Structural Family Therapy

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Structural Family Therapy was developed by Salvador Minuchin and colleagues during the 1960s as part of the growing interest in systemic ways of conceptualising human distress and relationship dilemmas, and in working therapeutically with those natural systems and relationships, thought to give rise to distress. Structural family therapy is underpinned by a clearly articulated model of family functioning, and has been developed and used most consistently in services for children and families. A growing body of empirical evidence attests to the efficacy of structural family therapy. As an approach it was extensively critiqued during the 1980s by feminist writers and during the 1990s by those interested in the implications of a social constructionist position. Structural family therapy continues to evolve in response to challenges mounted from within and outwith the systemic field, and as part of integrative practice and multi-systemic approaches, with practitioners ever mindful of the need for regular feedback from family members themselves.

Introduction

Structural family therapy is a body of theory and techniques that approaches individuals in their social and relational contexts. It was developed in the context of therapeutic work with families and young people. It is predicated on family systems theory, and brings with it many of the strengths and weaknesses associated with the appropriation of general system theory (von Bertalanffy, 1968) into the realm of social behaviour. This article reflects my interpretation of structural family theory and therapy, modified by my longstanding and continuing use of the ideas and methods. For me, the central creative thesis of structural family therapy is embodied within the paradigm shift of the relational therapies, that distress can be understood not only in the context of the relationships within which it arises and is maintained, but also in seeing the potential for relationships to be the cause of distress. The excitement and challenge of structural family therapy is in the focus on family members' interaction and in the broad definition of communication to be more than what we say and the way in which we say it.

Structural family therapy is an approach mainly identified with the work and writing of Salvador Minuchin, although many other influential thinkers have worked in association with the development of the ideas, such as Jay Haley, Braulio Montalvo, Lynn Hoffman, Marianne Walters, Charles Fishman and George Simon. Many of the concepts are familiar, such as family rules, roles, co-alitions, triangulation of conflict, subsystems and bound-aries, organisation, feedback, stability and change. How-ever, the thinking and practice of a structural family therapist will likely be characterised by formulation of family members' difficulties in terms of family structure and dynamic organisation and a preference for working in the here and now. At this point, I wish to note that in my experience in the UK, few working family therapists adhere rigidly to one school of thought; rather an integrated pragmatic approach to conceptualisation and practice is more likely, with a consideration of the fit between family members' style and preferences, therapist style and the nature of the difficulties driving the domi-nance of one family therapy model over another. Nor would I want this article to reflect the view that family therapy, of whatever approach, is always the treatment of choice when confronted with human distress. It may be the treatment of choice, or it may be part of an integrated package of care.

Model of change

The term structure refers to the organisational charac-teristics of the family at any point in time, the family subsystems, and the overt and covert rules that are said to

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influence interpersonal choices and behaviours in the family. Thus an aim of this therapy is to alter the organisational patterns, particularly where the modes of communication are thought to be unhelpful and where behaviours are considered to be abusive and neglectful or to have the potential to be so. When the structure of the relational group changes, the positions of members in the group changes. Thus it is said, each individual's experience changes and therein lies the potential to alleviate symptomatic distress. Structural family therapy works with the processes of feedback between circumstances and the people involved, tracking how changes made to our circumstances feedback into choices and decisions about further change.

This is a competence model, encouraging people to explore the edges of their known repertoires of responding, assuming that family members have the ability to innovate and draw on less tapped interpersonal and intrapersonal resources. Enactment as a structural family therapy technique is seen as central to this model of change (Simon, 1995) i.e., encouraging family members to problem solve and generate alternative responses to each other in the relative safety of the therapeutic relationship. Thus intervention is promoted at three levels: challenging symptomatic behaviour, challenging the family structure, and challenging family belief systems. The therapy is based on the tenet of action preceding understanding, and vice versa, with the use of cognitive techniques such as reframing. Family members are encouraged to think beyond symptomatic behaviours and current complaints and see their behaviour and choices in the context of family structures and process and in the relationships between the family group and other societal systems. The structural family therapy model of change does not exclude other models of change and structural therapists can work alongside other therapeutic approaches to change as part of a co-ordinated package of care.

Principal features of structural family theory

The theory is based on the clinical experience of Minuchin and his associates with families in distress. The development of the theory can be traced through their major publications: *Families of the slums* (1967), which focused on issues of parental authority and leadership in Black American women who headed lone parent families where children were in trouble with the law; *Families and family therapy* (1974), which outlined the key constructs, such as enmeshment and disengagement; *Psychosomatic families* (1978), where conflict, its avoidance and resolution, and styles of parent-child interaction are described; *Family therapy techniques* (1981), which detailed the different techniques of structural family therapy; *Family kaleidoscope* (1984), which brought family systems thinking to a general readership; and *Mastering family therapy* (1996), which provided a revision of some of the earlier principles and methods of the approach.

The key features of the approach can be summarised thus:

- The family is seen as a psychosocial system, embedded within wider social systems, which functions through transactional patterns: these transactions establish patterns of how, when and to whom to relate, and they underpin the system;
- The family tasks are carried out within bounded subsystems;
- Such subsystems are made up of individuals on a temporary or more permanent basis, and members can be part of one or more subsystems, within which their roles will differ;
- Subsystems are organised hierarchically in a way that regulates power within and between subsystems;
- Cohesiveness and adaptability are key characteristics of the family group, within which the balance between emotional connectedness and developing autonomy is seen to change as family members mature and live through life cycle transitions.

Minuchin writes about family structure metaphorically, as a device for describing family interaction in the here and now. His writing is *less* concerned with how family members evolve their interactional style and negotiate their interpersonal tasks and expectations. The boundaries of a subsystem are said to be the rules defining who participates and how. The function of boundaries is to protect the differentiation of the subsystem. Every family subsystem is said to have specific tasks and make specific demands on its members; and the development of interpersonal skills achieved in these subsystems is predicated on the subsystem's freedom from interference by other subsystems, as might be seen with a diffuse subsystem boundary. According to this approach, proper functioning within subsystems implies clear boundaries. Clarity is seen as more important than composition, for example, the responsibility for proper supervision and care of the children needs to be identified with person/s able to sustain and discharge such responsibilities. Family subsystems might include: parental, couple, parent-child, grandparent, male/female, organised by history, power, hobbies, interests and so on. Relationships between and within subsystems can be described as affiliations, co-alitions, with patterns of conflict resolution, detouring, enmeshment and disengagement.

The notion of a couple subsystem straddles different modes of family household composition and recognises the needs of adults for affection, confiding relationships, shared decision making and is seen as the primary mediator between the household group and the outside world. The parental or executive subsystem is vested with the authority for the care and safety of the children and fulfils major socialisation requirements within the family. If more than one person is responsible for caring for the children, this approach stresses the importance of teamwork and the ability to negotiate conflicting interests. Adaptability is seen as necessary because of developmental changes in the children and pressures of age related expectations from societal institutions. The parent/child

subsystem is the context for affectional bonding, gender identification and modelling, and where children learn to develop a degree of autonomy within unequal power relationships. The sibling subsystem was highlighted as an important social group early in the writings of Minuchin and colleagues, long before it attracted the interest of current researchers (see Brody, 1996). This is seen as the social context within which children learn to co-operate, compete, resolve conflict, cope with jealousy, and prepare for peer related activities and friendships as they mature.

The structural approach assumes families and family members are subject to inner pressures coming from developmental changes in its own members and sub-systems, and to outer pressures coming from demands to accommodate to the significant social institutions that have an impact on family members. Inherent in this process of change and continuity are the stresses of accommodating to new situations. The strength of the family system depends on the abilities of family members to mobilise alternative transactional patterns when internal and/or external conditions of the family demand restructuring. A family is said to adapt to stress in a way that maintains family continuity while making restructuring possible. If family members respond to stress with rigidity, for example, by reapplying 'old' solutions, unhelpful transactions may ensue. Symptomatic behaviour is seen as a maladaptive reaction to changing environmental and developmental requirements, and thus the presence or absence of problems does not define normality.

Thus we can see that the 'as if' notion of structure is helpful in providing a framework for thinking about belonging and loyalty, proximity, exclusion and abandonment, power, aggression (as reflected in subsystem formation), the relative permeability of boundaries, working alliances and coalitions. In the 1996 publication *Mastering family therapy*, Minuchin and colleagues made a commitment to the original formulation of family functioning, with a shift in perspective in the following areas of therapist functioning:

- Modified intensity of therapeutic encounters;
- A more fluid commitment to a key 'alphabet of therapist skills';
- An increased use of the self of the therapist in therapy, with a greater emphasis on feedback to family members of the effects of interaction on the therapist, aimed at offering more information about their interactions with one another;
- An increased interest in supervision, aimed at developing the therapist's under-utilised skills;
- Admission of his own impatience and speed in reading non-verbal cues;
- The recognition of relative perspectives, with the structural frame as an organiser of therapists' perceptions rather than universal truths;
- The role of the therapist in activating the family members' own alternative ways of relating: 'While the

therapist has ideas and biases about family norms, and about the best family fit, she can only go in the direction that the family indicates when they enact their drama and show possible alternatives' (Minuchin, Lee, & Simon, 1996).

Assessment for therapy

Structural therapy posits that for therapy to be effective, the therapist needs to form a new system with the family group (family plus therapist system). In order to do this, the therapist relies on techniques of accommodation and joining. Accommodation is said to be the process of adjustment of the therapist to the family members, which includes: a) planned support for the family structure i.e., offering support for what is going well, and helping to create changes in structures that will work; b) carefully tracking the content and process of family interaction; and c) accommodating to the family members' style and range of affect through mirroring. Joining refers to those actions of the therapist aimed directly at relating to family members. The therapist must therefore be aware of taking sides, and must offer support at times when being confrontational. This emphasis on the importance of the therapeutic relationship recognises its potential as a vehicle for therapeutic change.

Structural therapists assess and explore the family's structure (for example, subsystems, boundaries, functions, relationships, external relationships and social support) to identify areas of strength and resilience, possible flexibility and change. Assessment includes: a) family members' preferred transactional patterns and available alternatives; b) flexibility and the capacity to change, often based on responses to earlier demands for change within the family group; c) family members' sensitivity to members' needs, behaviours, attitudes, and so on; d) developmental issues, tasks and requirements; e) the meaning and relational significance of symptomatic behaviour; and f) the context of family life, with specific reference to sources of social support and sources of stress. Pitfalls within the assessment process can include: a) ignoring the developmental processes of family members and changing family subsystems; b) ignoring some family subsystems; and c) joining and supporting only one family subsystem.

Therapeutic change is seen to be a delicate process, whereby too little involvement by the therapist will lead to maintenance of the status quo and too much involvement and directiveness might lead to panic and premature ending of therapy by the family members. Change is thought to occur through the trusting relationship with the therapist, within which a context is created to actualise family transactional patterns through enactment and re-enactments, to recreate communication channels, to help members manage psychological distance and space, to delineate and reinforce individual and subsystem boundaries, such as helping a lone mother regain her parental authority with her children, to create therapeutic intensity by emphasising differences and exploring conflicts and

their resolution, to offer support, education and guidance, and to assign agreed tasks and opportunities to try out new solutions developed within the session between sessions.

Fish and Piercy (1987) used a Delphi procedure to examine the similarities and differences in the theory and practice of structural family therapy and strategic family therapy in the United States with the help of a panel of knowledgeable and well known structural and strategic therapists (which included practitioners of Milan family therapy). Of interest here are the findings that: a) structural panellists endorsed differently those theoretical assumptions that pertain to subsystems, hierarchy, boundaries, and families as organisations; b) structural panellists endorsed different goals of therapy, which included reorganisation of the family structure, the lessening of rules/roles constrained by narrow bounds of transactions, and resolution of the presenting problems through structural reorganisation; c) all panellists endorsed relabelling and reframing as a shared therapeutic technique, whereas structural therapists did not endorse any indirect techniques, only direct methods of working; d) all panellists endorsed a view of therapeutic change occurring when unhelpful sequences of interaction were altered, through a change in both family members' behaviours and perceptions. This study provides an interesting glimpse into the panellists' perceptions of family therapy practice in the mid 1980s, at a time when all schools of family therapy were reorganising to take account of the recent major critiques of thinking and practice.

Challenges to structural family therapy

Like most schools of family therapy, structural therapy was critiqued during the 1980s by feminist commentators (Hare Mustin, 1987), and by those concerned with issues of race and culture (Holland, 1990). The thrust of the feminist informed critiques was that family theorists and therapists had paid attention to issues of power and the effect on relatedness *between* the generations, i.e., the politics of growing up, but had systematically failed to address the issue of power *within* same generational relationships, such as couple relationships. Although it should be said that a power skew in either direction of the couple's relationship was seen as more likely associated with widespread distress and general problems within the family. The gender informed critique coincided with a growing body of demographic data that identified high rates of physical violence from men to their women partners (Straus & Gelles, 1990). This was a serious omission within the field, that has been addressed recently. See the work by Goldner (1998) and that of Vetere and Cooper (2000), which privileges the issues of responsibility and safety, when working with abuses of power in family relationships, and seeks to find ways of giving voice to women as they regain their parental authority with their children, and to redress relative power inequalities within couple relationships.

The challenges to structural family therapy have come from different quarters. The approach to assessment has been criticised as located solely within the household family group, ignoring the roles of extended family, neighbourhood and other social institutions and leading to an incomplete picture of the presenting difficulties. The problem here, in my view, lies more in the local application of the ideas, as there is nothing in the theoretical language and model that constrains assessment of wider systemic issues in the therapist's formulation (Vetere, 1992).

The direct and involved therapeutic style of the structural therapist does not find favour within the UK, amidst concerns of therapist burnout. Earlier excesses of enthusiasm around the therapist as leader and director of the therapy have led to moderation in the description and promotion of structural therapist style. Research by Hampson and Beavers (1996) has highlighted the importance of the fit between family members' emotional style and that of the therapist. The influence of constructivism and social constructionism have been profound, in that the focus on issues of therapist reflexivity have led to profound changes in how we think about our own a priori assumptions about families and cultural norms and in our increased search for integration of theory. However, an overemphasis on the value of uncertainty and uniqueness, often associated with postmodern critiques, runs the risk of injustice by assuming that abuse and issues of structural inequality can be seen as one narrative amongst others (Minuchin, 1991).

Arguably, many family therapists are interested in integrative practice, both within the field of family therapy and across the major psychotherapeutic domains (see Larner, 2000). Thus the structural focus on the here and now, in the description and attempted alleviation of symptoms, limits the ability to explain and predict symptomatic behaviour and possibly leads the therapist to search for other models that address these issues. In the absence of well articulated attempts to integrate theory at the conceptual level, this criticism remains a problem of application and practice. Therapists seem more interested in seeking multi-dimensional views of family members' behaviour and general functioning and tailoring their approaches to families rather than slavishly following 'schools'. There is no doubt in my mind that theory can be used narrowly and prescriptively; the challenge lies in using theory in an elaborated and sceptical way, such that we can be held accountable ethically for the connections between our thinking and our practice.

Another set of challenges have revolved around the structural view of problem maintenance and the purported function of symptomatic behaviour. The notion that the system is maintained by the problem has been popular within structural thinking, with a recognition that symptomatic behaviour is often the ironic consequence of attempts to solve problems and adapt. The punctuation of this thinking has been criticised for failing to acknowledge

that symptomatic behaviour may take on functional significance within the family group, or that a structural therapist may see dysfunction where none exists i.e., a family group is temporarily off track, so to speak. The structural focus on competence and strengths within the family is likely to temper this criticism, although Gorell Barnes (1998) highlights that an assumption of resilience may not be born out in practice, particularly with more fragile family forms, such as some newly formed step-family arrangements.

It is of interest to me that Minuchin has always been interested in his writing in the social and economic conditions that support family members' functioning. In particular, his awareness of the unrelenting and numerous external pressures on poor inner city families, that lead to problems in family functioning, and the legal context of the Courts and social policy changes around substitute care that serve to undermine the functioning of/and break up poor families (Minuchin, 1992). Structural therapists have always advocated cultural relativity in their practice, asking, does this family's structure, at this time, in this particular cultural and social grouping, sufficiently meet the needs of family members? However, recent critiques have questioned the extent to which any notion of structure, with its associated implications of norms and normality, can be helpful when addressing issues of cultural diversity.

An illustration of structural family therapy

The following excerpt is from an early therapy session with a family, self referred over their concern for Caroline's drinking problem. It is preceded by some information about the family to help the reader put the therapy session into context.

The household members are the mother and father and their adult younger daughter, Caroline, 22 years old. Jean, her older sister by two years, moved to live in independent lodgings over a year ago. Jean has a successful career in a software company. Caroline misses her sister. Caroline cannot help but compare herself adversely with her older sister. Caroline struggled with a college course in art and design and, since leaving, has not been able to find employment. Both parents are employed in a professional capacity. Caroline describes her drinking problem as a direct result of believing she has nothing to get up for in the morning.

The family therapy complements Caroline's individual work with her alcohol keyworker. The family work was requested by all family members as they wished to think together about the consequences of Caroline's drinking for family relationships and to understand how best to support her in her recovery. Initially tacitly, and then subsequently, overtly, the parents wished to understand whether their relationships with their daughter had somehow made it more likely she would turn to alcohol

for solace in the face of distress and disappointment. The alcohol keyworker made the referral to the family therapy team when Caroline had been abstinent from alcohol for a period of 2 months.

The family therapy team uses an integrative approach; however, this excerpt, which occurred in the third meeting with the family, is chosen to emphasise the structural aspects of the team's thinking and practice. In the early stages of the work, the team focused on family members' roles, relationships and expectations of each other, both in the context of their recent life cycle changes and the iterative, problem maintaining effects of drinking. Early in the third session Caroline said that she did not know how any of her family felt about anything any more, what they felt about their jobs, their lives, about each other, about her. Caroline's mother replied in a hesitant way that talking to her these past few years had been like walking on egg shells, unpredictable, uncertain and never knowing what would upset her, leading her mother to believe it was safest and prudent not to discuss anything of a potentially sensitive nature. Caroline listened to her mother intently, and then expressed deep regret at the loss of contact and personal understanding of each other that seemed to have crept up on them all. Jean looked at Caroline, seemed to take a deep breath, and said directly and clearly, that she wanted to talk to Caroline, not Caroline plus the bottle. At this point, the therapist asked the two sisters if they wanted to continue this discussion without having to talk over their parents, who were seated between them. Jean moved with alacrity to sit next to Caroline, and in what seemed like a gesture of support and intimacy, held each other's arms. They continued to talk further to each other about the importance of their relationship as sisters, their wish to confide in each other, their wish to support each other, thus reclaiming some of their past sense of closeness. In recognising how alcohol had come between them, as Caroline had seemed to form a primary relationship with alcohol, which she now wanted to challenge in her wish to reconnect with her sister, Caroline drew on the support of the therapist and the team as a bridging relationship to her family members.

Further on in this session, the father produced a set of house rules that he and his wife had agreed and then given to Caroline in an attempt to help her maintain her abstinence and to continue to live with them. The therapist asked about the rules, whose ideas were they, and what did Caroline think? Caroline said she had agreed to the list of rules and that she respected them. In our view this seemed to be linked to Caroline's attempt to reclaim her own sense of self-respect and to develop a different voice in her own family. Caroline took the list from her father and read out the first few rules to the therapist. The first one was 'To behave like an adult'. The therapist asked what this meant. Caroline paused and seemed very thoughtful. She raised her head and looked at everyone, 'It means to take more responsibility for my behaviour'. This generated much discussion, and afforded an opportunity for Caro-

line's father to praise her definition, saying it was much better than his, previously offered one. Caroline thought her father's praise was important, as she had previously described her father to the team as overly critical of her as a growing young woman. This interaction led the team to speculate that perhaps Caroline's father had an uncertain sense of his importance to his developing and now adult daughter. This theme was explored in subsequent meetings where we learned that Caroline's father had been raised as an only child, with an authoritarian father, as he saw it, with whom he had only made a more adult relationship in his mid-thirties. Caroline's father told us he had left home to get married to Caroline's mother. Thus connections between the generations and their remembrance and understanding of developmental transitions and relationship changes formed another bridge between Caroline and her mother and father.

This small excerpt can only offer a flavour of the complexity of the family work. The team's thinking complemented the family's focus on roles, communication and relationships, and how the transition into adulthood for Caroline had challenged family members' expectations of her and each other. Much that was hurtful had been said during periods of intoxication, and communication withdrawal had characterised periods of sobriety, creating an equilibrium within which nothing seemed to change or could seem to change. In our view, Caroline's commitment to working with her keyworker formed the first step in re-orienting her to relationships with people, thus paving the way for the family work to create a context for coping and support that facilitated forgiveness, reconciliation and hopefulness for the future.

Applications and efficacy

A recent survey of family therapists' practice in the UK identified that 21% of respondents identified themselves with structural family therapy (Bor, Mallandain, & Vetere, 1998). Jonathan Dare (1996) lamented what he saw as the decline in structural family therapy practice in the UK and his perception of common misunderstandings about such practice, such as the belief that structural therapists imposed Eurocentric middle class beliefs on everyone else. However, a significant minority of UK family therapists and systemic practitioners identify a primary loyalty to this modality, alongside a growing body of empirical research that attests to the efficacy of structural and behavioural based approaches to working with families. The field of outcome research does not differentiate between the earlier schools of family therapy, such that reviews include structural, strategic and some Milan based therapies with both families and couples.

According to Bergin and Garfield (1994), the marital and family approaches have been subjected to rigorous research scrutiny, with only a few forms of psychotherapy studied as often. Studies report the use of controlled and uncontrolled group comparison designs, single case de-

signs, and a few studies comparing the relative efficacy of the different family therapy approaches. The overwhelming findings from the research reviews and the meta-analytic studies is that family therapy works compared to untreated control groups, with some demonstrated superiority to standard and individual treatments for certain disorders and populations. Meta-analysis demonstrates moderate, statistically and clinically significant effects (Markus, Lange, & Pettigrew, 1990; Shadish et al., 1995; Goldstein & Miklowitz, 1995). The following list of people and problems is found to benefit both clinically and significantly from the marital and family therapies compared to no psychotherapy: marital/couple distress and conflict; outpatient depressed women in unsatisfactory marriages; adult drinking problems and drug misuse; adolescent drug misuse; adult schizophrenia; adolescent conduct disorder; child conduct disorders; aggression and non-compliance in children with a diagnosis of ADHD; chronic physical illness in children; obesity in children and cardiovascular risk factors in children. Marital and family therapy appears not to be harmful, in that no RCT study has reported poorer outcomes for treated clients than for untreated control family members (Pinsof & Wynne, 1995).

In my view, the structural model is attractive because it is parent-friendly, with its emphasis on team working and practical problem solving. It is a contractual and time limited model, it emphasises the importance of giving clear feedback and responding to the presenting problems, it is a consciousness raising model for families and organisations, and avoids using covert methods of intervention. It meets many of the criteria identified by Reimers and Treacher for 'user friendly approaches' (Reimers & Treacher, 1995). As Minuchin (1998) argues, it focuses on family interaction and multi-channel communication processes and keeps alive the value of family process for therapists in these days of the narrative therapies. Its applications have been wider than its original formulation within the field of child and family mental health, including the services and problems listed above and, in my experience, in services for people with learning disabilities (Vetere, 1993). *Family therapy in the 90s*, edited by John Carpenter and Andy Treacher, identifies further applications of the approach for the interested reader.

Sigurd Reimers, writing in the first number of the 2000 edition of the *Journal of Family Therapy*, comments that practitioners should never forget family therapists' excesses of certainty that preceded the postmodern challenges. In his view, collaboration with family members will be the most treasured contribution offered by recent advances, alongside the more explicit recognition of the 'as if' quality of our ideas about families and family members (Reimers, 2000).

Whilst agreeing with Sigurd Reimers, I would add to his reflections an enduring belief in the helpfulness of the notion of scepticism, born out of my training as a social

scientist within the tradition of British empiricism. It seems to me that amongst the clinical competencies we seek in ourselves, and in those whom we train as family therapists, are the abilities to be curious about what we do, to ask questions, to refine those questions in the light of observation and experience, to evaluate and re-evaluate our understandings, constantly checking with all participants as we go along. This list, for me, also describes a structural family therapist.

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