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The perspective has changed. Since Nathan Ackerman began in the 1950's to see whole families when the referral problem was a child or other member of the family with emotional difficulties, a school of therapists has arisen that agrees upon a new definition of the problem: the individual is no longer the unit of pathology, but is expressing the dysfunction in a set of relationships, in which he/she has been "chosen" to carry the problems of the entire family.

This is a systems view. It does not ignore the subjectively felt anxiety of the school-phobic child or the desperation of the anorectic adolescent. But it sees the development of these problems, and their cure, as a matter of family relationships.

The family is the matrix of identity — we are who we are within the context of our family, friends and society.

Thoughts, emotions and actions take their meanings not only from the intention of the individual to whom they belong, but also from the meaning that is given to them by the people with whom the individual is involved.

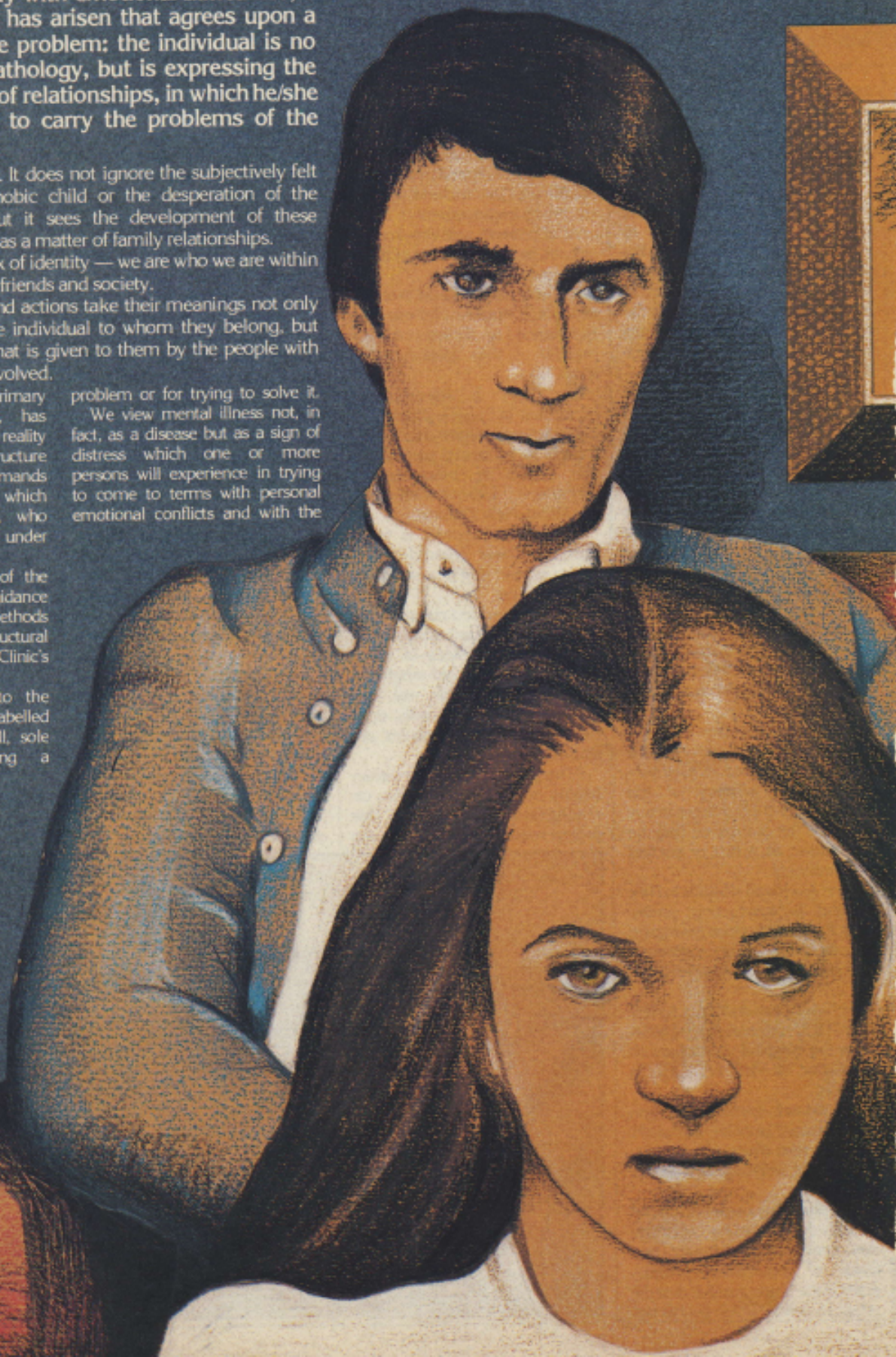
The family as the primary context of development, has immense power to define reality for its members. Family structure is the invisible set of demands that organises the ways in which family members interact, who relates to whom, how, and under what circumstances.

Dr Salvador Minuchin of the Philadelphia Child Guidance Clinic has developed the methods and principles called structural family therapy. In the Clinic's information leaflet they say:

"We do not ascribe to the individual, who is labelled mentally or emotionally ill, sole responsibility for bearing a

problem or for trying to solve it.

We view mental illness not, in fact, as a disease but as a sign of distress which one or more persons will experience in trying to come to terms with personal emotional conflicts and with the



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contradictory demands and expectations of their own psyches and the social and institutional context of the world in which they live".

Minuchin and his colleagues have had their work shaped by their involvement with psychosomatic problems — children hospitalised for diabetic acidosis, severe asthma or cachectic anorexia.

"We were drawn into the field of psychosomatic medicine, not by any fixed philosophical bent, but by the severity of the clinical problems posed by patients who came under our care".

Of the three conditions mentioned, children who had undergone unusually numerous hospitalisations for diabetic acidosis were the first who "forced us to question the methods for studying and treating the relationship between psyche and soma."

While acidosis may be one of the initial presenting symptoms in a child with previously undiagnosed diabetes, repeated bouts of diabetic acidosis are "distinctly unusual and are generally thought to be avoidable".

In addition these children did not respond as expected to an optimal medical regimen.

As a result they were virtually crippled by their disease, requiring as many as ten to fifteen hospitalisations a year to correct the acidosis.

The pattern prevailed despite the absence of complicating organic factors and despite the parents being given intensive diabetic education.

This was surprising because "these children had been easy to take care of while in the hospital and their diabetic control had been excellent".

The striking difference between the ease of diabetic control in the hospital and the impossibility of diabetic control in the home led to the conclusion that the family environment was some-

how noxious.

Metabolic studies by the Philadelphia group provided additional information.

Using the previous observations from the field of psychophysiology which had shown that free fatty acids can serve as a marker for emotional arousal, the group set up experimental situations in which changes in free fatty acids were used to document the relationship between emotional arousal and psychosomatic crisis.

Two interviews compared FFA levels in the diabetic child under both nonstressful and stressful conditions.

Emotional arousal in the stressful interview "was accompanied by a dramatic rise in the concentration of free fatty acids, which if sustained could have quickly led to diabetic acidosis in the child."

While this research shed light on the mediating pathways by which emotional arousal is converted to diabetic acidosis, the family context was at this point considered to be only one of several noxious factors affecting the child. Then one particular case led to a re-evaluation.

The child in question had averaged one hospitalisation every three weeks for diabetic acidosis for a period of two years. Individual psychiatric help had not been effective, and it was decided to take the child and her family into family therapy. This was accompanied by an immediate change in the pattern of hospitalisations.

The child now entered hospital in acidosis every week. However: "After several months of family therapy, major changes were observed in the family and in the child's role in her family."

In particular, the parents were able to initiate and negotiate conflicts without involving their daughter. Concomitant with these changes the pattern of hospitalisations was broken".

If ever it were assumed that it is only the hostile or emotionally distant family environment that makes for problems, we now know that this is far from correct.

Intense involvements — over-involvements which lead the family therapist to apply the term "enmeshed" — are the rule rather than the exception.

In the enmeshed family it is particularly difficult to experience a sense of identity or competence. For reasons relating to his own background, Minuchin is extremely concerned about respecting a sense of identity:

"My style is partly a product of a childhood spent in an enmeshed family with forty aunts and uncles and roughly two hundred cousins, all of whom formed, to one degree or another, a close family network ... Like an inhabitant of Chinatown, when I walked the street, I felt that a hundred cousins were watching me.

Thus, I had to learn as a child to feel comfortable in situations of proximity, yet to disengage sufficiently to protect my individuality".

Minuchin described his style as organised along two parameters: how to preserve individuation and how to support mutuality.

Structural family therapy gets its name from the fact that it is concerned to reorganize the structure of a dysfunctional family along specific lines. Families need, for instance, to establish appropriate boundaries:

"I am always concerned with preserving the boundaries that define individual identity. I do not let one family member talk about others who are present in the session. This rule can be brought alive by telling a family member "He is taking your voice".

I often separate people who are sitting together, and may gesture like a traffic policeman to block interruptions or inappropriate requests for confirmation.

I tend to discourage the use of one family member as the repository for others' memories.

I approve descriptions of competence and encourage family members to reward any competence that is displayed in the session.

I encourage and join family underdogs, supporting them so that they can win acceptance and change their position.

In particular, I support the struggle of growing children for age-appropriate independence".

Working with family structure has its effects on the symptomatic person in the system.

When, for instance, an asthmatic child can be freed from an active participation in its parents'

conflict by a therapist who categorically prevents the parents from drawing the child in, while at the same time encouraging the parents to thrash out their difficulties and to reach some degree of resolution on specific issues, the child is relieved of a sense of responsibility for the parents' relationship, relieved of a feeling of guilt, and much anxiety which normally exacerbates the asthmatic condition.

The fact of complementarity — that it "takes two to tango" — is something we take for granted in everyday life, but has only recently been recognised as a powerful homeostatic force maintaining family dysfunction.

It was believed some decades ago that the "cause" of schizophrenia was a "schizophrenogenic" mother whose malevolence, conscious or unconscious, unhinged a genetically vulnerable offspring.

This view yielded to the somewhat less incriminating but still one-sided view that the schizophrenic is a victim in a family that fails to fulfil certain essential developmental functions.

Thus the notion of the "schizophrenic mother" was displaced by that of the "schizophrenic family".

While undoubtedly correct in his observations, Lidz's formulation did not sufficiently stress something that is quite plain to anyone who observes the family system in interaction: the "victim" — whether anorectic child, anxious wife or depressed husband, — is heavily implicated in maintaining the pattern of relationships that sustain his/her dysfunctional (and often very painful) position in the family.

This fact of complementarity means that the "victim" is also in part the "perpetrator". It means that not only does Johnny, say, need to be helped with his tremendous overdependence, but we need to see what Mrs Smith is doing to keep Johnny dependent upon her, what part Johnny plays in this, and where the relationship between husband and wife is requiring this emotional entanglement between mother and son to diffuse what might otherwise be a stormy marriage.

From the therapist's angle complementarity offers a new perspective — we do not ask why Dad is depressed, we ask who in the family makes Dad depressed (or frustrated, angry, helpless, etc).

This perspective also increases the therapist's point of intervention: to help Sue with her school difficulties he may need to help

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mother keep her distance and gain some objectivity; this may be done by involving her more with another child, or working at the marital relationship.

If, to use a metaphor of Minuchin's, we appreciate that individual symptomatology is part of the "family dance", we may need to change the music, or oblige them to recognize who is dancing with whom, and to do it differently.

Although structural family therapy has addressed itself to the psychosomatic family, where it has had considerable impact, Minuchin's methods developed initially through his work with the low socioeconomic population, people whom the psychoanalytic and psychodynamic approaches have consistently failed to reach.

The psychoanalytically oriented theories are based upon methods that require that certain conditions be met.

The patient must, for instance, be able to observe his participation in events, reflect on his inner reactions and processes, remember past events, and be able to link them to present experience, and be open to language as a means of communication and problem-solving, in the context of the therapeutic relationship.

Because many people in the low socioeconomic population do not seem to fulfil these conditions, they are generally not considered as good candidates for this method of treatment, and hence tend to be treated predominantly by means of medication.

The characteristics of the working class family have been clearly described. Deutsch (1964), for instance, has noted the lack of privacy in families that are overcrowded, and the problem this poses for individualization.

Here too children lack varied stimulation, and, in a world in which the child is insufficiently

called upon to respond to stimuli, his general level of responsiveness diminishes and he learns inattention.

The relationship among adults and children is such that shared interpersonal experience is infrequent.

In better organised working class families, strong emphasis is placed on obedience to externally imposed standards rather than personally felt values.

Rules for appropriate behaviour often come from the lower class occupations that rely traditionally on obedience, manipulation of things, standardization and supervision.

In applying these values to the children, the important thing for parents is that they should not transgress externally imposed rules (Kohn, 1964).

In the more disorganized and unstable section of the low socioeconomic population, these patterns are seen in an exaggerated and destructive form (Minuchin, 1968). The essential feature of the environment is its impermanence and unpredictability:

"In home visits we encountered a world in which objects are moved around; beds shared by two or more children can be turned over to a different child or to a transient or semi-permanent visitor, while the child is crowded into a section of another bed.

The geography of the house and its arrangements handicap development of a sense of 'I have my place in my world'. Meals have no set time, order or place.

The same mother who prepares four individual and different dinners one day, according to the wishes of the children, will prepare nothing on another day, during which the children have to look in closets for available food, making their meals out of potato chips and soda" (Minuchin, 1968, p. 536).

Interpersonal contacts have the

same erratic and unpredictable quality. Parenting is often done by mother, aunt, grandparent or older sibling, and while there is some element of security in multiple figures it can create confusion and a sense of instability.

There are "don'ts" for the moment, but parents do not convey instructions for behaviour in the future.

The unpredictability of parental controlling signals handicaps the child's development of rules. He has difficulty ascertaining what actions are inappropriate, and he will rely considerably on parents' moods. Minuchin (1968) comments:

"Lacking norms to regulate behaviour and caught in experiences that hinge on immediate interpersonal control, the child needs continuous parental participation to organize interpersonal transactions. These transactions are inevitably ineffective; they perpetuate a situation in which an overtaxed mother responds erratically to a confused child," insights constructively.

The psychotherapy of these families clearly requires the application of methods very different from that of the psychoanalytic situation, where change is effected through understanding, reflection and the ability to tolerate frustration, to control impulses, and to use

There is another notion regarding communication that is highlighted in the low socioeconomic population but also has more general application in the sphere of family therapy. I am referring here to the fact that every communication has both a content and a relationship aspect.

Credit for recognition and elaboration of this principle is to be given to Gregory Bateson and his colleagues at the Mental Research Institute, Palo Alto, in California.

When A communicates with B, the verbal message is qualified in some other way, whether by tone of voice, facial expression, body posture or any of the other many non-verbal expressions man has at his disposal. The non-verbal message may alter or even contradict the content of the verbal utterance, and hence says something specifically about the relationship between the communicants.

Minuchin (1968) points out that in the low socioeconomic population, the child grows to focus more on the relationship aspect of his encounters than on the verbal meaning conveyed, and this focus handicaps him in that he is less free to address

himself to the content of what is being transacted at the moment.

"What seems prevalent in our population is that the constant defining of interrelatedness between people outweighs the meaning of the content of messages. This type of communicational exchange (developmentally correct in interactions between young children and parents) seems to achieve dominance in the low socioeconomic population."

As regards the technique of family therapy in general, the fact that the communication of relationship is ubiquitous and is sometimes the dominant feature of the communication, has alerted the family therapist to the importance of these processes, the role they play in the dysfunctional family, and the need to concentrate upon and change these relationship factors, rather than attending exclusively to the meaning conveyed in verbal content.

This, if anything, is the cardinal principle in family therapy — to change the way in which the members of the family have defined their relationships, so that instead of struggling to maintain their dysfunctional patterns (the only ones they know and feel safe with) they can be freed to deal more directly with the content of their transactions.

While the various methods used by family therapists to effect necessary changes are difficult to convey verbally and theoretically, the following gives, perhaps, something of the flavour of the work:

Once the therapist has joined the family — established some rapport with each of the family members individually — he will have to deal with the problem of being too central in the interactions and having the family, in consequence, simply describe things to him.

Since his centrality tends to exaggerate content at the expense of the interpersonal processes, the therapist will need to move himself out of the middle of the communication and encourage transactions between members of the family themselves.

As Minuchin (1974) puts it, "there is considerable value in making the family enact instead of describe. The therapist can gather only limited data from the family's descriptions.

To amplify his data, he must help them transact, in his presence, some of the ways in which they naturally resolve conflicts, support each other, enter into alliances and coalitions, or diffuse stress."

By creating scenarios in which family members interact within a clearly delineated framework (e.g., father and son only, without mother butting in to support or disqualify either party), members experience their own transactions with a heightened awareness, while the therapist can watch the family members in action.

When the therapist has this perspective — can be both catalyst and observer — he is then in a position to begin to understand the "family dance", that structured pattern of relationships that underlies the idiosyncratic behaviour of its members. Since family structure is nothing more than the repetitive patterns of relationship maintained by rules, whether tacit or explicit, the structural family therapist uses himself in various ways in order to effect change in these rules.

Doing this is often more difficult than it might seem, for a number of reasons. The first of these is that the family members operate as a system in such a way that they try not to permit change to go beyond certain implicit but definite limits.

When there is the risk that these limits will be transgressed, anxiety is generated and the status quo restored.

Don Jackson (1957) introduced the term "family homeostasis" to describe the repetitive and circular ways in which the family returns to the status quo, however painful and dysfunctional this precarious equilibrium might be.

A second reason for the difficulty in changing family rules has to do with the power of systems in general, and family systems in particular.

It is well-known that it is extremely difficult for an individual to counter the authority — irrespective of whether that authority is right or wrong — of an organization or other such system. For this reason trade unions and similar structures have evolved so that individuals can utilize the power of one system in dealing with the other.

Families likewise, although they do not have the impersonal and brute strength of the large organization, operate in ways that have certain parallels.

Through its rules and shared perceptions, the family imposes upon its members a version of reality that acquires its contours through years of shared experience.

This reality, governed by the rules that define transactions, determines how people experience and label themselves.

When the therapist enters the system, he is entering a context

where a specific version of reality has been created and is maintained with great tenacity by all the family members.

To the extent that the family's reality engulfs the therapist — inducts him, to use the usual term — into their reality, to that extent will he be ineffectual in being of help to the family. Montalvo (1973) has put it this way:

"The most basic assumption of all is that any family can absorb and orient the therapist and direct him away from his functions as a change agent; that any therapist can be caught behaving with the family in ways that will reinforce the very patterns that brought them to therapy".

If the therapist is capable of successfully joining the family, avoiding their attempts to induct him into the usual transactions of the system, and if he can decentralize himself yet catalyze and watch the family transactional patterns, he will have created a scenario through which the family will reveal its idiosyncratic characteristics as a system.

He will see the elements of complementarity operating — how father's feelings of ineffectuality and peripherality are supported by mother and children colluding to subtly define him as such, or how mother's inability to control her children is maintained by her spouse's protective attitude, and his annulling of her disciplinary efforts.

Similarly he may become aware of the boundary problems that exist in the family, the ways in which, unwittingly, the individuality and self-esteem of one member is undercut by others speaking for him, completing his sentences, or attributing thoughts, feelings or intentions to him in such a way that he is unable to counter what is being done.

Once the therapist has begun to understand the structure, he can begin to intervene; the family's response to his manoeuvre is itself a piece of information through which he can gauge their flexibility.

At times it is necessary to create some stress in the family in an attempt to change the dysfunctional transactional patterns which have developed.

This is done in a variety of ways. By seeking out, then emphasizing differences that family members have been glossing over, they are obliged to open up and work on conflicts that might previously have been dealt with inappropriately.

The therapist can act as "midwife" to the emergence and shape of the conflict, defining the dyad in which it should take place,

excluding interference from other family members, preventing premature closure, and where necessary supporting the underdog.

While the therapist will often take sides, entering into coalition with one family member against another, this has to be done with sensitivity and with the ability to shift his support when indicated. The therapist's ultimate goal is of course to benefit the whole family, and the family must sense this fact.

If, to paraphrase Selvini-Palazzoli et al. (1978), there are times when the therapist appears to be cold or calculating, it is worth remembering that it is not against the individuals that he is acting, but against the rules of the system, of which the individuals are in some sense victim.



Jeffrey Cumes

#### ABOUT THE AUTHOR:

I am a clinical psychologist registered with the S.A. Medical and Dental Council.

I have a Masters degree in Clinical Psychology, obtained at Wits in 1970.

I have been a staff member here in the School of Psychology since 1972, involved in undergraduate and Honours teaching, as well as in the training of M. Med (Psychiatry) and M.A. Clinical Psychology candidates.

I also have a limited private practice.

My interest in family therapy began with the visit in 1974 of Dr Donald Bloch of the Ackerman Institute of Family Therapy, New York.

My wife and I (she is also a Clinical Psychologist) have turned increasingly towards this way of working, and, during my sabbatical last year, we received additional training with the Ackerman Faculty and at the Philadelphia Child Guidance Clinic, under the directorship of Dr Salvador Minuchin.

At the university we have a training facility called the Children's Psychological Services, through which families are seen.

Although the number we see is very limited (maximum of 4 in therapy at any one time), we want to see more Black families (who do not, as far as we know, have a family therapy facility anywhere in this country).

Practical difficulties notwithstanding, we would welcome referrals of families belonging to any of the population groups.

We have trained two Black students, and have one Indian student currently doing the course.

I am 37, and I have two daughters, aged 9 and 8.

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