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Teaching the Structural Way[1]

On finishing one year of training in structural family therapy, a group of fun-loving practitioners produced a spoof videotape that they titled “The Structural Way.” In a comic fashion, the piece demonstrated the trainees’ understanding of a fundamental tenet in their teachers’ philosophy: that structural family therapy should be learned, not as an assortment of efficient techniques, but rather as a disciplined way of looking at families in pain, at the intricacies of change, and at the role of the therapist.

What is, however, the “structural way”? The adjective “structural” is usually employed to identify the approach originally developed by Salvador Minuchin at the Philadelphia Child Guidance Clinic. Today, however, a good number of family therapists invoke it to describe their practice —in some cases without much justification— while many others are producing excellent structural work that they do not label as such. Pinpointing the “real” structuralists is difficult by the absence of a formal model that would define the essential features of structural family therapy. Minuchin’s own theoretical writings, while abundant and inspiring, display noticeable variations in emphases and are not without inconsistency —probably the result of an open-minded interest in what other thinkers had to say about his own clinical work. The influence of Jay Haley can be detected through the pages of the classic *Families and Family Therapy* (Minuchin, 1974), and many clinicians and even taxonomists of family therapy would not acknowledge any substantial differences between the two masters. There have been attempts to systematize the essential tenets of the structural model (e.g., Aponte & VanDeusen, 1981; Colapinto, 1982; Nichols, 1984; Umbarger, 1983), but none of these renditions can be regarded as the “official” version.

THE STRUCTURAL PARADIGM

It could certainly be argued that there is no such thing as “the structural way,” but only the inimitable style of Salvador Minuchin, an idiosyncratic expression of genius that manifests itself anew each time and does not allow for formalization. Indeed, the master himself, worried that his creation might be turned into dogma by others, has all but disowned anything resembling a comprehensive model of therapy that can be taught and learned (Minuchin, 1982). The contrary position reflected in these pages is that there exists a core system of perspectives on families, change, and therapy that directs the structuralist’s work in the therapeutic arena and sets the “structural way” apart from other approaches. Such a paradigmatic core can be primarily distilled from certain redundancies in Salvador Minuchin’s clinical operations and in his case discussions, more than from his theoretical presentations —where the search for dialogue with other thinkers has occasionally blurred the shape and boundaries of the structural paradigm.

A Structural View of Families

[1] Originally published in Liddle, Breunlin & Schwartz, *Handbook of Family Therapy Training and Supervision.* New York, Guilford, 1988.

Family therapists of all persuasions look beyond the apparent behavior of family members in search of some kind of pattern that will introduce a unifying meaning into what would otherwise be a confused bundle of unrelated observations. But they are not all searching for the same kind of pattern (Scheflen, 1978). Some pursue clues to the distribution of power; others, styles of conflict resolution; still a third group, redundancies in the sequence of speakers. The list could continue almost indefinitely.

The structural way is one among many methods of putting together the richly complex manifestations of family life. Although generically speaking it conceptualizes the family as other systemic approaches do —as a system in evolution that constantly regulates its own functioning— it features a distinctive focus on concepts that describe space configurations: closeness/distance, inclusion/exclusion, fluid/rigid boundaries, hierarchical arrangements. The key notion of complementarity is used by the structuralist to denote not an escalation of differences (Bateson, 1972), but a fit among matching parts of a whole. Visually, the relational patterns that the structuralist "sees" can be better described by maps and jigsaw puzzle-like figures than by circular series of arrows.

From the structural point of view, symptomatic behavior is a piece that fits into a dysfunctional organization. An adolescent's anorexia may be related to a mutual invasion of the patient's and her parents' territories; a school phobia may reveal excessive proximity between mother and son; a runaway may signal a "leaky" structure. Structural configurations are deemed functional or not according to how well or how badly they serve the developmental needs of the family and its members. In a dysfunctional family, development has been replaced by inertia. Stuck in a rigid arrangement, such a family cannot solve its problems and continue growing. For example, following mother's death, a father and a daughter maintain the same distance that they had kept when mother was alive; the girl becomes a truant, mother is not there to make sure that she attends school, and the vacuum in parental functions is filled neither by the father nor by the relatives who are now mediating between him and the girl.

Thus, unlike other systemic approaches that focus on the *function of the symptom* ("Joey's temper tantrums distract his parents from their marital conflict"), the structural view focuses on the *organizational flaw* ("The couple's avoidance of conflict is crippling their parenting of Joey").

A Structural View of Therapeutic Change

Breaking away from such an organizational impasse requires the mobilization of resources that the family already possesses in latent fashion and which are often apparent in a different context; the widower of our example was a competent professional who could display leadership in his job but not in relation to his adolescent daughter. Systemic change, in the structural view, equals an increase in the complexity of the structure —an increment in the availability of alternative ways of transacting. The function of the therapist is to create a -context for the family to experience those alternative patterns as accessible (father does have an influence on daughter), possible (neither father nor daughter will collapse while dealing with each other), and necessary (daughter is in for trouble if she and father abdicate their relationship). This definition of the therapist's role explains the structuralist's preference for changing transactions in the therapy room, where he or she can punctuate sequences of behavior and literally create a different experience.

What the structural therapist is trying to build through his or her restructuring efforts is more important than -what he or she is trying to uncover. If father becomes

paralyzed when his truant daughter blames him for her mother's death, identifying the accuser —defendant pattern that renders him impotent is only a preliminary step toward the promotion of a more functional father-daughter relationship. This health-oriented search for the "missing pattern" is a characteristic mark of the structural approach: the survey of differing views about the nature of the problem, the gathering of information on family background arid history, and other diagnostic operations are guided by the need to assess the system's resources and weaknesses in preparation for a reorganization.

The structural therapist does not emphasize the pursuit of individual change or the prescription of specific solutions. Instead, he or she tries to modify, enrich, and make flexible the family structure. The goal is to help the family discover patterns that are missing and that will, when developed, provide the scenario for the solution of individual problems. The family (like a recovered ecosystem) is the healer, while the therapist's job is to recruit individual resources for the project and to provide a context that can defeat inertia. Unlike other systemic approaches that prescribe for the therapist the role of an invariably neutral commentator, the structural view requires therapists to become protagonists as well. The creation of healing scenarios and the mobilization of individual resources demand the therapist's active involvement as well as a broad perspective. In helping a father to find better ways of relating to his children, the structural therapist may resemble a coach —mostly straightforward, in principle benevolent, sometimes impatient, and rarely neutral. In undoing a rigid triangle in a psychosomatic family, he or she will enter into selective alliances, and will alternately imbalance, support, and push. Rather than cautiously operating from an invariable distance, the structural therapist constantly changes positions, oscillating between the objectivity of the removed observer and the intensity of the direct participant. From any of these two vantage points, families are seen not as passive mechanisms that resist the therapist's input, but as active organisms that need to be joined, explored, and expanded.

PHILOSOPHY OF TRAINING

The first trainers of family therapy did not need to pay much attention to the specifics of alternative paradigms. They were vanguard explorers, marching in different directions, somewhat ahead of their disciples, but participating with everybody else in the overriding excitement of a revolutionary, somewhat underground movement. They were expanding the frontiers of therapy, deriving techniques from new concepts and concepts from new techniques. Then, as the field grew in scope and respectability, the explorers "staked the unmarked corners with their trade names" (Minuchin, 1982), and schools developed. Today, clinicians are trained not just in family therapy, but in the structural, strategic, systemic and/or other model of family therapy —each one separated from the next by differences in the conceptualization of both families and therapy.

Mission of Training

The diversification of family therapy has brought about a rapid increase in available technology —and with it a danger. The numerous and heterogeneous techniques developed by various schools are sometimes presented to the beginning therapist as an assortment of free-standing tools, each one endowed with its own efficiency, independent of the conceptual frame from which it emerged. Such an approach can generate a field

> full of clinicians who change chairs à la Minuchin, give directions à la Haley, go primary process à la Whitaker, offer paradoxes in Italian, tie people with ropes à la Satir, add a pinch of ethics à la Nagy, encourage cathartic crying à la Paul, review a tape of the session with the family à la Alger, and sometimes manage to combine all of these methods in one session. (Minuchin & Fishman, 1981, p. 9)

The problem is that techniques do not work by themselves. Knowing how to join, reframe, or unbalance is useless if one does not know when and why to do it. Therapeutic competence requires a synthesis of many different and even contradictory abilities; the structural therapist needs to engage clients intensely and also to keep an efficient distance from them; to accept and disrupt the ways of the family; to be a leader and a follower, firm and flexible, poised and humble. In order to choose, organize, and time specific interventions, the therapist needs to rely on the master blueprint, the therapeutic world view that is provided by the structural paradigm. The heuristic value of the paradigm as a propeller and organizer of the therapist's operations surpasses the efficacy of any collection of techniques, and therefore its acquisition constitutes the main mission of training. Technical skills need to be learned as a natural expression of a consistent paradigm (Colapinto, 1983).

Training Strategy

The early emphasis on techniques in the teaching of structural family therapy was a reaction to the limitations of traditional training, with its deductive sequence from theoretical constructs to specific interventions; the availability of live and videotape supervision exposed the huge discrepancies that may exist between the apparent understanding of concepts and the actual behavior of the therapist in the session. The idea then, as Minuchin recalls, was to teach the "steps of the dance," to focus on the specific skills of therapy "without burdening the student with a load of theory that would slow him down at moments of therapeutic immediacy." Theoretical integration, it was hoped, would emerge spontaneously: "Through an inductive process the student, in 'circles of decreasing uncertainty,' would arrive at the 'aha!' moment: the theory." (Minuchin & Fishman, 1981).

Experience with this approach eventually showed that spontaneous theoretical integration was the exception more than the rule. The tactic of concentrating on the practice of skills while leaving conceptual understanding for later may require from the student a strong and lengthy attachment to the teacher. In Zen and other Eastern models of learning (often cited as an inspiration by family therapy trainers) the student is sometimes even -prevented from attempting to practice the master's teachings in the real world while in training (Herrigel, 1953). But in our world of licensing boards, third-party payers, and workshop show business, the relation of trainer to trainee offers little room for pure aesthetic contemplation and personal renunciation. Apprentices just will not wait for the master's anointment.

The student of structural family therapy should not be expected to infer the theory from the practice any more than the other way around. The conceptual understanding of the model and the practical operations in the therapy room need to be taught simultaneously and as an integral paradigm. A mere "balance" of theory and practice — such as the interspersion of theoretical seminars in a clinical program that otherwise focuses strictly on the practice of skills— is not enough, and may in fact defeat the purpose of integration by maintaining "theory" and "practice" as separate realms. A real integration of theory and practice can occur only in the arena of supervised clinical work,

and the best opportunity for the supervisor to facilitate it is immediately before or during the therapeutic encounter with a family when the therapist is at the highest point of motivation and alertness.

Pragmatics and Aesthetics of Training

The integrated approach to training presented in these pages offers one possible answer to the debate about the aesthetics and pragmatics of family therapy. Some authors (Allman, 1982; Keeney & Sprenkle, 1982), reacting to the pragmatic lure that "cookbooks" of techniques may exert on therapists, have argued for a more "aesthetic" attitude -one that would temper or counterbalance the pragmatic trend by enhancing a more contemplative understanding of underlying patterns of interconnectedness The opposition, however, is a false one. The cookbook approach thrives not on excessive, but on defective pragmatism. Therapists who only learn techniques that "work" turn out to be as "practical" as actors who only impersonate others: the effectiveness of their performances diminishes as a function of their narrowed creativity. An awareness of "underlying patterns of interconnectedness" -like the ones depicted by the structural paradigm- is necessary, not to temper the therapist's pragmatic goals but to improve his or her chances of achieving them. Aesthetics, far from being the opposite of pragmatics, constitutes its highest form.

To help the therapist develop an aesthetic perspective, the trainer must begin by acknowledging and respecting the therapist's pragmatic concerns. If a trainee is anxious to learn how to do better therapy, attacking his or her motivation as being too pragmatic will not help in promoting a paradigm shift. But the trainer also can and should challenge the trainee's notion of how this pragmatic concern is to be satisfied. For instance, if the trainee attributes his or her performance deficits to ignorance of the right recipe," the trainer can demonstrate that what is needed is better thinking; the pragmatic motive thus provides the incentive for a more integrated, "aesthetic" learning. This training strategy is evocative of the structural model of therapy, which accepts the focus on the presenting problem while repositioning it within a structural frame: the clients' immediate concerns with their symptoms are acknowledged and respected, but the clients are also told that in order to get rid of these symptoms their transactional patterns and views will need to change.

TRAINING CONTEXT

The training philosophy presented in the previous section has been implemented through several training programs. The example to be presented here is the Extern Program, a clinical practicum offered by the Family Therapy Training Center of the Philadelphia Child Guidance Clinic, and designed to teach generic concepts as well as specific techniques of structural family therapy.[2]

Extern students meet one day a week, from October through May. Organized in groups of eight, they work together with two supervisors for the entire training-day. The program is structured around live supervision, of family sessions that are also observed by the colleagues in the training group and subsequently reviewed on videotape. An additional one-day seminar, where all- groups participate, is held every month.

[2] The author was affiliated with the Philadelphia Child Guidance Clinic from 1976 to 1986. The description offered here reflects the program as it was in the mid-1980s.

Setting

The Family Therapy Training Center is part of the Clinic's Department of Training, which also offers other practica as well as internship programs for psychiatrists, psychologists, and social workers. In addition, a continuing education program offers workshops and conferences led by both Clinic staff and guest speakers. The Philadelphia Child Guidance Clinic is a large facility created in 1925 that provides outpatient and inpatient treatment to children and adolescents -within a family perspective. The ecosystemic orientation of the services provides the Extern program with a "friendly" environment that facilitates consultations, transfers, and other communications within the broader context. The Clinic is the primary source of mental health services for a large catchment area and has access to the entire range of mental health problems, which permits direct supervision of treatment as a preferred training modality. A close liaison has been established with the Children's Hospital of Philadelphia in the areas of psychosomatic dysfunctions and chronic illnesses.

Each group of eight students and two supervisors has permanent access to two videorooms with observation and videotaping facilities. Group discussions and review of videotapes are conducted in a separate conference room. A student room functions as a relief office for paperwork, phone calls, and individual review of videotapes. The program also makes extensive use of the video and library department, which includes hundreds of edited and unedited videotapes of sessions conducted by Salvador Minuchin and other experienced therapists. Students have the same responsibilities as regular staff members concerning the medical records of the families in treatment.

Trainers and Trainees

The core faculty of the Extern Program consists of supervisors who have been associated with the Clinic, in various clinical capacities, for periods ranging from 4 to 13 years. Their varied experience in the practice of structural family therapy within different contexts and populations is complemented by other members of the large and multidisciplinary Clinic staff, which covers nearly the entire range of specialties in the mental - health field and is available for backup supervision and consultation.

Students are required to possess a master's degree or equivalent in a mental health area, and a minimum of one year's experience in the practice of family therapy. They need to be currently employed in an agency setting where they must carry a minimum of five families. Applicants submit a letter of interest, letters of recommendation, and curriculum vitae. A preliminary screening of the written applications leads to the exclusion of candidates with insufficient academic and/or experiential background; the rest of the candidates are interviewed by at least two faculty members, and final decisions are made by a selection committee. Typically, the therapist who joins the Extern program is acquainted with the concepts of structural family therapy through readings, workshops, and edited videotapes, but is not consistently operating under a structural paradigm. He or she may juxtapose straightforward structural moves with psychodynamic interpretations or paradoxical injunctions, and not recognize the differences and eventual incompatibilities between the structural and other models.

TRAINING FORMAT

The Extern program begins with a three-day seminar on structural family therapy, intended to set a basic common ground for the training process. The seminar also provides the faculty with an opportunity to observe the students' responses to the concepts and clinical material presented, and Compare their understanding of families, the process of change, and the role of the therapist to the structural paradigm. The rest of the program revolves around direct supervision of the -trainees' work with families. Clinical work is conceptualized as the arena where an integration of theory and practice can best occur. Each trainee conducts one or two sessions per day under live supervision, and receives on the average an additional half hour of videotape supervision for each hour of therapy. The unit of training is a cycle that includes a pre-session discussion, live supervision, post session review, and videotape review.

Pre-session Discussion

The preliminary discussion of hypotheses about family dynamics and therapeutic strategies, based on intake information or the previous session, provides an opportunity to examine the trainee's thinking —how the trainee organizes the available material and perceives his or her own role. For instance, when the intake information on a case of school avoidance mentioned that mother had been beaten by her boyfriend, one trainee automatically focused his attention on mother's own "pathology." The supervisor then offered an alternative perspective, establishing a conceptual boundary between the woman's presumed incompetence in choosing partners, and her potentially competent role as a mother.

To facilitate the exploration of a trainee's paradigm, he or she is encouraged to participate actively during the pre-session discussion, presenting ideas and objections, as Opposed to passively receiving instructions for the conduct of the session.

Initial interviews are minimally structured in advance; they are mostly devoted to entering the system, listening, and redefining the problem. As therapy progresses, pre-session discussions may focus more on specific treatment and/or training goals ("Today you should make an effort to mobilize the sibling subsystem"). Role playing may be utilized to enhance the trainee's understanding of complex therapeutic processes, such as unbalancing or entering into multiple alliances. The primary roles of the supervisor in this stage are to help the therapist develop a structural frame for the upcoming session ("What do you think the daughter is doing that keeps mom ineffective?") and to correct faulty frames ("You won't get very far if you keep regarding mom as a 100% slob").

Live Supervision

In the session, the previously discussed structural frame helps the therapist to keep one foot out of the system; for instance, it prevents him or her from being organized into thinking of mother as a slob. Overviewing the process of the session to make sure that the trainee protects that frame from homeostatic-tic pulls or distractive contents is one of the functions of the supervisor at this stage. Other functions are to assist the therapist in dealing with unexpected developments ("My wife and I decided to divorce yesterday"), to correct the course if the unfolding of-the session requires a change in focus, and to take maximum advantage of opportunities to enhance the process. For instance, when a depressed mother who has all but given up on her family lights up a cigarette, the supervisor suggests, "Challenge her to refrain from smoking; make it a test of will."

Deciding to intervene

Sometimes supervisor and trainee can preplan the entire sequence of stages in a session, including a few "walkouts" by the therapist at specified times, for consultation purposes. The most frequent scenario in structural family therapy, though, is one that requires on- the-spot planning in response to feedback from the family, as the session progresses. Thus, live supervision usually demands quick decisions- as to whether, when, in which way, and to what degree to interfere with the process in the room. The supervisor who expects the session to flawlessly follow his or her own conceptualization —and proceeds to "proofread" it from behind the mirror— will at best make a puppet out of the therapist, and at worst ruin the process of therapy. Allowance needs to be made for the idiosyncrasy of the student, whose course of action may not totally agree with the supervisor's, but may still aim at the same goal. On the other hand, if the supervisor is too passive and accepting, both treatment and learning may suffer. Like the structural therapist, the supervisor is both an observer and an active participant in the process of change.

In extreme cases, such as when the continuity of treatment or the well-being of the family is at risk, the need to intervene may be obvious. More frequently, however, the decision is not simple. A typical situation might be the "inconclusive maneuver," where the therapist begins to unbalance the structure but falters halfway, allowing the system to reestablish homeostasis. In such a case the supervisor needs to decide whether to "let it go" or insist that the job be finished. Numerous factors are weighed in the decision: the more or less serious implications that an aborted unbalancing could have for the family; the strength of the therapist; the status of his or her relation to the family and the supervisor; whether there will be a next time; whether the supervisor's intervention really has a chance of bringing about success.

Another example is the "golden opportunity," where the therapist is not in error but the supervisor sees a chance of moving the process of training and/or therapy one notch up. For instance, while the therapist may be doing a good job of helping a family with teenage children negotiate curfews or schoolwork, the supervisor may react to a tender remark by the 15-year-old daughter, and indicate a change of subject -to her relation with the apparently distant father.

Forms of intervention

The supervisor can choose among various modes of intervention: talking to the therapist on the phone; calling the therapist out of the room for a quick consultation; entering the therapy room. (The same alternatives are of course available for the therapist at his or her request.) If the same goal can be achieved through any of these methods of intervention, the least disruptive should be chosen. However, an ostensibly intrusive intervention like walking into the room is not always the most disruptive. If the supervisor needs to communicate a brief message ("I think that father has the answer to this one") in the middle of an intense discussion, calling the therapist out of the room or on the phone might cause an undesired distraction. It may be better for the supervisor to join the session briefly, without even taking a seat, offer his or her input, and leave. 1f on the other hand, the therapeutic moment is so complex that the supervisor's message would either be too long ("Talk to father even if the girl cries. When she stops ask her about her mother, but if she does not stop, or if father gets distracted . . ."), or require minute-by-minute interruptions - of the session, the best solution may be for the supervisor to demonstrate the idea directly.

In the context of the Extern Program, where both families and trainees get used to the presence of the supervisor and the group behind the mirror, these interventions can be assimilated into the therapeutic process as a form of ongoing consultation or cotherapy. Families are informed at the beginning of treatment that the therapist is part of a team, which provides a rationale for the interventions of the supervisor and minimizes the risk of a negative impact on the family's relation to the therapist. When the supervisor walks into the room, he or she frames the intervention as a cooperative effort ("I came here because I wanted to tell mother that. . ."), and/or addresses the therapist in a collegial way ("You know, Susan, I think that. . .").

Content of interventions

If the supervisory intervention consists of a dialogue with the trainee (a phone call or a consultation behind the mirror), the supervisor needs to pay special attention to the con tent of the message. Ideally, it should include a request for a specific action, with a rationale for that action, as a way of promoting the integration of paradigm and technique: "Husband needs to feel your support as he stands up to his wife [rationale]. Move your chair closer to him [action]." Occasionally, however, the supervisor will need to prescribe an action without offering any rationale. One therapist, for instance, had been struggling unsuccessfully to motivate a 16-year-old girl to fix a dinner for her family. The family was already leaving when the supervisor rang and told the therapist; "Ask the girl if they have candlelight at -home". Puzzled but appropriately curious, the therapist asked the question; the girl then nodded slowly, looked intensely at the therapist, and answered, "I see what you mean." ("What did I mean?" asked the therapist after the session.) But these are exceptions, justified when time is running out or events are unfolding too rapidly. Of course, as supervisor and trainee progress in their mutual understanding, the rationale may not need to be explicit:
"Spend some time talking to the boy about his friends" may implicitly carry the comment, "You need to join the identified patient." Conversely, it may be the specific action that does not need to be detailed. When a trainee is told, "You are losing mother," or, "The kids have too much power in this family," that may be enough for him or her to implement the appropriate therapeutic interventions.

Post session Review

Immediately after the session there is a short debriefing, limited by the time that remains until the next family arrives. Emphasis now shifts to the therapist's progress in training. Successes -and failures are briefly discussed and linked to the paradigm: "You really joined mother today; that is what we mean when we insist that joining is not necessarily being nice," or, "I think the reason why you couldn't engage grandma was that you saw her only as a saboteur" This stage is also an opportunity to explain the reasons behind the supervisor's interventions, if they could not be provided during the session itself: "I asked you to mention the candlelight because they were really talking about wanting to be closer, not about chores." Finally, the trainee is instructed to locate specific segments in the tape for later review.

Videotape Review

The review of the session videotape, prior to the next appointment, facilitates a more thorough discussion of the trainee's perceptions and actions. Rather than reviewing the entire session, segments are chosen that highlight the family's dynamics and/or the therapist's performance; in-depth analysis of the implications of micro sequences is preferred to an-extensive overview. In this way the supervisor can concentrate on specific training needs of the therapist as reflected in the concrete clinical experience. The supervisor may ask- various questions to assess and eventually correct the therapist's perception: "What do you see happening here? What can you tell, from that dialogue, about the relation between husband and wife? Did you notice any differences in the responses of father and mother to the girl's temper tantrum?" Other questions, such as, "Why did you decide to support father?" or, "Do you think it was necessary for you to teach mom how to control the kid?" address the trainee's understanding of his or her own role. The supervisor may also comment on the family ("I don't think -this is an overinvolved dyad; look how mother responds to the child"), and on the therapist's performance ("You created an instant climate of comfort, but then became too careful not to risk it").
The trainee, in turn, asks for specific inputs: "What is going on in this family?" "How can I be less central?" He or she is primarily motivated to improve performance -in general and in the next session. The supervisor capitalizes on this legitimate interest and stimulates the therapist's integration of action and thinking, turning "what-should-I- do-next" questions into opportunities to develop the therapist's paradigm. The focus is on the clinical practice, but not in a theoretical vacuum: "Yes, you can go for the differences between mother and father, but are you clear as to why that is important at this point?" or, "I think you are not pushing father enough because you think too much of the function that the child's symptom may have for the couple."

The Group Format

The group format is essential to the process of supervision in the Extern Program. The group functions as a sounding board for the relation between the supervisor and each individual trainee, contributes useful suggestions and observations, and provides a safety net of mutual support. Through its comments, questions, and sheer presence, the group helps the supervisor to keep distance from the therapy itself- and to maintain the perspective of a trainer —particularly during live supervision, when the immediacy of the therapeutic process might blur that perspective. Alternating between the -roles of therapist and-observer, the group members learn both through the intense experience of conducting a supervised session, and through the more relaxed participation in the dialogue between the supervisor and other trainees.

On the other hand, the group context places extra demands on the supervisor. When reviewing a videotaped session, for instance, the supervisor must double as a group leader, balancing the need for group participation with the need for a focus on the specific training needs of the individual trainee. In live supervision, the supervisor has to be careful not to become subtly induced by the group into taking too much control of the session ("Is Carl doing what you asked him to do?"). By maintaining an equidistant relation to all members, staying clear of coalitions, and sticking to the function of guiding the trainees' learning, the supervisor fosters group cohesiveness and discourages destructive competition.

TRAINING CONTENT

The Extern trainee learns primarily in response to the requirements of clinical practice. Rather than following a prearranged curriculum, the program is shaped by the needs of the families in treatment and those of the trainees. The emphasis that the structural model places on cooperation with and accommodation to the family dictates, in principle, a natural sequence. Issues related to joining, entering the family system, and forming therapeutic alliances tend to be dealt with before those related to challenge, unbalancing, -or confrontation But some families or trainees may require an earlier focus on these latter issues, and it may also be that the more a therapist learns about changing families, the better he or she "reads" them in the beginning —and the better the reading, the better the joining.

The integration of theory and practice follows a pattern of alternation: the trainee works with a family, receives corrective feedback from -the supervisor, returns to the family, and so on. Generic concepts, such as joining, unbalancing, or enacting, are intertwined with the discussion of specific clinical situations throughout all the stages of the training cycle, particularly during videotape reviews when there is more time to do so. This integrative approach is occasionally complemented with readings, assigned in accordance with the needs of each trainee; videotaped sessions of experienced clinicians, which the supervisor discusses to illustrate specific points; and the monthly one-day seminar where all students and supervisors meet to talk among themselves and with guest presenters.

The trainee may frequently feel, "Ah! This time I got it." Then he or she will experience failure, and the supervisor will introduce yet another correction. The experience can be frustrating, particularly for the student who expects to learn by continuous increments -that is, to expand his or her already acquired knowledge without having to put it into question. Instead, the process of learning a new paradigm typically adopts the form of a spiral, where elating experiences of insight are followed by the feeling of being "back to square one." It takes time for the student to realize that each new turn of the screw finds him or her, after all, at a higher level of competence.

This spiral pattern of learning is consistent with the notion that structural skills, as part of an integral model, are interdependent. They can not be taught and learned as free-standing techniques; on the contrary, the student must be consistently reminded of the relation that each technique has to the other, and of the places the techniques have within the structural paradigm. The paradigm needs to impregnate training as a constant presence, a point of reference that confers meaning to each instance of learning. If the goal of training is to form autonomous therapists, its content must be dominated not by "how-to-do" questions and the practice of discrete techniques, but by "what-for" questions and the understanding of how specific interventions are dictated by the larger structural goals The following discussion of some of the typical problem areas in the teaching of structural family therapy illustrates these points.

Learning to See Structures

The ability to bring about structural change depends on the ability to "see" structures. A special scanning attitude is required so that data are gathered and organized in a way that will trigger structural interventions. A trainee who was assigned the case of a violent 12-year-old boy learned during the first interview that the boy's father had died two years before. The therapist immediately focused on mother's feelings of loss, and did not have much trouble in finding confirmation for his hypothesis

-that pathological mourning was *causing* the mother, via depression and hopelessness, to be ineffective as a parent. By gathering information according to a psychodynamic paradigm the trainee was setting the stage for a therapeutic strategy based on helping the mother to work through her bereavement so that she would become more available to raise her son.

The trainee was called out of the room and asked to find out how the family context (the structure) was contributing to the unresolved mourning and to mother's ineffectiveness. This time the trainee elicited structural information: mother's brother had been trying to help by volunteering anything from running errands (when mother did not feel like leaving the house), to half-fathering the boy. In the second interview, which was attended by the uncle, the trainee could also appreciate mother's complementary role in monitoring help: by summoning her obliging brother whenever a minor difficulty arose, she was cooperating in the pattern that kept her depressed and unavailable for parenting. The stage was now set for a therapeutic strategy aimed at changing the dysfunctional system.

Instructing the therapist to elicit context information is one way of encouraging him or her to perceive structures. Other ways include the use of visual aids such as mapping (Minuchin, 1974) and the metaphoric depiction of complex patterns, like the "accordion" and other types of families (Minuchin & Fishman, 1981). Constructive approaches, however, are not enough. The trainer often needs to disrupt deep-seated assumptions about the explanation for dysfunctional behavior ("Is mourning the reason that mother can not handle her son, or is that just a copout?"), the direction of change ("Couldn't the boy's needs be utilized as leverage to extricate mother from her exclusive preoccupation with widowhood?"), and the therapist's own role ("Are you there to help them express their feelings, or to help them solve the violence problem?"). Underneath these questions and their alternative answers lies the more fundamental level of value judgments on what constitutes good or better family functioning. A family structure is always seen, assessed, and eventually modified by reference to an ideal model, connoted by such concepts as "clear boundaries," "flexibility to transform," or "developmentally appropriate patterns." Sooner or later in training, the supervisor needs to gain access to this deeper level.

In the case of our example, the therapist succeeded in moving his focus away from mother's mourning and toward context, once he came to see his function as one of helping mother and son restructure their relation in a way more appropriate to the present stage in their family life cycle. In the words of the trainee:

> The notion that impacted me the most was that this boy was at a crucial developmental spot, and could not wait for his mother to work through her individual stuff. When I went back to them (after consulting with the supervisor) I kept repeating to myself: "12 years old" and "7th grade." And asking myself, "What would be the right context for him now? What needs to happen between him and his mom, that is not happening?"

As the therapist looked at the family from this vantage point, it became apparent to him that they were not working as a good team. There was too much nurturance going from the boy to the mother, and too little guidance the other way around; they were not dealing with each other because they were both more connected to father's ghost. The health-oriented search for the missing pattern organized the therapist's quest for structural information.

Learning to join

Because structural family therapy requires the cooperation of the family, it is essential for the therapist to participate actively in the formation of a therapeutic system (Minuchin, 1974; Minuchin & Fishman, 1981), where he or she temporarily joins the family in a position of leadership. The structural therapist needs to relate to family members in a way that validates their experience but does not preclude a challenge to the status quo.

This is not an easy task. A frequent misconception among therapists in training is to view Joining as just a preamble to "real" therapy -a social ritual that needs to be observed but can be quickly disposed of. Particularly vulnerable to this mistake are therapists previously trained to think strategically; they tend to plan their moves several steps ahead of the family's immediate feedback and may react impatiently to the supervisor's request that they slow down their thinking and "wait for the family."

Disregard for the complexities of joining often results in a superficial or an undifferentiated relation to the family: the therapist starts by smiling, being nice, and indulging in small talk, and ends up either in a peripheral position (without engaging the family) or inducted by the family process into a powerless predicament. The latter was the case for a trainee whom I shall call Mrs. Murphy.

Outside the session, Mrs. Murphy could articulate a rather sophisticated description of the family structure and its relation to the presenting problem. In the presence of the family, though, she appeared to lose that structural perspective. It was easy for her to engage individual members (she would, for instance, connect to children much better than their parents could), while the rest of the family watched appreciatively. Families liked her but their compliance with her prescribed tasks and other recommendations was low, and no significant change would occur. As a therapist, Mrs. Murphy positioned herself at the center of a star like configuration from where she made herself available to each individual member in succession, but she could not grasp the family system as such Thus, the focus of her work changed constantly, following the pulls and pushes of the different family members.

In this case the therapist was hindered by her own ability to establish quick rapport with individuals. On entering the family system, she entirely trusted her spontaneity and failed to recognize the need for conscious purposeful joining which would have enhanced her leadership and ability to promote change. The example is also illustrative of the close relation between the ability to join and the ability to see family patterns unfolding in the session.

But taking joining too casually is not the only mistake that a therapist in training can make. The nearly opposite misconception is to approach joining as a special technique or set of techniques that can be learned by practicing the appropriate sentences, voice intonations, gestures, and body postures. The therapist may then become over involved with his or her own maneuvering and lose touch with the family, thus defeating the very essence of joining and failing to develop the proximal relation to clients that structural family therapy requires.

A challenge for the supervisor, then, is how to call the trainee's attention to the dynamics of joining while at the same time discouraging a "technical" approach One possible avenue is to prescribe the trainee's behavior during the initial moments of therapy in a way that will facilitate joining, without disclosing this particular goal until later For instance a therapist who had a tendency to jump prematurely into the problem that brings you here" was asked to slow down and make sure that he contacted everybody in the family before addressing the problem. The supervisor's instruction, originally framed as a way of eliciting necessary information, helped the therapist to join better and was discussed from this second point of view after the session.

In other cases the trainer needs to reach for the deeper level of the trainee's basic perceptions and attitudes. One therapist who generally liked children but distrusted parents would almost invariably ignore the presence of a mother in the room. The supervisor therefore instructed the therapist to start an initial session by addressing the mother, and to obtain any information about the daughter only through the mother. The therapist complied, but within less than one minute she had managed to convey her disapproval of the way in which the mother was talking about her daughter. Here, the supervisor had underestimated the pull of the therapist's attitudes, which organized her to operate as a child rescuer. A therapist thus organized usually has difficulties in joining because he or she is always ready to protect the child from any insinuation of scapegoating within the family, and thereby loses structural perspective. The supervisor should have detected and addressed the more basic paradigmatic issues: "Do you think that mother can give you that information?" "Is your role to protect the daughter from the mother, or to help them develop as a more viable unit?" In general, the skeptical therapist who routinely expects incompetence, resistance, uncooperativeness and/or malevolence will find them -and will not be able to join families as required by the structural model, even after trying the most sophisticated techniques.

Joining is not the outcome of a calculated technique, but the outgrowth of a positive attitude toward families. To encourage such an attitude, the supervisor needs to nurture the therapist's curiosity about the inner workings of the family ("What kind of animal is this?" "How is it that they cannot solve this problem?") and his or her confidence in the availability of latent resources within the family ("They are larger than what they are presenting to us"). In the case of Mrs. Murphy -the therapist who was too central- this proved to be the turning point. Initially, the supervisor had worked on increasing Mrs. Murphy's awareness of certain dynamics in families that would organize her to become central, and on how to avoid them. With the help of much self-discipline and a few reminders, she managed to keep her centrality in check. But then a new problem surfaced: she looked uninterested and disconnected from what was taking place in therapy, and one family began to miss sessions.

The supervisor found out that in spite of her familiarity with the literature and her preference for the structural model, Mrs. Murphy did not really believe that family members could have a beneficial influence on each other. She had been professionally trained to distrust the resourcefulness of clients, and to think of herself as the only "healer" in the room. Against the background of such a paradigm, the exercises designed to counter her centrality had resulted in skepticism and a lack of interest once removed from the central position, Mrs. Murphy could not see herself as a therapist and, accordingly, would not expect any "real therapy" to occur.

This trainee's basic attitudes toward therapy could not be dealt with by just practicing techniques; a different context was needed. The length of her sessions was extended so that she would give families a chance to prove their strength, with the provision that she could always conduct "real therapy" in the last half hour if needed. The focus of the dialogue between Mrs. Murphy and her supervisor turned to their contrasting views on the level of strength available in each family, and what was needed from the therapist. During the sessions, Mrs. Murphy was directed to explore and push for the family's resources and for alternative configurations of the family structure. Her work began to show sustained progress. Her skepticism first acquired a different quality -she was intrigued with the possibility of altering her perception of her own role -and soon was replaced by a new intensity. Her curiosity became more invested in the process than in the individual pathologies, in the search for strengths rather than in the identification of weaknesses.

Learning to Challenge

The mobilization of family resources, an essential feature of the structural approach to change, requires the active involvement of the therapist as a protagonist more than as a mere commentator. In the process of motivating family members to try alternative patterns of transaction, the therapist often needs to challenge, more or less intensely, the family members' perceptions of their reality and/or their responses to it. Given that most therapists come to train in the structural model after having learned a more traditional definition of their role, the ability to challenge is usually regarded by both trainers and trainees as the most difficult to develop.

Like good joining, good challenging is the natural result of an attitude and cannot be taught or learned as a technique. Consider the therapist who by her own recognition was "too nice" and decided to practice a more challenging style. She wanted to help a passive adolescent to become angry at his mother for over controlling him. She tried variations of the same message: "You should react, you should get her off your back." The words were harsh, but the therapist maintained a casual posture that conveyed that she did not really expect the boy to deal successfully with his mother. Her "challenge," performed from a safe distance, sounded more like a put-down. In a situation like this, asking the therapist to lean forward or otherwise to reduce distance from the client would not be enough, because what is lacking is not a technical subtlety but the therapist's commitment to her actions Had she been more tuned in to the family s predicament than to the practice of a technique, she might have glimpsed a streak of competence beyond the apparent stubbornness of the adolescent, adding decisive force to her intervention —and, by the way, she would have leaned forward without even planning it.

Challenging to be effective must be predicated on the client's strengths Contrary to a common misconception, it is not the "opposite" of joining. Joining and challenging need to be seen as simultaneous qualities in any therapeutic intervention. Good joining includes a dimension of challenge: the intrusion into the clients' lives. Good challenging strengthens joining by cementing the alliance between the therapist and the better side of the challenged individuals. Both qualities express the same basic attitude of curiosity, commitment to change, and confidence in the family's latent resources, that is a natural corollary of the therapist's adhesion to the structural paradigm.

Thus, the belief in the worthiness and attainability of structural goals sustains the therapist in his or her challenge to the established ways of the family. Without it, the therapist will most probably falter in the face of intensity, back off and diffuse conflict For instance the father of a truant teenager would routinely escape from the pressures of parenthood by bringing up in sessions some ongoing feud with his wife. The therapist understood the supervisor's directive to block the distraction, but could not bring himself to challenge the father. It occurred to the supervisor that the therapist, having previously been trained to automatically refer any child problem to a marital conflict, might be in fact reacting sympathetically to the father's shift of focus Following a discussion where the supervisor argued against the policy of leaving children's needs on the back burner, and in favor of an immediate correction of the organizational flaw that was responsible for the truancy, the therapist was able to develop a more challenging stance toward the father.

The basic ingredients of a challenging attitude can be developed in the trainee by encouraging critical observation. The therapist needs to discipline himself or herself to watch and listen to the family's transactions with a questioning disposition, not taking anything for granted. Patterns of transaction that may seem obvious to the family should be met with a silent or overt interrogation. How come Billy doesn't care about bringing pink slips from school? How come father doesn't know more about Joanna's friends?

How come Vicky doesn't try to talk her way out of being grounded? The "how-come" mode of inquiry implies that patterns of transactions might, and maybe should, be different, and that it is within the power of the family to change them.

Because of the difficulties involved in conveying the meaning and role of the challenge, the supervisor is often in the position of teaching it by demonstration. When the supervisor enters the therapy room and challenges a family to move beyond its imaginary constraints, the purpose of the demonstration is not so much to show the trainee how to do it, but that it is possible to do it —that the family can be challenged without the entire therapeutic project falling, apart. The subject of the lesson is the worthiness and viability of the challenge, more than its specific shape. As with any other demonstration, the subsequent explanation of the intervention and its relevance within the wider strategy is a crucial ingredient of the learning process.

Understanding the structural model of change is vital not only to sustain a challenge, but also to avoid the pitfalls of compulsive challenging —which has reached epidemic proportions among therapists trained by "practicing techniques." The structural therapist does not routinely block the intrusive member of a triad, but does so only when some therapeutic gain can be derived from that challenge; lenient parents of manipulative children are not invariably made angry but are incited by the therapist only when their anger can be bound to the structural goal of increasing distance among subsystems.

Learning to Enact

Asking family members to do something in the therapy room may appear to be a simple, if sometimes awkward, endeavor. Yet because of its apparent simplicity, the procedure can easily become over-technified and the therapist can lose sight of the two functions that enactment plays within the structural model. One is to identify relational patterns that need to change; the other, more important, is to help the family experience that such change is both desirable and possible. The two functions need to become clearly understood and integrated by the trainee, to avoid some of the most common pitfalls in the practice of structural therapy. -

A typical example is the unilateral emphasis on "bringing the problem into the room," whereby the therapist may try to get a 7-year-old to display his temper tantrum before anything else happens —and then not know what to do once the tantrum is in the room Or the therapist may initiate a change oriented enactment but fail to direct it to a successful conclusion This is often the case when too much emphasis has been placed on the techniques of therapy and the trainee becomes overly anxious to "introduce" an enactment. For instance, a trainee has been told that he is too central and should practice "disengaging," so he eagerly moves to set up a conversation between two family members. They begin to talk, but the therapist does not know what to do about the process that is developing before his eyes. He may be thrilled by the release of emotional communication, the "husband finally being able to talk," and so on, or he may become fascinated with the content of the discussion, but he does not know where to go. The experience ends in failure. Emphasis on technique causes the therapist to lose sight of the fact that an enactment is only as good as the experience that it generates.

In helping the trainee to overcome these pitfalls, it may not be enough for the supervisor to restrain him or her from "premature enactment." A more comprehensive training strategy involves fostering an understanding of each enactment as a "sentence" in the script that the therapist is creating with and for the family. The therapist's punctuation of the experience generated by the enactment —the periods, commas, and footnotes that define the experience in one among many possible ways— is more

relevant to the therapeutic process than the enactment itself. The structural therapist looks at an enactment as a building block to be used in the construction of a therapeutic reality. Consequently, the supervisor that directs a trainee to an enactment needs to supply a clearly stated goal. It is not enough to get father and son to talk to each other; the therapist needs to be aware of and focused on what is to be accomplished by the talking. Instructions for the enactment need to include ways of monitoring progress in relation to the goal ("Once they are talking, watch for what makes it difficult for them to maintain focus"). During the transaction itself, the trainee may need to be made aware of unfolding transactional patterns ("Did you notice that son lowers his head when Dad starts lecturing? Get one of them to do something different")

TRAINING EVALUATION

The Extern Program is monitored by the faculty during weekly meetings Feedback from the trainees is gathered continuously —particularly at evaluation times: midterm and end of the program— from both informal verbal comments and written answers to questionnaires. As a result, various aspects of the program such as group composition, time allocation and type of leadership have changed over the years
The individual student's performance is' evaluated by the supervisors according to his or her ability to keep families in treatment, diagnose problems, and help families to change. Ongoing evaluation proceeds as the supervisors follow the students' cases in live and tape supervision week after week. Also 'before' and 'after' segments (from sessions conducted early in the program and toward the end) are used to evaluate progress. The trainee's colleagues in the supervisory group contribute their opinions to the evaluation. Specific remedial work with some students is planned by the two supervisors when needed; individualized goals are then set, which are periodically reevaluated by supervisors and trainees. Particularly difficult situations are brought to the attention of the faculty. The possibility of a student being requested to leave the program is built into the format but has very rarely been used.
The profile of the "ideal graduate" from the Extern Program includes the generic ingredients of a systemic paradigm: a disposition to make sense of problems by referring them to the dynamics of-the family rather than the isolated reality of the symptom bearer; a belief that positive change is facilitated or made difficult by rules of interaction rather than intrapsíquico forces or poor learning habits; and a preference for releasing the healing strengths of the family —by promoting functional processes and discouraging dysfunctional ones— rather than directly healing the individual. In addition to these generic qualities, the ideal profile also contains the specific marks of the structural paradigm: the ability to conceptualize problems in spatial terms (distance/proximity, inclusion/exclusion), to gather data that allow for a diagnosis of the "organizational flaw," to imagine possible structural rearrangements that might eliminate the problem, and in particular to adopt an active role in engaging, motivating, and leading the family toward change.

TRAINING RELATIONSHIP

While the supervisor works toward producing such ideal graduates, the trainee may have a different view of his or her own needs. Some implications of the resulting conflict are briefly examined here.

The relation between Extern supervisor and trainee is colored by a creative tension an oscillation between harmonic and. conflictive encounters. A basic, assumption of complementary cooperation sets the general tone: the trainee, no matter how experienced, is here to learn and the supervisor to teach. This hierarchical arrangement is prevalent through the entire training process; the level of dependence of the trainee on the supervisor may vary over the course of the year, but real autonomy for the trainee comes with the final disengagement as marked by the "end of the course" ritual.

There are naturally areas of conflict where the basic complementarity is challenged. The trainee's expectations may ask for a gradual, reassuring accumulation of skills (to be built upon his or her existing competence), while the supervisor's own assessment, may call for a drastic, and possibly unsettling, paradigmatic shift. From the trainee's point of view the supervisor s comments and directives may at times look senseless arbitrary irrelevant, or disruptive. To the supervisor, the trainee's objection may reveal paradigmatic "errors," non-structural thinking that needs correction. In such cases a sort of power struggle is likely to occur, where the trainee will tend to repudiate the structural approach and fall back into one where he or she feels more comfortable, while the supervisor may insist, "But you are here to learn our way." The rules of the game are biased in favor of the supervisor's position, because they allow maximum intrusiveness in the trainee's handling of the cases.

In teaching the structural paradigm, the supervisor will alternately support and push, encourage and restrain the therapist. This does not mean evenly balancing kicks and strokes but, rather, identifying and responding differently to strengths and weaknesses. The goal of learning is given priority over good feelings; a certain level of stress is accepted as a natural component of the process, which includes the possibility that the student may temporarily lose his or her sense of competence. Performance fears, misunderstandings, resentment and opposition are to be expected but not allowed to prevent learning. The supervisor must be careful not to promote unnecessary anxiety that might block learning but also not to abdicate the interests of learning just because the trainee might become anxious. For example, a trainee breaks down after 20 minutes of waiting for her family: if they do not arrive, it will be the third family in a row that has dropped from treatment. Tearful, the trainee claims that families "leave" her as soon as she challenges them —implying that the structural approach "is not for her." The supervisor insists on the need to discuss the upcoming session since the family may still show up. The therapist continues crying while examining with the supervisor alternative ways of challenging the mother in the family without making her feel attacked.

The family eventually arrives and the session opens with one of the daughters announcing that she will not attend any more sessions. Through the one-way mirror, the therapist looks shaken. The supervisor phones in and instructs her to establish the daughter's attendance as a condition for the continuity of treatment. After the session, the therapist reports that the intervention removed her from her usual begging stance and helped her to both challenge and keep the family.

This particular incident involved only the trainee and the supervisor. In a more typical scenario, the group of trainees would be in charge of meeting individual, emotional needs at times of crisis; by spontaneously providing the necessary support, it frees the supervisor to focus on the demands of the task at hand in his or her own relationship to the trainee.

As the training relation progresses, the cumulative experience of the trainee, and the growing understanding between trainee and supervisor, contribute to reduce the incidence of anxiety and interpersonal tension. Differences between supervisor and trainee, however, persist until the very end. And when the training relation comes to a

close, the supervisor finds out that the student did not learn exactly what he or she had intended to teach, but something less, or more, or at any rate different. The supervisor is then reminded of the words of William Morris: ". . . men fight and lose the battle, and the thing they fought for comes about in spite of their defeat, and when it comes it turns out not to be what they meant, and other men have to fight for what they meant under another name" (Morris 1948)

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