the consequences of change. For example, Nancy's continuous TV-watching and her overconcern for Michael begin to make sense when we remember that she has no other family members to support her at home and has a disability that limits her activities. If Michael and his father were to get closer, Nancy's isolation would increase. Although she and Rena might be able to renegotiate their relationship, the change would mean entering into dimly charted waters with few markers to guide them.

When family members are faced with such stress, it is not uncommon for triangular patterns to appear. *Cross-generational coalitions* can form when one child and parent become pitted against the other, undermining generational hierarchy. When it is chronic, this dysfunctional arrangement can result in symptoms ranging from psychosomatic illness to addiction (Minuchin, Rosman, & Baker, 1978; Stanton, Todd, et al., 1982). Conflict avoidance is a way for the system to maintain a level of stability and prevent the possible dissolution of the family. It does so at the cost of individual differentiation and growth, which are the result of conflict resolution (Colapinto, 1982).

Michael's poor social judgment, inappropriate laughter, and rejection from camp are poignant tributes to the status quo. The Shores—and all families—must struggle to walk the narrow path between the predictable and the unknown. To follow their route is to understand how families work and how they change.

ASSESSMENT

In structural family therapy, assessment and intervention are an inseparably woven fabric, tailored by the system's feedback. The therapist is included in this weaving process at the experiential level and at the intellectual level (i.e., he or she knows that the mere observation of a system affects both it and the observer). Assessment is both ongoing and inseparable from each stage of treatment and every intervention. From a structural family therapy standpoint, assessment is also less concerned with the etiology of symptoms and more concerned with current symptom maintenance. Sorting out past from present, and what factors are maintaining dysfunction, is no easy task. Therefore, the therapist must be an editor, choosing, from all the available data about the family, the in-

formation that best illuminates patterns and thus enhances therapeutic leverage.

Families create and maintain an idiosyncratic world view by punctuating some aspects of reality with greater emphasis and minimizing others. The therapist must come to understand the family's world view and the way in which it supports dysfunction. (For example, to the degree that Michael's frailties are accentuated, his strengths are overlooked.)

When families come to treatment, they have a world view that is at the level of *content*—their story is usually about one member, the identified patient. (In this case, the Shores might attribute their problems—Michael's lack of friends, Nancy's depression, and Charley's joblessness—to individual frailties or circumstance.) The structural therapist must have a competing *interactional* perspective that involves all the family members and their larger context.

Assessment becomes the ongoing process of the therapist's refining his or her world view while attempting to modify the family's world view (Lappin, 1984b). The therapist begins with an initial hypothesis about what structure(s) might be maintaining the symptom. This is done against a developmental backdrop based on universals of healthy family and individual functioning. In families, these universals would include clear boundaries, a clear and effective hierarchy, nurturance, and conflict negotiation (Lewis, Beavers, Gossett, & Phillips, 1976). These universals are both generic and specific; different families will fit into different subsets—that is, families with young children versus families with older children, single-parent families versus two-parent families, and so on for each family form.

In the session, what happens among family members and between members and the therapist is called *process*. Does the father sit looking absently away from the family? Does the mother do most of the talking? What happens when the therapist attempts to contact the son? Does he speak for himself or does someone interrupt? Who? and how often? During what content? By enacting familial patterns, the therapist tests for flexibility. How permeable are the boundaries? Through what channels does the family permit the therapist to have access? How does the family attempt to organize the therapist's behavior? Who is the most concerned about the problem, and the least? What happens when the problem surfaces? Who handles it and how?*

* Selvini Palazzoli and her associates in Milan, Italy, developed a method for working with severely disturbed families that uses a team of therapists. One therapist is in the room with the family, while the rest of the team observes from behind a one-way mirror. The interviewer asks questions that are "circular" (i.e., questions made on the basis of the feedback from answers to his or her questions to family members about the relationships between members). After the team meets and consults as a unit it prescribes a task for the family. The task is designed to dislodge dysfunctional patterns so that the family can begin to generate new, more functional sequences of its own. (See Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1978; Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1980a.)

What family members *say*—their world view, their story—is the content. (In this instance, Michael might describe his life as having a “scar” on it, and Rena might offer her “continual crises” theory.) All of a family’s stories relate to the level of systemic rules and functioning, but since the family members are so much a part of their own story, the level of process and pattern is, for the most part, unconscious and unavailable to them. However, because the therapist has greater distance from the system and is thus not as constrained by the rules organizing the family, he or she can begin to use this information in the service of change.

TREATMENT OF CHOICE

Structural family therapy has been applied to a wide range of presenting problems in almost every kind of treatment setting. As previously noted, psychosomatic families and drug abusers have been studied and written about extensively. Other areas described in the literature include adolescent substance abuse (Fishman, Stanton, & Rosman, 1982); school problems (Aponte, 1976a; Berger, 1974; Eno, 1985; Moskowitz, 1976); mental retardation (Fishman, Scott, & Betof, 1977); elective mutism (Rosenberg & Lindblad, 1978); encopresis (Andolfi, 1978); cross-cultural work (Lappin, 1983; Lappin & Scott, 1982; Montalvo & Guterrez, 1983); and low-income and single-parent families (Aponte, 1976b; Lindblad-Goldberg & Dukes, 1985; Minuchin & Montalvo, 1966, 1967; Minuchin, Montalvo, Guerny, Rosman, & Schumer, 1967). Instructional videotapes (with commentary) have also been made about a broad range of presenting problems and issues, including fire-setting, anorexia, depression, blended families, delinquency, and single parents.*

THE THERAPEUTIC PROCESS

As we look at the Shores, we are overwhelmed with data. What is important and what is not? Whose story are we to believe, and to what degree? Is Nancy telling the “truth” when she says, “I worry and Charley doesn’t give a damn”; or is Charley sacrificing himself so that his wife can feel better by being the familial nurse?

As we study this case, we need to keep in mind that reality, from a systems perspective, is an interlocking construction. The Shore family

* A brochure about Philadelphia Child Guidance Clinic videotape rentals is available through Videotape Library, Philadelphia Child Guidance Clinic, Two Children’s Center, 34th St. & Civic Center Blvd., Philadelphia PA 19104.

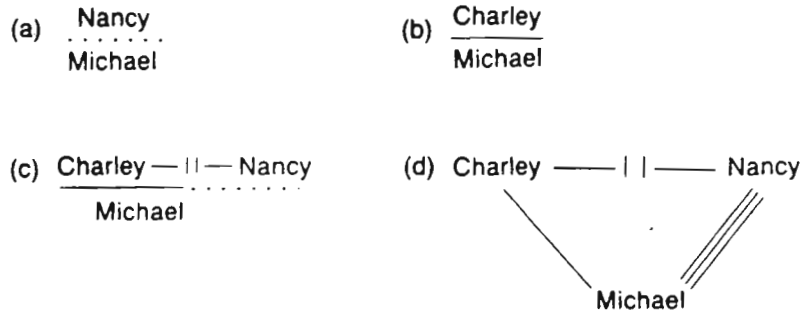
story, as presented in the case report, is merely one version of reality. Another therapist, in another book, at another time, would present another reality equally as valid: "Reality is what we take to be true. What we take to be true is what we believe" (Zukav, 1979, p. 310). However, if *everything* can be "true," where does one intervene, and how? Ultimately, the answer lies in the therapist's theory of change and how he or she uses it (Colapinto, 1979).

Maps: Blueprints for Change

The therapist is guided in the change process by the construction of a family map. Maps statically depict the family's current transactional patterns, much as blueprints statically represent the evolving process of building a home. During the assessment phase—and refined throughout treatment—maps serve the twofold purpose of concretizing a structural hypothesis and assisting in the formulation of treatment goals. Minuchin writes that a person who constructs a family map is like an anthropologist who joins the family's "culture," experiencing their system, connecting and disconnecting, constantly "making deductions that enable him to transform his experience into a family map from which he derives the therapeutic goals" (Minuchin, 1974, p. 124). With the Shores, for example, an attempt to contact Michael might result in Nancy's talking for him, while Charley and Rena might seem distant and uninterested. It is the nature of systems that these sequences of interactions will be repeated and that "regardless of their ultimate origin, symptoms (conflicts of any sort included) can only persist if they are maintained by ongoing interactional patterns" (Sluzki, 1981, p. 275). The presenting problem then provides a metaphor for the structure's maintenance of the symptom. Mapping simply provides the therapist with a heuristic device that aids in identifying family structures and helps to maintain the therapist's focus on the present.

The therapist's job is to organize the family so that its members can begin to restructure their relationship in the here and now. The Shores' current map would show great proximity (or overinvolvement) between Nancy and Michael, reflecting a diffuse subsystem boundary (Figure 2-a).

The subsystem of Charley and Michael, on the other hand, would have much greater distance between the two, indicating a more rigid or disengaged boundary between father and son (Figure 2-b). The executive subsystem of Charley and Nancy would reveal unresolved stress, or conflict, between husband and wife (Figure 2-c). These subsystem structures fit together like the complementary pieces of a jigsaw puzzle, presenting a partial picture of the Shore family (Figure 2-d).



Key to Figure

- diffuse boundary
- rigid boundary/disengaged
- ==== overinvolvement/enmeshed
- ||— conflict

Figure 2. Key adapted from *Families and Family Therapy* (p. 53) by S. Minuchin, 1974, Cambridge, MA: Harvard University Press. Copyright 1974 by S. Minuchin. Adapted by permission.

Other aspects of the system that would need to be explored as treatment progressed would be Rena's connection to the family system and a possible cross-generational coalition between Nancy and Michael against Charley.

An examination of the evolution of the Shores' current structure will illuminate how adhering to an adaptive organization that "fits" one context can cause problems if the structure is not flexible enough to accommodate itself to new conditions. As I indicated earlier, family structure is embedded in larger societal forces. Prevailing attitudes and policies concerning gender roles pulled the father out of the home to work and left the mother home with the daughter. However, when Nancy returned to work, the structure shifted to meet the family's new circumstances. Gram, Greatgrandfather, and Aunt Flo became more proximate and powerful. Gram, in particular, openly violated parental boundaries through her criticism of Nancy and Charley. To the extent that Rena was Gram's "angel from heaven," she was not her parent's daughter. Conversely, neither Charley nor Nancy attempted to retain control of Rena or retrieve her from Gram's overinvolvement. However, at that point, the fit between the family structure and its ecological and idiosyncratic requirements was "good enough."

When Michael was born, the family had to restructure itself again. This time, Michael's physical condition demanded even greater proximity from his parents than his sister's arrival had called for. Within a few

years, the family's structure began to crystallize into the shape it would retain for years to come. Michael's developmental and physical needs, Nancy's disability, Charley's unavailability, and Rena's proximity to the great-grandparents resulted in a structure that seemed to be the most effective for everyone at the time. It fit the constraints imposed by the environment of its day.

Ordinarily, restructuring would take place in a family when a child enters school. Proximity between mother and child is attenuated by the child's move to the world of peers and school, and greater proximity between mother and father is facilitated by their mutual support for each other and their child's move outward. Moreover, as the child becomes drawn into the subsystem of peers, he or she learns important social skills. This kind of restructuring did not occur in the Shore family. Instead, Michael's "problematic" behavior in kindergarten contributed to the distance between Nancy and Charley, which in turn contributed to the enmeshment between Nancy and Michael and to the distance between Charley and his son. Michael's symptoms maintained, and were being maintained by an outdated structure.

Therapeutic Attitude

Like all therapists, a structural family therapist is never neutral. Structural assumptions form the basis of all operations (Aponte & VanDeusen, 1981). The principal goal of therapy is to change the family's transactional rules that maintain the symptom. Once those rules have been modified, family members experience an expanded sense of "self" and "other," and the system's viability is improved through increased flexibility and problem-solving choices. Following change, homeostasis, which originally embedded the symptom, now works in the service of incorporating and maintaining some of the very role and rule changes that the system previously rejected or nullified.

The therapist must be both a challenger and an accommodator. Change cannot occur unless the therapist risks challenging the dysfunctional rules of the family. At the same time, the therapist must respect the family's culture, or the family will not return. An answer to this dilemma is for the therapist to adopt an attitude that balances elements of risk and respect (Lappin, 1983). The therapist challenges people's problem-solving methods, never their motives. That way, it is easier to remember that the therapist and the family have a common enemy—the rules that bind the system—which makes them colleagues in a shared endeavor. In order to understand this endeavor and what to do about it, treatment is divided into a series of stages.

Stages of Treatment

All family therapists agree that the road to symptom resolution is through system reorganization, but not all agree upon its route (Breunlin, 1985). One need only survey a pile of training brochures to get the feeling that the roads to change are indeed clogged (Lappin, 1987). Even though each stage has its own goals, techniques, and hazards, stages are not seen as discrete entities; rather, they are conceptualized as nesting interdependently, each one containing some proportions of all. Just as a cake tastes different depending upon when you sample the mix, so technique varies for each stage. The nature of the blend depends on the stage of treatment, its concomitant goals, the stage of the particular session, the techniques being used, and the idiosyncratic mixture between the therapist and the family—the point at which the therapeutic context is shared. Therefore, all five stages unfold over the course of treatment, but the stages can also be used as guidelines in the initial interview and in subsequent sessions.* I will discuss some of the techniques employed in this context as I describe the stages of treatment with which they are most commonly associated.**

The techniques of the structural approach can be classified into two categories: 1) those that help to form the therapeutic system and maintain the family's sense of self; 2) those that challenge the sense of self, disequilibrate the system, and promote change (Silver, 1983; Colapinto, 1982).

Stage One

The goal of the first stage is to form the therapeutic system. The technique that is most often used at this stage is *joining*. Therapists must come to know the families they treat and join their particular "culture" without compromising themselves or their goals. Guided by feedback, the therapist strikes a dynamic balance between proximity and distance, establishing leadership by following the clients through the aspects of joining known as *maintenance*, *mimesis* (mimicry), and *tracking*. Preliminary hypotheses are formed, tested, confirmed, modified, or refuted, and are then woven into the process of change. Any initial discomfort that the therapist and the family experience is only the momentary lapse of a context in transition, the rules of which are being established "in vivo." Such discomforts actually present a unique opportunity to connect with the families and to "read" and experience their structure.

* These treatment stages were originally developed (with the assistance of Braulio Montalvo) for a training manual as part of a grant application for research with adolescent substance abusers (Lappin, 1984a).

** See Haley (1976, Chapter 1) for a clear model of the stages in an initial family interview.

Joining is the temporary coupling of two systems (family and therapist), which occurs in order to create a workable treatment context. This in turn requires the therapist to have a "therapeutic attitude" (a belief that the problem is solvable and that she or he can help) that necessarily involves an element of challenge (Colapinto & Lappin, 1982). This attitude is not an absolute quality attached to certain behaviors and absent from others, but rather is the automatic result of the therapist's correct assessment of what it takes to gain a position of influence with each family (Colapinto & Lappin, 1982). This assessment is highly idiosyncratic and is based upon the style of the therapist, the "culture" of the family, the presenting problem, and the context of treatment.

Although joining is primarily present in the early stages of treatment, it is essential to every session. It is the "glue" that binds the therapeutic system (Minuchin & Fishman, 1981). Good joining stems from the therapist's conviction that the family is its own greatest resource. Family members should have the experience of being listened to and understood, but not necessarily agreed with. Nonverbal responses or mimesis on the part of the therapist can facilitate reciprocal cues such as a confirmatory head-nod, a smile, or a look of understanding as signs that joining is occurring. Other processes (such as positive responses to therapeutic directives and acceptance of co-responsibility for problems and change) also signal that the therapist and the family have joined.

Maintenance is a joining technique by which the therapist confirms and validates the reality of family members, reinforcing their strengths and highlighting proximity. The therapist, too, is proximate. Trust takes time, yet trust must be established between the therapist and the family in order for treatment to begin. The therapist uses questions and statements that compress time, which increases the family members' sense that the therapeutic system has been together longer than it actually has. The therapist must be accepted as the leader; leadership is contingent upon the ability to forge connections and convey a genuine sense of interest. At the same time, the therapist must balance this interest with respect by not being oversolicitous.

Maintenance operations emphasize accommodation. However, that does not mean that the therapist needs to accommodate to system rules that may be at the expense of an individual family member. For example, if Nancy Shore talked for her husband during an interview, the therapist could say, "Mrs. Shore, you already know your husband so well that I am sure it is tempting to answer for him, but I need a chance to get to know him myself. Perhaps you can fill me in on some of the details later." In this way, the family rule is gently challenged, the father is contacted, the therapist is in charge, and the mother knows that she, too, will be heard.

Tracking is the joining technique that the therapist uses to follow the content of what family members say, as well as the process of what is happening. Tracking is done from a median range of proximity. From this vantage point, the therapist can both participate and observe. The flexibility of modulating distance relative to family patterns is a luxury denied the family. They, after all, cannot see something of which they are so much a part. The median position helps guard the therapist from becoming "inducted"—that is, overly proximate or too distant. It is a calculated compromise between becoming either another family member or "the phone company." Either extreme offers little hope to the family. By asking clarifying questions and encouraging members to speak, the therapist watches familial metaphors and idiosyncratic aspects of family life unfold. Correct tracking means not only that the therapist knows the language of the family, but also that he or she knows how to use it contextually, as in a phrase or metaphor, which can be a transitional bridge between ideas or members.

For example, tracking Michael's Boy Scout experience could create opportunities for him to speak competently: "Why did you want to be a Boy Scout? Is it hard not to tell lies? Who is the proudest about your scouting? The most nervous when you go on trips? Does your Dad ever go? Would you like him to?" This line of questioning increases Michael's sense of self, begins to draw boundaries between him and his mother, and starts the process of testing the system's ability to tolerate more proximity between father and son.

Stage Two

This stage combines three operations: 1) identifying the problem; 2) identifying the structure; and 3) setting goals and planning.

Identifying the problem would be done with the family in a concrete, explicit fashion, focusing on why they are in treatment and on specific behaviors they want changed.

Identifying the structure occurs at the conceptual level within the mind of the therapist, who begins to form a map of the family, determining the constellation of interactions that maintain the symptom. This conceptualizing produces an "interactional diagnosis" (Minuchin, 1974, p. 131) about who speaks to whom and when; it also includes the therapist's sense of his or her impact on the system. Hypotheses about other relevant systems such as school, work, or extended kin also need to be incorporated in the tentative map that is being plotted.

The third component is both cognitive and operational: The therapist's world view and the family's are combined to create a workable reality (Minuchin & Fishman, 1981). This means establishing a shared paradigm between the family and the therapist so that individual causality is

replaced by co-responsibility. This transformation is an important signal because "the beginning stage of family therapy ends when a problem has been redefined and the redefinition has been accepted by the family" (Cimmarusti & Lappin, 1985, p. 17).

The techniques employed with greatest frequency in Stages Two through Four are aimed at restructuring and maintaining change. These goals can be achieved in two ways: by creating different behavioral sequences through *boundary-making* and *enactment*, and by fostering an alternative world view through *reframing*, *punctuation*, and *unbalancing* (Colapinto, 1982).

During reframing, family myths about the symptom-bearer, the symptom, or the family itself are challenged and recast into forms that are more workable. Such alternative perspectives offer members a face-saving opportunity to see things differently. For example, Charley's joblessness and hassles with employers could be framed not as stemming from depression but from his being "too honest." Similarly, Michael could be reframed as a son who is honoring his father's values by being a good scout, and his strange behaviors can be viewed as part of that tradition (they keep him home, protecting his mother from any more painful losses).

Such reframings "relocate" the problem from *within* people to *between* them. In this way, therapeutic goals become a natural outgrowth of reframing. In the Shores' case, Nancy could choose whether or not she wanted Michael's protection, perhaps reallocating it to a more productive and age-appropriate area. She and Charley could jointly help Michael to be less "scoutlike" (i.e., protective of others at the expense of himself) by encouraging peer relations and enforcing generational boundaries. It might not even be too optimistic to suggest that Charley and Nancy could begin to engage in a dialogue about how he could become *less* "honest" with employers and how they could become more honest with each other as a couple.

Complementarity, the systems principle of mutuality and reciprocity of functioning, takes concrete form as a technique for facilitating change and reframing. Remembering this principle can help the therapist avoid linear thinking (e.g., "Rena is immature") in favor of more circular thinking ("Who keeps her young?"). It is important, therefore, for the therapist to maintain a median position, always keeping in mind that the meaning of behavior is determined by its context and that context is shared (by the family and by the therapist). This posture allows the therapist to track sequences and content that are enacted in the session and offer reframings that are constructed with the family's raw material (as opposed to the therapist's agenda). The more systemic a family's view becomes, the closer the family moves to healthier functioning (Lewis, Beavers, Gossett, & Phillips, 1976).

Enactment (which can be either spontaneous or planned) refers to the actualization of family transactional patterns. This technique, which can occur in all stages, serves the dual purpose of diagnosis and restructuring. Minuchin and Fishman (1981) have characterized enactments in three movements. In its first movement, the therapist watches the family's spontaneous interactions, allowing the unfolding of sequences that may suggest structural hypotheses. For example, does the mother rush to take the coat off of her 12-year-old son? Who talks the most, and to whom? The therapist then decides which aspects to highlight in the second movement (eliciting transactions). Here the therapist is more active; he or she has seen possible clues to dysfunctional sequences and now needs to test the hypotheses. If we directed Charley to talk with Michael, for example, the following interactions might take place:

Charley: Well, son . . . uh, how is school?

Michael: Not so good, Dad. The kids pick on me.

Charley: How come?

Michael: They just don't like me—they say I'm weird.

Charley: Who? Who calls you weird?!

Nancy: Now Charley, calm down, you know how excited you get. Besides, it's not Michael's fault—he's just sensitive.

Charley: Oh, but . . .

Nancy: Michael, why don't you tell the nice man about how you think God is putting a "scar" on you?

Even though this brief enactment is hypothetical, it is based on what we know about the family from the case report. Enactments such as this reveal the structure of the family. They also offer therapeutic potential by giving each family member an opportunity to experience themselves and one another differently. This is done through blocking accustomed transactional pathways.

In the third enactment movement, the therapist can begin to suggest alternatives. Ideally, these new alternatives "take" (i.e., are adopted by the family), but many times they do not. In either case, the feedback yields additional diagnostic data about the family. The more rigid and resistant to change the family is, the greater the need for impactful and precise interventions.

For example, the therapist in the example above would quickly see that father and son have difficulty maintaining a dyad, and he could alter the family's experience simply by asking Nancy to stay out of the conversation and by preventing Charley and Michael from inviting her in:

Therapist: Nancy, I know that you are eager for Michael to tell his story, but he really needs to talk to his Dad now.

Nancy: But I was only trying to help.

Therapist: Yes, I know, but the more you help Michael, the less he learns to help himself, and I know you want him to be independent. [Complementarity/Reframing]

Nancy: Oh, well, OK. . . .

Therapist: Go ahead, Mr. Shore.

Charley: Uh . . . OK, Michael, tell me about these kids in school.

Michael: They pick on me, Dad, and I don't like it. (*He starts to cry.*)

Charley: (*Confused, he looks to therapist and Nancy. The therapist nods and points for Charley to move near his son.*) Don't feel bad, son. Kids used to pick on me, too.

This is a small step towards a larger goal. By creating an enactment and altering the "rule" that father and son have to "bicker and fight like small boys," the therapist has given the mother, the father, and the son an opportunity to experience family life from a different perspective. One can not expect families to change unless they have begun to experience change as a possibility.

Stage Three

Stage Three consists primarily of restructuring operations. The therapist now actively moves to incorporate the stated treatment and structural goals by attempting to introduce and strengthen appropriate boundaries, dissolve coalitions, reinforce the parental subsystem, and correct dysfunctional arrangements between the individual family members (as well as between the family and their larger context). Such dysfunctional arrangements would include those instances in which an institution (or other systems) becomes part of the symptom-maintaining structure. For example, in the Shore case, this might be the nightclub manager who encourages Charley, or a school or agency person who too readily agrees with Nancy that Michael should not be taxed and that Charley is no good.

Interventions should be consistent with structural goals and empowerment of appropriate hierarchies within the family. For instance, in the Shore case, assigning both the mother and the father to attend child-study team meetings would be congruent with therapeutic goals. Task assignment at this stage is both diagnostic and therapeutic; it can reinforce treatment goals and experiences from within the session and couple them with the family's natural environment. The tasks that are assigned, however, are only as good as the therapist's grasp of the family forces.*

* Proponents of the "strategic" school of family therapy attempt to solve presenting problems through indirect methods and through the assignment of tasks. These tasks and indirect suggestions interrupt family members' dysfunctional sequences of behavior that maintain the problem. The strategic school's roots can be traced to the pioneering work at the MRI. The "Milan group," along with Jay Haley and Cloé Madanes, has continued in this innovative tradition. (See Haley, 1976, 1984; Madanes, 1981, 1984.)

Like enactments, tasks may or may not go well, but they always provide essential information. The fishing trips between Michael and his father provided the feedback that this dyad needed more than a prescription to be successful; it needed systemic permission, that is, a clear and full sanction of the trip, negotiated within the parental subsystem and between the parents and Michael. For example, Nancy and Charley would need to agree that the trip was supposed to happen, Nancy would need to tell Michael that she wanted him to go, and Charley would need to tell Michael that he wanted it to succeed.

Boundary-making, another enactment technique, alters the psychological distance between family members by controlling who interacts with whom, about what, and for how long. In the enactment between Charley and Michael, for instance, the therapist enforced a boundary by temporarily excluding Nancy. Boundary-making is a powerful technique because it forces members to reach into the unfamiliar, to tap little-used aspects of self. In fact, it is possible to alter a person's experience of self and other simply by altering his or her subsystem membership. Different aspects of self are reflected by changes in context. Like when we stand in front of the different mirrors in a funhouse, the changes can both amuse and alarm, depending on where we stand. Through boundary-making, families with an enmeshed transactional style can become disentangled from overproximity, and families who are disengaged can reduce interpersonal distance.

Unbalancing is the name given to all techniques that destabilize the system. Boundary-making changes subsystem membership, whereas unbalancing changes hierarchical relations (Minuchin & Fishman, 1981). Because the goal is to create a crisis, unbalancing is the technique that requires the most therapist involvement.

Crisis challenges the family's stability and fosters a "discontinuous change" to new levels of organization (Hoffman, 1981, p. 102). Such reorganizations occur naturally in the life of the family following the birth of a child or a death (Combrinck-Graham, 1985). In treatment, the planned process of generating stress and providing support helps the family reach a new level of organization. The therapist is required to generate enough intensity, through effective use of self, to activate the family. The therapist may enter into a temporary coalition with one member against another, which serves to unblock stalemated transactions. For example, joining with Nancy against Charley would destabilize the couple's homeostatic "dance."

At first blush, unbalancing seems to be a technique of unfairness, yet unfairness of the moment is balanced by the greater needs of the system. This technique also requires careful monitoring of feedback. If resistance is too great, the therapist may have to retrench, rejoin, and try again at

another time, temporarily putting the crisis on the "back burner" until another opportunity is afforded.*

Unbalancing can tax therapists as well; they should have adequate institutional and personal supports. The effectiveness of unbalancing does not simply rely on technical virtuosity, but rather on the strategic use of the therapists' own interpersonal resources. Warmth, humor, authority, and nurturance are all qualities therapists call forth as they join the family in the process of change.

Stage Four

Stage Four focuses on maintaining change. The self-reinforcing gains made during previous stages need to be consolidated as the family struggles with the stress of change (Karrer & Schartzman, 1985). New rules and relationships, although more functional, are still subject to the pull of their preferred patterns. This is a critical transition point in the therapeutic process. These middle stages of treatment are long and arduous. The therapeutic context can be lulled into complacency, "now that the crisis is over." Frequently, some changes have occurred, and symptoms will have diminished or perhaps disappeared. At this point, both family and therapist tend to be tired of their struggle, as well as somewhat pleased with their progress. However, as Yogi Berra said, "It ain't over till it's over."

From a systems perspective, the consequences of change may be just as forceful as the dynamics maintaining the symptom—and, in fact, they are opposite sides of the same coin.** The Holmes and Rahe Social Readjustment Scale (1967), for example, lists "positive" events alongside their negative counterparts. Both positive and negative events are considered to be stressors. Consequently, the apparent benefits of symptom resolution are often thought to more than compensate for the loss of dysfunction. The point, however, is that at some level, the symptom(s) represented an attempt at survival. Any successful attempt, however flawed it may ultimately prove to have been, is one that was, for a time, "good enough." Relinquishing such powerful coping mechanisms does not come easily.

Keeping this in mind will help the therapist appreciate that all change is stressful and that we are always a part of the systems we treat. Because of the time spent together and due to the emotional nature of that time,

* I am indebted to Paul Riley for his development of this effective therapeutic technique.

** Karrer and Schwartzman (1985), in their chapter on the stages of structural family therapy, note that the strategic therapists often use paradoxical prescriptions at this stage to anticipate and counter the consequences of change.

both therapist and family are now even more subject to all of the same regulatory principles that apply to any social system. Therefore, as termination approaches, the therapist will need to carefully monitor both the family system and the therapeutic system for signs of reluctance to end.

Stage Five

Stage Five is the termination phase. Although it is often overlooked, it is no less important than the other stages. There is no "optimum" number of sessions in the structural family therapy model. However, treatment is usually brief, modulated by the family, their cultural background, and the presenting problem. For example, during the years in which the theoretical emphasis at the Philadelphia Child Guidance Clinic was most structural, outpatient cases averaged between 6 to 10 sessions (Aponte & VanDeusen, 1981). Psychosomatic cases, which, because of their more serious nature, sometimes involve both outpatient and inpatient work, averaged about seven months (Minuchin, Rosman, & Baker, 1978).

At this stage, the clear statement of goals that was developed in Stage One can help determine when treatment can be terminated. Other indicators, such as increased social time, more joking, or requests to schedule appointments further apart, can also signal that treatment is nearing its end. Structural reorganization provides useful and concrete markers for change and termination. For example, has the family's map changed? Is there increased variety and flexibility in the family? Are boundaries clear? Is there an absence of harmful coalitions? Are people developmentally on track? Can members speak and act in differentiated ways?

Again, these are therapeutic ideals, and one must always put any treatment goals into context. In the Shore case, it is not reasonable to expect that all the members will achieve interpersonal perfection (even if it existed). However, it is reasonable to expect that, within a therapeutic framework, the limits of their abilities can be tested, and that, in the testing, the family will be transformed.

In Stage Five, the therapist needs to begin the process of distancing from the family. The therapist should make it easy for the family to leave treatment, so that if the need arises, they can return more easily. He or she needs to punctuate the family's changes by supporting new behaviors and minimizing remnants of the past. For instance, if Michael raises concerns about school, the therapist could say, "That's to be expected. What does your father think?" Indications for ending would include Michael's report about his father's views (indicating that they had talked), Nancy's respect of the father-son dyad, and perhaps the parents' report that they had decided to take a specific course of action

At the end of the course of treatment, the therapist has to trust the family's natural ability to heal itself and to understand that his or her brief journey into the family's system is coming to an end.

LIMITATIONS OF THE MODEL

One inherent bias in the structural approach is that its principal development and applications have been in families in which the minor child is the identified patient. Exceptions have been Stanton, Todd, et al.'s (1982) work with heroin addicts and their families and Stanton's (1981) work with couples.

Hoffman, in her book *Foundations of Family Therapy* (1981), states:

Although Minuchin's theory is most eloquent about family systems and family structure, it does not contain a comprehensive theory of change to cover the area misnamed "resistance," and the moves which deal most successfully with it, especially in cases of what Minuchin would call "enmeshed" families. (p. 270)

Later that same year, Minuchin and Fishman published *Family Therapy Techniques*, and although they do not devote themselves to specific populations, their "how-to" approach provides useful treatment possibilities guidelines and strategies for change.

Structural family therapy has not yet been dismissed as ineffective with any specific client population or in any setting. This is not to say that it can work equally well with all people in all situations. As a theory, however, it is a useful starting point whose limits need continual testing so that growth and complexity of both clinician and theory are ensured.

RESEARCH

Some have argued, from a systems perspective, that all research is only relative to its cultural context (Colapinto, 1979). However, the attempt still needs to be made to discover effective therapeutic models and methods. The question of "what works and with whom" is central to the evaluation of any treatment paradigm. In the case of structural family therapy, it is a question that can be reasonably assessed.

In Gurman and Kniskern's *The Handbook of Family Therapy*, Aponte and VanDeusen (1981) present a comprehensive overview of 20 separate studies, cover both family functioning and treatment, and provide background information (both conceptual and historical) about the relationship between research and the evolution of structural family therapy. In another chapter, Gurman and Kniskern (1981) review research on marital

and family therapy and conclude that structural family therapy has "thus far received very encouraging empirical support for the treatment of certain childhood and adolescent psychosomatic symptoms" (p. 749). They go on to specify that structural family therapy "should be considered the family therapy treatment of choice for these childhood psychosomatic conditions and, to our knowledge, it is the most empirically supported psychotherapy approach of any sort for these conditions" (p. 750).

Stanton's excellent work with adult heroin addicts is highly respected and provides further validation of the model (Gurman & Kniskern, 1981; Stanton, Todd, et al., 1982). The structural approach has also proven effective when practiced by family therapy trainees (who have had little or no prior formal training in family therapy), which indicates that it can be taught successfully to people from diverse backgrounds (Flomenhaft & Carter, 1974, 1977). The areas of adult symptomatology and treatment of couples need to be fully investigated to test the model's applicability to these groups and to provide new ground for research and the evolution of the theory.

SUMMARY

The principal goal of structural family therapy is to restructure dysfunctional family organization. In this approach, the family and its members are conceptualized as systems that nest interdependently within larger systems, each influencing the other. The therapist is an active change agent, responsible for forming the therapeutic system and creating a context for transformation through restructuring.

The theory was developed in the 1960s by its main proponent, Salvador Minuchin. Although it was initially used as a treatment model for delinquent boys from low-income families, its reputation as an effective paradigm was made through research into treating families with psychosomatic members and later with heroin addicts and their families.

In the structural approach, systems thinking and normal developmental processes are woven together to form the basis for treatment. The ecosystem, or the larger sociocultural context, is considered to be an important aspect of family functioning. In order to meet the demands from this larger context (as well as adapt to the members' individual changes), a change is required in the family's organizational structure. Greater complexity and growth are counterbalanced by the need for protection and stability. Families that are "stuck" at a developmental plateau are unable to negotiate the stress of restructuring and instead adhere to preferred rules and roles. Through a dynamic balance of techniques of accommodation and disequilibrium, the therapist is responsible for organizing a therapeutic context with the family. This shared

treatment paradigm presents family members with the opportunity of discovering untapped aspects of themselves and transforms the family into a more flexible, developmentally appropriate structure.

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