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A REVISIONIST RENDERING OF STRUCTURAL FAMILY THERAPY

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The popular view of structural family therapy sees the structural diagnosis of families as lying at the heart of this therapeutic approach. This article challenges that view. It argues that the practice of structural family therapy is driven not by structural diagnosis but by two fundamental assumptions about human and family functioning: the assumption of competence and the assumption of uniqueness. Consequences of this revisionist view are explored in two areas: (a) the area of the dialogue within the family therapy field regarding the emerging tradition of second-order therapy and (b) the area of training in structural family therapy.

Ask a family therapist to associate freely with the stimulus *structural family therapy,* and you are likely to receive responses like *boundaries, subsystems, hierarchy,* and *coalitions.* Sluzki (1992) gives expression to the popular view of structural family therapy (SFT) when he describes how a hypothetical family therapist would probably conduct a first session with a family the morning after rereading Minuchin's (1974) *Families and Family Therapy.*

> You would probably notice, from the beginning of the interview, the family's seating arrangement, the subsystems, boundaries, and the alliances. You would react to the skewed structural organization of this family and its strong cross-generational, mother-daughter coalition that has marginalized the father. You would promote a discussion of ways to enhance the decision-making process within the parental dyad in order to empower the father and marginalize the daughter. (p. 218)

In the popular view, what lies at the heart of SFT is a scheme for diagnosing families, a scheme based on the notions of subsystems, boundaries, hierarchy, and coalitions. The diagnoses constructed by utilizing this scheme are seen as then providing the blueprint for therapeutic intervention.

To be sure, there have been some scholars of SFT who have articulated views of the approach that do not have the structural diagnosis of families as their centerpiece (e.g., Colapinto, 1983, 1988). However, these scholars of SFT appear to have been read only by other scholars of SFT. For the majority of family therapists—those whose primary exposure to SFT occurred in the context of coursework, those who do not practice SFT, or those who practice some of its techniques as part of an eclectic blend—it remains the case that what most defines the approach is the kind of structural diagnosis of families typified in the excerpt above.

It is the central contention of this article that this popular view of SFT is an inadequate one.

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WHAT IS WRONG WITH THE POPULAR VIEW?

What is wrong with the popular view is that it cannot account for the way in which SFT is *practiced.* The use of structural ideas to describe family functioning does *not* necessarily lead to therapeutic practice that would commonly be recognized as SFT.

Golann (1988), for example, has correctly observed the structural ideas informing the commentary of a reflecting team in a case reported by Andersen (1987). In this case, the reflecting team's commentary focused on a father who was depicted by the team as being marginalized in his family by the demands of his job and on an 8-year-old son whose problematic behavior was depicted as being related to his serving as a surrogate for his absent father. In a reflection observed by the family and primary therapist, one member of the reflecting team suggested that "... maybe the father and the oldest son should talk seriously together about what the boy might do when the father is away and what he should be careful about" (Andersen, 1987, p. 425). This reflecting team's commentary contained a conceptualization of family functioning and of problem generation, and a notion about a direction for possible problem resolution, with which any structural family therapist would feel very comfortable. Nonetheless, there was little, if any, resemblance between the practice of the reflecting team and the practice of SFT.

In a similar way, the model of psychotic processes in families developed by Selvini Palazzoli and her colleagues (1989) is replete with structural notions. At the core of the model lies the idea that psychotic symptoms are generated in a context of chronic, covert parental conflict and cross-generational coalition. Again, this conceptualization is one that any structural family therapist would find familiar and convincing.[1] However, it must once again be noted that there exists little similarity between the therapeutic practice of Selvini Palazzoli's team and the practice of SFT.

Defining Element of SFT Practice

What defines the practice of SFT and distinguishes it from the therapeutic practice of Andersen, Selvini Palazzoli, and others is *enactment.* To utilize Aponte's (1992) felicitous phrasing, "the enactment is to Structural Family Therapy what transference is to psychoanalysis" (p. 271).

The term *enactment,* as is well known, refers to those moments in therapy when family members interact directly with each other. In enactment, the therapist moves to the periphery of the therapeutic space while the client system moves to the center. The therapist may elicit an enactment either for the sake of assessment or as an intervention (Minuchin & Fishman, 1981). In the case of the former, the therapist decentralizes him/herself so that he/she can be "in a position to observe the family members' verbal and nonverbal ways of signaling to each other and monitoring the range of tolerable transactions" (Minuchin & Fishman, 1981, p. 79). In the case of the latter, the therapist moves to the edge of the therapeutic space in a way that invites family members to explore alternative ways of dealing with each other.

While enactment, in general, defines SFT practice, it is the use of enactment as a change-inducing intervention that lies at the very center of SFT practice. Thus, it is useful for anyone interested in understanding SFT to examine how enactment is used as an intervention. Specifically, it is illuminating to consider the respective contributions of the therapist and the family to the change process that occurs when enactment is used as an intervention.

In the midst of an enactment, the therapist is inactive, hovering at the edge of the therapeutic space. How, then, can he/she be contributing to whatever changes are occurring

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during the enactment? The answer to this question is that the therapist's contribution was made in the way he/she elicited the enactment. When enactment is used as an intervention, the therapist elicits the enactment via a frame that invites and motivates the family to search for some alternative mode of transaction. The way in which the therapist invites and motivates this search will vary significantly from family to family and from moment to moment in a given therapy (Aponte, 1992). The invitation may be delivered humorously or in a challenging tone. It may be accompanied by the therapist's announcement of confusion or assertion of expertise. It may be delivered from a neutral position or from a position of coalition with a given subsystem. What does not vary when enactment is used as an intervention is the fact that the therapist decentralizes him/herself via a frame that will serve a heuristic function for the family, orienting the family toward a search for alternatives in some specific area of its functioning (cf. Simon, 1992, 1993).

The therapist exits the center of the therapeutic space, leaving behind a heuristic frame. It then becomes the family's task to fill up this frame. The family performs this task in a way that is entirely idiosyncratic. It responds to the therapist's invitation to search for alternatives by accessing unused modes of transaction that are already in its repertoire. Over the course of many enactments, the family may briefly experiment with many such alternatives, stabilizing in the end only those that feel correct for the system at this point in its idiosyncratic evolution. It is the family that effects and presides over this search for alternatives. The therapist remains inactive, hovering at the edge of the therapeutic space.

Thus, the therapist's contribution to the change process in enactment is to motivate and invite the family to do what only it can do, that is, to replace some transactional patterns with others that fit the family's style and values and so preserve the family's integrity. Most of the structural family therapist's activity in therapy is devoted to this task of motivation and invitation. The degree of efficacy of this activity is to be judged by how well it succeeds in inducing family members to interact with each other in ways that represent a search for alternatives. To put it another way, the structural family therapist's *activity* is efficacious to the degree that it allows him/her to become *inactive*, observing as the client system goes about the task of changing itself (cf. Simon, 1992, 1993).

Enactment and Structural Diagnosis

What is it about diagnosing families in terms of subsystems, boundaries, hierarchy, and coalitions that leads the structural family therapist to enactment as his/her defining intervention? What is it about these structural notions that leads to the particular interweaving of family and therapist activity that has just been described?

The answer, quite simply, is *nothing*. There is nothing about conceptualizing family functioning in structural terms that leads to enactment as the centerpiece of therapeutic practice. Indeed, as was indicated above, structural conceptualizations of family functioning are compatible with very different modes of therapeutic practice. The conclusion, therefore, is inescapable that the popular view of SFT, which sees the structural diagnosis of families as lying at the heart of SFT, is simply an inadequate one. But if structural diagnosis does not constitute the essence of SFT, then what does?

FUNDAMENTAL ASSUMPTIONS OF SFT

Although the diagnosis of families in structural terms has an undeniable place in SFT, there are two assumptions about human and family functioning that are much more funda-

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mental to SFT and that are primarily responsible for driving the way in which it is practiced.

The Assumption of Competence[2]

SFT's assumption of competence is an assumption that families with problems are families that have simply gotten stuck using transactional patterns that no longer fit the families' current life circumstances.

> When families come to me for help, I assume they have problems not because there is something inherently wrong with them but because they've gotten stuck—stuck with a structure whose time has passed, and stuck with a story that doesn't work. (Minuchin & Nichols, 1993, p. 43)

It is assumed that such families and all of their members have access to alternatives that will work better. It is the task of the therapist to motivate and to invite family members to leave behind the predictability of patterns that are no longer useful and to venture into the uncharted territory of resources that are unsuspected or have been forgotten.

To the fixed perspective that families present, my answer is uncertainty.

> "Are you sure that no alternatives are available?"
>
> "You are more complex than you realize."
>
> "There is hope, there are resources that you have not yet explored." . . .
>
> The one axiom is: "You are richer than you know." (Minuchin & Nichols, 1993, p. 47)

It is not the therapist's task to supply these resources from the outside; they are already there. The therapist must simply convince families to risk the uncertainty of searching for alternatives of which they are already in possession.

> The basic quest of family therapy is to release unused possibilities.... Therapy may be a search for novelty, but all we discover is what is already there. (Minuchin & Nichols, 1993, p. 45)

The Assumption of Uniqueness

SFT's assumption of uniqueness is an assumption that, whatever characteristics it may share with other families, each family is fundamentally unique.

> One of the problems with having seen hundreds of families is that you become a little impatient. You think, I've heard this story before; let's move forward. You haven't. They're all different. (Minuchin & Nichols, 1993, p. 275)

This assumption leads to the conviction that assessment of a family by means of abstract constructions must be particularized by attention to that which is idiosyncratic to the family, for example, the family's history and the subjective experience of its members (cf. note 1).

> But a more important point to remember is that every family is unique, and to that extent every therapist is a little bit ignorant. Therapists must be alert to their ignorance and willing to allow families to educate them. (Minuchin & Nichols, 1993, p. 102)

The assumption of uniqueness also militates against viewing therapeutic intervention as an attempt to produce some specific targeted outcome. Interventions must be viewed as being oriented toward eliciting change *of some kind or other* in a fairly well-defined area of a family's functioning. Although it lies within the power of an intervention to define the area of the family's functioning in which change should occur, an intervention is powerless to determine in detail the specific contours of the change that may be produced. The specifics of the change emerge from the wellsprings of the family's uniqueness. "Treatment strategies

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are generic; the results are idiosyncratic" (Minuchin & Nichols, 1993, p. 121).

Competence, Uniqueness, and Enactment

It is not at all difficult to discern the relationship between SFT's assumptions of competence and uniqueness and the way in which SFT is practiced. Specifically, the connection between the assumptions and SFT's reliance upon enactment as its defining intervention is an easy one to map.

The assumptions of competence and uniqueness lead to a particular view of the family as it enters therapy. Under the lens of the assumptions, the family is seen as fundamentally sound and resourceful. It is seen as possessing a core of uniqueness that will largely determine how the family will change in therapy.

This view of the family requires that a therapy be constructed that, for the most part, places the family at the center of the therapeutic space. The therapist's fundamental activity in this therapy will be one of inviting and motivating the family to replace some aspects of its current manner of functioning with some idiosyncratic alternatives drawn from the reservoir of the family's unused resources. As was described above, a therapy constructed around enactment is just such a therapy. It is a therapy in which intervention serves primarily a heuristic function and in which the right, responsibility, and competence to determine the specifics of the changes that occur are assigned to the family.

The structural family therapist's use of enactment is predicated on the faith that if a family is correctly invited and motivated, it can and will begin to change within the therapy session in ways that will both lead to the resolution of the family's problems and, at the same time, preserve the family's integrity. Thus, enactment, at root, has little to do with the diagnostic notions of boundaries, subsystems, hierarchy, and coalitions. Instead, enactment is itself an enactment of SFT's fundamental assumptions of competence and uniqueness. Contrary to the popular view, it is these assumptions, rather than the structural diagnosis of families, that lie at the heart of SFT.

CONSEQUENCES OF THE REVISIONIST VIEW

Two important consequences of the revisionist view of SFT that is being presented here suggest themselves immediately. These consequences relate, first of all, to the dialogue within the field of family therapy regarding the emerging tradition of second-order therapy, and secondly, to the issue of training in SFT.

SFT and Second-Order Therapy

It is incontrovertible that one of the most important developments within the field of family therapy over the course of the past several years has been the emergence of a variety of second-order therapeutic approaches. While these various approaches offer somewhat differing conceptions of appropriate therapist role behavior (Tjersland, 1990), they are unified in their aspiration to construct a therapy that is nonpathologizing, nonjudgmental, and noncontrolling (Anderson & Goolishian, 1988, 1990; Cecchin, 1987; Hoffman, 1985, 1988).

There can be little doubt that the emergence of the second-order perspective has enriched the field of family therapy. Nonetheless, there has been a distinctly unfortunate element in the way second-order approaches have been presented to the field. Most often implicitly, but in some instances explicitly, second-order approaches have been presented as therapeutic alternatives that are irreconcilable with traditional, first-order family therapy approaches.

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Part and parcel with this presentation has been the characterization of first-order approaches as being inevitably pathologizing and controlling (Anderson & Goolishian, 1988, 1990). Simon (1992) has argued that an either-or framing of the first- and second-order perspectives is an unfortunate one, in that it betrays the systemic foundations of the field and could stifle creativity. A host of others have advised the field not to abandon all of its traditional formulations in a rush to mine the resources that are undeniably contained within the second-order perspective (e.g., Efron, 1991, 1992; Golann, 1987; Goldner, 1991; Held, 1992). As an alternative to the wholesale rejection of traditional notions, the construction of integrative, both-and framings of the first- and second-order perspectives has been proposed (Atkinson & Heath, 1990; Simon, 1992, 1993).

SFT is generally characterized as a first-order therapeutic approach. The popular view of SFT, with its emphasis on structural diagnosis, has contributed to the portrayal of first-order approaches as being inevitably pathologizing and controlling. However, in the revisionist rendering of SFT that is being presented here, SFT is anything but pathologizing and controlling. Far from being pathologizing, it is grounded in an assumption of competence which sees families and individuals as fundamentally sound and resourceful. Far from being controlling, it is founded upon an assumption of uniqueness which requires that families be seen as having the right and responsibility to determine the specific contours of whatever changes might occur in therapy.

A skeptical second-order theorist might well question at this juncture how SFT's purported assumptions of competence and uniqueness can be reconciled with its well-developed scheme for diagnosing family functioning. In order to answer this question, it must be recalled that structural diagnosis is thoroughly relativistic and context-dependent. In *Families and Family Therapy* (Minuchin, 1974), the notion of family structure is constantly connected with the notion of family development. It is emphasized that the assessment of the relative functionality of a given family's structure is wholly dependent upon the degree to which that structure enables or impedes the family in executing the task of responding to the developmental press being exerted on it by its sociocultural context. A structure that is adaptive in one developmental context may be maladaptive in another. Moreover, it is always assumed that whatever a family's current structure might be, "[a]lternative patterns are available within the system" (Minuchin, 1974, p. 52). Thus, structural diagnosis should not be viewed as capturing the "essence" of a family. Instead, structural diagnosis should be viewed as the construction of a description of the current ". . . state of affairs in the ongoing dialogue between the client system and its context . . ." (Simon, 1992, p. 382). When understood in this way, structural diagnosis is seen to be thoroughly compatible with the assumptions of competence and uniqueness.

The recognition of the centrality of the assumptions of competence and uniqueness to SFT practice undermines the portrayal of first-order therapies as being inevitably pathologizing and controlling. It bolsters the position of those who argue that it is both possible and desirable to construct both-and framings of the first- and second-order perspectives. In fact, a case can be made that SFT, as it has been rendered here, already represents an example of "having a second-order mind while doing first-order therapy" (Simon, 1992). By assigning primacy to those moments in therapy when family members converse among themselves in an attempt to stabilize new transactional patterns, SFT places client families at the center of the therapeutic space, thereby contributing to the realization of second-order aspirations to construct a therapy that is nonpathologizing and noncontrolling. Moreover, in allowing the therapist periodically to withdraw to the periphery of the therapeutic space, SFT provides the

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therapist with the freedom and the opportunity to get in touch with instinctive, nonrational thoughts and feelings, an activity which Atkinson (1992) claims is essential in order for second-order aspirations to be truly realized.

Training in SFT

The popularity that SFT has enjoyed over the years can be attributed in large measure to its reputation as being an eminently "teachable" model of family therapy. The aspect of the model that is undeniably simple and, therefore, easy to teach, is the structural diagnosis of families. As a result, when SFT is taught to beginners, the teaching usually begins with an exposition of the notions of boundaries, subsystems, hierarchy, and coalitions (see, e.g., Nichols, 1984). It is, perhaps, because most family therapists' exposure to SFT began (and ended?) with the structural diagnosis of families that the popular view of SFT depicts structural diagnosis as lying at the heart of SFT.

The revisionist view of SFT that is being presented in this article requires that the teaching of SFT *not* begin with an exposition of structural notions about family functioning. These notions have an immensely hypnotic quality. The power they have to impose order on and make sense out of the raw data of family processes can easily seduce trainees into being mesmerized by these notions. A trainee mesmerized by a diagnostic scheme is a trainee well on the way to becoming a pathologizing therapist. Such a therapist can never be a practitioner of SFT as it has been rendered in this article.

The view of SFT that is being presented here requires that training in SFT begin with the assumptions of competence and uniqueness. These assumptions cannot be taught in the same way that the structural assessment of families can. The assumptions of competence and uniqueness are precisely that—assumptions. As such, they occupy the realm of values. A trainee can be taught structural assessment through didactic presentations. A very different kind of training context is required if the goal is to help a trainee encounter his/her own fundamental therapeutic values and compare these with SFT's assumptions of competence and uniqueness.

If training in SFT must begin with its fundamental assumptions, then it is the *person* of the trainee and not the *head* of the trainee that must be the target of early training interventions. Such interventions need to be primarily experiential. They should provide the trainee with the opportunity to encounter his/her fundamental therapeutic values, not as these are verbalized in the context of intellectual discussion, but as they are enacted in the heat of the therapeutic exchange. Exposure of the trainee's therapeutic values provides the trainer with the opportunity to confirm or to challenge them. In this way, the trainee is provided with the opportunity to appropriate or to deepen the assumptions of competence and uniqueness which drive SFT practice.

Once the trainee has been adequately grounded in SFT's fundamental assumptions, training can safely move on, first to structural notions about family functioning and then to technical aspects of the therapeutic encounter. The grounding in SFT's fundamental assumptions that has preceded these later phases of training reduces the risk that the trainee will during these phases become mesmerized by diagnosis and technique. Viewed through the lens of the assumptions, diagnosis will be seen by the trainee in the ecological-developmental perspective described above and not as a hunt for families' pathological cores. Techniques will be seen as heuristic activators of a search by client families for idiosyncratic alternatives and not as attempts to engineer specifically determined changes.

Training in these later phases inevitably becomes a somewhat more cognitive affair.

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However, since SFT practice is ultimately driven in all its aspects by certain value-laden assumptions about human and family functioning, such practice can never be a merely technical exercise, emanating from the head of the therapist. In the end, SFT practice is always an existential exercise, involving the whole person of the therapist (Aponte, 1992). Accordingly, even when training in SFT becomes in its later phases a somewhat more cognitive affair, it is the whole person of the trainee that remains the ultimate target of training throughout.

The need for training in SFT to contain an experiential component has had some previous discussion in the SFT literature. Colapinto (1988), for example, has described a model of training that, like the one being proposed here, is primarily experiential in nature from beginning to end. Recently, Aponte (1992) has also proposed a model of person-focused training in SFT.

Although the model proposed by Aponte has much to commend it, it is beset by a major difficulty. Aponte (1992) asserts that "person training in SFT *assumes that trainees understand the basic theory and techniques of Structural Family Therapy*" (p. 274; italics added). The notion that a person focus can be postponed until a later phase of training, along with the attendant assumption that the basic theory and techniques of SFT can be adequately taught in a cognitive, didactic fashion, is precisely the view of training in SFT that is being challenged here, and that Colapinto (1988), too, finds unacceptable. Aponte's model of person training has much to offer for that phase of training in which the focus is on helping trainees expand their ability to assume a variety of relational postures in the context of therapy. Aponte is correct in identifying this as a late phase of training and correct in asserting that it presupposes fundamental competence in SFT. What is being argued here, however, is that acquisition of fundamental competence in SFT itself requires a form of person training, designed to help the beginning trainee appropriate or deepen SFT's fundamental assumptions of competence and uniqueness.

CONCLUSION

Although familiarity may not always breed contempt, it does, unfortunately, usually dull and stereotype perception. Most, if not all, family therapists are familiar with SFT. Most could easily give a thumbnail sketch of the approach. It has been the central contention of this article that the thumbnail sketch that most family therapists would give is an inadequate one. It is inadequate in its assignment of primacy to structural diagnosis in the practice of SFT. It is inadequate for not recognizing the pivotal role played by the assumptions of competence and uniqueness in determining the way in which SFT is practiced.

The inadequacy of the popular view of SFT is not merely a matter of academic concern. As a direct result of its inadequacy, the popular view has allowed SFT to be portrayed incorrectly as a pathology-focused and control-focused model of therapy. The popular view of SFT has contributed to the counterproductive trend to frame the first- and second-order therapeutic perspectives as opposed and irreconcilable. This article has endeavored to correct the distortions of the popular view. Minuchin tells us that his fundamental message to his clients is: "'You are more complex than you realize'" (Minuchin & Nichols, 1993, p. 47). The fundamental message of this article is: "SFT is more complex than you realize."

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NOTES

[1]Selvini Palazzoli and her colleagues (1989) would probably argue that their use of the game metaphor imparts to their model dimensions lacking in the structural model, namely, the historical dimension and the dimension of individual intentionality. However, these dimensions are not, in fact, lacking in the structural model. Minuchin (personal communication, January 20, 1993) has noted that interventions based on a structural assessment of a family will only have therapeutic efficacy if the structural assessment, admittedly abstract and generic in itself, becomes nuanced and textured by the therapist's attention to the subjective experiences of the family members and to the history of the family. It is the therapist's attention to these idiosyncratic elements that particularizes his/her structural interventions, so that the family is able to recognize itself in the interventions.

[2]Selvini Palazzoli and her colleagues (Selvini Palazzoli, Cirillo, Selvini, & Sorrentino, 1989; Viaro & Leonardi, 1986) also describe an assumption of competence that informs their therapeutic practice. Although this assumption is related to the one that will be described below, there is an important difference of emphasis between the two. Selvini Palazzoli's presupposition of competence represents a polemical stance against the presupposition of illness with which Viaro and Leonardi (1986) claim all families enter treatment, aided and abetted by the mental health establishment. Selvini Palazzoli's team will respond to behavior that is presented as "crazy" with the following implicitly or explicitly presented message: "If he/she is behaving like this, he/she must certainly have valid and comprehensible reasons for doing so" (Viaro & Leonardi, 1986, p. 16), where "comprehensible" is understood in terms of the family game. Thus, Selvini Palazzoli's assumption of competence leads to positive reframing of behavior presented by the client system. The difference of emphasis between this assumption and SFT's assumption of competence will be manifest in the following discussion.

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