CHAPTER 9
Structural-Strategic Approaches to Couple and Family Therapy

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INTRODUCTION

Other textbooks on family and couple therapy have had separate chapters for the structural and strategic approaches. In this volume, the two models, structural family therapy, as developed by Salvador Minuchin, and strategic family therapy, as developed by Jay Haley, are presented together because of their common emphasis on systems and structure. Both approaches aim to realign family organization to produce change in the entire system, and both are focused on the hierarchical organization of the family. We have chosen to highlight the branch of strategic family therapy developed by Jay Haley because of its structural framework. Other strategically oriented approaches are no less influential than Haley's and have, in fact, been precursors to many of the dominant movements in modern family therapy approaches.

There are key points of divergence between Minuchin's and Haley's approaches, however. The structural approach emphasizes family organizations composed of subsystems and focuses on boundaries between subsystems. The strategic approach focuses on repeating sequences of behavior, particularly those that break hierarchical rules through cross-generational coalitions. Structural therapists focus on resolving structural problems in the family, whereas strategic therapists focus on the presenting symptom. Although both therapeutic approaches are action- and present-oriented, structuralists utilize interpretation and tasks in the form of enactment, whereas strategists shun interpretation and utilize both straightforward and paradoxical directives. Minuchin and Fishman (1981) highlight another key difference: "The strategic therapist sees the symptom as a protective solution: the symptom bearer sacrifices himself to defend the family homeostasis. The structuralist, regarding the family as an organism, sees this protection not as a purposeful, 'helpful' response, but as a reaction of an 'organism under stress'" (p. 68).

Each section of the chapter presents elements that are common across approaches, as well as elements that are unique to each. This chapter draws heavily from seminal writings, including Minuchin's *Families and Family Therapy* (1974), Minuchin and Fishman's *Family Therapy Techniques* (1981), Haley's *Problem-Solving Therapy* (1987), and Madanes's *Strategic Family Therapy* (1981). Other publications were also influential and are cited when appropriate.

HISTORY AND BACKGROUND OF THE STRUCTURAL AND STRATEGIC APPROACHES

Common Elements

Both structural and strategic approaches stem from communication theory as advanced by Bateson and colleagues—most notably, Don Jackson, John Weakland, and Gregory Bateson, in Palo Alto (Bateson & Jackson, 1968; Bateson, Jackson, Haley, & Weakland, 1956). This group began its work in the area of schizophrenia but laid the groundwork for family therapy with all types of symptoms. Communication theory incorporates Wiener's (1948) theory of cybernetics, to emphasize relationships as homeostatic systems with selfcorrecting feedback processes, positing that human relationships are defined by the interchange of messages. Behavior is viewed in the context of a unit of at least two people, a sender and a receiver. Bateson proposed that communication can be described in terms of levels, describing how these levels can conflict in paradoxical ways. By 1962, the Palo Alto group had made the shift from describing mental illness as individual phenomena to describing it as communicative behavior between people. They identified processes that became the building blocks of the structural/ strategic approaches: the double bind, the focus' on dyadic interactions, family homeostasis, and complementarity versus symmetry. Subsequent therapies developing out of this view emphasized changing families by influencing family members to communicate in new ways.

Don Jackson was the first to apply communications theory to family treatment. Jackson recognized that family relationships consist of repetitive patterns of interactions. He outlined three types of patterns that exist in all families: (1) covert norms, (2) overt family values, and (3) metarules for enforcing norms and values. Jackson planted the seeds for the strategic concepts of the function of the symptom and the importance of hierarchical structures and "quid pro quo" arrangements in marriage (Jackson, 1965). He established the Mental Research Institute (MRI) in 1959 and, together with Haley, Watzlawick, Weakland, Virginia Satir, Jules Riskin, and other colleagues, started one of the first family therapy training programs (cf., Satir, 1964; Watzlawick, Beavin, & Jackson, 1967).

The MRI group in Palo Alto has had a tremendous impact on the family therapy field. In addition to being the birthplace of Haley's approach, it directly and indirectly influenced a host of strategically oriented models and therapists. Most prominent are the *MRI model* (cf. Fisch, Weakland, & Segal, 1982; Watzlawick, Weakland, & Fish, 1974), the *Milan model* (cf. Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1978) and *solution-focused therapy* (cf. de Shazer, 1988). The strategically oriented models are based on communications theory and the work of Milton Erickson. The model most closely related to Haley's strategic family therapy is the MRI model. They share a belief that symptoms are caused by repetitive sequences of behaviors that repre-sent the family's faulty attempts to solve problems, resulting in the escalation of problems through positive feedback loops. They are both brief, pragmatic, and directive, focusing on identifying and resolving the presenting problem, rather than on offering interpretations or providing

insight. Both use paradoxical directives and make strategic use of the family's resistance to bring about change, placing responsibility on the therapist for making change happen in the family. Haley's approach differs from that of MRI, in that it focuses on triadic and moderate-length sequences, rather than on dyadic and immediate sequences of behavior, and theorizes about the function of the symptom. However, the most fundamental difference between the approaches is that despite focusing on the presenting symptom, the ultimate goal in Haley's model is to change family structure. It is this structural framework, particularly with regard to hierarchy, that links Haley's strategic family therapy to the structural approach. In the sections that follow, we highlight the critical influence of Minuchin and Haley and include other important figures who have played a role in the refinement of these approaches. Most notable are Braulio Montalvo, on the structural side, and Cloe Madanes, the codeveloper of strategic family therapy.

Structural Family Therapy

Minuchin came to family therapy in the 1950s, from a background in child psychiatry. While working with juvenile delinquents at the Wiltwyck School for Boys, Minuchin and colleagues (Auerswald, King, Montalvo, and Rabinowitz) were confronted by the impotence of the individual approach, given the social context to which the children would return. They were influenced by Jackson's emphasis on interpersonal connections and recognized that the behavior of their patients was not only an action, but also a reaction. They started to conduct conjoint sessions, built a therapy room with a one-way mirror, and taught themselves family therapy by trial and error. Minuchin's work is quite unique because, from the very beginning, he has primarily worked with poor, ethnic minority families (cf. Minuchin, Montalvo, Guerney, Rosman, & Schumer, *Families of the Slums,* 1967).

In 1965, Minuchin became professor of psychiatry at the University of Pennsylvania and director of both the Philadelphia Child Guidance Clinic and the Children's Hospital of Philadelphia's Department of Psychiatry. Upon his arrival, Minuchin began to rebel against the psychiatric establishment and was deemed "dangerous" for zealously insisting that child psychiatry was family psychiatry, even for middle-class families. At about this time, Minuchin also started to treat the families of diabetic children who had been unsuccessfully treated with individual therapy. He discovered that all of the families had a common view of themselves as normal families who would be happy except for the diabetes, and that parents detoured their conflict through the diabetic child. Minuchin conducted clinical research with families of diabetic, anorectic, and asthmatic children, as well as those with other psychosomatic complaints, demonstrating the effectiveness of family therapy for psychosomatic children (cf., Minuchin, Rosman, Baker, Liebman, Milman, & Todd, 1975; Minuchin, Rosman, & Baker, 1978).

In the 1970s Minuchin and colleagues at the Philadelphia Child Guidance Clinic (Aponte, Fishman, Greenstein, Haley, Madanes, Montalvo, Rosman, Umberger, and Walters) shaped the structural approach into the most influential family therapy approach and, due in large part to this work, family therapy was accepted in the mainstream of child psychiatry.

Strategic Family Therapy

Jay Haley worked closely with and was influenced by the Palo Alto group, Milton Erickson, and Minuchin. Consequently, strategic family therapy is an integration of several seminal streams of family theory. From the Palo Alto/MR group, Haley acquired the communication theorists' understanding of the nature of analogical and digital communication (Bateson & Jackson, 1968) and the belief that giving families insight into the roots of their problems was not helpful. From Minuchin, he developed the structural view of family organization as a holding framework for his strategic techniques. Perhaps most important, from Erickson he borrowed many of the cornerstones of the strategic approach: the focus on symptoms, the use of paradox, the brevity of treatment, and the stance that the therapist should take responsibility for treatment failures. Haley added a focus on the functional quality of symptoms. Later, he adopted structural concepts and widened the lens on problematic communication to include longer sequences with three (triangles) or more people. Haley and Madanes worked together at Palo Alto/MRI and the Philadelphia Child Guidance Clinic and established the Family Therapy Institute in Washington, DC.

MAJOR THEORETICAL CONSTRUCTS

Common Elements

The structural and strategic approaches share many fundamental principles. The first is that human behavior, including psychopathology, must be understood within the *context* in which it occurs. Human contexts are *systems* with rules that regulate behavior and *reciprocal* processes, such that the behavior of one part of the system influences the behavior of other parts. The most influential human context is the family system. Over time, the family develops *structures,* that is, consistent, repetitive, organized, and predictable patterns of family behavior. The family is a *selfcorrecting, homeostatic* system, in which deviance from the normative pattern of interaction activates a governing process. If a person deviates from the repeating behavior and so defines a different interaction, the others react against that deviation and shape the behavior back into the habitual pattern. Thus family structures are self-perpetuating and resistant to change, but they are changeable. The goal of therapy is to increase the flexibility and complexity of these structures.

Structural Family Therapy

One of the goals of the structural approach is to help individuals to experience themselves, including their problems, as belonging to part of a larger whole. When the individual is seen as part of a larger entity, his or her behavior can be understood as *complementary* or reciprocal to another's behavior. Complementarity is the defining principle of every relationship, in that one person's behavior is codetermined by another's behavior. For example, one parent's leniency is balanced by the other parent's

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strictness; a wife's vulnerability helps her husband feel protective; an adolescent is kept young by his parents, and his immature behavior makes the parents treat him as a young child. The family organizes itself into smaller groups, or *subsystems*. Each individual belongs to various subsystems, requiring flexibility of roles. The most prominent subsystems are the couple, the parents, and the siblings.

THE COUPLE SUBSYSTEM

The most important task for the couple is the creation of boundaries to protect this sub-system from intrusions from other subsystems (e.g., children, in-laws). This is vital to the health of the family. Problems in this subsystem spill over to the rest of the family. This subsystem is a model for the children on adult intimate relationships.

THE PARENTAL SUBSYSTEM

This subsystem can vary in composition (particularly in minority and poor families) and may include a grandparent, an aunt, or a parental child. The therapist has to learn who comprises the parental subsystem. Parents have the responsibility to care for, protect, and socialize the children and the right to privacy and to make decisions related to the total system. The role of the parental subsystem changes as the children grow. Children must be given more opportunities for decision making and self-determination as they develop.

THE SIBLING SUBSYSTEM

Siblings are the child's first peer group with whom he or she learns to socialize; therefore, intrusions from adults are best kept at a minimum. Large families may have a variety of sibling groups, according to developmental stages. Although family therapists underutilize siblings, this subsystem can be very useful for changing family structures.

BOUNDARIES

These protect the autonomy of the family and subsystems by regulating proximity and hierarchy. Families or groups within the family may have boundaries that are too diffused, resulting in *enmeshment,* or too rigid, resulting in *disengagement*. Boundary patterns within a family tend to be reciprocal, such that, for example, there could be an enmeshed mother-child dyad and a disengaged father. Problems stem from these two extreme boundary patterns. Although enmeshed relationships offer the benefit of cohesiveness and support, symptoms may emerge from the extreme closeness and overprotection between family members. Enmeshed relationships tend to stifle individual growth because it is against the rules of the relationship for members to seek affiliation outside of the family. Disengaged relationships, in contrast, offer great opportunity for individual growth and autonomy. However, they do not provide the protective functions that are a crucial aspect of family affiliation, as family members are unlikely to be aware when one of their own is experiencing distress. Much of structural family therapy is focused on defining boundaries within enmeshed dyads.

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Strategic Family Therapy

Any behavior can be conceived in units of individuals, dyads, triads, or larger groups. The size of the *conceptual unit* leads to different ideas regarding what might be done to change a behavior. A therapist who thinks in terms of dyads can consider a person's behavior as a response to another person who is eliciting the behavior. A therapist who thinks in terms of triads can seek out the triangle involved in the behavior and the interactional sequence that requires the behavior. This level of conceptualization allows treatment flexibility because the therapist can demonstrate more variety in therapeutic interventions and can consider the *coalitions* involved. Therapists must also consider themselves members of the social unit that contains the problem. Therefore, therapists must consider the coalitions in which they are involved when they act.

A distinction should be made between coalitions, which involve a joint action of two persons against a third person, and alliances, which involve two or more persons with a shared interest that is not shared by a third person. Coalitions are particularly problematic because they are typically used to detour conflict between two people. For example, say Persons A and B have a conflict that they cannot manage directly; Person C enters into the conflict by allying with Person A against Person B; consequently, A and B do not resolve their problem directly and their relationship does not develop. The preceding *sequence* of interaction is an example of a *triangle*.

All organizations have *hierarchies,* which are maintained by all participants. The simplest hierarchy involves the generation line. At most moments, there ate three generations in a family therapy situation: the parents, where power often resides; the grandparents, who are usually moved to an advisory, if not superfluous, position; and the children. The most common hierarchy in poor and ethnic minority families is grandmother, mother, and child; or mother, parental child, and child. Therapists must be aware of their own position, so that they do not inadvertently form a coalition with members low in the hierarchy against those who are higher, unless it is done for strategic purposes.

PROPOSED ETIOLOGY OF CLINICAL PROBLEMS

Common Elements

The structural and strategic approaches view problems as stemming from rigid and repetitive patterns of interaction that restrict the repertoire of available behaviors. Both see pathology as a failure of the family to *adapt* to changed circumstances as the family proceeds through *developmental stages* and when outside forces impinge to require adjustment. In pathological families, instead of adjusting by expanding their range of behaviors, the family more rigidly adheres to its habitual patterns.

Both approaches also emphasize the importance of problems in the family hierarchy, particularly cross-generational alliances or coalitions in families presenting with a symptomatic child. Minuchin focuses on the horizontal aspects of hierarchies, that is, the

importance of defining subsystems in the family with clear generational boundaries (thus reducing cross-generational alliances). Haley focuses more on the vertical aspects of hierarchy, describing pathology in a child as involving a coalition across generational lines. Madanes adds a nuance to Haley's view by stating that the child's symptom reflects an *incongruous* hierarchical organization, in that the symptom serves the function of protecting the parents (by distracting the parents from their own individual or marital problems).

Structural Family Therapy

Pathology may be inside the patient, in his or her social context, or in the feedback between them. Certain symptoms are a clear indication of certain family structural arrangements. Therefore, presenting problems trigger an initial set of hypotheses with which the therapist will approach the family. For example, when parents are unable to control a young child, it is very likely that a parent is facilitating the child's behavior problems, either by undermining the other parental figure or by abdicating authority. When a child is functioning in a manner that is not commensurate with his or her age, it is likely that the child has an enmeshed relationship with one of the parents that keeps the child young.

Some family structures are inherently problematic. One such structure, as mentioned previously, is the cross-generation coalition. Other areas of dysfunction in a family frequently involve either enmeshment or disengagement. Therapy is thus, to a great extent, a process of monitoring proximity and distance. Symptoms arise in enmeshed families because the family overreacts to a stressor and, in disengaged families, because the family is unaware of a problem.

Some family structures are problematic because they represent a failure to adjust to circumstances. Families use only a small fraction of the full range of behaviors and often get stuck in patterns of behavior that are either limited or obsolete. When faced with stress, healthy families adjust their structures, whereas pathological families become more rigid. Problems arise when inflexible family structures cannot adjust to maturational or situational challenges. Failure to adjust may be due to inherent flaws in structure or merely a lack of flexibility.

Developmental Transitions

New functions must appear as the family goes through developmental stages, that is, couple formation, young children, school age and adolescent children, grown children, and non-normative transitional incidents (such as illness, loss of a job). Minuchin and Fishman (1981) have outlined several stages and the corresponding tasks that must be accomplished. An excellent resource for further understanding of family developmental stages is Carter and McGoldrick's *The Changing Family Life Cycle* (1989).

Strategic Family Therapy

In the strategic approach, symptoms are viewed as having a *function* within the family. It

is assumed that a symptom metaphorically expresses a problem. Symptomatic behavior is in some way an adaptive, albeit unsatisfactory, solution, in that a person must behave in abnormal ways when responding to abnormal social structures.

Problems in the family's hierarchical organization are at the root of symptomatic behavior. Typically, the hierarchical arrangement is confused. It may be confused by being ambiguous or because a member at one level consistently forms a coalition against a peer with a member at another level, thus violating the basic rules of organization. This type of coalition is particularly troublesome when it is secret.

Strategists define a symptom as a type of behavior that is part of a sequence of acts among several persons. In a repetitive sequence, all participants behave in a way that keeps the sequence going. Because the sequence repeats in a circle, there is a series of steps, each leading to the next and so back to the beginning again. Sequences are problematic when they either simultaneously define two opposite hierarchies or when they reflect an inconsistent (unstable) hierarchy—for example, if the parents at one point take charge of a child and at another point accept the child as the authority. For instance, a family has dual incongruous hierarchies when (1) the parents are in charge of their child by the fact of being parents, but (2) the child is also in charge of the parents because of the power of symptomatic behavior or because of the power given by coalitions with family members of high status.

MARITAL PROBLEMS

In the strategic conceptualization of behavior as determined by units of at least three persons, a marriage does not exist as an independent entity. Marital problems can present in therapy through (1) a symptom of an individual member of the couple, (2) a child problem, or (3) a direct request for marital counseling.

Whenever a married person has a severe symptom, the symptom serves some function in the marriage, and there will be consequences in the marriage when the symptom is cured. Madanes describes a marriage with a symptomatic spouse in terms of a hierarchical incongruity in the marriage. The symptomatic spouse attempts to change the hierarchical arrangement and to balance the power in the couple through the use of a symptom. The symptomatic person is in an inferior position to the other spouse, who tries to help, yet the symptomatic spouse is also in a superior position, in that she or he refuses to be helped. The couple becomes restricted to a situation where one behavior defines both an inferior and a superior position of each spouse in relation to the other. The symptom is a solution to the couple's difficulties, in that it equalizes the power of the spouses, providing a focus of interaction that stabilizes the marriage. The job of the therapist is to organize the couple so that power and weakness are not centered on symptomatic behavior.

According to Haley, couples who cannot deal with their marital problems directly, communicate their problem through their child. The child becomes the communication intermediary and so stabilizes the marriage. Adolescent or young adult problems sometimes present because the young person has reached the age of leaving home, requiring parents to enter into a new phase of their marriage. Madanes departs subtly from this presentation. She views the triangulation of the child in the marital problem as a

protective act by the child, in that the child's symptom keeps the parents involved in attempting to help the child or change the child's behavior. Parents have to put aside their own problems and hold themselves together to aid the child. In this sense the child's behavior is helpful in providing a respite from, and a reason to overcome, their own problems. This view is different from Haley's, in which, although the protective function of the symptom is understood, the child is typically thought of as involved in a coalition with one parental figure against the other.

When a couple presents a marital problem by seeking couples' therapy (as opposed to presenting as a problem in one of the marital partners or their child), it usually indicates an attempt to stay together. Presenting marital problems are the result of habitual rules of behavior, and the problem is at the level of those rules. One way to think about marital difficulties is in terms of flexibility. One of the functions of marital therapy is to enlarge the possibilities of the two partners so that they have wider range of behavior. Just as one way to see the goal of all therapy is to introduce complexity, so in marital therapy, the opportunities of the partners are greater if their relationship has more complex possibilities.

METHODS OF CLINICAL ASSESSMENT

Common Elements

For structural and strategic therapists, family interactions are the primary focus of treatment. The key to effective intervention thus begins with an accurate assessment and clinical formulation of family interactions that are related to the presenting problem. Assessment and clinical formulation always consider the general nature of family functioning, as well as the specific relationship between the presenting problem and general family functioning.

Assessment and clinical formulation involve identifying strengths and weaknesses within the family. Weaknesses (i.e., problematic interactions) may include parental conflict, parent-child relationship, triangulation, and a lack of subsystem differentiation and may all be related to behavior problems in a child. In contrast, strengths refer to adaptive family interactions, as well as to the particular capabilities of individual family members. This focus on strengths is not merely "lip service" or a reaction to "pathology-based" in-tervention models. Because structural and strategic interventions are brief and problemfocused, therapists must utilize the family's resources to maximize their impact on the family.

At a microlevel (moment by moment) in treatment, the therapist looks for intrapersonal and interpersonal strengths. Some examples of intrapersonal strengths include positive features such as love, commitment, and a desire to make things better. Interpersonal strengths include open and direct communication between family members, positive expressions of support, and the healthy expression of differences of opinion, Intrapersonal weaknesses at this level include hopelessness, anger (at worst, hate or contempt), and negative attributions about self or other. Interpersonal weaknesses include the expression of contempt (as opposed to appropriate disagreements), intense and

escalating levels of negativity, vague and indirect communication, and developmentally inappropriate parent or child behavior.

At a molar (e.g., refers to global patterns) level, the strengths and weaknesses of complex patterns of interaction are considered. Some examples of strengths at this level include the family's flexibility to respond to changing conditions and its ability to negotiate and resolve its differences of opinion. Weaknesses at the molar level include a lack of parental cooperation in setting and enforcing rules, overly connected or disconnected interpersonal boundaries, and the consistent denial, avoidance, or diffusion of family conflict.

Structural and strategic family therapists gather information about family interactions by asking directive questions about family responses to presenting problems and by encouraging family members to interact in the treatment context (enactment). The process of assessment and clinical formulation, however, varies across these approaches.

Structural Family Therapy

The core of assessment and *diagnosis* in the structural approach involves identifying repetitive interactional patterns within the family. Diagnosis of the family system is based on observing interactions that occur in the session. It is important to do this early in the therapy before the therapist is inducted into the family culture and thereafter fails to see structures because he or she has become a part of them. The focus is on process, not content. From these observations, the therapist can map the family system. For example, *mapping* (Minuchin & Fishman, 1981) is used to identify the position of family members in relation to one another. Family maps show who is aligned with whom, who is in conflict, who are nurturers or scapegoats, and who is in the family groupings for resolving conflict. The family map also shows the delineation of boundaries between subsystems.

Minuchin and colleagues (Minuchin, 1974; Minuchin & Fishman, 1981) were the first to emphasize the importance of *enactments* in assessment of the family systems. Through enactment, the therapist gathers information about family functioning directly, by facilitating family interactions in therapy, and does not have to rely on stories about what typically happens when the therapist is not present. Enactments reflect the family's overlearned behaviors that are present in most situations. Thus, by observing enactments, the therapist can directly assess strengths and weaknesses within the family, identify circular/systemic processes, and assess changes in family interaction that occur as therapy progresses.

Strategic Family Therapy

The most important aspect of clinical assessment in the strategic approach is to have a clear and operationalized treatment goal related to the family's presenting symptom and the sequences of interaction that are related to the symptom. This formulation is conducted in the first interview. Haley (1987) maps out five stages for the interview. These stages are as follows.

1. In the *social* stage, family members are greeted and made comfortable. The therapist respects the hierarchy in the family in order to gain cooperation and is most respectful toward the one person in the family who can bring the family back. The adult who seems less involved with the problem should be spoken to first. Usually, the most concerned person is the one most burdened with the problem. The most typical arrangement is a very concerned mother and a peripheral father.
2. In the *problem* stage, the therapist inquires about the presenting problem. Everyone is given a turn to present his or her view of the symptom. The therapist observes, but does not comment on, family process.
3. In the *interaction* stage, family members are asked to talk with each other (enact) to allow the therapist to identify problematic hierarchies. Every dyad is asked to communicate directly; subsequently, these interactions are expanded into triadic communications. The therapist brings the problem behavior into the room (e.g., asking a child to have a tantrum, if that is a symptomatic behavior) and observes the family process and organization in response to the behavior.
4. In the *goal-setting* stage, the family members are asked to specify the changes they would like to see occur in therapy. The therapist assists family members to concretely define these changes to make the problems solvable. A specific and detailed statement of the problem and the desired outcome is necessary for monitoring progress and outcome.
5. In the *task-setting* stage, the family is given a simple directive in order to keep it involved with the therapist between sessions.

A Combined Structural/Strategic Approach to Clinical Assessment

Szapocznik and colleagues have combined structural and strategic approaches to develop and validate a family approach for behavior-problem adolescents (Hervis, Szapocznik, Mitrani, Rio, & Kurtines, 1991; Szapocznik et al., 1991). In this combined approach, family interactions are identified along five interrelated dimensions: Structure, Resonance, Developmental Stage, Identified Patienthood, and Conflict Resolution.

1. *Structure* refers to the organizational aspects of the repetitive patterns of interaction within the family. Three specific categories of family organization are examined: leadership, subsystem organization, and communication flow.

   a. *Leadership* assesses the distribution of authority and responsibility within the family. This category includes *Hierarchy* (Who takes charge of the family's directorship? Is leadership in the appropriate hands?); *Behavior Control* (Who keeps order?); and *Guidance* (Who provides advice and suggestions?).
   b. *Subsystem Organization* is concerned with the formal and informal organization of the family system, including *Alliances* (Who supports whom? Are alliances appropriate?); *Triangulations,* defined as an involvement of Family Member C in a conflict between Family Members A and B across generational lines; and *Subsystem Membership* (Who is a member of which subsystem? Are subsystems appropriate?).
   c. *Communication Flow* is concerned with pathways of communication within the

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family, including *Directness of Communication* (Does every dyad communicate directly?); *Gatekeepers* (Is there a gatekeeper who channels communication?); and *Spokesperson* (Is there a family member who speaks for others in the family?).

2. *Resonance* is a measure of subsystem differentiation. At one extreme, boundaries can be either extremely rigid or impermeable (disengagement). At the opposite extreme, they can be too permeable (enmeshment).

3. *Developmental Stage* refers to the appropriateness of family members' interactions with respect to roles and tasks assigned to various family members, taking into consideration their age and position within the family. The following sets of roles and tasks are considered in examining this dimension:

   a. *Parenting Roles and Tasks* (Are parents parenting at a level consistent with the age of the children?).
   b. *Spousal Roles and Tasks* (Are spouses parenting at cooperative and equal levels of development?).
   c. *Child/Sibling Roles and Tasks* (Do the children function competently for their age and have appropriate rights and responsibilities?).
   d. *Extended Family Member Roles and Tasks* (Are parents able to assume proper parental position relative to their children in light of the role of their own parents and other relatives?).

4. *Identified Patienthood* (IPhood) refers to the extent to which the family is convinced that its primary problem is *all* the fault of the person exhibiting the symptom and uses that IPhood as a means of maintaining family homeostasis. There are five signs indicative of strong IPhood:

   a. *Negativity about the IP* (Is the IP seen as the cause of family pain and unhappiness?).
   b. *IP centrality* (Is the IP frequently the center of attention?).
   c. *Overprotection of the IP* (Does the family avoid confronting the IP's dysfunction?).
   d. *Nurturance of IPhood* (Do family members support or abet the IP's dysfunction?).
   e. *Denial of other problems* (Does the family imply that the IP is the sole cause of problems and pain?).

5. *Conflict Resolution* is a measure of the family's style in managing disagreements. There are five conflict-resolution styles identified:

   a. *Denial.* Disagreements are not allowed to emerge.
   b. *Avoidance.* Disagreement begins to emerge but is inhibited.
   c. *Diffusion.* Moving from one disagreement to another without letting any emerge fully or making personal attacks that are not part of the conflict issue.
   d. *Emergence without resolution.* Separate accounts and opinions regarding one disagreement are clearly expressed, but no solution is reached.
   e. *Emergence with resolution.* Separate accounts and opinions regarding a single disagreement are clearly expressed and a single solution acceptable to all family members is negotiated.

Formal Assessment Methods

In contrast to the rich clinical history of structural and strategic approaches, very little work has been done to develop and test methods of assessment that specifically target strategic or structural constructs. As such, only a few formal measures specific to these approaches are available. It should be noted that literally hundreds of family assessment measures include structural and strategic components; however, most of these measures are not based on principles of structural or strategic family therapy. Thus, these measures are not reviewed in this chapter. Table 9.1 presents a brief review of five measures that are specific to structural and strategic therapy.

CLINICAL CHANGE MECHANISMS/ CURATIVE FACTORS

Common Elements

Structural and strategic approaches share the tenet that symptom change and enhanced family functioning are inextricably linked. Because symptoms are caused by rigidly repeating patterns of interaction, it follows that the curative factor of therapy is to expand the family's range of available responses and its ability to use these responses to resolve its problems. Moreover, both approaches share an emphasis on the creation of an effective hierarchical structure that helps parents function as a cohesive executive subsystem. Although both approaches hold that changing a pattern of interaction (or a sequence of behavior) causes family members to undergo change, there is an important difference regarding the position of the presenting problem in this equation. That is, the structural school views symptom resolution as a byproduct of structural change, whereas the strategic school focuses on symptom resolution to bring about structural change.

Structural Family Therapy

Structuralists believe that the most effective way to change symptoms is to change the family patterns that maintain them. The goal of the structural approach is to facilitate the growth of the system to resolve symptoms and encourage growth in individuals, while also preserving the mutual support of the family. Therapy is therefore directed toward changing the organization of the family, unfreezing families from rigid habits, and thus creating opportunities for new structures. The goal is to activate latent adaptive structures that already exist in the family's repertoire. The underlying assumption is that families are inherently competent.

Strategic Family Therapy

Change occurs in strategic family therapy by requiring new behavior aimed at solving the presenting symptom. The presenting problem serves as a lever to change family structure. The therapist joins the ongoing system and changes sequences by shifting the ways people respond to each other because of the ways they must respond to the therapist. The

therapeutic task is to change the problematic sequence by intervening in such a way that it cannot continue.

Strategists do not subscribe to the structuralist notion that changing one part of a sequence can initiate a lasting change in an entire pattern of interactions. It is necessary to have a change in the behavior of at least two persons. Also in contrast to Structural therapy, Strategic therapy does not aim to make the family aware of the sequence, as this only causes resistance. Asking families to express feelings does not help either (unless they are expressing feelings in a different way—e.g., communicating directly, instead of needing a symptom). The way to bring about change in a sequence is to set up the situation so that people will change in order to avoid the ordeals inherent in being a client.

TABLE 9.1

Methods of Clinical Assessment: Observational and Self-Report Coding Systems

Coding System	Construct(s)	Coding Categories	Study Citations
Structural Family Systems Ratings *(Observational)*	Family Functioning	Structure *(Leadership, Subsystem Organization, Communication Flow)* Resonance *(Differentiation, Disengagement, Enmeshment)* Developmental Stage Identified Patienthood Conflict Resolution	Santisteban et al., 1996 Szapocznik & Kurtines, 1989 Szapocznik, Kurtines, Foote, Perez-Vidal, & Hervis, 1983, 1986 Szapocznik, Kurtines, Santisteban, & Rio, 1990 Szapocznik, Rio, et al., 1989 Szapocznik, Rio, et al., 1991 Szapocznik, Santisteban, et al., 1989
Wood's "Family Interaction Clinical Rating Scale" *(Observational)*	Family Behavior/ Interaction	Family Reactivity, Proximity Generational Hierarchy Enmeshment, Rigidity Overprotection Conflict Avoidance, Poor Conflict Resolution,	Wood, 1985 Wood, 1993 Wood, Watkins, Boyle, Nogueria, Zimand, & Carroll, 1989

		Triangulation, Quality of Marital Relationship,	
System for Coding Interactions and Family Functioning *(Observational)*	Family Functioning of Subsystems/ Dyads	Family (6): *Structure, Organization, Flexibility-Rigidity, Negative Conflict, Positive Affect, Focus of Problem* Marital Communication (1): *Decision Making* Parent (5): *Rejection/ Invalidation, Coerciveness, Triangulation, Withdrawal, Emotional Support* Child (2): *Affect* (Anger, Frustration) *and Behavior* (Withdrawal, Defiance)	Lindahl & Malik, 1999a Lindahl & Malik, 1999b Lindahl & Malik, 1996 Kerig & Lindahl, 2001
Family Coding System *(Observational)*	Effects of Marital Conflict on Parent-Child Interaction	Interparental Affect Parent-Child Affect and Communication Child Behavior Cross-Generational Alliance	Margolin & Gordis, 1992 Margolin, John, Ghosh, & Gordis, 1996
Structural Family Interaction Scale *(Self-Report)*	Family Functioning	Enmeshment, Disengagement, Flexibility, and Rigidity, Conflict Avoidance, Conflict Resolution, Conflict Without Resolution, Overprotection, Neglect, Generational Hierarchy, Patterns of Parent Coalition, Triangulation, Parent-Child Coalition, Detouring	Perosa & Perosa, 1982 Perosa & Perosa, 1990 Perosa & Perosa, 1993 Perosa, Perosa, & Tam, 1993

SPECIFIC THERAPEUTIC INTERVENTIONS

In addition to the seminal works noted throughout this chapter, literally hundreds of books, chapters, and articles have been written to describe structural and strategic intervention strategies. Two of the earliest and most influential are Watzlawick, Weakland, and Fisch's *Change: Principles of Problem Formation and Problem Resolution* (1974) and Minuchin and Fishman's *Family Therapy Techniques* (1981).

Common Elements

Both structural and strategic family therapy are directive, present, and action-oriented. They stress the importance of *joining* the family before changes in family structures can occur. Both rely on *enactment* of interactions within the therapy session for the purposes of diagnosing and transforming interactions, assign homework tasks, and prescribe *"unbalancing"* the system as a lever for changing family relationships.

Structural Family Therapy

Structural family therapy is not a set of techniques, but rather a way of looking at families. Structuralists aim to promote growth in the family by expanding the family's repertoire of interactions. The assumption is that the family contains the ingredients for better functioning, and it is the therapist's job to unearth these underutilized resources.

The therapist establishes himself or herself as leader of the therapeutic system, watches the family in action, identifies overly rigid family structures, and plans an intervention to loosen the old and establish new structures. To change the family's usual way of interacting, it is not sufficient for the therapist to be merely an observer. The therapist must enter the system to transform it. Therapists join the family and establish leadership by showing that they understand and are working to help family members, and by activating those aspects of themselves that are congruent with the family. Therapists adjust their position to accomplish therapy goals. When therapists validate, encourage, identify affect, or ally with family members, they are in a position of close proximity. In a median position, therapists listen, elicit information, and observe the family. This process is known as *tracking*. When therapists take a stance as an expert, impart information, or direct the family in a task, they are joining from a disengaged position.

Based upon their observations and experience, therapists form an initial hypothesis regarding the nature of the structural problem in the family. Every family structure, no matter how viable in some cases, has areas of possible difficulty. When therapists are familiar with the areas of potential weakness in a family shape, they can probe and plan therapy accordingly. The following are two common family configurations, the problems that tend to be associated with them, and therapist interventions.

PAS DE DEUX (2-PERSON) FAMILIES

A family consisting of only two people tends to have an intense style of relating that may foster mutual, almost symbiotic, dependence and resentment. The therapist in such cases can plan interventions to delineate the boundary between the dyad, while opening up the boundaries between the family and the outside world.

THREE-GENERATION FAMILIES

This configuration is common in ethnic minority and poor families. It has the strength of support and cooperation that allows for flexibility in family roles. However, because the boundaries between the top two generations do not conform to the more typically

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middleclass nuclear family, therapists tend to want to make delineations where these are not needed. Problems in such families occur when subsystem membership and hierarchy are unclear or inconsistent. The therapist can help clarify these boundaries, differentiate functions, and facilitate cooperation.

When families are undergoing a transitional crisis, the therapist can be helpful by imparting the normative stance that families are undergoing problems that are normal under the circumstances and can help them make the necessary adjustments. For example, therapists may assist in facilitating integration in stepfamilies, reassigning family tasks after the death of a family member, and connecting highly mobile families to extrafamilial resources.

To *restructure* interactions and thus expand the family's repertoire, the therapist must challenge the symptom, the family structure, and the family reality. The therapist challenges the family's view of the presenting problem to encourage it to search for alternative responses. The therapist maps out the family system, with special attention to boundary dysfunctions in subsystems, and corrects these dysfunctions by challenging family members' own definition of their roles and functions.

Structural family therapists use a variety of techniques to apply these strategies. Some of the most prominent techniques are described as follows.

In *focusing,* the therapist organizes the data provided by the family into a structural schema. This includes screening out some elements and emphasizing others, particularly process over content. Focusing helps the therapist make sense of the vast amounts of information to diagnose the family system and plan the therapy. It is also a strategy for shifting the family's frame of reality in a manner that facilitates change.

E*nactment* is asking the family to interact in the presence of the therapist, bringing problem sequences into the therapy room so that the therapist can observe and change these. Enactment allows for the gathering of information that is outside of the family's awareness and therefore cannot be gathered by asking questions. Enactment can also facilitate joining and helps therapists disengage if they have been inducted into the family's way of thinking or behaving.

Very frequently, family members will spontaneously enact in their typical way when they fight, interrupt, or criticize one another. However, because of the nature of therapy, it is not uncommon for family members to centralize therapists, in which case, the therapist will need to be more active in facilitating direct communication between family members. To facilitate enactments, the therapist systematically redirects communications to encourage interactions between family members.

There are three steps in enactment. The therapist (1) recognizes a problematic sequence, (2) directs an enactment, and (3) guides the family to modify the enactment. In enactment, the family members first experience their reality as they define it, and then the therapist introduces other elements and suggests alternative ways of transacting, thus challenging their reality and roles.

The therapist uses affect, repetition, duration, tone, and choice of words (clarity, not hedging) to get the message across to the family. In *achieving intensity,* the therapist heightens the impact of the therapeutic message. Intensity can also involve the family members's interactions with each other, for example, by extending an enactment beyond

where the family members would have it end.

The therapist *realigns boundaries* by regulating the distance or proximity between family members. The therapist may comment on boundary violations he or she has observed, with statements such as, "You serve as your son's memory bank," or "Are you his alarm clock?". Boundaries can also be regulated by manipulating space in the session or by excluding persons from a session. Greater proximity can be achieved by directing disengaged family members to do an activity together.

In *unbalancing,* the therapist uses himself or herself to destabilize the family hierarchy by temporarily taking sides. This can be achieved by allying with a family member, ignoring a family member, or entering into a coalition with one family member against another. Unbalancing requires the therapist to assume a position of close proximity and is a difficult technique for an inexperienced therapist.

Strategic Family Therapy

Strategic family therapy is a pragmatic approach, in which the therapist is expected to clearly define a presenting symptom and design a specific therapeutic plan for resolving it. The therapist keeps close track of therapeutic progress, and, if after a few weeks this plan is not successful, a new strategy is formulated. The therapist may borrow techniques from other models of therapy that are useful in solving a presenting problem. If the presenting problem is not resolved, the therapy is a failure (no matter what other changes have taken place), and it is the therapist who must accept responsibility for this failure.

To resolve the presenting symptom, it is not necessary to convince the family members that they have family problems, but they do need to be persuaded to cooperate in doing what the therapist asks. Persuasion and power in the family-therapist relationship are important elements in strategic family therapy. The therapist must join the family so that it will accept his or her leadership. Joining is achieved by focusing on the presenting problem, accepting the family member's definition of the problem, and not confronting them with what they are doing wrong.

The structural goal in all cases is to draw a generational line and to prevent consistent coalitions across it. The therapist may induce change by temporarily siding with one person in the family against another (unbalancing). The therapist might present analogies and metaphors to shift behavior, a method adopted from Erickson. However, the signature technique in strategic family therapy is the use of *directives*.

The therapist assigns clear and simple directives, both within the session and as homework, to change sequences of interaction in the family. Directives introduce action into the therapy and allow family members to have a different experience with one another. As such, directives can be used to bring disengaged family members closer, increase positive interactions, help the family establish rules, define generational boundaries, or set individual goals and plans to achieve those goals. Directives are also used for joining (by intensifying the family's relationship with the therapist) and for diagnosis of family functioning (by demonstrating how the family responds to the directive).

The best directives respect and use the content that the family considers important, the presenting problem, to bring about a change in family process. This is a creative

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endeavor, in which the therapist thinks about the presenting problem in terms of the problematic sequence in the family and designs a directive that changes both the presenting problem and the sequence. For example, if the goal is to have a mother and her fire-setting child (identified patient) be more involved with each other, and a parental child excluded, the therapist can ask the mother to teach the identified patient how to set a safe fire.

This type of *straightforward directive* can be given when the therapist expects family members to comply. It is essential that the therapist know how to motivate the family and assign tasks so that these are carried out. Motivational techniques involve finding some gain for each person involved and heightening the sense of urgency. Compliance is also enhanced by first getting the family to perform small tasks in the session (e.g., changing the seating arrangement or changing pathways of communication by asking the father and the mother to talk together without including their daughter). It also helps to involve the entire family, as long as hierarchy is not confused by involving children in adult aspects of the task. For example, if the directive is for the mother and the father to have a quiet dinner together, older children can be asked to help their younger siblings with homework, and younger children can be asked to help set the table. Finally, the directive must fit the family's style, and instructions must be precise and clear. The therapist asks the family members to report on the task at the next session and does not take lightly their failure to complete the task.

When the content of the intended behavior change is best not addressed directly, the therapist can use a *metaphorical directive*. For example, in the case of an adopted boy who is afraid of dogs, it might not be appropriate to talk about adoption directly. The therapist might ask the family to "adopt" a dog for the boy and thus work on both the presenting symptom (fear of dogs) and family processes related to adoption. A technique borrowed from Erickson for working with couples who are uncomfortable discussing their sexual problems directly is to assign the partners the task of enjoying a meal together, with an emphasis on doing it together, making it pleasant for all the senses, and satisfying each other.

Strategic family therapy is perhaps best known for its use *of paradoxical directives,* a technique borrowed from Erickson. When families are in a stable state, rather than in crisis, they are likely to resist attempts to directly change the system. Paradoxical directives allow the therapist to use the family's resistance to bring about the desired change. Paradoxical directives always include two contrary messages: "Change" and "Don't change." The therapist tells the family that he or she wants to help them change but at the same time asks them not to change.

One paradoxical technique is to ask the patient to produce more of the behavior that the patient wants to reduce. Regardless of whether the patient complies or resists, the nature of the symptom is transformed from involuntary to voluntary. Another paradoxical technique is for the therapist to tell a family that he or she is not sure the family is ready to accept the consequences of change. If the family accepts the directive at face value, then this opens the door to addressing the resistance directly. If family members do not accept the directive, they will change to prove the therapist wrong. A third type of paradoxical intervention involves exaggerating the symptom or rendering it absurd,

especially in a manner that makes maintaining the symptom an ordeal for the family. For example, a father who is in a coalition with his small daughter against his wife can be directed to wash the daughter's sheets when she wets her bed.

To use paradox, the therapist must be able to think about problems in a game-like manner. The therapist must be able to tolerate the emotional reaction of the family, and accept the family's "spontaneous" change. The therapist must avoid taking credit for the change and must seem puzzled by the improvement. If the therapist wants to ensure that the change will continue, he or she can suggest a relapse. Erickson would say, "I want you to go back to that time when you felt miserable, feel as you did then, and see whether there is anything from that experience you wish to salvage" (Haley, 1987, p. 78).

A creative variation on paradoxical directives is offered by Madanes (1981) in the form *of pretend techniques*. In this type of intervention, the therapist asks the identified patient to pretend to have his symptom and the family members to pretend to respond in their typical manner. When a sequence is labeled "This is pretend," it is difficult for the participants to go back to the framework of "This is real." Also, when someone is pretending to have a symptom, he or she cannot really have it, or else it would not be pretending. Thus, the symptom is brought into the therapy room in a manner that allows family members to change their usual process.

Strategic therapy uses a *planned, step-bystep approach* to eliminate the symptom. A typical chain of interventions moves the family from its presenting structure to a different dysfunctional structure, which in turn is shifted to a functional one. This intermediate abnormality can take many forms. One is to redefine or reframe the problem, such as relabeling a symptom from "mental illness" to "misbehaving." Another way to induce an intermediate dysfunctional structure is to request the family to exaggerate the presenting dysfunctional structure. Likewise, there are many ways to approach any problematic structure. For example, take the most common structure in cases of symptomatic children, a two-generation triangle. The therapist has at least three options to change a sequence: (1) direct the peripheral parent to take charge of the child's problem and the intensely involved parent to stay out of it; (2) direct the intensely involved parent to become even more involved, while the peripheral parent remains peripheral; or (3) ask parents to agree on what is to be done and to carry it out.

Madanes (1981) offers a simple protocol for dealing with adolescent delinquency and drug abuse, viewing these cases as situations in which a cross-generational coalition or an incongruous hierarchy has solidified and become, in effect, a reversed hierarchy—with the parents subordinate and the adolescent in a superior position. Parents in such cases typically attempt to disqualify themselves or each other and appeal to others (the therapist, another authority, or even the adolescent) to make decisions regarding the adolescent. Therapy is aimed at redistributing power so that the parents are in charge. The therapist must elicit competent responses from the parents and discourage messages that denote their weakness.

When conducting marital therapy, it is often difficult to formulate specific treatment goals, which require negotiation between the spouses. Therapists are warned to avoid entering into a consistent coalition with one of the spouses. Such coalitions should be used only strategically (and by skilled therapists), for the purpose of destabilizing a

marriage to produce change. Strategic therapists also utilize marital therapy to resolve individual symptoms in one of the spouses. The therapist does not offer any interpretation regarding the function of the symptom but helps the couple resolve the marital problems that make the symptom functional as improvement occurs.

EFFECTIVENESS OF THE APPROACH

The efficacy and effectiveness of structural/ strategic approaches have been carefully evaluated over the past 3 decades. For example, Minuchin and associates examined clinical outcomes in structural family therapy for children and adolescents with behavior problems, eating disorders, and diabetes. *Families of the Slums* (Minuchin et al., 1967) reports clinical improvement in child behavior problems in 7 of 11 families treated, noting that disengaged family-types did not respond positively to treatment. Likewise, *Psychosomatic Families* (Minuchin, Rosman, & Baker, 1978) presents substantial improvement in eating disorders for 45 of 53 families treated. Minuchin's uncontrolled studies provided a foundation on which the evaluation of structural/strategic approaches has been built. However, Stanton and associates' groundbreaking studies with drug addicts (1982) launched an era of controlled, rigorous empirical studies of structural and strategic approaches.

ALCOHOL, DRUGS, AND ANTISOCIAL BEHAVIOR

A substantial base of research findings supports the efficacy and effectiveness of structural and strategic approaches with adolescent and adults presenting with drug and alcohol problems and antisocial behaviors (cf. Alexander, Holtzworth-Munroe, & Jameson, 1994; Sexton, Alexander, & Mease, in press). This base is supported by Stanton & Shadish's (1997) meta-analysis, which concluded that couple and family therapy is, overall, as effective or more effective than alternative interventions in treating families with drugabusing adolescents. Stanton and Shadish (1997) further point out that the "preponderance of family-couples therapy outcome research on this population has been performed with some version or expansion of structural, strategic, or structural-strategic family therapy" (p. 183). Thus, this area encompasses one of the most widely researched areas in the entire field of family therapy.

FAMILY THERAPY WITH ADULT ADDICTS

The classic book *The Family Therapy of Drug Abuse and Addiction* (Stanton, Todd, & Associates, 1982) was the first formal documentation of empirically designed outcome studies focusing on the structural approach. These pioneer studies with young adult heroin addicts compared the effectiveness of family therapy combined with methadone, to nonfamily therapy combined with methadone. Results indicated that participants who received structural family therapy demonstrated greater rates of improvement than did those who had been in the non-family therapy conditions. Similar results were reported in a follow-up study (Stanton, Steier, Cook, & Todd, 1984) comparing structural family

techniques plus methadone treatment to individual counseling and methadone treatment for detoxification cases.

ADOLESCENTS WITH ALCOHOL, DRUG, AND OTHER DISRUPTIVE BEHAVIOR PROBLEMS

Outcome research with adolescent alcohol and drug users has exploded in the last 2 decades. Stanton and Todd's structural/strategic principles proved to be enormously influential in the development of family therapy approaches for adolescent drug abuse that emerged in the 1980s. For example, Joanning, Quinn, and Mullen (1992) and Lewis, Piercy, Sprenkle, and Trepper (1990) demonstrated the effectiveness of family-based interventions that integrated both structural and strategic techniques with drug-abusing adolescents, and as described further on, Szapocznik and colleagues' program of research has evaluated the efficacy of a combined structural/strategic approach with minority youths. It should be noted that many other empirically validated approaches have drawn heavily from structural/strategic principles. Some of these models are presented in Chapters 14, 15, and 18.

BRIEF STRATEGIC FAMILY THERAPY

For 3 decades, Szapocznik and colleagues have evaluated the efficacy and effectiveness of brief strategic family therapy (BSFT) with Hispanic adolescents and their families at the University of Miami (Florida) School of Medicine. Based on both structural and strategic principles, BSFT has been shown to reduce child and adolescent behavior problems and to improve family interactions (cf., Szapocznik, Robbins, et al., 2002). Perhaps the most significant findings on BSFT are in the area of engaging and retaining adolescents and their families in treatment. For example, Szapocznik, Perez-Vidal, et al. (1988) demonstrated that specialized engagement procedures substantially increased engagement into family therapy (92% versus 42%) and facilitated the completion of treatment (77% versus 25%). Santisteban et al. (1996) replicated these findings and further demonstrated that BSFT is also more effective in engaging youth and families with more severe behavior problems.

Couples' Therapy

Though the large part of structural/strategic outcome research developed over the last 2 decades has addressed a huge umbrella of family compositions, only very few outcome studies have focused specifically on marital and couples' therapy. Of the few in existence, Goldman and Greenberg (1992) demonstrated that a combined structural and strategic approach was as effective in helping couples improve their functioning as was an emotionally focused experiential approach (emotionally focused therapy). Moreover, the couples in the integrated systemic therapy group maintained and actually improved at follow-up, whereas the emotionally focused therapy couples did not. Extending the work of Goldman and Greenberg, Davidson and Horvath (1997) examined more specifically the efficacy of paradoxical and homework components of strategic time-limited couples'

therapy. They found that couples who received three sessions of immediate strategic intervention improved significantly more than those in the waiting-list control condition, in both marital satisfaction and conflict-resolution skills.

Process Research

Despite rich outcome research findings, process research into the change mechanisms of structural and strategic family therapy is limited. The lack of research in this area is surprising because early writings included rich descriptions of process research methods, coding procedures, and clinically relevant results (e.g., Watzlawick & Weakland, 1977, pp. 71–127), whereas the establishment of the *Journal of Strategic and Systemic Therapy* in 1981 provided an excellent platform for disseminating research on structural and strategic clinical practices, systematic research failed to proliferate with the same intensity as structural and strategic theory and clinical practice. Perhaps the only exception is the rich base of research and case studies investigating the impact of paradoxical directives and reframing techniques (cf. Weeks, 1985, 1991; Weeks & L'Abate, 1982). Further on, we review process research in the following areas: (1) therapeutic relationship, (2) dropout, (3) linking process to outcome, and (4) paradoxical interventions.

THERAPEUTIC RELATIONSHIP

Since the mid-1970s family theorists have focused on exploring the therapist-family member relationship, primarily addressing the importance of techniques such as joining with the family (Minuchin & Fishman, 1981) or attending to the coalitionary process (Sluzki, 1975). With respect to structural and strategic methods, Friedlander and colleagues (1985, 1987) explored Don Jackson's and Minuchin's in-session behaviors. Though focusing on each theorists' specific process strategies, the team concluded that Minuchin's method was characterized by (1) an active approach; (2) a focus on current or in-session behavior; (3) an emphasis on providing information, guidance, interpretation, or a course of action; and (4) less time seeking information. These structural sessions were further typified by the therapist's attempts at highlighting the parental executive subsystem, at confronting and using combined direct/indirect statements (addressing other than the target person), and at activating the system by explicitly requesting change. With respect to Jackson, Friedlander and Highlen (1984) found that he employed more strategic methods. As the forerunner of strategic family therapy, Jackson's sessions were characterized by a call for structure and management and a close alignment with the subsystem under the most stress.

DROPOUT

Taking an in-depth look at processes associated with treatment dosage and participant dropout, Shields, Sprenkle, and Constantine (1991) showed that noncompleter cases were more likely to make frequent attempts to structure the therapist and would engage in more within-family disagreements. On the other hand, the completer cases were more

likely to let the therapist do the structuring in response to family disagreements and be engaged in more family dialogues about problems.

Linking process to outcome

The most recent available finding in the area of structural and strategic process research attempts to link process to outcome. Robbins et al. (2002) demonstated that for families who showed improvement on measures of conduct disorder, regardless of pretreatment family functioning, positive changes in family interaction were observed over the course of treatment. In contrast, for those families who showed no improvement, family functioning did not change, or worsened, over the course of treatment.

PARADOXICAL INTERVENTIONS

Excellent analyses of paradoxical intervention theory and techniques and research findings are included in reviews by Weeks and L'Abate (1982) and Weeks (1991). In fact, in the latter book, Kim, Poling, and Ascher (pp. 216–250) provide an outstanding synthesis of available research on the effectiveness of paradoxical techniques for patients presenting with insomnia, agoraphobia, obsessive-compulsive disorder, disorders of elimination, and other clinical conditions. It is important to note that much of the research on paradoxical interventions is not specific to structural and strategic approaches because paradoxical directives have been adopted by many individual, couple, and family approaches.

FUTURE DEVELOPMENTS AND DIRECTIONS

Ecosystemic Models

Perhaps because structural family therapy was developed for and has always been used with poor families, it is natural that it has been applied with a focus not only on the family but on other systems that have an impact on the family. Minuchin has addressed the structural problems inherent in social and mental health institutions which can exacerbate the very problems these institutions aim to solve (Elizur & Minuchin, 1989).

Others have used structural principles to transform the family's transactions with larger systems that play an important role in the lives of poor families. Fishman (1993) has developed an intensive structural therapy model that details assessment and intervention strategies for working with extrafamilial systems and has paired family therapists with community resource specialists to intervene in the family's broader social context (Fishman, Andes, & Knowlton, 2001). Likewise, Szpocznik and colleagues have integrated Bronfenbrenner's (1979) ecosystemic model with structural family therapy to form structural ecosystems therapy, which has been applied to substance-abusing adolescents (Szapocznik et al., 1997), HIV-seropostive women (Mitrani, Szapocznik, & Robinson-Batista, 2000) and family caregivers of persons with Alzheimer's-related dementias (Mitrani & Czaja, 2000).

Research to Practice

Although the structural/strategic approach has been empirically validated as efficacious for a variety of presenting symptoms, there is a need to transfer this research out of university-based laboratory settings and into community-based service centers. A recent effort by the National Institutes on Drug Abuse is providing an opportunity to conduct a largescale test of brief strategic family therapy in such settings. NIDA's Clinical Trials Network is a major initiative to enhance the delivery of scientifically based treatments to drug-abuse patients by coordinating the efforts of researchers and community-based service providers to develop, validate, refine, and deliver laboratory-validated treatments at the community practice level.

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