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Commentary on "Family-Directed Structural Therapy: Ten Years of Building on Family Strengths"

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This is an original and ground-breaking article because the authors have operationalized important concepts in family-centered thinking and practice, developed assessment tools that can be used for testing the validity of these concepts and then collected data from control and treatment groups of families in four very different service areas, i.e., therapeutic family camp, traditional outpatient setting, residential treatment, and child welfare. This is challenging and inventive design and data collection that leads the way to understanding, through evidence-based research, how to test family-centered concepts in action and measure their efficacy. The field of family-centered practice desperately needs this kind of original evidence-based research to demonstrate that paying attention to a family's assessment of their own strengths and problems and using this information to guide treatment is not only good ethics, but is the most effective way to engage families and help them achieve lasting change.

Over the past few decades a family-centered ethic has been established in social work education and "basic competency training" courses in child welfare across the country. The message is something like, "If you want to be of any help to a family, you'd better find out how they define their problems and strengths and what it's like to live in their social system." If Erik Erikson, the great psycho-social pioneer of the 50s were alive today, he'd say this idea of carefully listening to families and using their insights to guide therapy is a superb example of a "common sense enlightenment"; one of those understandings that, when finally grasped causes us to slap ourselves on the forehead and say, "This is so obvious! Why didn't I see it in the first place?" The irony, of course, is that Erickson's wry notion of "common sense enlightenments" should serve as a warning that many human patterns of interaction, e.g., a family's structure, seem apparent once they've been called to our attention, but in reality are far from obvious (Friedman, 2000).

Over my thirty years of teaching in social work and clinical practice, these values and their related strategies, despite the proliferation of "family-centered" language, have not much influenced the systems of delivery or the actual behavior of workers in social agencies. The reasons for this have to do with the unintended organizational resistance of our own helping systems (Friedman, 2005), as well as the increasing pressure of larger societal forces of poverty, lack of housing, inadequate education and opportunity that often undermine whatever therapeutic gains may be achieved by family therapy with the low-income populations we serve.

We are all new to serious field-based research with family systems concepts; however, the authors use of terminology also raises important questions in my mind about what do we really mean today when we say “structural family therapy,” what does it mean to add “Family-Directed” to this equation, and how do we actually incorporate family-provided assessment data into the process of treatment planning with the family?

It’s good to recall that structural family therapy was the child of necessity, if we trace its origins back to the early 1960s when Salvador Minuchin was doing therapy, training and research at the Wiltwyck School for Boys in New York (Colapinto, 1982). The population at Wiltwyck consisted of delinquent boys from multi-problem, poor families and traditional individual and group therapy techniques did not have a significant impact on these youngsters. Most frustrating was the realization that any improvements that were achieved in the residential setting of the school tended to disappear as soon as the child returned to his family (Minuchin, 1961). In their search for more effective ways of dealing with juvenile delinquency, Minuchin and his co-workers began to focus on the idea of working with and changing families (Haley, 1971), and this led them to changing their focus of attention from the psychological world of the adolescent to the dynamic patterns of the family.

Structural family therapy is a model of treatment based on systems theory. Its distinctive features are a way of thinking that places all problems in living in their social context and emphasizes the complementary influence of all behaviors in a social system. The focus on structural change as opposed to individual change is the main goal of therapy. There is also attention paid to the therapist as an active agent of change in the process of restructuring the family. Consistent with its basic tenet that the problems brought to therapy are ultimately dysfunctions of the family structure, the model looks for a therapeutic solution in the modification of such structure. This usually requires changes in the relative positions of family members: more proximity may be necessary between husband and wife, more distance between mother and son. Hierarchical relations and coalitions are frequently in need of a redefinition. New alternative rules for transacting must be explored: mother, for instance, may be required to abstain from intervening automatically whenever an interaction between her husband and her son reaches a certain pitch, while father and son should not automatically abort an argument just because it upsets Mom. Frozen conflicts have to be acknowledged and dealt with so that they can be solved—and the natural road to growth reopened (Colapinto, 1982).

The FDST assessment tool developed in the article proposes five “core issues” to define the structure of family functioning, i.e., commitment, empowerment, control of self, credibility and consistency. It’s difficult to see how these abstract concepts, as important as they may be, reflect the behavioral metaphors of family structure like hierarchy, diffuse vs. rigid boundaries, rules for communicating a broader range of emotions, the changes needed in the relative position in proximity of family members, how the family’s response to a problem is maintaining the problem, etc.

The authors have developed measures for adult family members to rate their own and other’s role functioning in the family as parents and marital partners. These scales have been adapted for children to assess the core issues and to rate themselves. All of this is valuable, but these role perceptions are linear individual perceptions of self and others, and don’t capture the non-linear interpersonal patterns of family life as described by structural family theory. It’s similar to meeting with a family and then interviewing each person individually, without attention to the hallmark of systems thinking, i.e., how each family member is organized by and in turn organizes each other family member, and how this system of regulation is linked to maintaining the symptoms or problems the family is concerned about. Structural family therapy teaches us that what matters most is to focus on the interaction of the whole, not individual perceptions.

The terminology used for “core issues” and the assessment tools collect information about the linear perceptions of individual family members, and are not designed to reveal the complementarity among family roles—the dance of mutual regulation that exists in all social systems, so that a father’s unwillingness to get involved with crises at home helps to maintain the mother’s over-involvement with the problematic child. The whole point of structural family therapy is to elaborate a way of thinking that focuses on the interdependence of behaviors in all living systems—it’s a lens through which we can see the common sense enlightenment that we are interdependent and our perceptions and responses to problems influence, and in turn are influenced by, the other members of our social system. Finally, lasting change comes from intervening in this system of mutual regulation in a manner that helps the family realign its structure and continue on its way with a healthier patterning of behaviors.

What’s also not addressed in the article is how the data collected are actually used in guiding structural family treatment. By identifying individual assessments, can the worker then help the family see the interdependence of their perceptions, e.g., dad won’t be able to get more

involved at home until mom is comfortable disengaging a bit? These kinds of insights are almost impossible for members of a social system to observe about themselves. It takes a very active and skilled family worker to draw the lines of connection between behaviors without blaming anyone, and then help the family see that individual perceptions can't change until family structure changes. How does this concept of the helper as an active agent of change fit into "family-directed" structural therapy? How do we operate in family-centered and collaborative ways, but not give up our role as interpreter of family process and promoter of change in the family's structure? All of these dilemmas in how to use ourselves with families can be figured out, but first they must be made explicit and not obscured by our own terminology. First, I think we must acknowledge that certain elements of family-centered practice and structural family therapy are out of alignment. When we see this dilemma clearly, we can then use our clinical experience, evidence-based research, and the insights of our client families to find more subtle answers to the theoretical and practice challenges of helping families change.

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