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CHAPTER 13

Structural Family Therapy

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DEVELOPMENT OF THE MODEL

Structural family therapy is a method of conducting therapy that is predicated on a set of assumptions about the organization and dynamics of families, about how they relate to individual problems, and about the processes that effect change in families and individuals. The model shares with other family-systems approaches a preference for a contextual rather than an individual focus on problems and solutions. Distinctive of structural family therapy, on the other hand, are the use of spatial and organizational metaphors, both in describing problems and in identifying avenues for solutions, and the active role assigned to the therapist as an instrument of change.

Like the individuals and families that it has endeavored to understand and help, the structural model grew and changed as a function of context. First the Wiltwyck School for Boys and then the Philadelphia Child Guidance Clinic, both devoted to children's needs, but each serving a different population, provided Salvador Minuchin and his co-workers with the sources of challenge and inspiration for his development of a distinctive approach to clients—and left their marks in the process.

First Approximations: Wiltwyck

In the early 1960s, Salvador Minuchin was a psychiatrist at the Wiltwyck School for Boys, a correctional facility for young delinquents in the state of New York. There, he assembled a team of therapists and researchers[1] interested in transforming the institutional setting of the school into a family-oriented treatment program. Among others, the group included Braulio Montalvo, who after many years of productive association would be credited by Minuchin with having been "my most influential teacher" (Minuchin, 1974). Their rationale for embracing a family focus was typical of the then-fledging field of family therapy: gains obtained through con-

[1] *Editors' Note.* Among the various family therapies, structural therapy has been especially distinguished by its long-time connection with empirical research on basic family interaction processes and treatment outcome.

ventional treatment of the youngsters tended to evaporate once they were returned to their families (Minuchin, 1961).

The Need for Action Techniques

The predicament of the Wiltwyck group, however, was unique: while family therapists so far knew mostly of middle-class, verbally articulate, insight-oriented clients, the typical Wiltwyck client was "the ghetto-living, urban, minority group member who is experiencing poverty, discrimination, fear, crowdedness, and street-living" (Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967, p. 22). Because the style of interaction in these families tended to be concrete and action-oriented, rather than abstract and verbal, the team looked into alternative, "more doing than talking" therapies. Action techniques, role playings, home-based modalities of treatment, and other nontraditional forms served as inspiration for the development of diagnostic and treatment techniques tailored to poor families (Minuchin & Montalvo, 1966, 1967). A remarkable example—because it quickly became a distinctive feature of the emerging model—was the technique of "enactive formulation" (or, as it is now known, *enactment*), whose name was derived from Bruner's (1964) classification of experiential modes:

> The therapist can *say* something or *do* something that expresses the same meaning, or preferably, he can do both. For instance, in one family session a therapist found himself under heavy attack. He then changed his seat and sat among the family members. Pointing to the empty chair, he said, "It was very difficult to be there being attacked by you. It makes me feel left out." The therapist might have described in words alone that he felt left out of the family; instead, he changed his seat to be among the family members and then commented on his feelings. He sensed that although his verbal statement would pass unnoticed by all but the most verbal members of the family, his "movement language" would be attended to by everyone. (Minuchin et al., 1967, p. 247; italics in the original)

Context as Explanation

The Wiltwyck atmosphere not only posed a demand for new techniques, but colored the development of new concepts as well. In a 1978 interview, Minuchin reminisced: "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 theory started at the opposite end of its psychodynamic counterparts—with a sociological analysis of the impact of social context on poor families. In *Families of the Slums*, after reviewing sociological and anthropological reports on the life of the poor in various cultures, Minuchin's team adopted the view that "an action-excitement orientation, special styles of communication, limited number of usable roles, etc., seem to characterize low-income groups in a wide variety of social settings, and there is every reason to believe that ethnic and racial factors do not account for these characteristics but that social class variables do" (Minuchin et al., 1967, p. 24).

Minuchin and his co-workers went on to note that low-income groups differentiate into two subgroups: a more stable one, whose members enjoy at least the benefits of a support network; and the more unstable, disorganized, isolated group, plagued with various forms of social pathology (alcoholism, disease, mental illness, addiction, delinquency), from where the Wiltwyck residents typically came. Families from this most disadvantaged group provide a peculiarly dysfunctional context for child rearing, as vividly described in a 1965 report quoted in *Families of the Slums* (p. 26):

> The outstanding characteristic in these homes was that activities were impulse-determined; consistency was totally absent. The mother might stay in bed until noon while the children also were kept in bed or ran around unsupervised. . . . The parents often failed to discriminate between the children. A parent, incensed by the behavior of one child, was seen dealing a blow to another child who was closer. . . . Directions were indefinite or hung unfinished in mid-air. . . . As the children outgrew babyhood, the parents differentiated very little between the parent and child role. . . . (Pavenstedt, 1965, pp. 94–95)

The negative effects of this kind of context on the behavior of children had previously been documented in a study by Malone (1963), showing that preschool children from disorganized families exhibited low frustration tolerance, dominant use of motor action over language, concrete thinking, need-satisfying object relations, and other predictors of chronic acting out and impulse disorders (Minuchin et al., 1967).

The premise that social context is a most powerful organizer (or disorganizer) of families, and that family context is similarly powerful in organizing (or disorganizing) individuals, seemed to call for therapeutic interventions aimed at context rather than at an isolated problem—and indeed this would become a cornerstone of the structural model throughout its various phases of development. In the case of the Wiltwyck population, the "context of the problem" was of such dimension as to invite hopelessness; indeed, Minuchin has in retrospect regarded the experience as a reminder that therapy—individual or family—cannot provide the answer to poverty (Malcolm, 1978). This limitation notwithstanding, the knowledge gained at Wiltwyck inspired the development of structuring strategies for helping underorganized families through the mobilization of extended family and social network resources (Aponte, 1976a). More recently, Minuchin himself has led an application of structural thinking to the understanding and changing of the large systems of service delivery that make up the relevant context of poor families.

Function and Structure

In an attempt to understand the disorganized family better, the Wiltwyck group used as a background Talcott Parsons' model of the nuclear family (Parsons & Bales, 1955), where, by contrast, family members are neatly organized in a structure of roles or functions, along the axes of hierarchy (representing the differences in power between parents and children) and instrumental versus expressive functions (representing what Parsons considered to be the "normal" division of labor among father, mother, son, and daughter).

functions typical of the Wiltwyck population: spouses who tended to interact not as such but only as parents, or single-parent families in which the mother provided continuity while men were transient; parents who oscillated between autocratic power and helpless relinquishment of executive functions; sibling subsystems that became primary socializing agents. The child growing up within these structures "seldom finds enough moments of a 'cooperative collective,' and must, in general, settle for whatever sense of protection he can derive from people generally absorbed in the intrusive and conflicting aspects of living collectively" (Minuchin et al., 1967, p. 242).

The early connection between Parsons' gender-role paradigm and the structural model has attracted criticism from feminist writers (Luepnitz, 1989). In reading *Families of the Slums*, however, one does not get the impression that Minuchin and his co-workers regarded Parsons' stereotypical division of instrumental and expressive roles as the ideal solution for their disorganized clients. What one can see is how the Wiltwyck experience nurtured the conviction that families need *some* kind of structure, *some* form of hierarchy, and *some* degree of differentiation between subsystems.

Forging the Model: Philadelphia

While wrestling with the specifics of the Wiltwyck families, Minuchin maintained an interest in the universal. His discussion of the structure and processes typical of disorganized families opens with a famous quote from Harry Stack Sullivan: "Everyone and anyone is much more simply human than otherwise, more like everyone else than different" (Sullivan, 1962; quoted in Minuchin et al., 1967, p. 193).

The opportunity to test Sullivan's assertion came in 1965, when Minuchin was appointed director of the Philadelphia Child Guidance Clinic, and his developing model of family therapy came into contact with a more heterogeneous client population, which included both working-class and middle-class families.

A Training Context

Determined to turn the clinic into a family-oriented facility, Minuchin brought Braulio Montalvo from Wiltwyck and Jay Haley from California to help in training the staff. Teaching as they continued to learn, and benefiting from the systematic use of live supervision and videotape review (Montalvo, 1973), the three men generated an intensive and fruitful mutual exchange of observations and ideas on family dynamics and strategies for change. Years later, in his preface to *Families and Family Therapy*, Minuchin (1974) would credit the contributions of Montalvo and Haley to his thinking.

The needs of training-on-the-job, and Haley's own preference for focusing the training on change-eliciting skills rather than theoretical understanding, contributed to imbuing the developing model with a teachable, concrete, step-by-step quality. The focus was on showing the "steps of the dance," on teaching specific skills "without burdening the student with a load of theory that would slow him down at moments of therapeutic immediacy" (Minuchin & Fishman, 1981, p. 9). The trend was accentuated in the late 1960s, when the clinic obtained a grant to train "lay therapists"—minority paraprofessionals with no previous psychotherapeutic experience or formal education (Montalvo, 1973) —and culminated in the late 1970s, when one of the most popular workshops offered by the clinic was titled, "An Alphabet of Skills."

A New Challenge: Overorganized Families

At the same time, the clinic's association with the Children's Hospital of Philadelphia provided Minuchin with an opportunity to apply his vision of the family as a powerful organizing context to the understanding of psychosomatic conditions. In the early 1970s, he formed a research and treatment team at which core were Minuchin himself, the pediatrician Lester Baker, the psychiatrist Ronald Liebman, and research psychologist Bernice Rosman—a former collaborator at Wiltwyck and coauthor of *Families of the Slums*. The clinical and research findings of the team were later summarized in *Psychosomatic Families* (Minuchin, Rosman, & Baker, 1978).

The first patients to be approached were diabetic children with unusually frequent, medically unexplained emergency hospitalizations for acidosis. When conventional psychotherapy aimed at enhancing the patient's stress-handling abilities did not improve the condition, family intervention did (Baker, Minuchin, Milman, Liebman, & Todd, 1975). Minuchin and his co-workers began collecting data that showed a correlation between certain family traits (enmeshment, overprotectiveness, rigidity, absence of conflict resolution) and the special vulnerability of the diabetic patients. Similar connections were established for psychosomatic asthma, where children suffered recurrent attacks or depended heavily on steroids (Liebman, Minuchin, & Baker, 1974c; Minuchin, Baker, Rosman, Liebman, Milman, & Todd, 1975; Liebman, Minuchin, Baker, & Rosman, 1976, 1977), and for anorexia nervosa (Liebman, Minuchin, & Baker, 1974a, 1974b; Minuchin, Baker, Liebman, Milman, Rosman, & Todd, 1973; Rosman, Minuchin, & Liebman, 1975, 1977; Rosman, Minuchin, Liebman, & Baker, 1976, 1977).[2]

Most of the interactional traits identified by Minuchin and his co-workers in these largely middle-class, "intact" families had already been pointed out in the Wiltwyck families. There was a crucial difference, however: far from exhibiting disorganization and instability, the families of psychosomatic children appeared to be too tightly organized and, if anything, excessively stable. They called for a therapeutic strategy focused on *de*structuring the family's rigid patterns, and *re*structuring them according to more functional parameters: clearer boundaries, increased flexibility in transactions, conflict negotiation, and detriangulation of the identified patient. *Enactments*, first implemented at Wiltwyck for the purpose of effective communication with nonverbal clients, were now used deliberately to provoke destabilizing crises among

[2] *Editors' Note.* But note that the data of structuralists believed quite widely to support their theoretical stance about the "psychosomatic" family have not received universal acceptance (cf. Coyne & Anderson, 1988, 1989).

clients who talked too much (Minuchin & Barcai, 1969).[3]

Of the three syndromes treated by Minuchin and his team, anorexia nervosa was the best suited to a family-focused approach. Unlike asthma and diabetes, in which the dysfunctional context plays just an exacerbating role on a primarily physiological condition, anorexia has no demonstrated physiological basis, which opens the possibility for a well-designed family intervention to bring about a "cure," not just an amelioration of an otherwise chronic condition. Indeed, Minuchin's success in the treatment of anorexia nervosa was a major factor in attracting therapists to the structural model. Clinical experience with cases of anorexia nervosa also played an important role in clarifying the tenets of structural family therapy; an early "prototype" of the model (Minuchin, 1970) utilized one such case as an illustration.

A Comprehensive Model

Minuchin's first systematic formulation of his model was published in 1972, in an article entitled, precisely, "Structural Family Therapy." Some of the tenets presented there, like the displacement of the locus of pathology from the individual to the transactional context, the emphasis on present reality rather than history, and the notion of constructed realities, were held in common with other contributors to the field of family therapy; others, like the special attention paid to the diverse points of entry that different families offer to the therapist, and the characterization of therapy as a realignment of the family's structure of transactions, were more specific to the approach.

Further expansion and refinement of the model were the natural consequences of the wide range of clinical experiences being gathered in the clinic, which was gradually becoming a major service agency with sizable outpatient and inpatient components, and of Minuchin's intellectual association with Haley and Montalvo. This phase culminated in the publication of the classic *Families and Family Therapy*, a fully developed account of the structural way of understanding and treating families (Minuchin, 1974).

In 1976, Minuchin stepped down from the politics of directorship and concentrated on the training of family therapists. The continued effort to break down structural family therapy into discrete skill components that the trainee could rehearse is reflected in Minuchin's latest rendition of his therapeutic approach, *Family Therapy Techniques* (Minuchin & Fishman, 1981), in which most chapters are named after techniques. Running parallel to such effort, however, was the growing recognition that the effectiveness of structural family therapy depended on its being learned as a therapeutic stance rather than as an aggregate of useful tools (Colapinto, 1983, 1988). The dilemma, yet to be satisfactorily resolved, is also reflected in *Family Therapy Techniques*, whose "technical" chapters are preceded and followed by conceptual frameworks that attempt to put techniques in their place. Minuchin's preference for biosocial over physical models of systems is evident in those frameworks, which draw metaphors from Lewis Thomas' essays on animal life, Arthur Koestler's efforts at capturing in language the relationship between whole and part, and Ilya Prigogine's theory of change in living systems.

THE FUNCTIONAL FAMILY

A quotation from Lewis Thomas opens the chapter on families in *Family Therapy Techniques*: "There is a tendency for living things to join up, establish linkages, live inside each other, return to earlier arrangements, get along whenever possible. This is the way of the world" (Thomas, 1974, p. 147).

Structural family therapy sees the family as a living organism, constantly developing and adapting to a changing environment—"an open sociocultural system in transformation" (Minuchin, 1974, p. 51). One implication of the organismic view of families is a sense of acceptance of and respect for different forms of family life,

[3] *Editors' Note.* Such destabilizing enactments remind us of Roberto's (Chapter 14) description of some symbolic-experiential family therapy techniques that are designed to "destroy crystallized forms" of family patterns.

and a wide definition of normality. "Freud," wrote Minuchin, "pointed out that therapy changes neurotic patterns into the normal miseries of life. His comment is just as true for family therapy" (Minuchin, 1974, p. 51). A well-functioning family is not defined by the absence of stress, conflict, and problems, but by how effectively it handles them in the course of fulfilling its functions. This, in turn, depends on the structure and adaptability of the family.

Family Function and the Individual

The function of the family in society is the "support, regulation, nurturance, and socialization of its members" (Minuchin, 1974, p. 14).

A fundamental premise of structural family therapy is the inextricable association of family and individual: the family exists for the individual, the individual exists within the family, to which he or she must adapt. The family context has the power "to organize the data and to maintain definitions of self and others" (Minuchin & Fishman, 1981, pp. 144–145); the position of the individual in the family conditions his or her experience.

Adaptation to one's family, far from being a surrender of individual identity, is its main condition. Unlike Laing (1976), who saw in the family an enemy of individual differentiation, Minuchin sees the family as the matrix of identity: the individual becomes such as a result of participating in multivariated family transactions. One differentiates within, rather than against, the family group; individual and family are not contraries, but different cuts of reality.

Structure

How well a family fulfills its function vis-à-vis its members depends on the family structure and on its adaptability. Like other adapting organisms, families need some form of internal organization that dictates how, when, and to whom to relate. These *transactional patterns* make up the structure of the family.

Generic and Idiosyncratic Constraints

The structure of transactional patterns operates as a set of rules that constrain the family members' freedom of behavior. Some of these constraints are generic: for instance, no family could function as such unless its members accept some degree of interdependency (as between husband and wife) and some form of hierarchy (as between parents and children). Other constraints or rules are mutual expectations that develop idiosyncratically within each family:

> The origin of these expectations is buried in years of explicit and implicit negotiations among family members, often around small daily events. Frequently the nature of the original contracts has been forgotten, and they may never have even been explicit. But the patterns remain—on automatic pilot, as it were—as a matter of mutual accommodation and functional effectiveness. (Minuchin, 1974, p. 52)

Family rules may not be readily apparent to an observer. A therapist interviewing a family whose children get up and down from their chairs and leave the rooms unexpectedly (in the therapist's view) may conclude that the family is chaotically dysfunctional; a closer observation, however, may reveal that family members can predict which child will be leaving the room, how far the child will go, and when he or she will return, and that the entire dance has an adaptive purpose.

Complementarity

Family rules develop primarily through a process of correlated differentiation: the behaviors of any two family members mutually accommodate in such a way that one develops selective aspects of himself or herself, while the other develops a complementary trait. Typical examples are the harsh and the soft parent, the active and the passive spouse, the left-brain and the right-brain siblings. When all the members of the family are considered, the resulting image is like a jigsaw puzzle, where the irregular borders of the various pieces fit—complement—each other. Carrying the metaphor further, the salient borders of each piece represent the traits expected from each member (harshness, passiv-

ity, left brain), while the concave sections represent traits not expected. In well-functioning families, complementarity takes the form of effective teamwork.

Although the notion of complementarity may appear to be identical to that of circular causality—they both underscore the mutual determination of behavior within a family system—there is a difference. Circular causality designates a *sequential* two-way interaction (A's *behavior* causes B's *behavior*, and vice versa), represented by arrowed lines connecting A and B (thus, A⇆B). Complementarity, on the other hand, designates a *spatial* configuration (A's and B's *shapes* fit), represented by the interlocking pieces of the puzzle. This semantic difference is not trivial, but is consistent with the structural therapist's preference for tackling spatial arrangements (literal and metaphorical) among family members, rather than sequences of behavior.

Subsystems and Boundaries

The structural model discerns various subgroupings within the family, defined by their function. Individual members of a family participate in several subsystems.

Thus, a husband and a wife form the spouse subsystem, which serves as a powerful context for mutual support (or for disqualification), and they also participate with their children in the parental subsystem, which is organized around issues of nurturance, guidance, and discipline. The children, in turn, are also members of the sibling subsystem—their first peer group and a laboratory for supporting, enjoying, attacking, scapegoating, and generally learning from one another.

Rules that prescribe who should be in contact with whom about what are called *boundaries*. They can be depicted graphically as encircling lines that surround a subsystem or an individual and separate that subsystem or individual from the rest. Examples of boundaries are the rules prescribing that children should not participate in arguments between spouses, or that parents should knock at the door of a teenager's room before entering.

Like the membrane of a cell, boundaries need to be strong enough to protect the healthy development of subsystems—and, therefore, individual growth. The siblings' subsystem needs to enjoy some autonomy vis-à-vis the parents if the siblings are to learn to accommodate to each other. A father and a son can only get to know each other if they abstain from using the mother as a mediator. A diabetic adolescent needs to be more alert than her parents to the signs of dehydration if she is to own her body.

Excessively rigid and impermeable boundaries, on the other hand, would impinge on the effectiveness of the family, and even its viability as an organism: "If the boundary around the spouses is too rigid," for instance, "the system can be stressed by their isolation" (Minuchin & Fishman, 1981, p. 57).

Permeability of boundaries is necessary not only for the viability of the family, but for the healthy growth of the individual as well. The tendency of many therapists to regard "strong boundaries" as an absolute positive from the point of view of the differentiation of the individual is the expression of a cultural bias that extols the virtues of independence and privacy. Structural family therapy adopts in this respect the "countercultural" position that individual differentiation is achieved through multiple dependency—through participation in multiple subsystems, beginning with the family's. What to some other therapists looks like mastery of autonomy, to the structuralist may look like isolation.

Frustrated by the linguistic difficulties in communicating his ideas on the interdependency of individual and family, of part and whole, Minuchin resorted to Koestler's coining of the term *holon* as a synonym for "subsystem."

> Every holon—the individual, the nuclear family, the extended family, and the community—is both a whole and a part, not more one than the other, not one rejecting or conflicting with the other. A holon exerts competitive energy for autonomy and self-preservation as a whole. It also carries integrative energy as a part. The nuclear family is a holon of the extended family, the extended family of the community, and so on. Each whole contains the part, and each part also contains the "program" that the whole imposes. Part and whole contain each other in a continuing, current, and ongoing process of communication and interrelationship. (Minuchin & Fishman, 1981, p. 13)

It is through the individual's adaptation to various subsystems—being a holon in holons, entering into a variety of complementary relationships—that his or her identity is forged. In healthy families, subsystem boundaries are "defined well enough to allow subsystem members to carry out their functions without undue interference," but at the same time, flexible enough to "allow contact between the members of the subsystem and others." Clarity of boundaries is more crucial than the specific composition of each subsystem: "A parental subsystem that includes a grandmother or a parental child can function quite well, so long as lines of responsibility and authority are clearly drawn" (Minuchin, 1974, p. 54).

Hierarchy

The hierarchical arrangement of a family is expressed by rules that prescribe differential degrees of decision-making power for various individuals and subsystems. While some form of hierarchical arrangement is a condition of family functioning, families can function with many different kinds of hierarchy. Generally, in a well-functioning family, the parents are hierarchically positioned above their children—they are "in charge," not in the sense of arbitrary authoritarianism, but in the sense of leadership and protection. In single-parent families, a functional hierarchical arrangement may include the role of a parental child, when his or her clearly defined responsibilities contribute to the overall coping capabilities of the family.

In clinical practice, it may be difficult for the therapist to differentiate between the concepts of "boundaries" and "hierarchy." Wood (1985) and Wood and Talmon (1983) have provided a useful clarification of the relation between the two.

Adaptation and Development

The structure of a healthy family changes over time, as it accommodates to changing needs generated by its own evolution: children are born, grow up, and leave; adults get older, develop new interests, or lose strengths. In the process, boundaries are redrawn, subsystems regroup, and hierarchical arrangements shift.

A simplified model consisting of four broadly defined developmental stages, each requiring some form of restructuring, is offered by Minuchin and Fishman (1981). In the first stage, *couple formation*, a new system is formed through mutual accommodation; the new spouses need to give up part of their respective ideas and preferences, develop new rules, negotiate a different relationship with relatives and friends. In the second stage, *families with young children*, the arrival of each new member forces a rearrangement of closeness and distances in the family, a new differentiation of functions among the spouses, and a renegotiation of their patterns of relationship with the extrafamiliar—relatives, friends, work. The third stage, *families with school-age or adolescent children*, is dominated by the need to relate to powerful extrafamiliar systems—first, the school itself, then other children's families, and finally the peer group. In the fourth stage, *families with grown children*, parents and children once again renegotiate their relationship, this time as adults, while the parents themselves become again a twosome.

The model has value only as an illustration of the fact that structures need to evolve:

> This developmental schema describes only the middle-class family, with husband, wife, and 2.2 children. More and more, it is likely that the family will also form some sort of extended network or will experience divorce, desertion, or remarriage. In moving through such stages, people also face very complicated challenges. But whatever the circumstances, the basic flow remains: a family has to go through certain stages of growth and aging. It must cope with periods of crisis and transition. (Minuchin & Fishman, 1981, p. 26)

Demands for structural transformation do not originate only in the family's developmental needs. They may also be forced upon the family by idiosyncratic changes in its social environment—a move to a new town, a change of jobs, a major shift in the family's financial situation. The family's ability to transform itself in response to internal and external demands depends on its ability to plumb and mobilize individual resources, potential coping behaviors

that may have remained underutilized by virtue of the dynamics of complementarity. Some families manage better than others to access those resources.

Maintenance and Change

Structure and adaptability are complementary features. In its pursuit of its function, a family needs both to maintain a stable structure and to change it. On the one hand, the family's continued viability requires that members develop a mutual accommodation to each other's preferences, strengths, and weaknesses; transactional patterns of distance and hierarchy need to be formed and maintained. On the other hand, existing structures may need to be challenged in response to new circumstances inside or outside the family: conflict may need to be raised and dealt with, hidden resources may need to be actualized.

Well-functioning families manage to survive without sacrificing differences and enrichment; they have the capacity alternatively to establish and challenge transactional patterns. For instance, a close protective relationship between a parent and a handicapped child may serve an important maintenance function over a relatively extended period, and then change as the child begins to show evidence of competence that might be hampered by overprotection.

Hierarchical arrangements in healthy families also change over time in response to changing contexts; the hierarchical position of a child, for instance, varies according to his or her age, order of birth within the sibling subsystem, whether the parents are two or one, and so on. When the child is an increasingly competent adolescent and the influence of the peer group grows, issues of autonomy and control need to be renegotiated. Fluid structural arrangements may emerge at these transitional junctures that may appear dysfunctional to an observer who assesses them in the abstract; however, they may represent a healthy way of dealing with the transition. Similarly, a 14-year-old girl may assume a parental role when her mother temporarily succumbs to physical illness or depression, and thus she prevents the dismemberment of the family that might result if her siblings and herself were placed in foster care.

The dialectics of maintenance and change can be synthesized in the notion of steady growth. A healthy family is in a continuous process of structural growth. It has the capacity to become increasingly complex, to develop an ever-increasing availability of alternatives—which, in turn, favors the growth, development, and complexity of its individual members.

The emphasis that structural family therapy places on structural growth and complexity as a marker of health is evident in two statements published 14 years apart. The first one is that fathers should play a role in the family—not because of the "need for a male role model," but because "we feel that the family has more possibility for change as the complexity of its system increases. When a man participates in the family in the role of an adult male, he adds differentiation and specialiation to the family's manner of approaching life; therefore, the possibility of mobilizing resources for change within the family increases" (Minuchin et al., 1967, p. 316).

The second statement is a reference to Prigogine's dissipative structures:

> For years family therapy emphasized the power of systems to maintain themselves. Now the work of Prigogine and others has shown that if a system is partially open to the inflow of energy or information, the ensuing instabilities do not lead to random behavior . . . instead, they tend to drive the system to a new dynamic regime which corresponds to a new state of complexity. (Minuchin & Fishman, 1981, p. 21)

THE DYSFUNCTIONAL FAMILY

A dysfunctional family is one that cannot fulfill its function of nurturing the growth of its members. The structural theory of family dysfunction includes (1) a description of dysfunctional family structures, (2) an explanation of family dysfunction, and (3) a description of the relationship between family dysfunction and individual symptoms.

Description of Dysfunctional Structures

The first observations of structural dysfunction in families go back to the early recognition of five patterns among the Wiltwyck families: the "disengaged family," the "enmeshed family," the "family with the peripheral male," the "family with noninvolved parents," and the "family with juvenile parents" (Minuchin et al., 1967, p. 352). In *Families of the Slums*, Minuchin and his co-workers describe how their original focus on disorganized families evolved into the now-familiar *disengagement/enmeshment typology*:

> Our simple concern . . . with the relinquishment of executive functions on the part of the parents gave way to the realization that *some* families apparently functioned as if the parents (the mothers in particular) were *overly* concerned with executive functions. This led us to the further realization that actually there seemed to be an axis of disengagement-enmeshment along which our research families were oriented, mostly toward either extreme. (Minuchin et al., 1967, p. 350)

In the disengaged family, boundaries among family members are overly rigid, emotional distance is excessive. The "syndrome" of disengagement includes failure to mobilize mutual support, underdevelopment of nurturant and protective functions, and excessive tolerance to deviation.

> Observing this family, one gets the general impression that the actions of its members do not lead to vivid repercussions. Reactions from the others come very slowly and seem to fall into a vacuum. The overall impression is one of an atomistic field; family members have long moments in which they move as in isolated orbits, unrelated to each other. They act as parts of a system so loosely interlocked that it challenges the clinician's notions that a change in one part of a system will be followed by a complementary change in other parts. (Minuchin et al., 1967, p. 354)

More concrete descriptions of interaction in disengaged families include delayed responses and a paucity of contacts.

> There are situations in which the children and their mother are involved in parallel play or in activities devoid of any contact among them; at other moments the children activate themselves in ways that are seemingly designed to activate their mother into making a relating response. But even when there is an increase in acting-out, the activities of the children do not seem to be related to a need for contacting others. One notices little attentiveness from member to member and few attempts to engage in reciprocal interplay . . . (Minuchin et al., 1967, p. 355)

In enmeshed families, on the other hand, boundaries are excessively weak and there is excessive proximity among members. The family appears to turn upon itself; there is a low level of individual differentiation and autonomy, and the response of the group to any "deviant" behavior is very intense. Indicators of enmeshment include an increase in the rate of communication, exaggerated concern and protectiveness, mutual demands for loyalty, narrow perceptions of self, and paralysis at times of transition when different responses are needed. "This family system is characterized by a 'tight interlocking' of its members. Their quality of connectedness is such that attempts on the part of one member to change elicit fast complementary resistance on the part of others" (Minuchin et al., 1967, p. 358).

Enmeshed and disengaged families are "ideal" types; most or all families include enmeshed and disengaged areas of transaction. Typical examples of enmeshment are the absence or fragility of individual boundaries (for instance, the parents of a diabetic adolescent know better than she does when she needs insulin), and the intrusion (or the recruitment) of one family member in the subsystem of two others (for instance, a father and son always have their differences mediated by the mother, or a brother and sister always have their fights interrupted by their parents).

Hierarchies can also become excessively weak and ineffective, or excessively rigid and arbitrary. In the first case, the younger members of the family may find themselves unprotected because of a lack of guidance; in the second case, their growth as autonomous individuals may be impaired, or power struggles may ensue. A special case of hierarchical dysfunction is the *cross-generational coalition*, in which the spouses argue their conflict through a child, and each tries to enlist the support of the child against the other. Chronic cross-generational coalitions have been structurally associated with psycho-

somatic illness (Minuchin et al., 1978) and with addiction (Stanton & Todd, 1982).

Explanation of Family Dysfunction

Dysfunctional family structures result from a combination of stressors impinging on the family and the failure of the family to cope with them. Stressors may be external (the family faces financial hardship or lives in a violent neighborhood) or internal (children reach adolescence, a parent dies). They may be universal, as in the case of developmental transitions in the lives of family members, or idiosyncratic, such as having an accident, suffering from chronic or catastrophic illnesses, or losing a job.

Structural family therapy's sensitivity to the role of external stressors in family dysfunction originated with the Wiltwyck experience. Disengaged structures were seen there as a response to apathetic, overwhelmed, self-derogatory single mothers who experienced themselves as exploited, often presented with psychosomatic and depressive symptoms, and could not establish control or guidance over their children (Minuchin et al., 1967). The mother's predicament, in turn, was explained by her social context—which has obviously not changed much in 25 years:

> A prominent feature of disengaged families is the isolation of the mother, who seems unable to contact the external world and to draw on extrafamilial sources. In the most extreme forms of this profile one must look beyond the chronicity of incompetence in mothering to a family history usually lacking in anchorage points such as stable work patterns and stable relationships to a male, friends, or other social groups. . . . Though the family may have contacted many social agencies, the mother's relationship to them is characterized by extreme passivity and dependency. . . . As a group . . . disengaged families are seldom contacted or "reached." Even if they are, however, they soon become dropouts from community programs.

Enmeshed structures were also explained as a response to the hardships of single parenthood—this time under the shape of an overcontrolling reaction to the sense of helplessness:

> We are impressed by the constant engagement maneuvers in these families, most of which reflect or are in response to controlling operations on the part of the mother. These include fast interchanges around her controlling responses and the children's rebellious activities. . . . In the enmeshed family profile any evidence of loss of control over her children makes the mother anxious. The predominant fear is that of becoming helpless, rather than of becoming "mean . . . ". She has an overwhelming need for a continued hold on the children. These families usually do not include an adult male, but if there is one, his power is clearly restricted and controlled by the woman.

While the socioeconomic makeup of the client population at Wiltwyck helped to highlight the role of social context as stressor, the working- and middle-class families served by the Philadelphia Child Guidance Clinic—comparatively better sheltered from the vicissitudes of the social environment and more autonomous in their functioning—called Minuchin's attention to the other component of the dysfunctional equation, the internal variables that account for a family's inadequate, stereotypical response to stress.

The most basic of those variables is defined in the negative. The family *lacks* the capacity to challenge and modify patterns of transaction that have ceased to satisfy the needs of its members; instead, it exhibits an inertialike tendency to stick to obsolete patterns. For instance, young spouses who have developed a tightly interdependent complementary relationship, with limited occasions for open conflict or for developing relations outside the couple itself, fail to review the rules of their implicit contract following the birth of their first child, or a family with older children who require increasing autonomy continues to deal with them as if they were younger children, needing only nurturance and discipline.

Explanations for structural inertia range from unawareness (where dysfunctional patterns are perpetuated because family members simply cannot think of alternative ways of dealing with each other, or see the need for them) to fear (where dysfunctional patterns are perpetuated because family members are afraid of the consequences of experimenting with such alternatives). In either case, the underlying mechanism is complementarity: in the course of their transacting, family members shape each other's behaviors and mutual expectations, and gradually

make each other unaware and/or fearful of the possibility of behaving in ways that depart from established patterns. Joe does not expect Sue to be able to handle the baby while he is working; Sue is afraid that Joe will explode if she demands more cooperation from him.

The most common transactional expression of "fear of change" is the mechanism of *conflict avoidance*, by which two parties shy away from inflicting upon themselves and each other the pains inherent in conflict resolution. Disengagement and enmeshment represent different strategies for avoiding conflict—in one case by curtailing contact and in the other by denying difference and disagreement. Even the constant bickering in which some couples engage serves the purpose of conflict avoidance, inasmuch as it allows for the chronic expression of each party's hostility without pressing for either to change or for a resolution of the conflict. When a third party, such as a child, is present, cross-generational coalitions serve a similar function in covertly channeling conflict.

While there is a universal capacity for conflict avoidance in human groups, some families may have more of a reason to use it. The study of the enmeshed two-parent, middle-class families of psychosomatic children provided a rich observational field for the exploration of the dynamics of overprotection, showing how the involvement of the whole family with the sick child, the heightened concerns regarding the physical welfare of the child, and the constant eliciting and supplying of protective responses helped to submerge potential conflicts (Minuchin & Fishman, 1981).

Relationship Between Structure and Symptom

The structural model describes various types of relationships between family structure and symptoms.

Family Context as Ineffectual Challenger

The family may support the symptom in a *passive* way, just by failing to challenge its continuous display. In this case, the family contributes to the problem "by default": the other members adapt complementarily to the symptomatic one, and structural inertia hinders the emergence of events that might challenge the symptomatic behavior. For instance, a pattern of overprotection and heightened loyalty makes it impossible for anybody in the family to challenge one member's drug habit.

Family Context as a "Shaper" of the Individual

From a historical perspective, the family's structure contributes a more *active*, if generic, role in the development of symptoms: family context shapes the individual's experience and behaviors—and this includes *problem* behaviors. The handicapping effect of dysfunctional family structures on individual experience has been a basic premise of structural thinking ever since the Wiltwyck days.

Thus, a family may foster dysfunctionality just by hindering the development of the more mature forms of behavior. In families of anorexics, for instance, the excessive parental involvement with the daughter and the family's devaluation of womanhood discourage a developmentally appropriate feeling of autonomy and an inner sense of worth, encouraging by default an excessive reliance on external achievement and control maneuvers. More generally, children from enmeshed families learn to depend exclusively on their families for a sense of support and loyal belonging, at the expense of their ability to respond differentially to various social settings. Disengaged families, on the other hand, instill in their children a skewed sense of independence.

Family Context as a "Beneficiary" of the Symptom

Some families go beyond the passive acceptance of dysfunctional behaviors or the creation of a context that facilitates them: they *encourage* the recurrent display of a specific symptom. In these families, the symptom performs a regulatory function. The origins of the symptomatic behavior may lie in the family dynamics itself, or in biological or social circumstances of the

individual family member; in either case, the behavior is now serving the purpose of protecting the stability of the whole system.[4] Thus, in a *detouring-attacking triad*, a delinquent boy may offer an opportunity for the parents to join in *anger* against him, while in a *detouring-protecting triad*, a diabetic girl may allow the parents to focus their joint *concern* on her. In either case, parental conflict is sidetracked. For the sake of system maintenance, parents and child appear alternatively to request the symptom and volunteer it.

The Symptom Bearer

Family dynamics contributes to determining *who* becomes symptomatic: the structure of alliances and coalitions developed over years of spousal negotiation and child rearing renders some people more vulnerable than others to the label of deviance. Other factors, however, may play an equal or stronger role; examples are organic conditions such as asthma, a mild learning disability, or a chemical imbalance in the brain, and circumstantial events originated in the extrafamilial, for example, a bad year in school.

Specific Correlations Between Structures and Symptoms

The most comprehensive attempt to correlate specific family structures with specific categories of symptoms came from the psychosomatic project. As mentioned before, a cluster of traits—enmeshment, overprotectiveness, rigidity, and absence of conflict resolution—was consistently identified in families of psychosomatic children. However, many elements of those traits have been found in clinical practice among other dysfunctional families that do not present psychosomatic problems, and there are no comparative studies demonstrating that the cluster itself is specific to psychosomatic families. In the area of antisocial behaviors, the Wiltwyck experience has shown that a juvenile delinquent may come from an enmeshed family where there is too much control and little room for experimentation, or from a disengaged family where there is little guidance.

In fact, the terms "enmeshed family" and "disengaged family," while convenient as shorthand, are misleading. Most families include elements of both enmeshment and disengagement, and the current emphasis of structural family therapy is on identifying functional and dysfunctional areas of the family structure, rather than on categorizing pathological structures as such. Minuchin has celebrated the absence of a taxonomy of families: "Fortunately for family therapy, therapists have not been able to develop diagnostic categories for families that can pigeonhole some family forms as normal and others as deviant; with any luck, we never will develop them" (Minuchin & Fishman, 1981, p. 263).

ASSESSMENT

Structural family therapy focuses on change more than on diagnosis. It subscribes to the concern that the demands of a comprehensive diagnosis may draw the therapist into a disheartening obsession with pathology. Assessment does not precede intervention, but is an inextricable part of it.

Focus of Assessment

Assessment is inseparable from joining because it is conducted as the *therapeutic system* (see below) is being formed. It is also inseparable from the challenge to the system because it is conducted with an eye on change. Its purpose is not to render a detailed account of everything that is wrong with the family, but to be a map that will guide the therapeutic intervention.

Family Shape

The map offers an overall view of the family and some specific features of the terrain. The overall view is a picture of the more easily recognizable features of a family: How many people are in the family? How are they related? How

[4] *Editors' Note.* Structuralists share with strategic therapists (e.g., Madanes, Chapter 12) a belief in the interpersonal functions of psychological symptoms.

old are they? The picture may be titled, "A three-generation family," "A blended family," "A single-child family," and so on, which convey some impressionistic information of how the family is shaped—something akin to the gestalt impression of a puzzle.

Some shapes are named for the developmental stage that the family is negotiating: families with babies, families with adolescents, families that include elderly parents. Other names are more reflective of the therapist's idiosyncratic response to the first bits of information about the family. Minuchin, for instance, talks about "accordion," "shoe," and "fluctuating" families (Minuchin & Fishman, 1981, pp. 53–55). These shapes have an anthropological rather than a pathognomic flavor, reminiscent of the structuralist's preference for normalizing over stigmatizing labels. Other shapes may be more indicative of a specific area of trouble, like the "out-of-control families" and the "families with a ghost."

Points of Entry

Within the overall picture of the family, the therapist focuses specifically on two areas of detail. One is the set of family characteristics to which he or she will need to adjust: the family's preferred style of communication and problem solving, accepted range of distance/proximity for interpersonal exchanges, stance regarding issues of autonomy and control, distribution of functions, ways of dealing with conflict, beliefs, attitude toward outsiders, hierarchical arrangement, leaders of change and resistance.

Structural Strengths and Weaknesses

The other specific focus of assessment is on transactional patterns that may be supporting the problem and/or can contribute to its solution:

> The family map indicates the position of family members vis-à-vis one another. It reveals coalitions, affiliations, explicit and implicit conflicts, and the ways family members group themselves in conflict resolution. It identifies family members who operate as detourers of conflict and family members who function as switchboards. The map charts the nurturers, healers, and scapegoaters. Its delineation of the boundaries between subsystems indicates what movement there is and suggests possible areas of strength or dysfunction. (Minuchin & Fishman, 1981, p. 69)

Structural Assessment and the Individual

Minuchin has criticized the error of "denying the individual while enthroning the system" (Minuchin et al., 1978, p. 91). This does not imply an endorsement of traditional individual assessment, but rather the recognition that individuals hold the key to systemic change. A change in the system consists of individuals changing each other, and, therefore, requires the detection and mobilization of untapped individual resources.[5]

The structural assessment of individual members does not look for what the individual *is*, but for the many different ways of being that the individual may actualize within a variety of different contexts: What kind of a husband is he to his wife? Of a father to his son? Of a son to his mother? And how else could he be, were it not for the idiosyncratic constraints of his family structure? It is an assessment predicated on the premise that family members mutually activate, reinforce, trigger, and sustain, and, therefore, selectively develop, certain aspects of each member's self, while other potential aspects are suppressed or remain underdeveloped. Umbarger (1983) has noted that although the notion of reciprocal influence is common among system thinkers and other behavioral scientists, "the structuralists have made it more emphatic than others have through the persistent reevaluation of individual psychology as bound to the interpersonal context. The special theoretical contribution of this model is to return consistently to these interactional structures, showing how they constrain and shape the individuals within the system" (pp. 21–22).

The structural therapist wants to access the latent aspects of the individual's self, not on the

[5] *Editors' Note.* This comment reminds us of Duhl and Duhl's (1981) notion that "You can't kiss a system," i.e., that therapists do not change family systems per se, i.e., at the level of systemic organization.

assumption that they are hiding under the individual's defenses, but on the assumption that they are being discouraged by context. A 12-year-old girl may behave more maturely when she is treated as the oldest daughter than when she is treated as a fragile child. A 34-year-old woman may appear incompetent as a mother when her husband is around, but manage nicely when he is away on a business trip. A man may be tentative and wimpy at home, but a respected leader at work.

Unit of Assessment

Structural family therapy allows for flexibility in selecting the unit of assessment. Of course, at least two people are required, because the model's reliance on observation of interaction for diagnostic purposes renders individual verbal accounts of family dynamics largely useless. *Three* people are required for the therapist to be able to observe coalitions, protection or invasion of subsystem boundaries, and detours, without having to become the third member.

Naturally, the ideal assessment unit would include "everybody who is relevant" in the case. But this admits at least two interpretations: (1) those who are a part of the *problem*—without them, the therapist cannot obtain a comprehensive understanding of the underlying dynamics; or (2) those who will play an important part in opening certain avenues for *change* and/or obstructing others—without them, the therapist cannot access potentially valuable resources and crucial roadblocks.

The two criteria do not necessarily overlap. In the case of a child who is failing in school, for example, where transactional patterns enacted in the school setting are most probably "a part of the problem," the first criterion would call for always involving the school in the process of assessment (and treatment). The second criterion, on the other hand, provides a choice. The therapist may choose to assess only the family, according to the rationale that the investment of the family in the child is enough for the project of therapeutic change; or the therapist may still choose to assess the system of family–school—but now on the grounds that the school can be made to play a part in bringing about change (Aponte, 1976b; Eno, 1985).

Because they are more interested in change than in diagnosis, structural therapists tend to think about the unit of assessment in terms of the second criterion. Of course, it is impossible, for any given family, to know a priori which of the two criteria harbors the best promise—and, in any case, who will be relevant. Paradoxically, the definition of the appropriate unit of assessment depends on assessment, and it may vary as assessment progresses. A sensible guideline is to begin with the group of people who, because of their regular transactions with the identified patient, could hardly be ignored in terms either of understanding the problem or of exploring avenues for change; in practical terms, this usually means the household. As the formation of the therapeutic system progresses and the therapist collects additional information, other members of the extended family—or even the extrafamilial, such as school personnel—may be involved in the process of assessment.

Assessment Procedure

Preplanning

Assessment begins with the information gathered during an initial telephone call or by reading an intake sheet. On the basis of simple, concrete information, such as the composition of the family and the ages of its members, as well as more subtle data, such as who makes the initial call and how that person describes the family problems, the therapist generates his or her first impressions about the family's "shape" and some of the possible strengths and weaknesses. These initial hypotheses are invaluable in guiding the first contacts of the therapist with the family, even if they may have to be discarded quickly at that point.

Tracking

Following the content and the process of the family interaction, like the needle of a record player follows a groove, is the basic structural procedure to collect information on the family map. As the therapist listens to and encourages the contributions of family members, observes

their mutual dance, and asks for clarifications and expansions, he or she begins to draft first answers to structural questions: whether family members can converse without being interrupted, whether they tend to interact in age-appropriate ways, how they organize each other's behaviors, how they deal with or avoid conflict, what alliances they tend to form.

On the assumption that structure is expressed through action, the structural therapist tracks actual transactions more than verbal accounts; "When a family member is talking, the therapist notices who interrupts or completes information, who supplies confirmation, and who gives help" (Minuchin & Fishman, 1981, p. 146).

Staging Enactments

In addition to the observation of spontaneously enacted transactions, structural assessment requires the active creation of scenarios to probe further the strengths and weaknesses of the family. If a parent and child dyad exhibits what appears to be a healthy relationship, the therapist may introduce a more difficult subject to test whether they can handle the additional stress. If, on the contrary, the subsystem appears to be floundering, the therapist may change the subject, or modify the seating arrangement, to explore whether the quality of the transaction improves under different conditions.

> The therapist can then intervene in the process by increasing its intensity, prolonging the time of transaction, involving other family members, indicating alternative transactions, and introducing experimental probes that will give both the therapist and the family information about the nature of the problem, the flexibility of the family's transactions in the search for solutions, and the possibility of alternative modalities for coping within the therapeutic framework. (Minuchin & Fishman, 1981, p. 79)

Search for Strength

Staging enactments is particularly useful for assessing individual strengths that may lie concealed under the weight of the family structure. The therapist needs to resist the pull to focus on pathology and be drawn into a pessimistic view of the family. He or she needs to take the initiative in bringing to the foreground the "more competent ways." He or she may direct family members to behave unusually ("Could you talk to him as if he is your brother, not a mental patient?"), or briefly occupy the stage himself or herself ("Right now, with me, you were able to be 15 years old"). In the opening moments of a consultation with the family of an "uncontrollable" 5-year-old girl, even before people take their seats, Minuchin addresses the identified patient, who is already showing signs of agitation, and asks her a question about her younger sister. In response, the patient shows that she can act like a normal 5-year-old (Minuchin & Colapinto, 1980).

The technique of searching for strength sometimes consists of eliciting competent behaviors, as in the example above, and at other times of translating apparently "obvious" or even negative descriptions into evidences of competence. This requires from the therapist a disciplined way of looking and listening. Says a mother, famous for her negativistic descriptions of her children: "I've always had a problem with them. . . . Miranda is outgoing and tomboyish. She used to be very tomboyish. Ruby used to be more domesticated . . ." Reflects the therapist: "The mother's description is highly differentiated; she is clearly a sensitive person who is observant of the children's individual developmental processes" (Minuchin & Fishman, 1981, p. 106).

Reframing the Problem

Tracking and staging enactments is a collaborative form of assessment. Information does not only proceed from the family to the therapist, but also proceeds the other way around, as the therapist selectively chooses to highlight certain transactions and contents and ignore or downplay others. The technique of *punctuation* is used by the therapist to feed back to the family members a transactional version of their sayings and doings in the session: "You are a close family." "You are protective of your daughter." "It's easier for you to talk to your mother than to your father." Because these statements are comments on transactions, they challenge the notion that

individual behaviors are a straightforward expression of individual motivation. They help the family members to see their behaviors as part of a larger whole, and prepare the ground for a change in their perceptions of the problem—from an individual-based problem, requiring exploration and "rewiring" of the individual's inner life, to an interaction-embedded problem, requiring exploration and rewiring of the family's ways.

The reframing of problems requires from the therapist the ability to capture the family's reality with "transactional lenses" that highlight the complementarity of behaviors. In another moment of the consultation quoted above, Minuchin observed the mother's futile attempts to control the behavior of the girl in the room. Eventually, he asked, "Is this how the two of you run your lives together?" Had he asked if that was the usual behavior *of the girl*, he would have confirmed the family's perception that the problem was, indeed, owned by the girl; as it was, the consultant exposed the transactional nature of the problem.

TREATMENT GOALS

Goals of treatment are negotiated between the therapist and the family. In one sense, goals are relatively simple to negotiate. If the family does not have one specific complaint, but a general sense of *malaise*, the agreed-upon goal might be an equally generic exploration of the family's patterns. Usually, however, there is a specific complaint, and in that case the agreed-upon goal would be to eliminate the source of the complaint—to get Johnny to improve his performance in school, Annie to start eating, Pete not to run away, Betty to stop shoplifting. Of course, concern with the original complaint may or may not be shared by all family members. While Johnny might agree with the rest that school improvement is a good idea, Pete might not see anything wrong with his spending a few nights out of the home—maybe even Pete's stepfather does not think it is as bad as the mother feels. So the therapist listens, invites a discussion with other family members, explores what it is that each one wants, establishes congruences and oppositions between the respective goals, helps the family formulate common goals when this is possible, and recognizes the areas of dispute when it is not. Since all of this also provides information about the shape of the family, the possible points of entry, and especially the possible ways of reframing the problem, goal setting does not need to be thought of as a separate activity.

Family's Goals and Therapist's Goals

In another sense, however, the family and the therapist necessarily disagree on goals. The family's goal includes not only some kind of formulation of the desired outcome, but also the members' expectations of the kind of service they will get from the therapist. Often, what the family expects is a focus on the identified patient.

The family's expectations of therapy are consistent with dominant cultural myths about psychopathology and the role of therapy—myths to which therapists themselves have contributed:

> Though we pay lip service to the strengths of the family, and talk about it as the matrix of development and healing, we are trained as psychological sleuths. Our instincts are to "search and destroy": pinpoint the psychological disorder, label it, and eradicate it. . . . We are the specialized personnel who have earned our credentials to defend the normal by developing and maintaining a typology that frames deviancy as mental illness. (Minuchin & Fishman, 1981, p. 263)

The goal of the structural therapist, on the other hand, is to help the family change so that the individual changes, because he or she sees individual problems as parts of patterns and potential solutions as parts of structural realignments. To help the family, the therapist needs to challenge the family's ideas of where the problem is located and how it should be solved, which amounts to challenging the family's expectations of the role of the therapist. "The word *challenge* highlights the nature of the dialectic struggle between family and therapist within the therapeutic system" (Minuchin & Fishman, 1981, p. 67).

The disagreement between family and therapist at this level of goals is inherent in the pro-

cess of structural family therapy. The family's goal is elimination of the complaint *with maintenance* of the family's structure; the therapist's goal is elimination of the complaint *through transformation* of the structure.

Connectedness and Differentiation

The pursuit of family transformation involves a dialectic interweaving of the themes of connectedness and differentiation. In the early Wiltwyck days, developing a sense of connectedness was the major goal in the treatment of disengaged families:

> The therapist aims at providing to all members some sense of "re-echoing"—some evidence of contributions to the interpersonal field and of interpersonal causality. By organizing different situations, he demonstrates repeatedly the phenomenon of complementarity or reciprocity, which the family has difficulty experiencing. (Minuchin et al., 1967, p. 355)

With enmeshed families, on the other hand, the goal was to help the family members differentiate:

> In this profile the therapist must focus on decelerating the basic tempo and intensity of reverberations within the field. (If not) responses by one member continue to merge with the counterresponses of others, and the experience of the distinctness of one's own actions and the feeling of responsibility for one's actions are blurred. (Minuchin et al., 1967, p. 359)

While the emphasis on family typologies diminished as the structural model developed, the polarity of connectedness and differentiation as treatment goals has remained. The pursuit of differentiation within the family is at the core of the characteristic boundary-making interventions of the structural therapist, while "challenging the world view" of the families that cannot recognize the interconnectedness of their reality is the main thrust of structural reframings (Minuchin & Fishman, 1981, pp. 64–72).

The goal of individual change is pursued simultaneously with pursuit of the structural goal. A change in family structure implies a change in the positions occupied by the individual members; their experience changes accordingly. Reciprocally, it is through changes in individual behaviors that the structure is made to change.[6]

STRUCTURE OF TREATMENT

It makes ecological sense to regard the family as the overall framework for therapy. "The family is the natural context for both growth and healing, and it is the context that the family therapist will depend on for the actualization of therapeutic goals" (Minuchin & Fishman, 1981, p. 11).

Clients

Within this overall framework, the structural model allows for flexibility in the configuration of treatment sessions. While most may be attended by the whole family (typically including parents and children, and sometimes grandparents who live in the same household or participate actively in transactions), others may be reserved for selected members, depending on the need to concentrate on the development of specific subsystems. The children, and sometimes the parents, may be excused from specific sessions, "since not everything will happen at once and not every family member need be involved each step of the way" (Umbarger, 1983, p. 56).

Therapist

Structural[7] family therapy is more appropriate for a "solo" therapist, because of its reliance on *joining*, *tracking*, and the therapist's *use of self*, none of which lends itself to easy coordination with another person. When a second therapist or a team is available, they are more effective

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[6] *Editors' Note.* Unfortunately, in our view, data are hard to come by that support strongly the view that symptom change (in the individual) in the absence of structural change is less enduring. It is not that there are contradictory data, but that there are few bearing on the matter.

[7] *Editors' Note.* But the therapist's use of self *may* lend itself to very useful, if not easy, coordination in at least some types of family therapy, e.g., Symbolic-Experiential Therapy (cf. Roberto, Chapter 14).

as observers—preferably placed behind a one-way mirror—who can monitor the therapist and periodically feed back their observations to him or her, without introducing an element of distraction in the joining of therapist and family.

Time and Space Parameters

The structural model does not prescribe standards regarding length of treatment, number of sessions, or duration of each session; they are subject to negotiation between therapist and client. Actual experience in the application of the model has proved that it varies widely along all these parameters, reflecting the variety of therapists' preferences and styles, cultural backgrounds of the client families, presenting problems, and institutional settings. When it comes to length of treatment, for instance, some therapists simply are faster than others at challenging family patterns and pushing for transformation; some may limit their intervention to facilitating a difficult transition, while others may stay connected to the family for a more ambitious project. Some families use the therapist as a catalyzer and neither expect nor become interested in a prolonged relationship; other families may appreciate the thrill of a continued challenge. Similarly, the duration and frequency of sessions may depend on the therapist's own preferences, on the families' availability of time, or on the bureaucratic structure of any given agency.

While the model itself does not set standards concerning time variables, the structural therapist may use them to the advantage of the therapeutic process—for instance, by designating a special session to be longer, allowing for more time between sessions when prescribing a certain task, or cutting a session short as a way of intensifying the effect of an enactment. The various roles and techniques available to the therapist may also be structured in a sequence of stages, adapted to the needs of specific clinical environments (Karrer & Schartzman, 1985; Lappin, 1988).

Structural family therapy is more prescriptive regarding the *spatial* arrangement within the therapy room, which needs to be flexible enough to accommodate the therapist's restructuring maneuvers. A standard recommendation is a combination of individual chairs and a two-person sofa, no obtrusive furniture, and toys appropriate to the family's children.

ROLE OF THE THERAPIST

Structural family therapy assigns a decisive role to the therapist as an instrument of change. It is the therapist's behavior, rather than the intrinsic efficacy of techniques or prescriptions or the appropriateness of interpretations, that helps families change.

As noted earlier, the structural therapist's distinctively active stance was initially justified by the specific characteristics of the population at Wiltwyck, which limited the value of the "talking therapies" and required more concrete forms of communication. Subsequently, the experience in Philadelphia demonstrated the power of action to bypass abstract verbalization and effect substantial organizational change in other, more "verbal" families.

The structural therapist is expected to engage the family in the therapeutic project, introduce challenges that force adaptive changes, and support and coach the family members as they cope with the fallout. Over the course of treatment, the therapist needs to vary the level and intensity of his or her involvement with the family; there is even some (although not much) room for quiet reflection and neutrality.

The primary injunction from the model to the therapist can be summarized in three words: "Make it happen." This requires the performance of a variety of roles.

The Therapist as Producer

One of these roles is production of the conditions that will make therapy possible—the "formation of the therapeutic system." It involves the techniques of *joining*, in which the therapist gains the family's acceptance of him or her as a special, nonpermanent, but influential member, with the capacity to challenge the system from within: a *search for strength*, the localization of family resources that will be used by the family and therapist as "building blocks" in the construction of alternative patterns, and

the *reframing of the problem* as a family rather than an individual one, so as to encourage the participation of the family in the healing endeavor.

The Therapist as Stage Director

A second role of the structural therapist is to create situations that challenge the existing structure and push the family toward more functional patterns. Here, the therapist takes advantage of his or her position as a temporary member of the system. As a stage director, the therapist sets up scenarios for enactments, where he or she can then have an impact on the complementary patterns—monitoring the flow of transactions and directing the family members to interact in novel ways.

The Therapist as Protagonist: Use of Self

From the role of director, the structural therapist may shift to the role of protagonist, intervening directly in family transactions—interrupting, pushing, challenging, supporting family members selectively. By using himself or herself as an additional participant in family transactions, the therapist effectively unbalances the family organization.

As an instrument of change, the use of self should not be confused with self-disclosure of the therapist's personal experiences, which the structural model discourages because it attracts attention to the therapist and distracts from family process. In the structural model, stories from the therapist's own life are only justified as instruments of joining ("I have two sons of the same ages").

The Therapist as Narrator

The structural therapist is also a coauthor, with the family, of a revised "script" for family transactions. The therapist's challenge to the family's belief structure—the assumptions that family members hold about the motivations, preferences, capabilities, and limitations of one another—proceeds hand in hand with the challenge to the transactional structure. By commenting on observed transactions, old and new, the therapist questions the family members' attribution of meaning to each other's behavior, and assists in the development of new meanings.

Therapist's Profile

The structural model requires from the therapist a respectful curiosity about diverse forms of family experience and strengths, a commitment to help families change, a preference for concrete behavioral changes over talk about changed feelings, a disposition to construct hypotheses on the basis of scanty data and to have them corrected through a close encounter with clients, the ability to set clear goals and to express them frankly, a willingness to direct, a directedness of expression, a tolerance for intensity in human transactions, and the courage to raise intensity when necessary.[8]

> Minuchin is powerful, but his intensity is not a function of his personality; it reflects his clarity of purpose. Knowledge of family structure and a serious commitment to help families change make powerful interventions possible. Families will usually respond to messages delivered with the kind of intensity that comes from being clear about the goal. . . . Therapists too often dilute their interventions by overqualifying, apologizing, or rambling. (Nichols, pp. 495–496)

TECHNIQUES OF STRUCTURAL THERAPY

The structural therapist utilizes a variety of techniques in the pursuit of structural change. Their use is selectively dictated by the vicissitudes of the therapeutic process as continually assessed by the therapist; the structural model does not

[8] *Editors' Note.* We agree with Colapinto's implicit message here, that not every therapist can effectively practice every type of family therapy, and that it is extremely important that the match between therapists-as-persons and the requirements of adopting a given therapeutic style or model be given its due consideration. This position obviously has significant implications for education and training.

prescribe specific matches between a given technique and a given problem.

Techniques can be classified in two broad groups, depending on whether their primary application is to the formation of the therapeutic system or to a change in family patterns.

The Formation of the Therapeutic System

The first order of business for the structural therapist is to be accepted *in* the family; that is, to be accepted not just as somebody to meet once a week, but as a regular, if temporary, participant in family transactions, with the right to engage family members and, eventually, challenge them.

Joining

The therapist gains such a position through a series of movements generically called "joining." They include simple rules of etiquette, such as making friendly contact with all family members, and deliberate techniques such as *confirmation*, in which the therapist responds sympathetically to family members' expressions of concern, sadness, anger, fear, even rejection of therapy, and *maintenance*, in which the therapist is mindful and respectful of the rules that govern distances and hierarchies within the family system—for instance, by addressing the parents before addressing the children. Confirmation may also take the form of a nonjudgmental description of a transaction among family members, such as when the therapist comments, "You seem to be engaged in a continuous struggle."

Selective Joining

Structural joining is not the same as being nice to people. While needing to be accepted, the therapist does not want to accommodate to the point of being "inducted" into the system and, thereby, rendered impotent. One way of introducing an element of challenge in the very process of joining is to emphasize the affiliation with one member more than with others. In some cases, the therapist may want to position himself or herself closer to the most peripheral member of a family; the therapist may then select his or her wording carefully to indicate special affiliation with that member, or enact a nonverbal *mimesis* of the member's mood, tone of voice, posture, or behavior.

Joining as an Attitude

The skill of joining requires more than the application of a technique:

> Joining a family is more an attitude than a technique, and it is the umbrella under which all therapeutic transactions occur. Joining is letting the family know that the therapist understands them and is working with and for them. Only under this protection can the family have the security to explore alternatives, try the unusual, and change. Joining is the glue that holds the therapeutic system together. (Minuchin & Fishman, 1981, pp. 31–32)

The attitude that joining requires combines elements of proximity and affiliation (respectful curiosity, acceptance, the ability to put oneself in the other's shoes, sensitivity to corrective feedback) with elements of distance and differentiation (questioning the family's ways, hinting that there are others, encouraging dissent). Good *tracking* of process, as discussed in the section on "Assessment," may help put the therapist's effort to join the family on "automatic pilot."

Other Techniques

The techniques involved in searching for strength and reframing the problem were discussed in the section on "Assessment."

While the focus on the formation of the therapeutic system is more obvious during the initial encounter with the family, the need to maintain the viability of the system is a continuous one. The techniques of joining, searching for strength, and reframing continue to be used throughout treatment, as the therapist protects his or her gained position within the family, and

regains it whenever he or she claims the right to challenge the family structure.

Changing Family Structure

The structural approach to changing the family relies on the challenge to current patterns of transaction. Here, the word "challenge" does not necessarily connote a harsh confrontation. Although some challenges may take the form of confrontation—for instance, in the technique of unbalancing—the word has a more generic meaning, designating any therapeutic intervention that makes it difficult for the family to engage in its usual modes of transaction. The challenge is to the dysfunctional pattern, not to the motivation of those who participate in the pattern.

Challenging techniques especially developed by the structural model are aimed at directly affecting the family's structure of transactions by creating an alternative pattern in the room.

Enactment, the actualization of transactional patterns under the control of the therapist, is usually regarded as the most distinctive structural technique, because it best expresses the premise that more change comes from dealing with problems than from talking about them. If the family claims that the mother does not have any control over her children and depends on the father for law and order, the therapist may create a situation in the therapy room that requires the mother to organize the children's play, and then block the rescuing attempts of the father until the mother succeeds.

The purpose of enactment is to offer a context in which the family can experience the substitution of functional for dysfunctional transactions. The therapist "makes it happen" by monitoring the transaction in progress—one moment supporting it with a suggestion, and the next moment pulling back to leave room for the family members to transact, occasionally refocusing them. At the same time, the therapist also intensifies the family's experience by commenting on stumbling blocks and successes: "He gave you that look again and you stopped dead in your tracks." "Now you are talking to your father like a real 16-year-old."

Enactments rarely beget instant change. The family needs to repeat the experience of possible alternatives in many different forms before new patterns can be maintained. Each successful enactment contributes a bit to enlarging the experience of the possible, showing that change is possible and what it might look like. The therapist may prescribe "homework" as a way of extending an enactment beyond the boundaries of the session. For instance, the sibling subsystem may be instructed to prepare a pleasant surprise for the parents, as a way of both reinforcing the boundaries of that subsystem and promoting internal negotiation. Naturally, homework cannot be monitored by the therapist with the same immediacy as an in-session enactment, but it has the advantage of taking place in the natural environment and over an extended period.

Boundary making is a special form of enactment in which the therapist modifies patterns of over- and underinvolvement by allowing some members, but not others, to participate in a transaction. Examples of boundary making are the prescription of a physical movement that results in the formation of a group of people facing each other, with their backs toward the rest; asking a family member to watch in silence from one corner of the room or from behind a one-way mirror; prolonging a dyadic interchange; using phrases that convey the desirability of separation ("You talk for him," "Do you need to check every answer with her?"); and using physical gestures aimed at blocking interruptions or distracting visual contacts (raising a hand, standing between people).

Boundary making disrupts the operation of detouring mechanisms and other conflict-avoidance patterns, and encourages the emergence of underutilized skills within the subsystem in question—such as a couple that is being protected from interruption by the children, or children who are being protected from interruption by the parents. New skills sometimes emerge spontaneously (the siblings, for instance, develop their own way of solving their differences without parental arbitration), but more often they are identified through the therapist's intervention in the bounded subsystem—pointing out the ways in which subsystem members shape each other's behaviors, highlighting their complementarity, and encouraging experimentation with new shapes. To a father locked in a hopeless contest of recriminations with his daughter, the therapist may say: "You keep say-

ing that you have no influence over your daughter, but right now she is asking for your help. She is giving you power. Accept her request." This modality of intervention, known as *working on complementarity*, is the main contribution of the structural therapist to an enactment, once it has been initiated.

Intensity is a quality that the structural therapist attaches to some of his or her interventions to increase the level of challenge to the family system. Intensity can be achieved through numerous repetitions of the same message, through tone of voice, or through a dramatic statement or intervention. Examples of particularly intense techniques are unbalancing and crisis induction.

In *unbalancing*, the therapist capitalizes on the expertise that the family has allocated to him or her to challenge a rigid family hierarchy. The therapist, for instance, may purposefully ignore a domineering family "switchboard." While this "goes against the grain of the therapist's cultural imprinting, because it requires the capacity to speak and act as if certain people are invisible" (Minuchin & Fishman, 1981, p. 173), it may force a realignment of family hierarchy, for example when the ignored member attempts to draw the other members into a coalition against the therapist.

In a more active form of unbalancing, the therapist becomes a protagonist of family transaction, entering into a coalition with a family member. For instance, the therapist may support a devalued family member against another member, in which case, "the family member who changes position in the family by affiliation with the therapist does not recognize, or does not respond to, the family signals. He operates in unaccustomed ways, daring to explore unfamiliar areas of personal and interpersonal functioning, highlighting possibilities that were previously unrecognized" (Minuchin & Fishman, 1981, p. 162).

Crisis induction is the creation of a situation that leaves the family no choice but to face a chronically avoided conflict. An example is the lunchtime session in anorexia cases, in which the symptom literally is brought into the room and the family is asked to deal with it.

Unbalancing and crisis induction are risky operations that may threaten the continuation of treatment. They require from the therapist clarity of purpose and a difficult balancing of commitment to change and sensitivity to corrective feedback from the family.

Challenge to the Family's World View

In addition to techniques that directly alter the transactional structure of the family, the structural therapist utilizes others that affect the structure indirectly by challenging the family's world view. Universal truths, moral imperatives, cultural traditions, folkloric common sense, invoked expertise, and the family's own preferred metaphors can be used by the therapist as vantage points from which to challenge the premises that underlie family rules, provide alternative explanations, and suggest directions of change.

In the West family, who came to therapy because the father, a minister was having difficulties controlling his two adolescent daughters, Mr. West refers to his wife and daughters as "the three girls." The therapist rises, "stopping the clock," and points up a moral: "You must have difficulties in your relationship with God, since you don't understand that He created hierarchy in the family. There is a right place for the parents and a right place for the children." (Minuchin & Fishman, 1981, p. 215)

Some Common Technical Errors

Most of the technical errors that a structural family therapist can make are generically gathered under the rubric of *induction*, a phenomenon in which the therapist inadvertently becomes organized by the rules of the family. Induction should not be confused with the accommodating moves of the therapist who intentionally adopts the rules of the system as a part of his or her joining.

Centrality is a variety of induction in which the therapist accepts the family's enticing for him or her to become the central figure of treatment, which inhibits family transaction. The therapist may fall into constantly asking questions, responding to requests for advice, or always being at one end of a power struggle. Or the therapist may unwittingly respond to family clues and rush to the protection of a member

who appears to be at the losing end of a transaction—an induction known as the *rescuing maneuver*; for instance, an adolescent is being verbally abused by her parent and the therapist anxiously interrupts the transaction or admonishes the parent.

Another common error is *overfocusing on content* at the expense of visible structural patterns. "If family members are avidly telling their story, the therapist's attention may be locked into content. Sometimes a therapist tracks the communication of the most verbal family members, unaware of the family life being enacted before his unseeing eyes" (Minuchin & Fishman, 1981, p. 34).

The power of family rules to induct therapists is complementarily reinforced by traditional clinical training, which encourages therapists to be central, helpful, and focused on content.

On the other hand, structural therapists may also err in the opposite direction—by not allowing themselves to be inducted enough. When this happens, the therapist does not pay enough attention to the family rules, fails to accommodate to them, and "loses touch" with the family. He or she then operates at a distance that is not appropriate for the structural model, relying excessively on the free-standing value of the techniques and unable to register feedback from the family. It is the error of *overtechnicism* (Colapinto, 1983, 1988). The therapist may, for instance, set up an enactment and expect the process to take care of itself ("You two talk about this"), or grossly miscalculate the consequences of an unbalancing.

DYNAMICS OF CHANGE

Structural family therapy operates on the basis of a set of assumptions about change, derived from the structural understanding of family dynamics.

1. Change and resistance to change. Change, in families and individuals, is a natural process of growth that can be arrested. When that happens, the potential for change and a resumption of growth is still inherent in the family itself, and, more specifically, in areas of its individual members' selves that have so far been suppressed by virtue of complementarity. Family members "are always functioning with a portion of their possibilities. There are many possibilities, only some of which are elicited or contained by the contextual structure. Therefore, breaking or expanding contexts can allow new possibilities to emerge" (Minuchin & Fishman, 1981, p. 14).

A family may change spontaneously when it realigns its structure to cope with a changed environment. On the other hand, the family may resist spontaneous change and reinforce its current structure. Resistance to change is then expressed through the predominant adhesion to existing family rules, with individual members countering others' movements toward change.

2. Family change and individual change. The family, as a powerful organizer of its individual members' behaviors, is a major influence in shaping the individuals, and whether and how that shape can change. The family is the natural context for change, and even though individual members can initiate change without the help or the "permission" of the family, such change necessarily brings about reverberations in the family, some of them in the form of resistance. Harnessing the power of the family on behalf of the individual, and attending in vivo to the reverberations of change in the family, are the two major advantages of family therapy.[9]

3. Therapeutic change. Individuals and families who fail to change spontaneously may change with the assistance of a therapist who opens for them the possibility of experiencing alternative patterns. Resistance to change is either circumvented (typically through the use of enactments) or directly challenged (for instance, through a crisis induction).

4. Behavioral change and cognitive change. Changes may be initiated at the level of behavioral interaction or at the level of cognitive or emotional experience. The way family members experience each other changes when their interaction changes, and the way they interact changes when their experience of each other

[9] *Editors' Note.* We wish to underline that Colapinto is speaking here of family therapy-in-general, not just of Structural Therapy. These two characteristic advantages of family therapy may constitute a good deal of the potency of family methods that is attributable to so-called "nonspecific" factors that are common to all family-therapy approaches.

changes. Therefore, both a disruption of actual transactions and a challenge to the clients' mutual experience can initiate change.

However, even when choosing the latter route, the therapist uses actual transactions in the room as referents. Changes in clients' experiences are brought about not by the therapist's long explanations, but by his or her brief punctuation and reframing of enacted transactions. The same applies to cognitive processes that contribute to therapeutic change, such as the understanding of the phenomenon of complementarity: they need to be anchored in concrete experience.

WORKING WITH COUPLES

The structural model has not developed a separate set of concepts or techniques for the treatment of couples. The couple is conceptualized as a subsystem that may become one of the foci in the treatment of a family, or that may itself take the initiative of requesting treatment. In either case, assessment and treatment of the couple subsystem follow the same guidelines that apply to the family.

There are some differences in emphasis in the choice and application of techniques. For instance, it may not be necessary to reframe the problem as an interactional one, because couples requesting therapy are comparatively closer to perceiving their problems as interactional anyway; on the other hand, reframing may be needed to change the definition of what kind of interactional problem it is. Similarly, the consistent focus on an already identified subsystem offers comparatively more opportunities to apply techniques for working "inside" the subsystem—such as enactment and working on complementarity—than to use techniques for differentiating subsystems, such as making boundaries. However, the structural approach also pays attention to the context of the couple and its relationship to other subsystems; for instance, how being a father and mother affects the relationship of husband and wife. Stanton (1981) has developed a model for couple therapy that combines elements of the structural and the strategic approaches.

TREATMENT APPLICABILITY

Structural family therapy has been primarily developed and applied in clinical settings, both agency-based and private, where children, including adolescents, are the identified target of intervention. There is comparatively little documented experience on the application of the model to the treatment of adults; existing reports suggest that the model applies when there is a strong involvement of the family in the life of the individual adult (Fishman, 1979; Stanton & Todd, 1982).

The model applies to all shapes of families, from the disengaged to the enmeshed end of the continuum. Naturally, the extremes pose a higher level of challenge. An extremely disengaged family may make it difficult for the structural therapist to reframe the problem and recruit the necessary resources. An extremely enmeshed family may present too rigid a front against the therapist's attempts at restructuring. But these obstacles to applicability are not absolute; they can be overcome by the therapist's determined joining or intensity. It is fair to say that limits to the applicability of the model to families are determined by the therapist's style rather than the family's.

A more complex issue, because it interfaces with the controversy about the validity of the psychiatric diagnosis, is the applicability of the model to specific individual syndromes, such as character disorders. Again, the less a problem lends itself to an interactional reframe (whether the result of family rigidity or of the weight of a diagnosis), the less are the chances for a successful application of the structural model. Again, these obstacles are not absolute, but are relative to the therapist's ability to reframe and challenge. Depression can be seen as an interactional phenomenon (Minuchin, 1974).

There are problems to which the model definitely does not apply. The organic substrata of some psychotic phenomena do not respond to structural family therapy, any more than the organic substratum of diabetes does. However, just as structural family therapy can be effective in reducing the number of acidosis crises (Minuchin et al., 1978), it is also applicable to the interactional fallout of organic psychoses. At the

other end of the explanatory continuum, while the model cannot cure the social context of poor, underorganized families, it can help them develop the interactional skills that help other poor families cope better.

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