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STRUCTURAL FAMILY THERAPY
THEORY AND PRACTICE

BY

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STRUCTURAL FAMILY THERAPY

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PREAMBLE

The overall objective of my practicum project has been to acquire advanced skill in the practice of Structural Family Therapy as proposed by Salvador Minuchin and his collaborators. Of particular interest to me are the families in which a child is the identified patient, either because of misbehavior, a social problem, or a psychosomatic illness.

In order to accomplish this I had the following objectives:

(a) to develop a knowledge base in family therapy by tracing its history and considering some of its influential thinkers

(b) to consider the basic concepts of family therapy and the evolution of models of family therapy

(c) to make a study of the theory and treatment model of Structural Family Therapy. This study would include the literature as well as video and audio tapes, etc.

(d) to engage in actual family therapy sessions under the direction and supervision of a structural family therapist

The practicum project upon which this report is based was undertaken between September 1978 and June 1979.

STRUCTURAL FAMILY THERAPY

I. Introduction

The idea of trying to change a family appeared in the late 1940's and 1950's. The major thrust for the development of the family perspective was due to frustration on two counts, namely, from attempts to apply conventional psychiatric principles to work with schizophrenic families and from attempts to deal with behavior difficulties and delinquency in children.

Looking back on that period we can see many sociological, psychological, political, economic factors that favored its emergence. The world was going through the aftermath of World War II and the bomb. There was a noticeable amount of family togetherness, a backlash to the separations of World War II. The social sciences also became more social; the study of small groups flourished, animals were observed in their natural environment, ecology developed as a special field with man and other creatures looked upon as inseparable from their environments. As a part of this shift to a social view, therapists began to call in whole families of a schizophrenic patient for observation, in order to actually observe how a schizophrenic patient interacted with his family. This small step of observing family interaction led to a breakthrough in thinking about human problems. It proved to have enormous consequences and in fact led to a new

field of psychotherapy. Once there were more than two people in the treatment room the therapist found himself forced to think and behave in a different way. His focus had to change from the accustomed place within the individual psyche to a different place, outside and between people. The original view of the patient as the victim of a conspiracy to keep him sick yielded to the notion that the family itself was sick--that it needed treatment rather than the "patient" who was only and almost accidentally an emblem of the family disorder.

This new view of the psychiatric symptom as a reflection of a current interpersonal situation, rather than of an inner conflict rooted in the past was a radical shift in thinking about mental illness, and it brought therapists face to face with the question of what to do with their previous training. Working on a dysfunctional family system many found the Freudian concepts of the unconscious, etc., useless if not an encumbrance.

The movement toward family therapy occurred just when the dynamic concept of the individual, and psychoanalytic treatment had, after a long struggle, won power and prestige in the psychiatric establishment. Everyone who was respectable wanted to practise psychoanalysis and therapy was defined as a medical treatment. As a result anyone treating whole families was penalized by professional isolation. A number of therapists in the 1950's began to deal with whole families, often without knowing

that anyone else was doing so and even a decade later many experienced family therapists had not met each other nor had they discussed their work or sought a common view on what changing a family is all about. In 1970 Nathan Ackerman wrote:

> The most striking feature of our field today is the emergence of a bewildering array of diverse forms of family treatment. Each therapist seems to be doing 'his own thing.'[1]

II. Basic Concepts

A. DOUBLE BIND

In spite of the diversity, Family Therapy assumed a special character and form because of what may be called an "historical accident." This was the appearance in the field of a man who had no business to be there (and who has now left it to work with dolphins) and who radically altered its future course. He was the English anthropologist Gregory Bateson, who stumbled into family therapy by way of a project dealing with paradox in human and animal communication. In 1953 he was joined by Jay Haley and John Weakland. The study of special or disturbed modes of communication led to a general theory of communication which states that in all communication there is no such thing as a simple message. Rather every message is qualified by another message on another level of abstraction.

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[1] Ackerman, N., Family Psychotherapy Today, Family Process 9:123, 1970.

In 1954 the Bateson group decided to focus on schizophrenic communication. From this study was born the famous Double Bind hypothesis which was published in 1956 by Bateson, Haley, Weakland, and a new member, Donald Jackson.[2] The notion that the schizophrenic's bizarre pattern of thought and utterance was essentially, not something disturbed within himself, but rather a result of family interaction, was a radical idea indeed. Other investigators, such as Frieda Fromm-Reichmann, Ridz, Bowen and Wynne were arriving at similar conclusions and the idea that schizophrenia could be cured by getting the patient and his family together and somehow talking them out of their strange and terrible way of interacting with one another fell on fertile ground. The idea has of course been modestly modified since that time, and family-therapy by itself is no longer the treatment of choice for schizophrenia.

The chief importance of the Double Bind is now felt to be that it gave shape and structure and theoretical back bone to the shapeless clinical findings of the early family therapy practitioners. It also propelled communication theory into the mainstream of psychiatric thinking and put family therapy on the map where no other therapy since psychoanalysis has appeared.

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[2]Bateson, G., Jackson, D., Haley, J., Weakland, J., Toward a Theory of Schizophrenia in Jackson, D., ed., Communication, Family and Marriage, Palo Alto, Science and Behavior Books, 1968.

The notion of the double-bind has become a central concept among family theorists, and is not confined to schizophrenic families alone but occurs in a mitigated form in a large number of so called normal families. The double bind has been described as a situation of no alternatives and feeling so terribly on the spot at all times.

B. GENERAL SYSTEM THEORY

The general system theory is by far the most important concept in family therapy, and the one which dominates the field at present.

David Olson gives a working definition of family therapy. He suggests that any intervention focusing on the family system rather than the persons in it, merits the name of family therapy.[5] Family therapy is centered on the family system and the changes that can be made in that system. Such a stance implicitly conceptualizes the family as a system and all major family therapists since the death of Nathan Ackerman in 1971 can be classified as system theorists in that the general system approach underlies their thinking.

General system theory had as its originator or prime mover the late Ludwig von Bertalanffy, a biologist. He presented it in

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[3]Olson, D., Marital and Family Therapy: Integrative Review and Critique. J. Marriage Fam. 32:501-538, 1970.

1945 and later showed how it might be applied specifically in the field of psychiatry. Von Bertalanffy sought to find those principles which would be valid for all systems--for systems in general. His concern was for wholeness and organization rather than reductionism, "the nothing but approach." General system theory has been called "...a new approach to the unity-of-science problem which sees organization rather than reduction as the unifying principle, and which therefore searches for general structural isomorphisms in systems."[4]

Von Bertalanffy tells what systems are and in what they basically consist. He states that systems are "complexes of elements standing in interaction."[5] As such it is clear that system thinking is not limited to any single subject but applicable in many diverse ways. Besides Von Bertalanffy, many others in various fields have been searching for the basic structures of reality, the patternings which are common to our experience. This search goes by the general name of structuralism and "connotes a belief that there is in all human social organization and behavior an underlying unifying structure or pattern."[6]

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[4]Gray W., Rizzo, N., History and development of a general system theory in Gray, W., Duhl, F., Rizzo, N. (eds): General System Theory and Psychiatry, Boston, Little, Brown, 1969, p. 7.

[5]Von Bertalanffy, L., The meaning of general system theory in General System Theory, New York, Braziller, 1968, p. 33.

[6]Levenson, E., The Fallacy of Understanding, New York, Basic Books, 1972, p. 31.

Levenson notes that structuralism is of extreme importance because it is not just another way of viewing reality, but a paradigm, a model which enables us to see a new reality.[7] It can be put more simply: structuralism as seen in system theory gives us a new gestalt. The pieces of the picture are the same but the way in which they are seen is quite different. To view pathology from the point of view of a person and to see it from the point of view of a system is not to just get another picture, but to see a new reality, a new picture. The paradigm that a system approach gives is certainly not the one that the intrapsychic paradigm gives. Issues which may seem abstract and not germane to practice are in reality critical to how one proceeds. For instance in family therapy the focus is on the sick family system and its interaction and the individual is more a symptom of the sick system. The family system is now in the foreground and the individual member in the background, a reverse of the traditional way. This way of thinking is revolutionary and leads to new ways of doing therapy.

Von Bertalanffy claims that there are two kinds of systems: an open system and a closed system. The former found in a family, is characterized by a continuous flow of component material, whereas the closed system does not have such a continuous flow. Besides, an open system has three

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[7] Ibid., pp. 43-45.

properties: wholeness, relationship, and equifinality.

A system is not made up of independent parts, but of interdependent parts. Therefore a system is not the total sum of its parts, but is characterized to some extent by wholeness or unity. We recall von Bertalanffy's definition that systems are "complexes of elements...in interaction." Without the interaction there is no system but merely adding up separate entities. Von Bertalanffy uses the term wholeness to describe such interaction.

The second property which flows from this is relationship. The term relationship in system theory has a technical meaning and refers to the basic structure of the elements and how they relate. For instance one can not analyze the persons of a family independently because this would distort the picture. The only alternative to this is to study the connections between the parts and to see how they interact. Furthermore, in system theory these elements are isomorphs or transformations of each other.

Von Bertalanffy uses the color spectrum to illustrate the concept of transformation.[8] The color spectrum ranges from violet to red on a continuum. A person who is not color blind can be taught that green is the opposite of red

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[8] Von Bertalanffy, p. 241.

and halfway between red and green we find yellow on the color spectrum. Thus the green, yellow, red of the color spectrum and the go, warning, and stop of our traffic signals have the same structure and are isomorphs or transformations of each other.

On the perennial question of the relationship of content to form, the structuralist insists that it is the latter which determines the former. Content changes but not structure. This leads to the third propery of system, namely equifinality. This means that no matter where one begins, the conclusion will be the same. Von Bertalanffy calls this the reason why "the same final state may be reached from different initial conditions and in different ways."[9] A closed system does not have this property of equifinality since its final state is determined by the initial conditions.

The property of equifinality is not new as the medieval scholastics had an axiom: whatever is received is received according to the manner of the one receiving. This axiom has great relevancy for the clinician, as the pattern will always be the same. If one takes a system view of an ongoing interrelationship such as a marriage, it is not necessary nor even useful to get a long history of the couple. Whether the

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[9]Von Bertalanffy, p. 40.

subject is money, sex, children, or in-laws, the pattern will be the same. The clinician need only get some idea of the couples' interaction in a given area to understand how they relate. This has great practical consequences for the therapist.

C. FEEDBACK

There is one question unanswered and it is: If the elements of a system are not the sum of their parts, how are they related? Von Bertalanffy answers by saying that they relate through a process of feedback which maintains the system's functioning. Feedback is not derived from a cause-effect model, that is, a affects b affects c, etc., but from a cybernetic or circular model, c leads back to a.

A system approach gives a new model or paradigm, which in turn influences practice. In the old paradigm "sickness" meant some kind of a break down of parts or malfunctioning of the machinery. For example, an obsessive compulsive neurotic would have broken down machinery or a punitive super-ego. In the new paradigm the malfunctioning of a person is not caused by this but to a failure of his system to function properly because of a lack of information. Treatment would therefore consist in correcting the informational gap that is changing or altering the feedback mechanism.[10]

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[10] Levenson, pp. 54-75.

Jackson tries to clarify the dual meanings of homeostasis and negative feedback. In view of this ambiguity he uses the terms of a steady state or stability of a system which is maintained by negative feedback mechanisms which act to minimize change. In this sense he cites the example of the thermostat activating the furnace until the deviation is corrected (negative feedback). Clinically the role of the identified patient can illustrate negative feedback. He will act out to get the father and mother to unite and stay together "for the sake of the children" and to save the family system.[10b]

On the other hand, positive feedback is the kind that can destroy a system. It forces the family into new ways of acting by making the old positions untenable. It produces runaways in the system according to Jackson. It uses paradoxes to accomplish its goals as in much of Haley's work.

Whether using positive or negative feedback, one person, the "identified patient" is not isolated and labelled as sick. Therapy is looking at the whole system and how it operates and using feedback to produce movement in the system. Intraphysic forces are not considered, so we can see how therapy depends on the paradigm one chooses.

D. MODELS

Paradigms are important because one frame of reference looks at different dimensions and produces different material

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[10b] Pragmatics of Human Communication, by Paul Watzlawick, J. H. Beavin, Don D. Jackson. W. W. Norton & Co., Inc., New York, 1967, pp. 146-147.

than another. Onc can see very different things. Levenson[11] claims that in therapy there have been three models: the work machine model, the communication model and the organismic model. In the first model cure was going back and undoing the past. In the communication model cure is in the here and now present, and in the organismic model, the emphasis is on organization, so that "we are no longer as interested in the machinery as we are in its patterns of consequence."[12]

Family therapy from its beginning has used the communication model, and has stressed the importance of communication within the family system. But at present family therapy is moving toward the organismic model. We quote Levenson:

> The communication theorists and family therapists are the first relatively pure second paradigm therapies. Family therapy at its inception focused on the failures of communication between members of the family. It has, more recently, shifted to an interest in the family as a perspectivistic whole and the family members as transformations of each other. In this sense, members of the family invent each other. Rather than communication, the focus is now on control and organization. Family therapy and group therapy (the artifactual family) have moved most easily into the third paradigm, of organismic relationships.[13]

E. RESEARCH

As mentioned, various pioneers in the family movement began research independently thinking that there might be a significant

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[11]Ibid., pp. 68-70.

[12]Ibid., p. 70

[13]Ibid., p. 67

connection between the pathology of an identified schizophrenic patient and his family system. During the decade from 1950 to 1960 this research began to show results and gave solid evidence to the relationship between the patient and his family system. But more importantly the results were most productive because they were not confined to the schizophrenic and disturbed families only, but could be applied to so-called normal families. Therapists were learning how to deal with family systems.

The actual observing of families and trying to change them produces information which had never been gathered before. Rather than family therapy developing because of a theory, it appeared that people were struggling to find a theory to fit their practices. A theoretical framework for these new ways of thinking was difficult to conceptualize. To change an individual required one way of thinking, and to change the interaction among family members required quite another. By the end of the 1950's it was becoming clearer that family therapy contained within it a completely different concept of change that could not be added on to individual or group therapy. Family therapy's goal was on changing the structure of the family and the sequences of behavior among the members. When it is understood that family therapy is not a method of treatment but a new orientation to the human situation it is clear that any number of methods and approaches might be used. Because of this, Family Therapy does not have a super-star like Freud to help shape its public image. Instead there is a

constellation of leading practitioners, teachers and writers who are the major figures in the field.

F. INFLUENTIAL THINKERS

In 1967 the Group for the Advancement of Psychiatry on the Family surveyed the family therapists to find the most influential thinkers in the field. The survey listed in order: Virginia Satir, Nathan Ackerman, Don Jackson, Jay Haley, and Murray Bowen.[14] It is thought that this list would remain unaltered today, although the order may have changed, and Minuchin may have been added. These are the most influential thinkers of family therapy.[15]

Nathan Ackerman was trained as a psychiatrist and psychoanalyst, but was also influenced by social psychology. He began his writings about families in 1938 and is looked upon as the grandfather of family therapy. He was the transition figure between an exclusively intrapsychic orientation and an emphasis on the system approach.

For Ackerman the outcome of family therapy is a dual orientation: "the dissolution of pathogenic conflict and fear, and the promotion of residual forces toward positive emotional health,"[16] and families change when its conception of itself,

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[14]Group for the Advancement of Psychiatry. Field of Family Therapy 7, (78): 570, 1970.

[15]Foley, V.D., An Introduction to Family Therapy, New York, Greene and Stratton 1974, p. 53.

[16]Ackerman, N., Family focused therapy of Schizophrenia, in Scher, S., Davis, H. (eds): The Outpatient Treatment of Schizophrenia, New York, Greene and Stratton, 1960, p. 165.

its way of thinking changes. It changes by shifting the balance within the family, by learning to relate to each other in new ways, and by examining its value system and deciding to make changes if that seems appropriate.

Don Jackson, Jay Haley, and Virginia Satir are all classified as communication theorists but with a difference. Don Jackson is considered communication and cognition, Jay Haley communication and power, and Virginia Satir as communication and feeling. These three illustrate the notions of a second model paradigm, mentioned above. Jackson was influenced by Von Bertalanffy's approach to system theory and places a heavy emphasis on the cognitive aspects of communication, so that what one thinks, influences what one does. Haley has been influenced by hypnoses and Milton Erickson approach; Haley is mainly concerned with power and its meaning for therapy. Satir is concerned about emotion or feeling in a family system. How one feels toward himself and towards others in his system is her main concern. Satir accepts much of Jackson's theory as a basis for her practice.

The building block of Jackson's system is the notion of homeostatic balance, which maintains constancy in the internal environment of a family, and a family changes when it reaches a point of realizing it can not establish a proper balance. Therefore a therapist can disturb a system. Jackson's approach emphasizes the four major areas distinct to family therapy:

1. The therapist is not a passive listener but a participant observer who is most active in the therapeutic process.

2. A major goal is to change behavior rather than aiming at insight.

3. A focus on the here and now rather than delving into the past.

4. A concentration on the interaction of the system rather than the intrapersonal.[17]

Haley is interested almost exclusively in a power struggle that goes on in a relationship between people. There are two central ideas in Haley's thinking; a relationship takes place through communication and communication exists at different levels of meaning. Haley insists that any relationship by definition is a power struggle and the people involved are constantly struggling to define or redefine the relationship. The core notion in Haley's thinking is "when one person communicates a message to another, he is maneuvering to define the relationship.[18]

Haley sees change in the system as the only valid outcome of therapy. Change behavior and you change feelings. First the therapists offer the family an educational model to help them

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[17]Jackson, D., Weakland, J.: Conjoint family therapy; some considerations on theory, technique, and results. Psychiatry 24:30-45 1961.

[18]Haley, J., An Interactional Description of Schizophrenia. Psychiatry 22:1959, 323.

behave differently, and therapeutic paradoxes to force them to do so. The educational model means the therapist himself as model. With regard to awareness Haley insists that it is not necessary for the family to become aware of their behavior for effective change. But he states that therapy is a power struggle in which the therapist must be in control if change is produced. The therapist forces the family to deal with new situations and to produce new solutions. He moves the family system to a new way of operating so that it can stabilize at a different and more comfortable level of functioning.

Haley's insistence on power and paradox may sound harsh and cold. Instead in therapy a situation is created in which:

1. The therapist sets up a benevolent framework in which change is to take place.

2. He permits or allows the client to continue with unchanged behavior.

3. He provides an ordeal which will continue as long as the behavior remains unchanged.[19]

Virginia Satir's main book is Conjoint Family Therapy where she translates her basic philosophy into concrete examples. She emphasizes the feeling aspect of communication.

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[19]Haley, J., Strategies of Psychotherapy, New York, Greene and Stratton, 1963, p. 181.

> There are four wrong ways people communicate. You can blame, you can placate, you can be irrelevant or you can be 'reasonable.' There is something incomplete about each way. The blamer leaves out what he feels about the other person, the placater leaves out what he feels about himself, the reasonable one leaves out what he feels about the subject being discussed and the irrelevant one leaves out everything.[20]

This is Satir's summary statement as she spells out how communication is focused on feelings. As to the causes of poor communication she links it directly to a person's self concept and low self esteem.

The outcome of family therapy for Satir is clear from her following statement, "If illness is seen to derive from inadequate methods of communication...it follows that therapy will be seen as an attempt to improve these methods."[21] She also contends that pathology is found in the family system and not in the individual members. The information that is being communicated is not being sent clearly or being received accurately. The therapist then is a teacher and a model. He leads a family into new ways of thinking and behaving. He does this not only by talking but more effectively by modelling. He demonstrates communication, especially on a feeling level.

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[20]Howard, J., Please Touch, New York, McGraw Hill, 1970, pp. 149-150.

[21]Satir, V., Conjoint Family Therapy (ed 2), Palo Alto, Science and Behavior Books, 1967, p. 96.

Murray Bowen's thinking developed over the years from analysis to a system model. He began to study schizophrenia in 1954 and made a study of hospitalized families with a schizophrenic member. Whole families were hospitalized from six months to two and one-half years. Bowen hypothesized at first that schizophrenia was influenced by the mother, then the role of the father was considered, then the role of the whole family and soon Bowen added the role of the grandparents.

The central concept in Bowen's theory is the "undifferentiated family-ego mass" or stuck togetherness, or the emotional oneness of the family.[22] And his basic building block for any emotional system is the triangle.[23] The outcome of family therapy is stated clearly by Bowen: "The basic effort of this therapeutic system is to help individual family members toward a higher level of differentiation of self."[24]

He has listed four specific functions for the therapist to perform.

1. Defining and clarifying the relationship between the spouses,

2. Keeping self de-triangled from the family emotional system,

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[22]Bowen, M., The use of family theory in clinical practice in Haley, J. (ed): Changing families, New York, Greene and Stratton, 1971, p. 171.

[23]Ibid., p. 185

[24]Ibid., p. 184.

3. Teaching the functioning of emotional systems, and

4. Demonstrating differentiation by taking "I position" stands during the course of therapy.[25]

Minuchin - Salvador Minuchin is credited to be the chief collaborator in the development of Structural Family Therapy. He was born in 1921 in a small town in Argentina, finished his medical studies in 1947, joined the Israeli Army and after the war trained in New York as a child psychiatrist. In 1958 while working at Wiltwyck, he took his first real step into family therapy. He began as an intake psychiatrist and two years later was switched to the out-patient service. He saw many of the same children back in their families after a two year stint at Wiltwyck. They were not very different, so he thought that they might be doing something wrong. He decided to see families and he describes it as a great "adventure." Since Nathan Ackerman and the Palo Alto Group and others doing family therapy were working with middle class families, Minuchin and his collaborators had to develop new concepts and new techniques to reach his "unreachables," the disorganized multi problem families. His technique of enactment, the bringing of the problems into the

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[25]Bowen, M., Principles and techniques of multiple family therapy, in Badt, J., Maynihan, C. (eds): Systems Therapy, Washington, D.C., 1971, pp. 187-203.

room and acting them out came from this period. He was working in a no man's land of poor families who had frustrated all efforts to help them.

In 1965 Minuchin took over the Philadelphia Child Guidance clinic with eight or ten people on staff. He introduced the family therapy concept and ten years later it had a staff of 225 people and the clinic was part of the modern new Children's Hospital complex on the University of Pennsylvania campus. In 1975 Minuchin stepped down as director and is now more involved with teaching and writing. Although he was trained in psycho-analysis, he claims that it is a 19th century concept as it deals with man as an individual and out of context. Our century is one of relatedness and he foresees family therapy taking over psychiatry in one or two decades.

As we have seen above,Levenson suggests that in therapy there have been three models,namely the work machine model, the communication model and the organismic model. Structural family therapy falls into the third model, the organismic model with emphasis on organization and its patterns of consequence. Minuchin, with over simplification says the goal of therapy is a more adequate family organization. However, others trying to frame structural family therapy have come up with a much more complex description. Guerin states:

> "The Philadelphia Child Guidance team under Minuchin's and Haley's leadership was able to take some of the basic family system concepts of Bateson, Bowen, Erickson, and Jackson, add to them Haley's strategic brilliance and Minuchin's considerable clinical artistry, simplify them, concretize them, and demonstrate their effectiveness in a clinical setting with families, and in teaching other family therapists.[26]

Structural family therapy then uses the communication model, the symptom focus, and the use of paradox. But in addition Minuchin takes into consideration the characteristics of families, boundaries, sub-systems, and structural concepts such as triangulation. Since Minuchin is more of a clinician than a theorist, one of his collaborators, Braulio Montalvo has evolved as a conceptualizer and commentator on Minuchin's clinical artistry. Another collaborator, Harry Aponte, a social worker, has succeeded Minuchin as Director of the Philadelphia Child Guidance Clinic and has become an expert in intervening with lower socio-economic families. Another, Ron Liebman, a child psychiatrist, advances Minuchin's methods in the psychosomatic area.

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[26]Family Therapy, Theory and Practice, ed. by Guerin, P.J., Gardner Press, Inc., New York, 1976, p. 12.

III. Structural Family Therapy Theory

In a structural approach to family therapy, the therapist conceptualizes the problems presented to him by the family as products of the way the family structure is functioning. He then works to change the structural organization of the systems.[27] A family is a natural social system, made up of a complex of subsystems, that has evolved ways of organizing and transacting that are economical and effective for that particular group. Each system or subsystem includes two or more family members organized around a family related function. The family comes into therapy when stress overloads the system's adaptive and coping mechanisms and handicaps the optimal functioning of its members. The family usually diagnoses and presents the problem as one member who is behaving in ways that are stressful for the family. They want the therapist to change this one member.

> The family therapist, however, focuses on the whole group. One of the members may be expressing family stress in ways that are clearly visible but the problem is not confined to the identified patient. The whole family is responding to a stressful situation.[28]

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[27] Aponte, H., Organizing Treatment around the Family's Problems and their Structural Bases in Psychiatric Quarterly 1974 (48:2) p. 209.

[28] Minuchin, S., Structural Family Therapy, in American Handbook of Psychiatry, Vol. II revised edition, G. Caplan, ed. Basic Books 1972, p. 178.

Minuchin further explains: The family "governs its members responses to input from within and without. Its organization and structure screen and qualify family members' experience."[29] Structural family therapy is thus directed toward changing the organization of the family. When the structure of the family group is transformed the positions of members in that group are altered. An individual's experiences change and he acts and reacts differently, to different social contexts.

When Minuchin speaks of family structure he means the "invisible set of functional demands that organize the ways in which family members interact. A family is a system that operates through transactional patterns."[30] And transactional patterns regulate family members' behavior, and remain on "automatic pilot."

The goal of therapy is the transformation of the structure of the family. This transformation does not mean changing the composition of the family. The change occurs in the way in which the same people relate to each other. Minuchin defines transformation of the structure as "changes in the position of family members vis-a-vis each other, with a consequent modification of their complementary demands."[31] These changes in position and demands lead to an individual's different experiences and changed behavior.

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[29]Minuchin, S., Families and Family Therapy, Harvard Press, Cambridge, Mass., 1974, p. 7.

[30]Ibid., p. 51.

[31]Ibid., p. 111.

Although Minuchin is well known for his fast interventions he says that the concept of transformation deals with large movements in therapy that take place over time. The therapist must know how to map his major goals, but must also know how to facilitate the small movements that carry the family toward those goals. For instance a person's ability to move from one circumstance to another depends on the support he receives. It is vital to provide systems of support within the family, and within the therapeutic system.

There are two major activities involved in Structural Family Therapy. These are (a) forming the therapeutic system and (b) restructuring operations. These are not separate, but are intertwined.

A. FORMING THE THERAPEUTIC SYSTEM

Joining and accommodation are two of the therapist's methods of creating a therapeutic system and positioning himself as its leader. These are all important because unless the therapists can join the family and establish a therapeutic system any attempt to achieve the therapeutic goals will fail and restructuring can not occur. Joining is used when emphasizing actions of the therapist aimed directly at relating to family members or the family system. Accommodation is used when the emphasis is on the therapist's adjustments of himself in order to achieve joining. These operations are often called the "glue that unites the family and therapist throughout therapy."

[32]Ibid., p. 124.

Assessment

Another intertwined activity of the therapist is assessment. This is a working hypothesis that the therapist evolves from his experiences and observations upon joining the family. The therapist begins assessing the family structure and how the relationships between the members are creating the problem. He will try to see how the identified patient helps maintain the dysfunctional family system. He also looks for strengths, and tries to learn who can contribute to resolving the problem. This assessment (also called diagnosis) of the family is achieved through the interactional process of joining and appears on the family map.[33]

Therapeutic Contract

An essential element of the formation of a therapeutic system is the agreement on a therapeutic contract. The family wants the identified patient changed without interference with their preferred transactional patterns. But this change will depend on the family's transformation. Consequently the family and the therapist must come to an agreement on the nature of the problem and the goals of therapy. Very often this contract is not clearly defined, but it must be present. The contract offers help for the problem that the family brought into therapy.

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[33]Ibid., pp. 123-133.

B. RESTRUCTURING THE FAMILY

The separation of joining and restructuring is an artificial distinction as the therapeutic unit is in continual movement and it is quite possible that in actual therapy a restructuring intervention may develop before a tentative assessment has been made.

> Restructuring operations are the therapeutic interventions that confront and challenge a family in the attempt to force a therapeutic change. They are distinguished from joining operations by the challenge they pose.[34]

Joining operations and restructuring operations are interdependent in that therapy can not be performed without joining, but it will not be successful without restructuring. Restructuring operations are the dramatic interventions that create movement toward the therapeutic goals. They are the high lights of therapy and are maneuvered by the therapist from his position of leadership. "The therapist's job is to manipulate the family system toward planned change."[35] The therapist must be recognized as an expert and must be able to engage with the family in operations that facilitate movement.

The target of intervention is the family system. The therapist joins the system and then uses himself to transform it. By changing the position of the systems members he changes their subjective experiences, and the family system has self

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[34]Ibid., p. 138.

[35]Ibid., p. 140.

perpetuating properties. Once a change has been effected the family will preserve the change by providing altered feedback which continuously qualifies or validates family members experience.

Minuchin sums up the major activities of therapy by stating that in the joining operations the therapist becomes an actor in the family play. In the restructuring operations the therapist functions like the director as well as an actor. He creates scenarios, choreographs, highlight themes, and leads family members to improvise within the constraints of the family drama. He also uses himself, entering into alliances and coalitions, creating, strengthening or weakening boundaries, and opposing or supporting transactional patterns. He uses his position of leadership within the therapeutic system to pose challenges to which the family has to accommodate and change.

This is a brief resume of the theory of Structural Family Therapy. Minuchin claims that these are by no means complete, and he "has not even begun."[36]

Description of Clinical Practice

Minuchin has gained renown as a clinician rather than as a theorist, and art and clinical artistry have been applied to his therapy. Helping professionals from Europe and North America apply to the Philadelphia Child Guidance Clinic to learn how to do family therapy. Less than one-third can be

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[36]Ibid., p. 157.

accepted. The core of the course is therapy itself. Students are almost instantly plunged into therapy sessions under the supervision of a teacher and the observation of other students. They learn through practice, the way hospital interns do. I feel I was most fortunate to have a graduate of the Philadelphia Child Guidance Clinic to provide training and supervision in my practicum, aimed at advancing my skills in Structural Family Therapy.

The skill development objective of this practicum was pursued by conducting family therapy sessions at the McNeill Clinic in Saskatoon, under the supervision of George Enns, who is a graduate of the Philadelphia Child Guidance Clinic. George Enns is very involved with conducting training sessions in family therapy as well as carrying a caseload of families.

Training sessions with George Enns included a seminar in structural family therapy, private training sessions, training tapes, both audio and video, observation of live supervision therapy sessions of other trainees, and written material. Besides there were supervision sessions every week with a critique of my therapy sessions, and numerous consultations.

A total of six families were seen in an average of one and one half hour sessions. Length of therapy ranged from two to seven sessions.

The clients were all families or all the members currently living in a household. These families had either

voluntarily sought help from McNeill Clinic or had been referred by the school social worker, public health nurse, doctor, or some other agency. All families agreed to come as a family and to have the session recorded. A large proportion of the interviews were video-taped, and the rest were audio-taped.

Treatment Model

As mentioned, a structural family therapist conceptualizes the problems presented by the family as products of the way the family structure is functioning and he thinks of therapy as a structural means of resolving conflicts and problems.

A family usually asks for help when one member of the family is labelled as "the problem" or as "having problems" that are serious enough to warrant a request for help. What frequently happens is that families are continually faced by demands for change, and a dysfunctional family refuses to change. Demands for change are countered by reification of the family structure to the point of rigidity which blocks any possibility of alternatives. "Selecting one person to be the problem is a simple method of maintaining a rigid, inadequate family structure."[37] The function of the family therapist is to help the identified patient and the family to solve these problems by facilitating the transformation of the family system.

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[37]Ibid., p. 110.

The transformation process involves two main operations which in actual therapy are inseparable. These are (a) joining the family in a position of leadership and unearthing and evaluating the underlying family structure, and (b) creating circumstances that will allow the transformation of this structure.

The first, the joining operations and the evaluating of the family structure, can be very similar to the techniques presented by Jay Haley.[38]

(a) The first step in the joining operation is the social stage in which all present members of the family are contacted by the therapist and made to feel at ease and involved.

(b) The next step is the problem stage in which everyone is approached to contribute ideas about the problem. Again everyone has a turn and no interpretation nor advice is given. The therapist listens to the problem with an attitude of helpful interest.

(c) The third step is the interaction stage in which everyone, at least the participants, interact with each other around the problem, and try to clarify the problem.

(d) The fourth step is the goal setting stage, which again includes the involved participants specifying what changes are derived from therapy.

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[38]Haley, Jay, Problem Solving Therapy, Jossey Bass, Inc., San Francisco, 1976, pp. 9-47.

Harry Aponte explained that in the problem stage and interaction stage, the therapist assesses

> ...what the family structure is and how the relationships between the members or the participants are creating the problem for which they seek help. He needs to know how each family member is participating in the problem so that he can understand the structural underpinnings of the problem.[39]

After this and according to the nature of the problem, the therapist will engage a specified number of participants to get commitments from them to help change certain structural relationships of which they are a part.[40]

These commitments are pledges for change or contracts by members of a system to seek agreed upon changes through agreed upon means. Usually a pledge involves family tasks, tailored specifically to the structural changes called for.

Minuchin and Aponte give many examples of their model of therapy. Aponte gives the example of a family with a twelve year old "delinquent." The therapist responds to the family's request to stop the boy's delinquency by focussing attention on the family's other problem areas "from which the stress on the boy was being displaced."[41] Within ten minutes

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[39]Aponte, H., "Organizing Treatment around the Family's Problems and their Structural Bases," in Psychiatric Quarterly, 1974 (48:2), p. 211.

[40]Ibid.

[41]Ibid.

of the first interview he learned that the mother felt very overwhelmed and inadequate, that the fourteen year old brother was maintained housebound as parenting-child, and the ten year old sister was a spoiled mother's pet causing jealousy among the siblings. When the therapist gave these problems more attention than the delinquency problem the family responded as if these were the reasons the family came for help. Aponte explains that the family's responsiveness was an implicit contract to deal with the structures in the family that were creating these other problems. These three other problems were all linked to the family's enmeshment and disorganization. There was no generational boundary between children and mother and few personal boundaries around each individual. When these three other problems were dealt with, the twelve year old boy's delinquency ceased to exist as an issue.

Minuchin is somewhat more precise in describing his therapy. He speaks of the two major activities involved in structural family therapy and then subdivides into smaller activities and then lists techniques that may be used with these activities. The first major activity that he lists is the joining operations or also referred to as "forming the therapeutic system." The second major activity is the restructuring operations.

Forming Therapeutic System

The activities of the joining operations are:

(a) Joining activities - which are very similar to the social stage of Haley and emphasizes the actions of the therapist aimed directly at relating to family members or the family system.

(b) Accommodation activities are those that emphasize the therapist's adjustment of himself in order to achieve joining.

There are several accommodation techniques. The first of these is maintenance, which is the technique of providing planned support of the family structure, family sub-systems, and of individual members, as the therapist perceives and analyzes the family structure.

A second accommodation technique is "tracking" in which the therapist follows the contents of the family's communications and behaviour and encourages them to continue.

The third accommodation technique is "mimesis" in which the therapist mimics the family's style, affective range, tempo of communication, etc. The mimetic operations are usually implicit and spontaneous.

(c) Assessment. Another intertwined activity of the therapist during joining operations is assessment of the family structure, the coalitions, boundaries, etc. This is a working hypothesis that the therapist evolves from his experiences and observations upon joining the family. In assessing the family's interactions, the therapist concentrates on six major areas:

(1) he looks at the family structure, its preferred transactional patterns, and the alternatives available;

(2) he considers the system's flexibility and its capacity for elaboration and restructuring;

(3) the therapist examines the sensitivity to individual members actions. This sensitivity falls on a scale from enmeshment to disengagement;

(4) the therapist considers the family life context, looking for the sources of support and stress in the family's ecology;

(5) he examines the family's developmental stage and its performance of the appropriate tasks;

(6) he examines the ways in which the identified patients' symptoms are used for maintenance of the family's preferred transactional patterns.

This assessment of the family is achieved through the interactional process of joining. The therapist transforms his experience into a family map, from which he derives his therapeutic goals.[42]

(d) Therapeutic contract. Another important activity of the formation of a therapeutic system is the agreement on a contract. Very often the family only want the presenting problem solved, without any other changes. The therapist realizes that changes in the identified patient will depend

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[42]Minuchin, S., Families and Family Therapy, p. 124.

on family transformation. So the therapist broadens the focus of the problem to include family interaction. The focus of the problem can usually be made to include the interactions of the family regarding the problem. Or as Minuchin gives examples he uses the "yes but" and the "yes and" techniques to broaden the focus, which indicates that he can see more to the problem than they can. He often challenges the family's perception of reality which may also be a restructuring move. But with more information Minuchin often observes, "You have a problem in disciplining your children; I will help you with this problem, too." And later he covers a new area: "You and your spouse are on opposite sides in relation to child rearing. We will need to explore this area together."[43]

The contract always must contain a general understanding of the logistics of therapy. The place of therapy, other agencies involved, the frequency of sessions, and the length of therapy, etc., all need some degree of understanding from the start.

Restructuring the Family

The other major operation of therapy is restructuring the family. Restructuring operations have been called by Minuchin the highlights of therapy and the dramatic interventions that create movement toward the therapeutic goals. In restructuring the therapist uses himself, to enter into

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[43]Ibid., 132.

alliances and coalitions, to create, strengthen, or weaken boundaries and to oppose or support transactional patterns. "He uses his position of leadership within the therapeutic system to pose challenges to which the family has to accommodate."[44] Minuchin stresses that this operation can only be done from a position of leadership with freedom to maneuvre and to manipulate himself as well as the family. He makes interventions that challenge the family organization, forcing its members to accommodate to him in movements toward the therapeutic goals.

This is a very critical operation. It is the very essence of therapy. "Therapy cannot be performed without joining, but it will not be successful without restructuring."[45] We recall that the goal of structural family therapy is changing the position of the family system's members so that the members' subjective experiences change. The family system is organized around the four tasks of support, regulation, nurturance and socialization of its members. Therefore the therapist joins the family, not to educate or socialize it, but rather to repair or modify the family's own functioning so that it can better perform these tasks.[46]

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[44]Ibid., p. 139.

[45]Ibid., p. 138.

[46]Ibid., p. 14

Family Structure

Family structure is defined by Minuchin as the invisible set of functional demands that organizes the ways in which family members interact.[47] Repeated transactions among family members establish patterns of how, when, and to whom to relate. These interactional patterns "underpin" the family system and regulate family members' behavior.

These patterns are governed by two systems of constraint, the first one being generic or the universal rules governing family organization. For instance, society requires that parents have a different level of authority than their children. The second system of constraint is idiosyncratic in that it varies from family to family involving mutual accommodation and functional effectiveness.

Thus the family system maintains itself and offers resistance to change. But the family structure must be able to adapt itself when circumstances change. Since the family must respond to internal and external changes, it must be able to transform itself without losing the continuity that provides a frame of reference for its members.

The family system carries out its function through sub-systems. Subsystems can be formed by generation, by sex, by interest or by function. Husband and wife can be the spouse

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[47]Ibid., p. 51.

subsystem as well as the parental subsystem, which involves different levels of powers and different skills.

Boundaries

"The boundaries of a subsystem are the rules defining who participates and how."[48] The function of boundaries is to protect "the differentiation of the system." For proper family functioning the boundaries of a subsystem must be clear and well defined enough to allow subsystem members to carry out their functions without undue interference, but they also must allow contact between members of the subsystem and others.

Minuchin states that the composition of subsystems is not nearly as important as the clarity of subsystem boundaries. He uses the clarity of boundaries as a parameter for the evaluation of family functioning. And he also states that his therapeutic style is organized along two parameters: "how to preserve individuation and how to support mutuality."[49] In other words human identity requires both a sense of being separate and a sense of belonging.

Minuchin sees two extremes in boundaries, one blurred and diffuse and the other too rigid. When a family turns in on itself, there can be an increase in communication and concern among the family members. As a result distances are decreased and boundaries are blurred. He refers to this as an enmeshed

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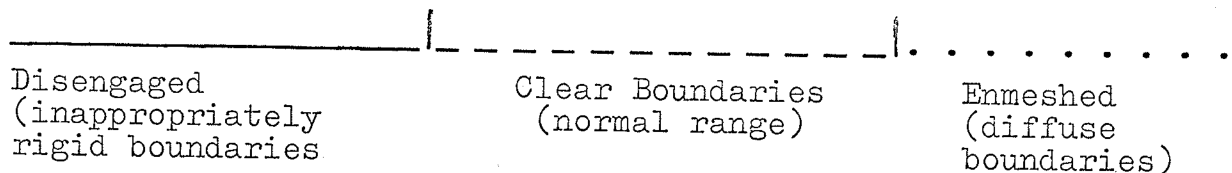
[48]Ibid., p. 53.

[49]Ibid., p. 120.

family. Other families develop overly rigid boundaries so much so that communication and concern can only cross subsystem boundaries with difficulty. This is called a disengaged family. Both types of families are handicapped and are liable to be overstressed. Minuchin conceives of all families as falling somewhere along a continuum whose poles are the two extremes of blurred boundaries or overly rigid boundaries, with most families falling within the wide normal range.[50]

Figure I



Operations at either extreme indicate areas of possible dysfunction. The enmeshed family responds to any variation with excessive speed and intensity, while a disengaged family tends not to respond when a response is necessary. The therapist may have to function as a boundary maker, clarifying diffuse boundaries, and opening inappropriately rigid boundaries.

Restructuring Operations

"Restructuring operations are the therapeutic interventions that confront and challenge a family in the attempt to force a therapeutic change." They always pose a challenge. Families come into therapy because they are in pain from preferred patterns of interaction that are dysfunctional. These families

[50] Ibid., p. 54.

can be helped only by changing these patterns and improving functioning. "The therapist's job is to manipulate the family system toward planned change."[51] He must be an expert in experimental social manipulation. However, Minuchin adds a caution. "Any therapist who does not have the capacity to imbue the family with a strong sense of his respect for each one of them as individuals and his firm commitment to healing, will lose the family in the processes of transformation."[52]

The family's reliance on the therapist for support is extremely important. When the therapist unbalances a family system by joining with one member or subsystem, the other members experience stress and usually insists on maintaining the system as is. The therapist must then insist that the family members move in the direction of the therapeutic goals, even though they are enduring uncertainties of the transitional period. This movement is made possible or facilitated by the therapist's understanding, support, and confirmation of the family members' felt needs and experiences.

Minuchin states that his patients move to a new, more functional family structure for three reasons. First, they are challenged on their perception of reality. Secondly, they are given alternative possibilities that make sense to them, and

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[51]Ibid., p. 140.

[52]Ibid., p. 113.

thirdly, once they have tried out the alternative transactional patterns, new relationships appear that are self-reinforcing.[53]

Minuchin lists seven categories of restructuring operations, namely: (1) actualizing family transactional patterns, (2) marking boundaries, (3) escalating stress, (4) assigning tasks, (5) utilizing symptoms, (6) manipulating mood, and (7) supporting, educating or guiding.

Each of these is subdivided.

1. Actualizing family transaction involves:

(a) enacting transactional patterns, which helps the family members to experience their own transactions with heightened awareness,

(b) recreating communication channels, which have become blocked,

(c) manipulating space--or rearranging geographically those who are close or distant within the family. This effects alliances and coalitions, centrality and isolation. A child can be separated from his mother, or a husband and wife can be moved closer together. This also can encourage dialogue.

2. Marking boundaries. Boundaries are the demarcations between autonomy and interdependency. In an enmeshed family, there are blurred boundaries and little individuation. In disengaged families, the boundaries are definite and rigid.

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[53]Ibid., p. 119.

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(a) delineation of individual boundaries to protect individual autonomy--children need opportunity and freedom to learn and experiment with growing up,

(b) subsystem boundaries--especially the spouse subsystem needs clear delineation. When the boundaries around a subsystem are strengthened, the functioning of that subsystem will increase. This may be caused by the lack of intrusion, or a system may become more conflictual as the number of its members increase.

3. Escalating stress. Families coming for treatment have usually developed dysfunctional transactional patterns for handling stress, and are stuck or unable to experiment with alternate ways of relating. Increased stress can be used to jar loose a rigid pattern.

(a) blocking transactional patterns along usual channels, can be frustrating or it can increase contact directly--eliminate the middle person who translates everything,

(b) emphasizing differences that the family has been glossing over,

(c) developing implicit conflict, which is used to detour contact,

(d) joining in alliance or coalition for longer periods.

Stress can challenge the accustomed ways of transacting, and its preferred methods of negotiating or avoiding conflict. If spouse conflict is avoided by scapegoating a son, stress can

be used to bring out the actual conflict and its resolution without scapegoating.

4. Assigning tasks. Tasks create a framework within which the family members must function. Tasks can be assigned within the session or as homework. Tasks offer a means of testing family flexibility and a new framework for transactions. They can offer experimentation and practice in alternate transactional patterns.

5. Utilizing symptoms. An individual member's symptom is seen as an expression of a contextual problem. There are several focuses:

(a) focusing on the symptom can often be the quickest route to diagnosing and changing dysfunctional family transactional patterns,

(b) exaggerating the symptom--or increasing its intensity, usually points out that the symptom is a mask for a different problem, which can be dealt with,

(c) de-emphasizing the symptom--as an avenue away from the identified patient to the real conflicts; ignore or devalue the symptom,

(d) moving to a new symptom to focus on another member of the family,

(e) re-labelling the symptom--may mean a reconceptualization in interpersonal terms. An example is redefining in one case a girl's anorexia as disobedience and as making her parents incompetent, and

(f) changing the symptom's effect. Instead of anger a parent may react in a competent, educating fashion.

6. Manipulating Mood. Many families demonstrate a predominant affect and adhere to a restricted mood level under all circumstances. The therapist may use an exaggerated imitation of the family style or he may demonstrate a more appropriate affect, such as a relaxed and accepting mood. The persons may model the therapist or recognize the ridiculousness of the behavior, and change.

7. Support, education and guidance. The nurturance, healing and support a family offers its members are vital for the individual family members and for the maintenance of the family system. If these and so many other functions could be taught, then significant change could be achieved.

> In family therapy, transformation or restructuring of the family system, leads to change, or to the individual's new experience. Transformation usually does not change the composition of the family. The change occurs in the synapses--the way in which the same people relate to each other.[54]

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[54]Ibid., p. 111.

IV. Evaluation

A. RATIONALE

When Minuchin and his collaborators did the Wiltwyck study of delinquent boys as a research project, they did an elaborate evaluation on the outcome of therapy. This is presented in his book, "Families of the Slums."[55] The evaluation was useful in the development of structural family therapy, but Minuchin and his associates have since simplified and concretized the goals of therapy radically. Aponte explains the present goals. The structural bases of family systems have produced problems serious enough to bring a request for therapy. "The therapist is meeting with the family for one purpose--to solve these problems.[56] Minuchin states similarly,

> When the therapist joins the family, he assumes the leadership of the therapeutic system. This leadership involves responsibility for what happens. The therapist must assess the family and develop therapeutic goals based on that assessment. And he must intervene in ways that facilitate the transformation of the family system in the direction of those goals ...the therapist's focus is on enhancing the operation of the family system.... The responsibility for reaching this state, or for failing to do so, belongs to the therapist.[57]

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[55]Minuchin, S., Families of the Slums, Basic Books, Inc., New York, 1967.

[56]Aponte, H., "Organizing Treatment Around the Family Problems and their Structural Bases," from Psychiatric Quarterly, 1974 (48:2), p. 210.

[57]Minuchin, S., Families and Family Therapy, p. 111.

And Jay Haley, who was with Minuchin at Philadelphia until 1976, refers specifically to the approach of the Institute of Family Counselling of the Philadelphia Child Guidance Clinic. He is even more elaborate.[58] He also states that the responsibility for change belongs to the therapist who is expected to plan a strategy of change "to bring about what the patient is paying money to achieve. If change does not occur, he is a failure. Blaming the client for not changing is not allowed."[59]

Haley contends that the role of a therapist is a problem solver. It is his job to clarify and get people over the specific problems they bring to him. If a child is presented as setting fires the goal of the therapist is to arrange that the child no longer sets fires. In the process of doing this, organizational changes may be made so that the whole family may function better. If a symptom is offered by the family, the therapist engineers change through the symptom. If a child is presented as the problem, the therapist accepts the description and only later may he shift to other children or the marital problems.

Haley also contends that training a therapist is teaching specific skills. These skills are aimed at helping the therapist do his work well and in particular to help him solve the problems he meets in therapy. He sees therapy as being for the

[58]Haley, Jay, Problem Solving Therapy, pp. 179-180.

[59]Ibid., p. 171.

handicapped people who wish to get back to normal. Therefore the therapist must plan a strategy and devise directives requiring new behavior. The directives may be types of behavior programs for an individual, or they may be directives for a family.

Structural Family Therapy is a therapy of action and it can not be expected that a problem will be solved by merely talking about it. Both therapy and training a therapist emphasize bringing the problem into the therapy room. If a couple has a problem of fighting they should fight in the room, because only having a discussion about behavior is not likely to lead to change. Also Haley has grave misgivings about the reliability of self report. He considers self report to contain many fantasies that are not true to the life situation nor relevant to therapy. Family therapists discovered years ago that what was said about a family problem and what could be observed in therapy was markedly different. That was the reason whole families were brought in to therapy and made to interact. What the therapist observed was different from the family members' description.

The same holds true with regard to what is actually happening in a therapy session and what a therapist thinks is happening. Because of this Structural Family Therapy requires that a student therapist appear in action before a supervisor. This can be done either live, through a one-way mirror, or on a video-tape or even on audio-tape. A supervisor does not

believe that a therapist can accurately report what happens in a therapy session. The supervisor wants the action in front of him so he can observe it, and focus on what really happens and on the interviewing skills needed to mount the hurdles. "The task is to teach therapy as a skill."[60]

This therapy has a problem orientation rather than a method orientation, and what a therapist does varies according to the problem. And it is emphasized that this therapy can not be learned by reading about it, hearing lectures about it, having discussions about it or even watching others do it. It can only be learned by doing it. "Therapy is a personal encounter and a therapist can only learn how to do it, by doing it."[61] The ideal situation is to do therapy while being guided by a supervisor at the moment therapy is happening.

Likewise in this type of therapy, theory grows out of action, not action out of theory. Reading of theories should come after the student has done therapy and has an idea of what he needs to know. It may also help him to think more tactically and to be more articulate about his work. But the goal is not to produce theoreticians but practitioners who can offer effective therapy.

Minuchin in an above statement has named in global fashion

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[60]Ibid., p. 179.

[61]Ibid., p. 181.

some of the skills in Family Therapy. These would be, joining the family in a leadership position, assessing the family and developing therapeutic goals, and intervening in ways that transform the family system in the direction of the goals.[62] Haley elaborates on the assessing and restructuring operations. "A student must be taught to think strategically; he must develop skills in diagnosing a sequence and structure; and he must be able to design a directive that will produce the change he wants."[63] Again, his is a global statement as he devotes a whole chapter to giving directives, and recommends that the best way to train a student to skillfully use directives is to give training in hypnosis.

B. CASE REVIEWS

For our evaluation we shall review the cases to see if therapy was effective. We shall see if the problem was solved or if there was a change in the family function. We shall also see if the joining operations and assessments were adequate.

In family D the presenting problem was stealing by a six year old. The stealing was never at school, but from the local store and neighbors and home. It was found that the mother was a single parent who was shy and very much alone.

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[62]Minuchin, S., Families and Family Therapy, p. 111.

[63]Haley, Jay, Problem Solving Therapy, p. 184.

The joining operations seemed good.

Assessment - This one parent family is assessed as a dysfunctional family system with a child acting out as symptom of the dysfunctional system. The mother has no adult social life, and is using her oldest son as her support. There would be no clear boundary between the parental subsystem and the sibling subsystem. The mother would be imposing adult responsibilities on her child. The child is responding and trying to keep mother more involved or less depressed, by using inappropriate means. Also because of the lack of a clear boundary between mother and child, the mother is unable to discipline the child.

Goals - Get mother more involved socially.

Get her to follow up child's misbehavior by corrective actions. This will not only help control his behavior but will distance child from his mother and allow a clear boundary between child and parent.

Directives and support were given by therapist to help mother move in these directions.

Results - Initially good and mother became more concerned about her personal needs and her parenting role than about child's misbehavior. But child began stealing quite seriously again and mother appeared ambivalent re disciplining. Directives were given by therapist and stealing stopped.

Mother continued to seek her own social needs and to act like parent to her child.

Case terminated with invitation to return in case of need.

Family H. The presenting problem was a 12 year old having difficulties at school to the point of his suspension. Referral was by the school as a family problem. The family stoutly resisted uncovering even the smallest family problem, claiming it was a school problem. A good joint meeting with the school was held and the problem was again considered to be a family problem. Subsequent efforts in therapy to focus on child's behavior or on family were completely in vain. Case was terminated with invitation to return when they had a problem.

Joining operations were carefully attempted and since the mother was resistant, joining activities focused on other members. However, the mother controlled the family completely. The problem stage was never reached.

Assessment. This family offered opportunity for assessment while presenting itself as an ideal, completely problem free family. Instead it was assessed as an enmeshed dysfunctional family system. There was enmeshment in that no family member presented even the smallest problem. Likewise all family members responded actively and defensively to the identified patient's school problem by categorically blaming the school. The parental subsystem had no clear boundary between it and the sibling subsystem in that they sided with the child against the school to

the detriment of the child. It was hypothesized that this child had no boundary between himself and the parents and in fact he would be using all his energy to parent his parents. The parents probably had serious hostility between themselves and the child was intervening to decrease this hostility. As a result he had no energy for himself to develop academically or in responsibility as a separate individual. His performance at school was an indicator of this. He was victimizing himself to hold together the family and maintain a dysfunctional family system. Inadvertently the family did mention hostility and alcoholism, but no clarification could be made.

Since the family did not admit to a problem we were unable to go farther. However, since the family is obviously so dysfunctional I expect the problems will escalate and the family will return. This was a most challenging therapy encounter.

In Family F the presenting problem was a six year old girl having learning and behavior problems at school. The family was found to be an unstable multi problem family that included divorce from a wife and child beating husband and father, custody struggles, common law relationship with loss of money on a house, and moving four times to different school areas in one school year, severe friction between identified patient and common law husband's teen age daughter and minor molestation by common law husband's teen age son. The mother's mother was

increasing the mother's guilt and the children's insecurity. The identified patient's long list of problems included physical abnormalities, disobedience and temper tantrums, being very active, poor concentration, poor memory, anti social behavior, no friends, lack of appetite, poor sleeper, nightmares and failing the school year, etc. The mother felt extreme trauma, responsibility, and guilt over the molestation event, even though it seemed to be forgotten by the child.

Assessment. This family appeared at the extreme of the enmeshed-disengaged axis where "the qualities of interpersonal contact seem to be significant in the development of cognitive affective characteristics in the family members."[64] And we recall that Minuchin uses the two parameters for his assessment, and that is "how to preserve individuation and how to support mutuality."

This mother appears to have little of a personal identity, with low self esteem and a great dependency on outside anchoring for definition of self. She feels helpless and incompetent and hopelessly exploited by men, even though she found her second lonely and incompetent male very quickly. She would validate herself by being needed especially in her mothering role. However this mother would not be child-oriented in her mothering role. She would be a mother in a generic sense with little relationship to a sense of being the mother of a particular

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[64] Minuchin, S., Families of the Slums, p. 211.

child and related to according to his individualized needs. For instance a child's evaluation of the correctness of his opinion or the adequacy of his performance requires an experience of bouncing against discrete, interpersonal boundaries. There has to be a confrontation of an "I" and a "you." This would be lacking and as a consequence this child would be confused about his behavior and performance.

Besides this the mother feels absolute responsibility for her child's behavior. For instance a child's failure at school loses the demarcation and boundary of personal responsibility of child and shifts to the mother's responsibility. And similarly, the mother felt the emotional trauma of the molestation far more than the child, in an enmeshed way.

And the mother's unpredictable global presentation of stimuli has a strong influence on the child's cognitive learning style. This prepares the child for a clash with the demands of the school, and prepares for failure through lack of attention and under achievement. (For further clarification of the Disorganized and Disadvantaged Family see Families of the Slums, pp. 192-242.)

Goals - To help mother establish boundaries for her own individuation.

To offer support (avoiding dependency) so mother can move toward individual identity.

To distance mother and help desensitize her about molestation event.

To have mother act as a caring parent and to speak to child about this event and about visiting in bachelor's house.

To have psychiatric and physical assessment of the child as soon as possible.

Problem Solving - Therapist used the painful event (molestation) as a task for the mother to build a boundary between herself and child. But first the mother had to be desensitized so therapist modelled speaking directly and openly with mother alone. The mother appeared relieved. The mother was given task of talking to her child regarding the event and also visiting a bachelor's house. The mother was coached and supported by therapist to have this mother-daughter talk which mother found very difficult. It appeared to be mainly the mother's problem and the mother was more relieved. An appointment was made with a psychiatrist and to an on site social worker who will facilitate the arrangements and will continue to help mother towards individuation.

With Family M the presenting problem was a kindergarten child wetting herself at home after kindergarten. Upon joining it was found that the mother had recently separated from her husband and was feeling guilty about this separation and about

working full time away from her children.

Assessment - This mother through guilt and uncertainty of her parenting role had lost the boundary between her parenting subsystem and the children subsystem. From observation it was noted that the identified patient was telling mother what to do regarding parenting of younger child. As we recall the purpose of a boundary is to protect the differentiation of a subsystem so that it may carry on specific functions. In this family the mother was unable to function as a parent as the boundaries between her and her child were very diffuse. Since decisions had to be made it was hypothesized that the mother tried to explain and democratically get approval from her child. The child was unable to understand for instance, the necessity of the mother's working full time and it was hypothesized that in an attempt to keep her mother home and to exploit the mother's guilt the child began to wet herself. The child was examined by a G.P. and found healthy and was referred.

Goals - To have mother take over her parenting role and set limits for the child.

To be supportive of this unsure single parent and to help allay guilt feelings.

Problem Solving - The mother was directed to take action and not impose too heavy decisions on her child, nor to offer explanations for misbehavior. The action chosen was refusal to change wet clothes immediately. This established a boundary. The

results were that the wetting problem changed quickly. The child seemed much happier in her child role and was not struggling with her mother. The mother was much more at ease and confident in her parenting functions, without the interference from her child.

Problem solved so case terminated.

In Family Q the presenting problem was a Grade 5 boy who was acting strange and doing poorly in school. By strange was meant that he was very childish and immature and made queer noises that made him unpopular with peers as well as teacher. At home he was always wanting something and when he got it he was very unsatisfied with it. He used to lie and steal. He also acts inappropriately when his mother returns from work.

Assessment - The parents are different in age, work, time of work, social interests and showed open conflict, especially regarding child discipline. There were indications from the child that the father was not his father. The father was rigid in every way and the mother was quite inconsistent. Communication and understanding were at a low level. The parents used "avoidance" to stay together. It appeared that the only thing that the parents shared together was the child's misbehavior. We mapped this system as hostility between Mother and Father which invalidated the spouse system, and placed it in jeopardy. But to detour the conflict both parents would attack the child to reduce danger to the spouse subsystem. At times the mother seemed to

seek a coalition with the child against the father to form a cross generational subsystem of mother and son. And the conflict of the parents could again be detoured to the son. It is hypothesized that the child cooperated by playing scapegoat to keep attention off the marital problems and possible dissolution of the family. He was devoting all of his energies to keeping the family together and was not developing academically or in maturity. It is hypothesized that the child was being a problem in order to keep the parents together. Any interactions between child and therapist to check this hypothesis were good.

Goals - To use child problem to get parents to unite to form a parental subsystem.

To later work toward a spouse subsystem.

To get mother to stipulate consequences of misbehavior to help distance her (form a boundary) from her child and to teach child scapegoating is unrewarding.

Give child support and assurances that therapist will take care of family so that he can attend to his own development.

Problem Solving - This was a very fragile family and any effort to foster interaction or communication showed fear, resistance and side tracking. The parents wanted only the child treated and did not think the whole family should be involved. Consequently the father came only once but the

mother and children came for two more interviews. Since I thought it was a family problem I asked them to contact me when they all could come, which they never did. The child appreciated the family focus and stated that if the father loved him he would have come. He also interacted well with mother and therapist.

In Family I the presenting problem is a two year old boy referred by a G.P. and thought to be by parents to be either over active or in need of management and discipline. The child is very determined and throws tantrums. The grandparents and baby-sitters have no problem until the parents arrive. The parents' social life was going out in company which has been curtailed by the child and is adding stress. The family attended a seminar and took holidays which interrupted therapy.

Assessment - The parents have little in common and have neither formed a spouse subsystem nor a parental subsystem. The only thing they have in common is the child and both parents dote on him and cast him into the role of a very important and powerful person. He is not cast into the role of a sibling subsystem. There were signs of hostility between parents which also surfaced when either parent tried to deal with the child and which further eroded the parental boundary, and the spouse subsystem, and rewarded the child's negative behavior.

Goals - Revive spouse subsystem by an appropriate task.

Focus on child problem and have parents unite in task for benefit of the child. This would help form parental subsystem and a boundary between child.

Later make available some parenting skills which seem to be lacking.

Problem Solving - Proceedings were hampered by parents being away on holidays and therapist's time drawing to a close.

Task was assigned to help form a parental subsystem and sibling subsystem, namely to unite and carry out a consistent action in face of misbehavior. Parents found this difficult and task was not carried out. Efforts were renewed and it was felt that parents were unable to function as parents because of the hostility and lack of communication in the spouse subsystem. Because of lack of time referral was made for psychiatric assessment for hyperactivity. Hopefully family therapy will resume.

C. INTERPRETATION

We have reviewed the families in therapy to see what structural changes could be made to solve the problem or to change the family function. We also considered the joining operations and assessments.

In Family D the presenting problem of stealing was solved.

A boundary formed between the mother and her child so that both could function in their respective subsystems. The mother met her social needs by meeting with adults so she did not lean socially on her child and burden him to provide adult company. He could now function as a child seeking his own development. Once the mother had a boundary between herself and her child she could act more effectively as a parent in guiding and disciplining him. It appears that therapy was effective.

In Family H the mother and the entire family presented their family as the ideal family without any family problems. This was obviously a very enmeshed and defensive family with a child displaying the symptom at the interface with the school. The problem at school was declared to be the teachers' problem only, or teachers picking on the child. When therapist sought family or child involvement the defenses of the family became impregnable. Perhaps reframing or the use of paradox could have been used in the face of such an enmeshment. The therapist was unable to get the family to admit a problem and was in this sense ineffective. However, since there was no presenting problems, there was no family problem to solve. The effectiveness of this therapy will be judged better at a later date when this progressively more dysfunctional family will seek help again.

In Family F, which was a multi problem unstable family, two of the problems were focussed on. The first of these was the mother's hypersensitivity and guilt over the molestation event.

The mother was first of all desensitized with apparent relief. The mother was able with coaching to act as mother to her child in guiding and talking about a very sensitive issue. This appeared as effective therapy.

The second problem focussed on was that of the physical problems of the child. A referral was made to a child psychiatrist with the suggestion of further social work intervention after that.

In Family M the mother was feeling responsible for the child's misbehavior and was becoming more controlled and more enmeshed. Through support the mother was able to take on her parenting role and establish a clear boundary between herself and her child. The wetting problem was solved quickly, and this could be effective therapy.

In Family Q, which was a very fragile family, the father was lost from therapy after the first session. Good efforts were made for joining, but in retrospect it appears that the assessment did not recognize the fragility of the marriage nor the rigidity and inability to work together at that time. There obviously was no therapeutic contract reached and interventions to get the parents to work together on the child problem was too challenging too soon. This would have to be classed as ineffective therapy. However, the child and the mother uncovered some problems that they began to work on.

In Family I the joining operations were adequate, but the assessment did not portray the seriousness of the dysfunctioning and hostility in the spouse subsystem. This in retrospect appeared

to be the parents main concern. Without dealing with this first the parents were not able to work together regarding their child's behavior. In contrast to the previous family, this one needed a challenge to help form a spouse subsystem so that they could form a parental subsystem with a boundary between them and the child. The impact of the interventions was dissipated by the interruptions. If therapy could have continued better results may have ensued, but since the problem was not solved, this can not be classed as effective therapy.

D. OUTCOME FOCUS

Jay Haley recommends that every therapy student check outcome to see if he has produced a change in the families he has seen. The purpose is to produce therapists who think about the outcome they want and as it will appear months or years from now. He suggests that where there is a group of students they can do follow up interviews with each other's cases.

> Focussing on outcome forces the therapist to orient toward change, to formulate problems that can be changed, and to think about how the people he is assisting now will manage without him in the future. It also helps a therapist think experimentally. If his outcome is not good, he can change his procedures to do better.[65]

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[65] Haley, J., Problem Solving Therapy, p. 186.

CRITIQUE

From the very beginning Family Therapy was used when other forms of treatment had failed. The two areas in which family therapy was most successful were families with a schizophrenic member and families with a child with delinquent behavior. Nathan Ackerman, on the other hand, looked at the characteristics of certain families and has noted a number of contraindications for family therapy. For most of these, it is not that the family therapy approach would be harmful but rather that it is likely to be unsuccessful and unworkable. He lists the following characteristics:[66]

(1) The presence of a malignant, irreversible trend toward the breakup of the family, which may mean that it is too late to reverse the process of fragmentation.

(2) The dominance within the group of a concentrated focus of malignant, destructive motivation.

(3) One parent who is afflicted with an organized, progressive paranoid condition, or with incorrigible psychopathic destructiveness, or who is a confirmed criminal or pervert.

(4) Parents, one or both, who are unable to be sufficiently honest; lying and deceitfulness that are deeply rooted in the group negate the potential usefulness of family therapy.

(5) The existence of a certain kind of valid family secret.

(6) The existence of an unyielding cultural, religious, or economic prejudice against this form of intervention.

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[66]Nathan W. Ackerman, Treating the Troubled Family, Basic Books Inc., New York, 1966.

(7) The existence in some members of extremely rigid defenses which, if broken, might induce a psychosis, a psychosomatic crisis, or physical assault.

(8) Finally, the presence of organic disease or other disablement of a progressive nature that precludes the participation of one or more members.

Many family therapists do not share this view of contraindications to family therapy, but rather see the issues raised by Ackerman as challenging problems in the conduct of family therapy programs.

Because of this divergence of opinion there has been a great increase in the production of family therapy outcome research. Efforts have been made to demonstrate specific areas of superiority in outcome over other available treatments. Three ways have been identified in which one form of therapy may be superior to an alternate treatment.[67]

First, two therapies may be compared in order to determine which delivers the greatest absolute amount of improvement.

Second, a therapeutic approach may be equal in outcome to an alternative approach but could be superior in efficiency. Efficiency could be demonstrated by (a) less time in therapy is required, (b) less highly trained personnel are employed, and (c) less costly therapists are needed for intervention.

Third the approaches might again be equal in outcome, but one approach might have less side effects than the other. For

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[67] The Results of Family Therapy Revisited: The Nonbehavioral Methods, by R. A. Wells and Alan Dezen, Family Process, September 1978, Vol. 17, 3.

instance there could be fewer signs of deterioration and hospitalizations, etc.

Despite the increased production of family therapy outcome research the conclusions that can be drawn continue to be limited and restricted to particular areas and are sometimes inconsistent. But at a broad level family therapy has been legitimized and can no longer be viewed as a rank newcomer of uncertain validity and doubtful status.[68]

One of the main reasons for the lack of solid data on which to lease valid consistent conclusions is found with the proliferation of schools under the umbrella of family therapy. Family therapy as an entity can scarcely be said to exist. Even the primary goals of family therapy differ according to the various schools.

But in spite of the difficulties there is evidence that family therapy is as equally effective as other forms of therapy in dealing with families with children. There are two areas which show strong treatment effects. These are especially apparent with psychosomatic disorders in children and with adolescents.[69] However among 297 family therapists surveyed there was an "almost universal feeling among the respondents that family therapy is more effective, and that results can be seen more quickly and often more clearly. They are comfortable with the method and feel that

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[68] Ibid, p. 262.

[69] Ibid, p. 266.

it 'makes sense' theoretically. Although it is usually not practised exclusively, it is felt to be the preferred treatment forcertain families."[70]

When we consider Structural Family Therapy in particular, we recognize that it is the third model or the organismic model.[71] According to Levenson, family therapy has shifted from the communication model which focussed on the failures of communication to the organismic model which focuses on control and organization within the family. This newer model is concerned with the patterns of consequence and is considered to be more effective therapy than the communication model.

Because of this newer approach and focus on organismic relationships there is less likelihood that the focus will remain strictly on the identified patient who often is the family scapegoat. Therapy will consider the family as "a perspectivistic whole and the family membersas transformations of each other."[72] There will be less chance that the victim will be victimized further as could happen in some other forms of therapy.

Because structural family therapy is considered to be more effective it can be considered as a short term therapy. This short term therapy can have many advantages, including less

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[70] The Field of Family Therapy by the Group for the Advancement of Psychiatry, Vol. VII, Report No. 78, March 1970.

[71] Levenson, The Fallacy of Understanding, pp. 68-70.

[72] Ibid., p. 67.

intrusion in the family and less creation of dependency which will have to be broken.

Structural family therapy was developed with the very poor unstable and disorganized families. The techniques that are used do not require a high degree of communication skills, nor other social skills. Instead very simple behaviors are required which make this type of therapy effective with the multi problem families who have often been thought to be beyond help. Another group of families that Structural Family Therapy has claims to be highly effective with is the family with an anorectic child. Their claimed success rate is often four times higher than other forms of treatment. However, we have not been able to find comparable studies that validate such claims.

Another claim of Structural Family Therapy is that it is a logical practice that can be taught to students of family therapy. The Philadelphia Child Guidance Clinic holds to this claim and trains family therapists from North America and Europe. However, because of the many applications for admission the clinic is able to be very selective of the students to be trained. And in contrast to psychoanalysis which was considered to be a medical practice, the students of Structural Family Therapy are listed as social workers, psychologists, psychiatrists and others. There are many advantages to having therapists from different disciplines, especially in co-therapy situations.

Another positive consideration for Structural Family Therapy is that in spite of dealing primarily with a nuclear family of

any pattern, the therapy often includes the extended family and the significant others such as the school teachers, etc. This type of therapy readily utilitzes an ecological approach to reach its goal.

But all models of therapy are more or less inadequate and must constantly be revised and updated. Structural Family Therapy has weaknesses as well as the strengths mentioned above.

One weakness which is noticeable is the gap or time lapse between theory and practice. Structural Family Therapy has developed as a practice and then has searched for a theory. Fortunately it has avoided the pitfall of allowing practice without theory. However, there is room for more systematic research, better conceptual models and a higher priority for theory. It is noted that practice without theory has wounded the encounter movement and can be a caution to Structural Family Therapy. Family Therapy must always be the result of an interplay of theory and practice. The clinicians and thinkers can not sit in ivory towers and theorize nor can they ignore the demands of theory in their practice.

Another perceived weakness of Structural Family Therapy lies in the notion that it is an effective short term therapy in all cases. It happens that there can be an apparent change in family structure with a consequent improvement in symptomatic behavior. In these cases there is termination too soon as only an immediate goal was attained. Very often long term goals were not considered nor of course achieved. Likewise with short term therapy a goal may be achieved on a superficial level, but the older well

engrained pattern of dysfunctional behavior will recur causing a relapse into the presenting problem, or a similar problem may surface. There is a feeling among other therapists that there are instances where therapy should have continued longer. On the other hand family therapists maintain that symptomatic improvement is rarely or never a goal.

There are a number of weaknesses cited by therapists who prefer the individual approach versus the structural family therapy approach.

One of these questions the very basic hypothesis of structural family therapy. It is questioned whether the traditional family structure is an adequate model of functioning or whether it is an historical anachronism. For instance should there be a spouse sub-system and a parent sub-system that has clear boundaries from the sibling subsystem? And further should this parent sub-system be invested with executive functions that makes decisions for the whole family? The Adlerian approach used by Rudolf Dreikurs for effective parenting on the other hand recommends a very democratic approach. He recommends that all decisions made involving the family should be made democratically and at a weekly family council meeting where parents and children participate quite equally. Structural Family Therapists hold that democracy can place too heavy a burden on children, often subjects them to an adult responsibility, that they are incapable of handling. This view could in some instances provide the excuse for an historical authoritarian approach, which was more successful in the past

than in the present.

Another shortcoming of Structural Family Therapy is based on the assumption that each family is an adequate system capable of carrying on the four major tasks of support, regulation, nurturance and socialization. Using this assumption Minuchin claims:

> Hence the therapist joins the family not to educate or socialize it, but rather to repair or modify the family's own functioning so that it can better perform these tasks. ...the family system has self perpetuating properties.[73]

Others disagree with this optimistic view that the therapist is needed for minor repairs or modifications that will be maintained in his absence by the families self regulating mechanisms. It is claimed that there is a great need for parent education, marriage enrichment and communication and emotional education programs. Besides there are some families plagued by mental retardation, mental illness and instability that make them incapable of performing the major tasks of the family system. These families would need more intervention than to "repair or modify the family's own functioning."

Other weaknesses of the individual versus the family approach has been called therapeutic fadism based on the notion of "either-or" or "this or nothing" stance. For instance in cases where there is a conflict over individual autonomy and differentiation of a child there could be a contraindication to conjoint

[73]Minuchin, Families and Family Therapy, p. 14.

family therapy which may cause further psychological fusion. Family therapists believe that genuine individuation can best be achieved by working with the family conjointly so that the patterns and bonds that bind them together can be altered on a fundamental and emotional level. Other therapists contend that differentiation and individuation can only be achieved by geographic separation.

Again therapists who work particularly with couples quite often believe that a long standing marriage must have at least a basis for love and satisfaction even though this may be well obscured by bickering. Some family therapists may be biased in favor of continuing the current marriage and family and may only continue therapy as long as the present family system remains intact.

In contrast other therapists take a very neutral stance about whether or not a family or married couple stay together. They continue therapy in the belief that the marital pair will make a more sensible choice about staying together or not. And if divorce is decided upon then divorce counselling will also be offered. This approach seems to accept that divorce is a fact of life, and is a time of therapeutic need.

From the above shortcomings it is clear that polarization at the extreme of family therapy alone can not serve the client in every case. Family theory combines two bodies of knowledge:

personality dynamics and multipersonal system dynamics.[74] Some proponents of family theory emphasize the transactional or multi-personal level as a replacement for, rather than an addition to the knowledge about the individual system level or mental organization. What hopefully will ensue will be a synthesis of familial and personal levels of conceptualization that will integrate the compatible elements of the two approaches. The thorough integration of these two systems levels into a comprehensive theory is a long range task. Both of these fields have to develop conceptually as well as methologically before a mature integration can take place.

The ideal goal for any helping profession will always be the prevention of disorders. This will depend more on large scale social planning than on therapy itself. Knowledge obtained from the study and treatment of families and their structures may provide the relational point of view without which any social planning may miss its best points of leverage. For instance Structural Family Therapy understands the role of the male in all families. However, in impoverished families, welfare payments can usually only be made to fragmented families in which the male is absent. This effectively destroys family structure and may lead to troubles that are very costly in human and financial resources.

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[74] The Field of Family Therapy, by the Group for Advancement of Psychiatry, p. 565.

Family therapy has developed and shown good growth over the last three decades. It has moved from the strict communication model to the Organismic model. Structural Family Therapy is an example of this newer model. Because of its perceived effectiveness family therapy is the preferred approach of a great many therapists. This has created such a great impact that psychiatry is radically shifting from individual to relational psychology as its theoretical understructure.

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