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STRUCTURAL FAMILY THERAPY

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The distinctive features of Structural Family Therapy are its emphasis on the power of family and social context to organize individual behaviors, and the central role assigned in therapy to the family, as the generator of its own healing.

Development of the Model

Wiltwyck

Like the individuals and families that it endeavors to serve, Structural Family Therapy was shaped by the contexts where it developed. In the early 1960s Salvador Minuchin set up a family-oriented treatment program at the Wiltwyck School for Boys, a correctional facility located in upstate New York and serving young delinquents from poor New York City neighborhoods. *Families of the Slums* (Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967) documents how the context of the institution inspired two seminal features of the model.

One of them was the attention paid to *family structure.* Wiltwyck's clients came from unstable, disorganized, and isolated families. Improvements achieved during the youngsters' stay at Wiltwyck tended to dissipate when they returned to their families (Minuchin, 1961). However, families from the same neighborhoods that did not have delinquent children showed more stable, consistent, and predictable interactions, and were more connected to others. The observation that families contribute to organize (or disorganize) the behavior of their members led to a therapeutic approach aimed at families rather than isolated individuals.

The other essential characteristic of Structural Family Therapy that emerged from the Wiltwyck experience was the reliance on *action* as the main vehicle for therapeutic change. The typical Wiltwyck client was "the ghetto-living, urban, minority group member who is experiencing poverty, discrimination, fear, crowdedness, and street living" (Minuchin et al. 1967, p. 22). Verbal, insight-oriented treatments did not fit the concrete and action-oriented style of their families. Role playing, in-home treatments, and other non-traditional "more doing than talking" approaches served as models for the development of alternative techniques (Minuchin and Montalvo, 1966, 1967). One example that would become a distinctive feature of Structural Family Therapy was the "enactive formulation" (later known as *enactment*), whose name derived from Bruner's (1964) classification of experiential modes.

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)

The Wiltwyck experience also sensitized Minuchin to the power that *social context* exercises on families. "Is there a relationship," he posed, "between the undifferentiated communicational style at the family level, the inhibition of cognitive exploration in the child and his reliance on the adult as problem-solver, and at the social level, the undifferentiated mapping of the world by the poor, who are surrounded and trapped by institutions designed by and for the middle classes?" (Minuchin et al. 1967, p. 372). In retrospect, Minuchin would look at the Wiltwyck years as a reminder that therapy cannot solve poverty (Malcolm, 1978). Still, the knowledge gained at Wiltwyck informed structural strategies for empowering underorganized families (Aponte, 1976), and later led to the utilization of structural thinking and action to promote family-friendly changes in the procedures of child welfare organizations (Colapinto, 1995; Minuchin, Colapinto, & Minuchin, 1998).

Philadelphia Child Guidance Clinic

In 1965, Minuchin left Wiltwyck to assume the directorship of the Philadelphia Child Guidance Clinic. Serving a heterogeneous urban population, the facility made Structural Family Therapy available to a wider spectrum of families and problems. The Clinic's association with a children's hospital provided a context for the application of the structural approach to the treatment of psychosomatic conditions (Minuchin, Rosman and Baker,

1978). Families of diabetic children who required frequent emergency hospitalizations were found to show patterns of enmeshment, overprotection, rigidity, and conflict irresolution, and family interventions proved more effective than individual therapy in helping patients manage their condition (Baker et al., 1975). Similar connections were found in cases of asthmatic children who suffered recurrent attacks or became excessively dependent on steroids (Liebman, Minuchin and Baker, 1974c; Minuchin et al., 1975; Liebman et al., 1976, 1977), and in cases of anorexia (Liebman, Minuchin and Baker, 1974a, 1974b; Minuchin et al., 1973; Rosman, Minuchin and Liebman, 1975, 1977; Rosman, Minuchin, Liebman, & Baker, 1976, 1977, 1978).

Unlike the disorganized and unstable families of Wiltwyck, families with psychosomatic children tended to be too rigidly organized and too stable. In therapy, it was necessary to deconstruct the family's patterns, to allow for greater flexibility. Action techniques originally adopted in Wiltwyck to facilitate communication with "non-verbal" clients were now used to challenge clients who talked too much (Minuchin and Barcai, 1969). Thus Structural Family Therapy moved further away from the classical conception of therapy as a reflective, calm endeavor, protected from the untidiness of everyday relational life, and towards a more committed practice, where the therapist actively participated in the family drama, raising the emotional temperature as necessary to facilitate the transformation of established interactional patterns.

The wide variety of clinical experiences offered by the clinic helped expand the model and make it more precise. In 1972, in an article entitled "Structural Family Therapy," Minuchin formulated the approach's central concepts: dysfunction is located in the transactional context rather than on the individual; the present of the family is more relevant than its history; "reality" is constructed; therapy consists of realigning the transactional structure of the family. The classic *Families and Family Therapy* (Minuchin, 1974) develops these themes in detail and illustrates them with abundant clinical material.

In 1975 Minuchin left the position of director and set up the clinic's Family Therapy Training Center, which over the next years

offered workshops, conferences, summer practica, and year-long externships to practitioners interested in learning the model. As Minuchin recalls in *Family Therapy Techniques* (Minuchin and Fishman, 1981), teaching at the Center emphasized the specific techniques of Structural Family Therapy, and avoided "burdening the student with a load of theory that would slow him down at moments of therapeutic immediacy" (p. 9). However, Structural Family Therapy is not a collection of free-standing techniques; it is a way of thinking and a therapeutic stance (Colapinto 1983, 1988). In recognition of this, the "technical" chapters in *Family Therapy Techniques* are prefaced and followed by conceptual frameworks that put techniques in their place. "Close the book now," Minuchin concludes. "It is a book on techniques. Beyond technique, there is wisdom which is knowledge of the interconnectedness of things" (Minuchin & Fishman, 1981, p. 289).

Family Studies and the Minuchin Center for the Family

In 1983, Minuchin left the Philadelphia Child Guidance Clinic and founded the Family Studies Institute in New York, from where he endeavored to apply the structural paradigm to the work with larger systems that impact the lives of low-income families. Thus he was returning to a concern of the Wiltwyck years, when he experienced the disempowerment of families by the very same agencies that seek to help them. The key structural notions of boundaries, coalitions, and conflict resolution were put to the task of changing the relationship between families and agencies, so that the families could retrieve their autonomy and resume responsibility for the welfare of their children (Minuchin et al., 1998).

Following Minuchin's retirement in 1993, Family Studies was renamed the Minuchin Center for the Family, which remains dedicated to the further development of Structural Family Therapy (Colapinto, 2006; Fishman, 1993, 2008; Fishman & Fishman, 2003; Greenan & Tunnell, 2003; Lee, Ng, Cheung, & Yung, 2010; Lappin and Reiter, 2013; Nichols and Minuchin, 1999; Simon, 1995, 2008) and of family-friendly programs in human services organizations

(Colapinto, 1995, 1998, 2003, 2004a, 2004b, 2007, 2008; Lappin, 2001; Lappin and VanDeusen, 1993, 1994; Lappin and Steier, 1997).

Theory of Family

Family Structure and Dynamics

> Family structure is the invisible set of functional demands that organizes the ways in which family members interact. A family is a system that operates through transactional patterns. Repeated transactions establish patterns of how, when, and with whom to relate, and these patterns underpin the system. When a mother tells her child to drink his juice and he obeys, this interaction defines who she is in relation to him and who he is in relation to her, in that context and at that time. Repeated operations in these terms constitute a transactional pattern.
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> *(Minuchin, 1974, p. 51)*

The family's structure is the key to understanding behaviors, including problematic behavior. If a mother cannot get her child to obey, the structural therapist does not focus on psychodynamics ("She cannot assert her authority because of her low self-esteem"), but on context: both the mother's apparent ineffective parenting *and* her low self-esteem are part of a larger drama that includes her two children and a father who alternates between aloofness and authoritarianism.

At the most general level of organization, family structures range from *overinvolved* to *disengaged*. In overinvolved families there is excessive closeness among the members. Indicators include communication entanglement, exaggerated worry and protection, mutual loyalty demands, lack of individual identity and autonomy, and paralysis in moments of transition when novel responses are needed. "The 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). At the other end of a continuum, disengagement denotes a lack of mutual support, underdevelopment of nurturing and protection

functions, and excessive tolerance of deviant behavior. "Observing these families, 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 over-all impression is one of an atomistic field; family members have long moments in which they move as in isolated orbits, unrelated to each other" (Minuchin et al, 1967, pp. 354–355).

There are not "purely" enmeshed or disengaged families. Typically, families exhibit both enmeshed and disengaged areas of transaction. Early in the development of the model, Minuchin articulated enmeshment and disengagement as two phases of one process:

> Usually the mother has been exhausted into despair and helplessness by her need to respond continually in terms of "presence control." She has been so overburdened that by the time the family comes to the community's attention, all one can witness is an overwhelming interactional system in which the mother attempts to resolve her plight by fleeing into absolute abandonment or disengagement from her children . . . Unaware that this state of affairs was part of a natural process, we centered our attention primarily on the apparent disengagement, the relinquishment of executive functions, until we fully realized the other strains, reflected in the enmeshment processes discussed previously.
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> *(Minuchin et al., 1967, p. 215)*

Various *subsystems* coexist within the family: the parents, the siblings, the females, the males. Each family member participates in several subsystems: husband and wife form the spouse subsystem, which constitutes a powerful context for mutual support—or disqualification. They also participate with their children in the parental subsystem, organized around issues of nurturance, guidance, and discipline. The children, in turn, are also members of the sibling subsystem, "the first social laboratory in which children can experiment with peer relationships. Within this context, children support, isolate, scapegoat, and learn from each other" (Minuchin, 1974, p. 19).

Boundaries define who interacts with whom about what. A boundary can be depicted as an encircling line around a subsystem that shields it from the rest of the family, allowing for self-regulation. Children should not participate in the spouse subsystem so that the parents can work through their conflicts. The sibling subsystem must be relatively free from parental interference so that the children can accommodate to each other. Like the membrane of a cell, good boundaries are defined well enough to let the members of a subsystem negotiate their relationship without interferences, but also flexible enough to allow for participation in other subsystems. "If the boundary around the spouses is too rigid," for instance, "the system can be stressed by their isolation" (Minuchin & Fishman, 1981, p. 57).

The *hierarchy* of a family reflects differential degrees of decision-making power held by the various members and subsystems. In a well-functioning family, the parents are positioned above their children—they are "in charge," not in the sense of arbitrary authoritarianism, but in the sense of guidance and protection: "Although a child must have the freedom to explore and grow, she will feel safe to explore only if she has the sense that her world is predictable" (Minuchin & Fishman, 1981, p. 19). While some form of hierarchical arrangement is a condition of family functioning, families can function with many different kinds of hierarchy. "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). Hierarchical patterns that are clear and flexible tend to work well; too rigid or too erratic patterns are problematic—in one case the children's autonomy may be impaired, in the other they may suffer from a lack of guidance and protection.

The various positions that family members occupy in the family structure—the lenient and the authoritarian, the passive and the active, the rebellious and the submissive—*fit* each other, like pieces in a jigsaw puzzle. *Complementarity* is the concept that denotes the correspondence of behaviors among family members. It may be a positive feature, as when parents work as a team, or a problematic one, as in some authoritarian/

lenient combinations. Although the notion of complementarity may appear to be synonymous with that of circular causality, there is an important difference. Circular causality designates a *sequential* pattern that can be represented with a series of arrows (A➔B➔C➔A), while complementarity refers to a *spatial* arrangement: A's, B's and C's shapes fit each other. The difference is not trivial; it underlies the structural therapist's preference for tackling *spatial* arrangements (literal and metaphorical) among family members, rather than *sequences* of behavior. A mother explains: "I have to be extra soft with Andy because Carl is so rough, they need to have somebody who does not scare him." Carl reciprocates: "I have to be firm because Anne lets Andy run all over her."

Family development

Structural Family Therapy views the family as a living organism, constantly developing and adapting to a changing environment. Distinctive of structural family therapy is the use of biosocial metaphors—taken from Lewis Thomas' essays on animal life, Arthur Koestler's *holon*, Ilya Prigogine's theory of change in living systems— rather than physical models to describe family dynamics. The chapter on families in *Family Therapy Techniques* opens with a quotation from Thomas: "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).

The family structure develops over time, as family members accommodate mutually to each other's preferences, strengths, and weaknesses. "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). In accounting for the development of family patterns, the model privileges current context over history, and the

history of the current family over the childhood experiences of the parents. The family's relational patterns are not seen as a mirror replication of those of previous generations, or as having been fixed in the parents' early life, but as the result of the continuous process of transformation and adaptation that turned yesterday's children into today's adults.

As a biosocial system, the family must maintain stability while at the same transforming itself. *Homeostasis* designates the tendency to conserve the family's relational structure. Once the complementary roles of Anne, Andy, and Carl have been set, deviations from the script will be countered by corrective movements. "I do try to ignore Andy's demands sometimes," says Anne; "but then Carl starts to roll his eyes and I end up giving in for the sake of peace." Homeostasis, however, does not fully describe the family: counterdeviation moves notwithstanding, the family system tends to evolve toward increasing complexity. *Adaptation* designates the ongoing change of the family structure in response to needs generated by its own evolution—members are born, grow, develop new interests, leave— as well as by changes in its milieu—a move to another town, a change or loss of job, divorce, remarriage, a marked improvement or deterioration in the financial situation of the family. In the process, boundaries are redrawn, subsystems regroup, hierarchies shift, relationships with the extrafamiliar are renegotiated. For instance, when children reach adolescence and the influence of the peer group grows, issues of autonomy and control need to be renegotiated.

In well-functioning families, adaptation triumphs over homeostasis. These families can mobilize coping skills that have remained hidden underneath established complementary patterns. Faced with an increasingly demanding and rebellious Andy, Anne may bring into play the assertiveness that she demonstrates in other relationships; Carl may allow his tender side to show through the apparent gruffness. A well-functioning family is not defined by the absence of stress or conflict, but by how effectively it handles them as it responds to the developing needs of its members and the changing conditions in its environment. Conversely, a family becomes

dysfunctional when homeostasis trumps adaptation. The family then gets "stuck" in a relational structure that no longer works. Anne, Carl, and 12-year-old Andy continue dealing with each other as they did when Andy was five. Structural explanations for a family's inability to adapt range from unawareness—the dysfunctional patterns persist by inertia because family members cannot think of alternative ways, or do not see how they are connected to the presenting problem—to conflict avoidance—family members fear the consequences of bringing the conflict into the open.

The individual in the family

The family is the "matrix of identity" (Minuchin, 1974, p. 47), the primary context where children develop their selves as they interact with parents, siblings, and other family members.

> The child has to act like a son as his father acts like a father; and when the child does so, he may have to cede the kind of power that he enjoys when interacting with his younger brother. The subsystem organization of a family provides valuable training in the process of maintaining the differentiated "I am" while exercising interpersonal skills at different levels.
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> *(Minuchin, 1974, pp. 52–53)*

As this process unfolds, some individual traits are selected and others discouraged. But the latter remain latent, potentially available to be activated within future contexts. "The individual's present is his past plus his current circumstances. Part of his past will always survive, contained and modified by current interactions" (Minuchin, 1974, p. 14). The resulting image of the adult individual differs from the traditional psychodynamic one. The self is not visualized as a series of concentric layers surrounding a core of identity ("She *is* passive"), but as a "pie chart" where "passivity" represents one slice and coexists with others— including an "assertive" one (Colapinto, 1987). Qualities that may not manifest within one context, may be shown in others. Anne's ineffectiveness with Andy is not seen as the manifestation of deep-seated low self-esteem, but as part of her role within her family. Anne may appear incompetent in the presence of her husband, Carl, but not when alone with the children. She may think poorly of herself in the context of her family, but be self-confident with her colleagues at work. Carl may be a heartless disciplinarian when responding to conflict between and Andy and Anne, but show a tender side when playing with the children. Andy may display more maturity when functioning as the older sibling than when relating to his parents.

Theory of therapy

The pie metaphor is an essential ingredient of the structural approach to therapy. The viability of the therapeutic endeavor rests on the assumption that even when families get "stuck" in their development, the potential for a resumption of growth is still inherent in the family itself—in the areas of the individual selves that have become deselected through a history of mutual accommodations. The structural therapist believes that there is more than meets the eye—that the overanxious parents are able to draw a boundary around their conflicts, the inconsistent mother to persevere, the distant husband to show affection, the depressed wife to engage in an interaction—if the relational patterns that block the actualization of those potentials are removed.

Four tenets of Structural Family Therapy derive from this premise. *First*, the family is not a mere recipient but the *protagonist* of therapy— its own change agent. Regardless of how much or how little responsibility it has for creating the problem, the family always possesses the keys to the solution. The practice of Structural Family Therapy does not require the physical presence of the family at all times, but it does require that the therapist "think" family, even when working with subsystems or even the individual child or the individual parent.

Second, the job of the therapist is to *catalyze* change, to help the family recover the "slices" that have been historically deselected. A structural arrangement that renders an "ineffective" mother and an "authoritarian" father is not good; better aspects of the respective selves must be

retrieved. This requires a proactive stance; the structural therapist cannot afford the comfortable position of the neutral observer, but must actively influence the family. When structural therapists set up enactments, prescribe changes in the seating arrangement, block family members from interrupting a transaction, unbalance, or induce crises, they are not just applying disembodied techniques. They are using themselves as the primary instrument of change.

Third, therapeutic change proceeds *from the relation to the individual*; change in interactions is a condition of psychological change rather than the other way around. It is not necessary for Anne to work through the historical roots of her low self-esteem before she can become a competent parent; if Carl does not interfere in her relationship to Andy, she can actualize her latent competency. The structural therapist "confirms family members and encourages them to experiment with behavior that has previously been constrained by the family system. As new possibilities emerge, the family organism becomes more complex and develops more acceptable alternatives for problem solving" (Minuchin & Fishman, 1981, p. 16).

Fourth, the therapist must help families develop new patterns—not just dismantle the old ones. The structural therapist does not endeavor to extricate individuals from family binds, but to make those binds more nuanced, allowing for both belonging and differentiation. When the therapist encourages more distance between a mother and a child, it is not to isolate either one, but to make room for them to participate in other subsystems—child/father, wife/husband, child/siblings. Restructuring techniques are rooted in the belief that individual differentiation is not achieved through retrenchment into oneself, but through participation in multiple subsystems. The goal is not the self-sufficiency of the "rugged individual," but the mutual reliance of the network.

The therapeutic process

Structural therapists relate to their client families in three modes—joining, assessing, and changing patterns of interaction—that can only be separated artificially. They assess as they join, intervene as they assess, and tend to their joining as they intervene.

Joining

In joining mode, the therapist gains the acceptance of the family, as a temporary member with permission to influence the system from within. The therapist is in a better position to identify, question, and help expand the transactional patterns of the family if he or she experiences them "from the inside." Joining is "the glue that holds the therapeutic system together" (Minuchin & Fishman, 1981, pp. 31–32).

Joining is a stance more than a technique. It involves respectful curiosity; respect for the rules that govern distances and hierarchies within the family—for instance, addressing the parents before the children; sympathy toward expressions of concern, sadness, anger, fear, even rejection of therapy; sensitivity to corrective feedback, and trust in the latent strengths of the family.

But joining is not just being supportive of the family. The therapist needs to be accepted, but not to the point of becoming totally *inducted* into the family and rendered impotent to help. To communicate that therapy can make a difference, joining must include some measure of differentiation from the family. This may consist of a challenge to the family's presentation of the problem ("You say that you have had it with your son, but as I listen to you it is clear that you are very concerned for him"). Or the therapist may subtly join with the less dominant family members, adopting their language or mimicking their mood. Support and challenge need to balance each other, so that the efforts to make a difference do not alienate the family. The therapist's challenging interventions are probes; if the family rejects a challenge, the therapist pulls back and tries a different route.

Assessment

In Structural Family Therapy, assessment neither follows joining nor precedes interventions, but coexists with both. The therapist learns about the family as he or she joins them, and the tone and content of the inquiry is already an intervention.

Assessment begins before the first face-to-face meeting with the clients, through a preliminary *mapping* of the family system: Who are the members? What are their genders and ages? How are they related? Answers to these questions convey preliminary information about the "shape" of the family—whether it is a single-parent family, a one-child family, a reconstituted family; whether it includes babies, teenagers, or elderly parents.

When meeting with the family, the therapist *tracks* their interactions looking for patterns, paying attention to the process being displayed more than to the verbal content. "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). The therapist may also observe that a mother and daughter do not relate as such but more like siblings, that the parents do nothing when the children run around the room, that a grandmother caresses her granddaughter while talking disapprovingly of the child's mother. Gradually the map becomes populated with information about "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 switch boards" (Minuchin & Fishman, 1981, p. 69).

Sharing the assessment with the family ("I can see that your daughter responds differently to each one of you") introduces another element of challenge, as the problem is *reframed*; the parents who brought to therapy an "uncontrollable" daughter are shown that the girl fights with the mother but promptly obeys the father. "Families present themselves as a system with an identified patient and a bunch of healers or helpers. But when they dance, the lens widens to include not only one but also two or more family members. The unit of observation and intervention expands. Instead of a patient with pathology, the focus is now a family in a dysfunctional situation. Enactment begins the challenge to the family's idea of what the problem is" (Minuchin & Fishman, 1981, p. 81). It can also provide, both to the family and to the therapist, evidence of the family's latent strengths ("You told your daughter to put that toy back, and she did").

In addition to tracking the spontaneous transactions of the family, the therapist can also direct them ("Discuss that with your wife, and make sure that your daughter doesn't distract you").

> When the therapist gets the family members to interact with each other, transacting some of the problems that they consider dysfunctional and negotiating disagreements, as in trying to establish control over a disobedient child, he unleashes sequences beyond the family's control. The accustomed rules take over, and transactional components manifest themselves with an intensity similar to that manifested in these transactions outside of the therapy session.
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> *(Minuchin & Fishman, 1981, p. 78)*

Here-and-now tracking can be complemented with an inquiry about events at home, the "there-and-now" ("What happened this morning, before you all decided that Carlos was not going to school?"), and also extended into the past, the "there-and-then." In accordance with structural theory, the development of the current family is granted more relevance than the childhood experiences of its adult members, Anne's weak parenting may be a response to her perception of her husband as "rough," which in turn has grown from their shared experience as a couple—"He has a temper," she has learned over the years. Tracking family history can also uncover forgotten strengths: "How did you manage to raise the children by yourself before you remarried?"; "What was most enjoyable about spending time with your son, before he started to go out with friends you don't like?"

Unlike some other systemic approaches, Structural Family Therapy recognizes the need for individual assessment of the family members. "The systems model could carry the practitioner into rigidities that mirror the mistakes of linear therapists, denying the individual while enthroning the system" (Minuchin et al., 1978, p. 91). But the structural assessment of the individual differs from traditional forms. Following the pie metaphor, the structural therapist does not look for what the individual "is," but for her or

his different ways of being in different subsystems. What kind of a husband is he to his wife? A father to his son? A son to his mother? And more importantly, how else could he be, what are the qualities that have been deselected in the course of the family's development?

Changing Patterns of Interaction

Structural family therapists promote change in families through two kinds of interventions: *challenging* existing patterns of transaction, and supporting the *enactment* of healthier patterns. Blocking a father's interference in the relationship between mother and children ("Let your wife handle it") goes hand in hand with the encouragement of a different interaction ("You said that you would like the children to play with the puppets—make it happen").

Challenging is not to be confused with flexing muscles. Although some rigid patterns may call for intense confrontation, in most situations the challenge is more subtle. It can consist of any intervention that makes it difficult for the family to continue engaging in its usual modes of transaction: "Discuss this with your wife and don't let your daughter distract you"; "Don't check with your mother when you are talking to your father." What is being challenged are not the motives of the participants, but the constricting patterns of relationship that prevent the actualization of their potentials, and the belief that those are the only possible ways of relating.

A challenge must satisfy three conditions:

1. *Joining.* The family needs to trust the therapist before they can accept the challenge; the therapist must feel comfortable with the family before he can challenge, and be sensitive to the corrective feedback that that may come.
2. *Purposefulness.* The therapist must be clear about the direction of the structural change that is being sought. "The only thing I can do," says the mother, "is go there and stay playing with them." "No, do it so that the children are involved in playing there and you are here, with your husband and me. Make a difference between the children who play and the adults who talk."

3. *Conviction.* The therapist must believe that the expected change is possible. Challenging the Anne/Carl/Andy pattern will not succeed if not supported by the therapist's confidence that Anne can handle Andy without Carl's intervention. This does not need to be a leap of faith—it can be based on evidence gathered in the course of tracking.

The therapist's direct intervention in the family process being played out in the session best expresses the model's preference for *enacting* healthier patterns of interaction rather than just talking about them. *Boundary making* is a form of enactment where the therapist modifies patterns of proximity and distance by directing some members to participate in a transaction, and excluding others. This disrupts the operation of 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 from the children, or children who are being protected from interruption from the parents.

Examples of boundary making are the prescription of a rearrangement of chairs that results in the formation of a group of people facing each other and giving their backs to the rest, or asking a family member to watch in silence from one corner of the room or from behind a one-way mirror.

Sometimes just getting two members of the family to interact without interference from others is sufficient to allow for the emergence of new patterns: siblings, for instance, can develop their own way of solving their conflicts without parental arbitration. More often, the therapist must intervene actively on the process, prolonging the duration of a dyadic interchange, raising a hand or standing between people to block interruptions or distractions, removing an empty chair between spouses, or changing the composition of the bounded subsystem. The therapist can also create enactments "from scratch." If the family includes a mother who appears to have no control over her children and to depend on the father for law and order, the therapist may set up a scenario that requires the mother to organize the children's play, and then block the rescuing

attempts of the father until mother succeeds in her own way.

The structural therapist does not prescribe what to say and do; the mother will not get instructions on *how* to organize the children's play—not even elementary tips such as the observation that it is virtually impossible to organize the play of two active toddlers without leaving one's chair. In accordance with the pie metaphor of the self, the development of new patterns of transaction does not require teaching the clients new skills, but just setting up a context where they can or must actualize skills that have been so far deselected in the course of the family's process. It's not that mom doesn't know that she has to get up from her chair; but that usually she doesn't need to, because her husband takes over. However, the structural therapist does comment on the enactment, not by way of prolonged interpretations, but by *punctuating* stumbling blocks ("She gave you that look again and you dropped the issue") and successes ("Good, now you got the children to play on their own and we can resume our conversation").

Intensity

To sustain an enactment, the therapist needs to resist the pull of the family's established ways. If the mother makes only a feeble attempt to organize the children and turns to the therapist for conversation, the therapist may answer by reminding her of the task at hand: "You said you wanted the children to play by themselves." Depending on how rigid the family patterns are, the therapist may need to be more or less active. Encouraging clients to try behaviors that upset the equilibrium of the family requires tolerance to the natural intensity of family life, and readiness to increase that intensity when needed.

> The therapist's intervention can be compared to an aria. Hitting notes is not enough. The aria must also be heard beyond the first four rows. In Structural Family Therapy, "volume" is found not in decibels but in the intensity of the therapist's message . . . when family members show in a session that they have reached the limit of what is emotionally

acceptable and signal that it would be appropriate to lower the level of affective intensity, the therapist must learn to be able not to respond to that request, despite a lifetime of training in the opposite direction.
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> *(Minuchin & Fishman, 1981,*
> *pp. 116–118)*

Extending the time of an enactment (waiting for the mother to organize the children) and repeating a message ("You said you wanted the children to play by themselves") are relatively simple ways of raising intensity. When more is needed, it can be achieved through *unbalancing*—for instance, by supporting a devalued family member against another. In this 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" (Minuchin & Fishman, 1981, p. 162).

The most intense intervention is the *crisis induction*, the purposeful creation of a situation that forces the family to face a chronically avoided conflict. The crisis is induced "by allowing a pattern that has been repeated often at home to play itself out in the concentrated time of the therapeutic session" (Minuchin et al., 1978, p. 167), and then intervening forcefully. In a lunch session with the family of an anorectic adolescent, as parents and daughter stage a three-way fight over whether and how much the daughter should eat, the therapist confronts the parents: "The problem here is you two! You say, 'You should eat,' and you say, 'You shouldn't eat.'" After having each parent try separately to get the daughter to eat—and fail– the daughter is declared the victor and the parents' shared defeat serves to draw a boundary around the spouse subsystem: "Well, you know you are on a really difficult boat. You will get out of this boat only by pulling together." The parents leave "feeling the continued seriousness of the situation, but also, with a feeling of something accomplished, and of hope . . . They now felt that they were dealing with a conflict between an adolescent girl and her parents, rather than with a mysterious individual disease" (Minuchin et al., 1978, p. 180).

An enactment, no matter how intense, does not bring about change by itself. A challenging

intervention such as "The problem here is you two!" shakes the family out of their homeostatic arrangement and opens new possibilities—in this case the daughter, following the session, asked for a big meal and ate everything—but consolidating the structural change—thickening the boundary around the parental subsystem, making more room for an adolescent's autonomy, shifting to a different way of negotiating power and control—requires more work. New ways of relating need to be experienced repeatedly until they hold; each successful enactment contributes to the expansion of the family's repertoire, showing that change is possible and what it might look like.

Case Example

Sonia, a 35-year-old single mother, had lost custody of her four children due to her use of drugs. When she became pregnant with her fifth child, Sonia tested positive again but then entered a rehabilitation program that offered her a chance to keep the baby. Because the program had a family orientation, Sonia was able to maintain regular if infrequent contact with her other children, and develop a relationship with their temporary custodians. After giving birth and successfully completing the program, Sonia set out to reconstitute her family.

The first child to return was Tanya, by then 8 years old. However, within a few weeks Sonia started to complain that the stress of dealing with Tanya was "jeopardizing my recovery." She felt that Tanya should return to foster care, but was persuaded by her social worker to have a family consultation.

Paula, the social worker, reported that Sonia had grown up in three different foster homes herself, not forming strong bonds in any. "Deep down," said Paula, "she doesn't want to be a mother, because she wasn't mothered herself. She has unrealistic expectations of Tanya, basically wants to be left alone." Upon graduating from the program, Sonia was referred to an individual therapist to work on her "attachment issues," but dropped out after a few sessions.

I met six times with Sonia, her children, Paula, and workers from the agencies involved with the other children.

In the first session, Sonia explains her predicament: "Tanya is getting on my nerves. She doesn't do anything by herself. When she first came back she was so independent, she would comb and wash herself. Now I have to do it." As Sonia talks in a detached, impatient tone, Tanya sits downcast across the room. Meantime, her older sister stands next to Sonia, the youngest circulates between her mother and the workers, and the two boys busy themselves on the blackboard.

While Sonia's statement may sound to Paula as evidence of Sonia's "attachment issues," I look at it in the context of the family's developmental history—or lack thereof—and its relation to the larger structure or the child welfare system. Sonia and her children have not been together as a family long enough to develop stable patterns of interaction. Years ago the child protection agency granted Sonia a sort of "leave of absence" from parenting, so she could focus "on her own needs"—meaning the need to be sober, but not the need to raise her children. As her children adapted to life elsewhere, Sonia did not have a chance to hone her parenting skills; actually, her substance abuse counselors encouraged her to focus exclusively on her recovery and not be distracted by anything that might interfere with compliance with the program—including her children. Given this context and history, there is no need to blame the difficult reunification on Sonia's childhood experiences.

Paula challenges Sonia, reframing Tanya's behavior while at the same time recognizing that Sonia *can* be nurturing: "Don't you think that maybe Tanya is trying to get some nurturance from you, the same you give Tina?" Sonia protests: "But I do that! Sometimes I baby her!" So, I think, not all is clinginess and irritation—there is more in the pie than meets the eye. I ask for a description of the different pattern: "How do you baby her?" "I let her come to my bed, I hold her, I caress her" answers Sonia, her voice shifting from harsh to tender.

Is Sonia describing "good" nurturance, or "bad," regressive enmeshment? Paula, interested in Sonia's inner experience, cautiously poses a neutral question: "How do you feel about that?" Almost simultaneously, making a judgment that at this moment in the development of the family

closer contact is good, I ask for an enactment: "Can you show how you baby her?"

Sonia summons Tanya to her lap, initiating an affectionate interaction that the rest of us witness. Eventually the other children converge on the dyad, forming a tight group around Sonia. When Paula tries once again to explore feelings, I playfully block the move: "Would you like to be there too?" I want to extend what I see as the family's enactment of reunification. For the duration of the sequence, Sonia is not a recovering addict who happens to have children, but a mother who happens to be recovering from addiction. The family spontaneously starts reminiscing about their life years ago, before the children were removed from Sonia's care. They talk about food, play, sibling rivalry. Sonia is pleasantly surprised: "How can you remember so much? You were so little."

Again, one enactment is not enough to correct a dysfunctional pattern. But it does provide the family and the therapist with the evidence that alternative ways of relating are within the family repertoire. Even if Sonia reverts to a preference for more distance from her children, they may refuse to allow it. "Cut it off! Leave me alone!" says Sonia, but she is laughing and keeps her arms around them. "Why are you all over me?" "Because," says one of the children, "you're our mom!"

There was no more discussion of a possible return of Tanya to foster care. The remaining sessions framed the problem as one of a difficult transition rather than individual deficits, and featured additional "enactments of reunification"—discussions of the children's school and social life, stories about the extended family, planning for the return of the remaining children. A recommendation was made, and followed, to accelerate the pace of reunification and support it with home-based services, which required coordination and collaboration among the various agencies that were involved in the life of the family.

The road for Sonia and her children was not without its bumps. Cory, the oldest son, eventually became truant and got involved with older teenagers that the school suspected of dealing drugs. This time, however ,Sonia did not threaten with an expulsion from the family but called Paula ("I am having another of those transitions,"

said Sonia), who helped her reassert parental leadership over Cory.

"Development," Minuchin reminds us, "always involves new challenges, new contexts, and inevitable periods of disequilibrium while individuals and social systems find new patterns of adaptation." Some families and individuals are able to continue to cope and change.

> Out of some mixture of competence in their own makeup, paralearning from the therapy, and fortunate circumstances in their outside life that support the transition [while others] need intermittent help as they move into new circumstances, away from the family, at least until viable mechanisms for negotiating change in new contexts are learned . . . This model of continued treatment is analogous to the practice of the family practitioner, who is available as issues arise. In the long run, it seems an economic approach to therapy.
>
> *(Minuchin et al., 1978, pp. 202–203)*

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