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STRUCTURAL FAMILY THERAPY AND SOCIAL RESPONSIBILITY[1]

When I was invited to attend this congress, I was very excited to see that the organizers had listed as one of their first concerns the social responsibility of the therapist. I am a structural family therapist, and, among all family therapy schools, structural family therapy is the one with the longest tradition of dealing with issues and problems in a socially responsible way. The model was forged in the 1960s, in an institution for delinquent children, and at the time it was benevolently tolerated by the mental health establishment, which did not want or know how to deal with that population. The strong commitment of the model to facilitate family change through the intense involvement of the therapist was viewed as acceptable for that particular population.

Later on, when structural family therapy moved to a mental health clinic in Philadelphia and started tackling the problems of middle class America, it was enthusiastically embraced by many of the new generations of therapists. With time, however, the bulk of the field of family therapy in USA shifted to the more "neutral" stance that therapists cannot or should not try to change people.

So I was excited about the theme of social responsibility, and I tried to persuade the organizers to include the structural family perspective in the plenary, this morning. As you can see, that has not happened, so I will say here what I would have liked to say there. I will start by showing a very short vignette from a session, and then I will discuss the various levels of social responsibility involved there. The session took place in a drug rehabilitation clinic, located in a big New York hospital. Present in the session are a single mother who has recently completed her treatment, but who continues coming to the service, among other reasons because she is in the process of being reunited with several of her children that had been placed in foster care. At the time of this session, she had been reunited with two girls, and she also had a younger daughter who had never been taken away from her. All three girls are present in the session, as are two boys, who are currently not living with the family. Also present, in addition to myself, are the social worker from the drug rehabilitation clinic and a worker from the institution where the two boys are currently living.

> *(At the beginning of the videotape segment Sonia, the mother, is complaining about the fact that one of the girls, Tania, has regressed since the time that she was returned to her. By "regression" Sonia means that the little girl, who is 8 years old, used to be very independent when she first came from the institution, that she used to dress and clean and comb herself in the morning, but now she expects her mother to do it. This sort of complaint, about one or another child, was typical, and was usually accompanied by threats that she would have to place one or two of the girls back into foster care, because the stress was getting to be too much, and her own recovery from drugs was at risk:)*

[1] Presented at the X World Family Therapy Conference (Düsseldorf, Germany, 1998)

Sonia: Tania has been getting on my nerves. She doesn't do anything for herself. I have to do everything.
Jorge: Like what?
Sonia: Like, when she first came she was so independent. She would comb and wash herself. Now I have to comb and wash her. I shouldn't be doing that. She's not a baby anymore.
Social worker: But it is part of your job as a mother…
Jorge: (interrupting the social worker): She asks you to comb her?
Sonia: No, she doesn't ask. She just doesn't do it, so I have to do it.
Jorge: And she lets you?
Sonia: Yeah. She does it on purpose, I guess.
Jorge: I guess she doesn't reject you anymore, eh?
Sonia: Yeah. But now she wants me to baby her.
Jorge: Do you?
Sonia: Sometimes I do. She sort of manipulates me into babying her.
Jorge: Would you show me how you baby her?
Sonia: OK. *(To Tania, in a commanding voice).* Come over here*. (Tania rushes to Sonia and climbs on her lap. Sonia starts caressing Tania; her voice softens.)* I caress her and talk in her ear, like this. *(Demonstrates talking into Tania's ear. The other children, who had been playing, approach them.)*
Jorge: (To the children): Do you want to be there, too*? (The children surround Sonia and Tania and form a big hugging group.)*
Sonia: (Laughing). Cut if off! Leave me alone! *(But she keeps her arms around the children, and the children continue to laugh and hug her.)*

So, let us look for my social responsibility here. A good way of attempting this is to consider various questions and challenges that students and colleagues have presented to me when I have shown this tape or discussed the case.

The first type of questions, or challenges, has to do with my style, which is directive. I am telling the mother and daughter what to do, at one point I am blocking the intervention of the social worker, I support certain interactions and comments and discourage others. Many of my students and colleagues come from a less directive, more neutral tradition, where they prefer to be "in conversation with" their clients. In many instances, there seems to be no purpose for those conversations, other than the conversation itself. I recently attended a conference where one distinguished proponent of therapy as conversation, was asked what the expected outcome of a therapeutic conversation was. The answer was: "Out of the talking will come out whatever comes out of the talking".

So, what I explain to my students and colleagues, when they question me about my directiveness, is that my directiveness is a function of my social responsibility: I believe that the product of the therapeutic conversation should not be just "whatever comes out", but something good; so I do take responsibility for encouraging people to change in some directions rather than others. Here I am making two ethical statements: one, that it is good to encourage people to change (as opposed to, for instance, "accepting them the way they are"); and the other, that it is good to try to influence the direction of change.

I have a very strong position in favor of encouraging change. I feel that not to encourage change is irresponsible, because it encourages accommodation and conformity. Proponents of the "don't push for change" stance often refer to clients' and

therapists' "unrealistic expectations" about change, and argue that telling clients not to expect too much from themselves or each other in the way of change "liberates" people from the pressure to perform and/or the self-blame. But the effect can equally be seen as oppressive, because lowering expectations is a form of social control. It may create a bubble of self-esteem (like the patient who says, 'I love coming here because you really give me permission to be myself'), and the bubble may be made larger through the "virtual community" that some narrative therapists talk about, but the pressures to perform and the unfair blames can still be very real out there in the world.

I find very interesting that the move away from change-oriented therapy coincided in the USA with the medical advances in the development of psychotropic drugs, and with the collapse of the War on Poverty and almost every other social reform movement. A couple of years ago a pharmaceutical company published an advertisement for a psychotropic drug in the back cover of a journal on constructivist therapies. The advertisement reads: "We cannot change the world, but we can change the way you experience it".

For somebody who upholds an ethics of change, being a structural family therapist is almost a necessity, because structural family therapy is one of the two schools of family therapy (the other being Bowen's) that has a theory of the family, of behavior in the context of the family, and of family change. That prepares structural family therapists to look for and learn about processes in the family, and about which ones are better for the people involved. Based on my experience as a structural family therapist, it would be irresponsible for me to just "be in conversation"; on the contrary, I am compelled to use what I have learned from other families to have a transforming conversation with Sonia and her family, a conversation that helps them to relate better to each other --for instance, that leads to Sonia cuddling her daughter rather than complaining about her "lack of independence".

Another ethical underpinning for my directiveness is that I think that therapy should be a brief encounter, that it should not take a long chunk of somebody's life; and directive therapy tends to be briefer, because it takes less time for the therapist and the client to figure out whether the therapy is worth the effort and the expense or not. The cards are more on the table. On the other hand, a "stance" of free floating dialogue, with a recursive validation ("Out of the talking comes whatever will come from the talking") tends to make therapy longer, because the most usual outcome of talking is even more talking. Having an existentially meaningful relationship with a client for a long time would be socially irresponsible for me.

The second kind of questions has to do with the direction of change that I pursue. A colleague once told me: So, granted that you may have a point about being directive, but why do you always direct in the direction of favoring a relationship, contact, connection -as, in this case, between the mother and the daughter? Why didn't you make room for Sonia to fully express and explore the side of her that was *not* interested in mothering? Why didn't you make room for the possibility that the daughter's behavior was really regressive, developmentally inappropriate?

This is a fair question, and the answer is that my decision was guided by the value that I place on the connectedness between mother and daughter. I do recognize -in fact this was one of the critical contributions of structural family therapy to the understanding of the individual-, that the self is multifaceted and “populated by many

voices", but I am not neutral as to which voices are specially valuable. (Incidentally, I don't think that my colleague, who would have fostered the non-mother voice of Sonia, is neutral either). In the situations in which I work (and this is an important qualification, as we will see later), I tend to feel more sympathetic towards the voices that speak for connection and mutual dependency than to the voices that speak for disconnection and independence; more interested in the part of Sonia that wants to care for her daughter than in the part that wants her daughter to take care of herself. When I look at Sonia and her daughter, what I think is that they have been recently reunited, that they have lost a big chunk of their life as a duo, and that now is the time for cuddling together, not for exploring differentiation. More in general, I tend to support more whoever is on the side of process, conversation, dialogue, the relationship, the team spirit if you will.

The third kind of question that I have been answering a lot lately is: Why am I working with so many people? Why are the mother, all of her children, and several workers from various agencies in the room? Why don't I interview some of them separately, or not at all? Thirty or thirty five years ago, when family therapy was in its infancy, these were the kinds of questions that individually oriented psychotherapists would ask. Today, I am being asked the very same questions by people who consider themselves family therapists, indeed in some cases have become leaders in the field, but whose experience consists primarily of working with individuals. These colleagues, some of whom are good friends of mine, see me, with a mixture of curiosity and concern, as some kind of dinosaur who insists in having people come to his office, or rather, as in this case, go to the drug rehabilitation clinic where this people are, and then proceeds to interview all of them together, which often can become a very unstructured situation, with people talking on top of each other, arguing, sometimes screaming at each other, and often not wanting to be there at all. Why would I do this, when it would be so much easier to sit in my office and talk to whoever is willing to come?

Well, that is the point. The point is that I don't think that family therapy should be easy, or can be easy -not for the client, nor for the therapist. As a matter of fact, I think that the ethics of "taking it easy", had a lot to do with the fact that over the last 15 years the field of family therapy has been retreating from the interaccional back to the intrapsychic. In the United States, two phenomena were taking place at the time that this retreat started. One of them was that hundreds of family therapy institutes had produced, very quickly, thousands of family therapists, few of which were able to replicate the successes of their masters. The other was that, because of changes in the economics of mental health, family therapy ceased to be a profitable activity. So we had a conjunction of an oversupply of manpower, a narrowing market, and uncertainty about the quality of the recently acquired tools. And then, the field "rediscovered the individual". Theories started to emerge, validating systemic work with individuals and working with the "internal family", and the pendulum that has been oscillating since psychotherapy was invented moved back to the nondirective pole: trying to change people was declared either unrealistic or immoral. Epistemological and moral permission was given to those who wanted to retreat from the turbulence of human interaction to the slow-motion world of people's heads and reflexive conversations.

As if to validate this theory of mine, practically every main author that is now recounting the process of his or her transformation from "systems" to "narrative" therapy, reports on the exhilarating feeling of personal liberation that accompanied the move, specially the not feeling constrained by the need to work with the family, to help people change, and on the calmer, more reflexive interactions that they started to have with

their clients. In my own ethics, however, the therapist's feeling of liberation, even if accompanied by a similar feeling in the client, would not be enough to validate the therapeutic enterprise. Of course it would be possible for me to talk to Sonia at length about the dilemma of being a mother to Tania versus stabilizing her life as a recovering addict. I might talk to Tania as well. It is very possible that Tania will express herself more "freely" in the absence of her mother. In other words, I might become the expert conversationist with whom they can interact in ways that they cannot with each other. (I find ironic that many colleagues who vowed to free themselves from the hierarchical "position of expert", have now become master conversationalists).

These privileged conversations can go on indefinitely. But they wouldn't be relevant to the dilemma of Sonia and Tania's relationship, because I wouldn't be dealing with that relationship. I would be relating to a Sonia-minus-daughter or Sonia "apart" from her daughter, and to a daughter-minus-Sonia, or a daughter "apart" from Sonia. And even though it might seem that meeting with Sonia's daughter alone might help me understand her better, I would know, because of my experience as a structural therapist, that the girl that I am getting to understand is not the same that Sonia is dealing with. So I can only be relevant to the relationship between Sonia and Tania if I see them together, because that is when they are relating. Sonia would not have complained in the same way that she did if Tania had not been there -and certainly Tania would not have ended on her lap. Therefore, the fact that whole family sessions may become too disorganized and not conducive to reflexive conversation cannot be allowed to discourage my meeting with Sonia and her children together.

There is more that bothers me about the idea of the therapist as an expert conversationist. I think it can be very disempowering for the family. For instance, if I turn out to be very good in talking to a child, I might end up "out parenting the parent". I might be contributing to what the community psychiatrist Matthew Dumont has called "the professionalization of connectedness", the process by which regular people have delegated the function of making personal contact to the experts, so that the more people talk to therapists about their lives, the less they do it with each other. Each time I have an individual session with a child, the parents lose a part of their relationship to the child, part of their knowledge of the child. I might be communicating to Sonia and her children that they cannot exist without my mediating presence.

So, the need to empower my clients, rather than anesthetize them, is the reason why it is so important to me to have so many people in the room. I think of therapy as an important event in the life of a person, and therefore that person's significant others should participate. I feel that whoever participates in therapy, owns the process. If Sonia experiences the dilemmas of motherhood, it is important that she experiences them in the presence of her children. If the children need to be "given a voice" it is important that they do so within the family. There is a huge difference between talking with a therapist about longing for contact, and experiencing it in therapy with your family. And if Sonia is bringing to her relationship with Tania the shackles imposed by a parenting skills trainer who taught her about boundaries and independence, it is important that Sonia and her daughter participate together in the ritual by which another expert –in this case myself- frees them from that injunction.

I see my own role as facilitating interaction among family members, so that that can change and grow together. I position myself as a nurturer of family process, an expert who knows more about, is more curious about, or has a different point of view

about relationships. I do not need to know much about the inside of the individuals -only to the extent that the inside contains obstacles to their relating to each other. I am there to interfere only when their interaction gets stalled -as it happened in this session, where I felt that Sonia and her daughter were moving apart from each other and I allowed them to come closer.

Of course, doing family therapy does not require the physical presence of the family at all times. But it does require that the therapist "think" family: takes into account the family context, the power of relationships, etc., even when working with the individual child or the individual parent. It does mean having the family in the picture all the time, and not keeping it "out of the loop" for too long. For instance, if the obstacles against a relationship are too strong for me to surmount within a family session, I may meet with family members separately, but only to help them deal with those obstacles. Whatever information emerges in those partial encounters, it will be part of my responsibility to find ways to help them share it, to "bring it back to the family". In this modality, I see myself as a "hinge" or a bridge, but a very short one, so that people can use me to make contact with each other rather than to stay apart from each other.

Finally, the last question that my students and colleagues ask me: Why am I there? Why in the drug rehabilitation clinic? This is the most important question in terms of social responsibility: not so much what I am doing, but where I am doing it, and why. I am doing this session in a drug rehabilitation clinic because the session is part of a much larger effort to reform a whole therapeutic community, to make it more family friendly. This in turn is part of an even more ambitious project to change the way foster care is delivered in New York City. And foster care, as it is currently being practiced, is one of the areas where the “culture of disconnection” of today’s USA –the self-destructive idealization of isolated self-sufficiency, and the corresponding denigration of interdependency– is best (or worst) represented. So that is a natural place for a socially responsible therapist to be.