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BEYOND TECHNIQUE: TEACHING HOW TO THINK STRUCTURALLY[1]

> The presenter held a potato in his left hand and a refreshment straw in the right one. Seconds later the straw had neatly perforated the potato from side to side. Most of the aspiring young executives in the audience accepted the invitation to try themselves, but after a few frantic attempts, the table was littered with dented potatoes, broken straws, and damaged egos. The presenter then called the executives' attention on a technical trick: his right thumb was firmly placed on the upper end of the straw, cutting the air flow and giving the straw more rigidity. With renewed enthusiasm, the leaders-to-be tried again-—and again they failed. Now the presenter was ready to make his point: "I observed that your movements were hesitant, as if you were wondering whether the straw would go through the potato or not." He demonstrated his own movements once more. "You see, I know that I can get the straw through the potato, so I move my right hand in one single, fast thrust, and I do it."

Fifteen years after that demonstration I was discussing with Salvador Minuchin one of his sessions. Minuchin had spent a considerable amount of time pushing father to accept that he had more influence over his daughter than either father or daughter would acknowledge. I asked Minuchin: "Did it ever cross your mind that they might be right, that he was not strong enough to handle her?" Minuchin's answer was emphatic, almost indignant: "I never believe that. To me, the question is not whether the strength is there or not, but where the strength is, and what is preventing it from materializing in this context." Like the executives in the first story, I was being hindered by a self fulfilling prophesy, a wrong paradigm or, in the simpler language of so many mothers of adolescents, a "bad attitude".

The practice of structural family therapy requires a paradigm shift, a conceptual leap that no accumulation of techniques can substitute for. Because the model's tenets about family dynamics, meanings of symptoms, process of change, goals of therapy, and function of the therapist are the heuristic motors that propel and organize the structural therapist in his clinical work, they have richer practical implications than the techniques themselves. A training experience can fail when structural skills such as "joining," "making boundaries," or "unbalancing" are taught by the teacher or practiced by the disciple without enough regard for the structural thinking that gives them sense:

> After watching a session where Minuchin said "You are wonderful" to a domineering old lady that was blasting her granddaughter, a disciple repeated the same words in a similar context. The "joining" attempt did not work for him, among other reasons because he was thinking of grandma as a mean woman that had to be neutralized through the use of "positive connotation". Minuchin, on the other hand, really thought that it was wonderful for somebody to be so strong at 75.

If the therapist finds the client to be disgusting ("undermining," "a bitch," "disqualifying") chances are that he will not join that person —regardless of the technique used. In order to join (or to challenge, for that matter) the therapist needs to actually see the best of his

[1] Originally published in *Journal of Strategic and Systemic Therapies, 2*, 12-21(1983)

client, rather than pretend that he has seen it. The structural paradigm represents the glasses that facilitate such a perception.

Non-Structural Thinking

Acquisition of the structural glasses is often made difficult by the interference of alternative, more established paradigms. Psychodynamic thinking, for instance, has long been recognized as an obstacle to the assimilation of structural concepts. If the pathological mourning for a deceased husband is incompatible with a mother's effective parenting, a therapist with psychodynamic reflexes may automatically conclude that he needs to work on repairing mom's relation with her internal objects. The alternative, structural strategy of utilizing the children as a resource to pull mother out of her obsessive memories requires a dramatic change of perspective regarding the dynamics of emotions and the functions of therapy.

Not so readily noticed is the incongruence between the structural and the behavior modification paradigms. Some therapists think that the structural approach consists of teaching skills to patients —parenting skills, communication skills, assertive skills—, or "reinforcing" desired behaviors by nodding or shaking hands. However, teaching skills and scheduling reinforcements are not representative of structural thinking, which views families as already possessing --although not using— the resources that will be needed to solve their problems. While the behaviorist sees patients as being individually incompetent and tries to give them competence, the structuralist sees them as being collectively prisoners of a pattern, and tries to give them freedom. The two attitudes may occasionally lead to identical discrete interventions, but the processes that they organize are clearly distinct.

Also incompatible with structural thinking is a pretty common (if not dominant) way of looking at families, which can be described as "systemic malevolence". We all experience this syndrome from time to time: it feels like living in a paranoid world of people primarily invested in accumulating personal power undermining each other and, above all, refusing to change. Whoever wants to master structural family therapy needs to divest of this "bad attitude". A basic tenet of the model is that family members do whatever they do to each other primarily out of good will, and it is the effects of their misguided helpfulness that can go wrong. If mom addresses son with a soothing voice immediately after dad reprimanded him, the structural therapist needs to look beyond the "undermining coalition" so that he may discern a pathetic rescue maneuver. Should she "resist" to stay out of the transaction between father and son, the therapist needs to see not a commitment to not changing, but a temporary inability to consider a viable alternative to her intrusiveness.

One concept that has become heavily contaminated with the malevolent worldview is the "function of the symptom," originally introduced as a way of encouraging therapists to shift their focus from etiology (how the symptom started) to current process (what keeps the symptom going). Many of us were originally attracted to the field by elegant clinical presentations where the function of the symptom for the family was dramatically demonstrated. At this point in time, however, the concept may have outlived its usefulness. Considerable amounts of time and energy are spent in determining the "function" and making sure that each person's part in the plot is accounted for —time that is then unavailable for the therapist to meet the family and do therapy. If the clinician arrives at an intellectually satisfying assessment of the "function," the emerging picture is

frequently one that is hard to share with the family, because of its negative (malevolent) connotations; for instance, “Johnny has nightmares so that mom has to spend the night with him and doesn’t need to confront dad over his impotence”. In addition, the family system looks rigid and difficult to change, since the members appear to be so tightly committed to their secret endeavor.

Structural therapists tend to focus less on the function of the symptom and more on helping the family outgrow the symptom. While traditional psychotherapy asks the therapist to think about the past, and systemic therapy generically emphasizes the present, the specific mark of structural family therapy is the projection into the future — the other side of the potato. The focus is not so much on the current patterns that maintain the symptom, but on the absent patterns that need to be brought into existence. In the case of a runaway child, for instance, a structural therapist should not spend much time wondering why his family needs him to run away; rather, he needs to help them develop the more “holding” structure that is apparently missing.

Not only does structural training require a departure from established forms of therapeutic thinking, but to a large extent it is asyntonic with deep-seated cultural assumptions about human relations. In the world of psychotherapy, distance has been a valued asset ever since Sigmund Freud chose to describe therapeutic transactions in terms of transference and counter transference; a good deal of the painstaking efforts to protect ourselves from being swallowed by families is a heritage of that psychoanalytic tradition. Behaviorist approaches have imported the business world’s obsession with quantified results into the field of parent-child relations. It is culturally normal for the mother of a 13-year-old who is failing at school to think that he “should know by now,” to expect him to bring good grades, to withdraw some privileges if he does not, and then to wait until the next report comes. It is also culturally normal for a family therapist working in a results-oriented environment to approve of such a behavioral contingency. He may even instruct mom to keep cool and just enter a mark on a checklist taped to the refrigerator whenever the 13-year-old curses her. What is missing from these culturally normal transactions (and is essential to structural family therapy) is an experience of struggle, conflict, relational stress, negotiation and compromise——the pain and joy of human encounter.

Structural Thinking

Incorporation of the structural paradigm requires perceptual and attitudinal changes on the part of the trainee. Perceptually, he may need to move from seeing cause-effect relations to seeing spatial relations. It is not enough for the therapist to enlarge the frame so that he can see interaccional (even circular) consequences of behavior; what is required is the gestalt perception of the painter, the photographer or the moviemaker. The therapist needs to discipline himself to see not that father authoritarianism triggers mother’s leniency towards son, or the other way around, or even both ways; but that the father/son and the mother/son pattern fit each other as well as the mother/father dyad, and that all three patterns acquire sense only when perceived against the background of the larger context. In other words, the structural therapist needs to learn to perceive reality in terms of complementarity, to view dysfunctional events in one area of the system as matching other events that are happening or not happening somewhere else in the system. Neither the son is intrinsically obnoxious, nor is his obnoxiousness being

triggered by his mother. Rather, the son, mother, and father each contribute areas of their selves that complement each other in a consistent pattern.

The structural attitude is a corollary of the structural perception. If the complementary pattern shows mother invariably failing to get Bobby to listen to her, and father having only a disciplinarian relation to Bobby, the therapist should have questions about such an arrangement. How can this be possible? Isn't it strange that Bobby should have more power than mother? Does father enjoy his limited role? Does Bobby believe that mom doesn't mean it when she shows anger? The structural therapist's attitude is one of curiosity about "how come" the family members are utilizing only restricted versions of themselves. How come they do not try other ways of relating to each other? How come father comes to the rescue of mother, thus preventing her from completing a transaction with her son? How come this family spends so much time around disciplinary issues, which prevents them from having more fun together? The "how come" attitude, supported by the structuralist's conviction that there are other alternatives available within the potential resources of the family, organizes the therapist to work in proximity with the clients. His curiosity can only be satisfied through an encounter that is at the same time close and disquieting. Minuchin once compared the structural therapist to an uncle that visits us once a year and creates havoc through his affectionate interest in our family life. The how-come attitude conveys interest, concern, trust in the family's strengths, and a commitment to change. Reaching for the resources that hide beyond the superficial presentations of self, it synthesizes joining and challenging into one single attitude. It is a challenging way of joining, or a joining way of challenging, very different from the cool, distant operation that characterizes other modalities of family assessment, and also from the "first join, then challenge" kind of sequence that is sometimes identified with the structural method.

The structural therapist's curiosity is not "free" but disciplined, organized by his commitment to change. It is the curiosity of the inventor who needs to solve a problem and asks the questions that can lead to a solution —not the curiosity of the explorer who wants to know more and asks all the questions. The structural therapist needs to know about the family's fears, misguided helpfulness, and available resources, enough to be able to challenge existing patterns and promote new ones.

Genuine interest in existing and alternative complementary structures organizes the therapist to first observe the family dance, then feed back his observations within a structural frame, and finally promote the enactment of an alternative pattern —to be continued by another sequence of observation/framing/enactment.[2] Structural techniques are extrapolations from this process. As illustrated above, they only "work" when utilized to implement structural thinking; they are not free-standing skills that can be learned independently of the underlying perceptions and attitudes that give them justification.

Conflicting Paradigms in Live Supervision

Incorporation of the paradigm is then a precondition for mastering the techniques. The clinician wanting to "do" structural family therapy needs to learn the structural way of perceiving, thinking and being with families. This is as different from just learning what to do, as it is from simply "being oneself".

[2] I am indebted to William Silver, DSW, for articulating this sequence.

Traditionally, the paradigmatic dimension of a model is taught away from the clinical situation itself. Theoretical presentations and/or session reviews provide the typical scenario for the discussion of concepts and, in some cases, the exploration of the trainee's thought processes; live supervision is usually considered the wrong moment to impinge on the therapist's worldview. As the following example illustrates, however, live supervision often becomes the forum for clearly delineated conflicts of paradigms-—the trainee's and the supervisor's--and can provide an excellent opportunity for paradigmatic input:

> A trainee is assigned a case of a family composed of a single mother and her two children, 10 and 5 years old. The older son is involved in violent fighting at school and in the neighborhood, and is flunking the grade. Mother presents herself as a woman with a rough life, hints that she might be involved in prostitution, and puts down her competence and even her rights as a mother. Complementarily, the son appears not to listen to her. The therapist detects mother's self-disqualification and, in what seems to be an orthodox structural move, decides to provide her with an experience of success: mother is asked to bring her son's homework to the second session so that they can work together. The second session opens with mother laughing at her own forgetfulness: she did not bring the homework. The therapist says: "Oh, okay," and the supervisor immediately buzzes.

Among the many considerations that organized the therapist to say "okay", the most important one was that she did not want to underscore yet another failure, or put mother down in the presence of the son. Here the therapist was misinterpreting the structural concept of search for strength as if it meant that a client's weaknesses need to be overlooked, ignored, excused —that the therapist should always smile appreciatively to whatever the client does. This is not correct structural thinking.

The supervisor buzzed because mother's forgetfulness and her light reaction are not okay. This does not mean that mother should be labeled as an irresponsible person (her forgetfulness needs to be put in the context of a complementary perspective), but the element of irresponsibility cannot be ignored. It has to be challenged, precisely because the therapist need not buy the myth that mom should be predictably irresponsible —and saying that it is okay for mom to forget amounts to confirming her incompetence. Either condemning mom as absolutely irresponsible, or taking her forgetfulness for granted, are two different ways of arriving at the same unfortunate conclusion: the therapist is inducted into the system's myth. To challenge her need to be irresponsible ("How come you forgot?") is a way of keeping alternatives open.

> Following the supervisor's directive on the phone, the therapist refocuses the session on mother's forgetfulness, and its relation to the problems that brought the family to therapy. Eventually the therapist develops a structurally relevant theme: mother needs to get her son to take her seriously. Under the therapist's push, mother demands that the child should behave in school, not cause aggravation to her, listen to her advice, and in general be a good citizen. She crowns her list of expectations with the threat of taking away a couple of privileges that the boy values a lot, and then sets her eyes on the wall and falls into silence.

The therapist is satisfied with this process. From her point of view, mother has made a clear punishment contingent on the boy's misbehavior, and the next thing to do is make

sure that mom will follow through. This way of thinking is consistent with a behavior modification paradigm. The supervisor, however, has a different view. He does not notice any change in the child's general attitude of disregard for what mother has to say, and interprets mother's threat and her subsequent disengagement as a withdrawal before the point of breaking homeostasis. Mother's exclusive reliance on punishment (take away privileges) and on conventional values (citizenship) that do not seem to be her own, continue to feed the myth of her helplessness. From the point of view of therapy, the supervisor needs to deal with the message —now reinforced through the therapist's acceptance-- that mother is not equipped to cope with her child. From the point of view of training, he needs to do something about the trainee's thinking.

One possibility, as pointed out above, is to postpone any discussion of structural thinking until a later time. Some trainers favor this alternative out of a concern that their own thinking might confuse or distract the therapist in the middle of the session. There are two variations of this strategy:

(a) The supervisor may leave the session mostly in the trainee's hands, which would minimize the trainee's anxiety during the session and the level of stress in the supervisor/trainee relationship——but would also reduce the value of live supervision as a learning experience, and increase the risks of therapeutic failure.

(b) The supervisor may try to correct the process of the session without trying to change the trainee's thinking. He could, at this point, phone in once more and ask the therapist to enact a situation where mother can get her son to follow her directives in the room. Since the therapist will probably continue thinking from a paradigm that is incongruent with the supervisor's, the supervisor will need to continue steering the session through a series of corrective maneuvers, which in turn will transform the therapist into a passively dependent puppet. Her thought processes disrupted by the frequent directives, she will eventually give up all initiative and wait for the supervisor to tell her what to do next. Usually this does not result in the kind of therapeutic process .that the supervisor wants to unfold, which reduces the value of the post-session discussion as an opportunity to improve the therapist's structural thinking.

Teaching the Paradigm in Live Supervision

The alternative to the "postponing" strategy is to deal with paradigmatic issues right in the middle of live supervision. While this approach is more risky in terms of provoking confusion and stress, it also offers a better opportunity for a real integration of thinking and action, since the connection between paradigm and technique can be made by the trainee "on the spot" and at a time when her motivation to learn is greater. The following are examples of training interventions in three typical modalities of live supervision.

Phone-In

The supervisor may call the therapist to communicate not a specific intervention but a way of perceiving the situation ("He is not taking mom seriously right now, and she is allowing that to happen"), or an attitude ("You are being too lenient; how can you be satisfied with mom talking about punishments for next week?"). If supervisor and trainee have been working together for some time and share a basic "code," this kind of brief phone intervention can alert the trainee to some aspect of the paradigm (for instance, "complementarity," or "challenging the therapist's role") that she may be disregarding. In

this specific instance the supervisor did not feel that such a basic code existed yet between himself and the trainee, so he did not use the phone. In a similar situation with another trainee, however, this was the chosen intervention.

> The trainee was exploring, with a 13-year-old boy and his 50-year-old mother, a suspiciously sudden improvement in the son's behavior at school. This was the second session and mother and son had been the only participants in therapy, although the family also included a father and two older daughters. The therapist eventually uncovers a quid pro quo arrangement between mother and son, whereby mother had convinced father to authorize son to take a paper route, and son had promised in exchange to improve his behavior at school. The therapist seems to accept the explanation as valid and moves on to explore other issues. At this point the supervisor phones in and says: "This looks like extortion to me. Now mother cannot allow father to take it away either, or else the kid will misbehave again at school. There is something wrong with this structure,"
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> In the context of this particular supervisor/trainee relationship, the suggestion is enough for the trainee to develop a meaningful intervention. He expands the concept of extortion into the metaphor of a Mafia operation, a very concrete structural framework from where they can explore the role of other elements in the system. With the aid of empty chairs, father and one of the daughters come to be perceived as bodyguards that prevent mother from reaching the child, which eventually gives experiential meaning to the therapist's insistence in having the rest of the family in the room.

In this case the metaphor (extortion) provided the therapist with a pattern and organized him to look for the missing pieces in the structural puzzle. Once he saw the situation as extortion, the search for the absent elements that would complement the present ones was an automatic consequence. No specific intervention needed to be prescribed by the supervisor.

Call Out

If the teamwork between supervisor and trainee is not developed to the point where a quick metaphoric comment on the phone can promote a change in perception, the supervisor may attempt to achieve the same goal by calling the trainee out of the room and engage in a more extended dialogue. The following case is an illustration:

> The trainee was having trouble in keeping with his own goal of supporting the father-son dyad and challenging mother's position. The supervisor called him out so that they could talk:
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> *S: Father was talking to son and mother interrupted. Why did you let her do that?*
> *T: Well she was saying that he was doing a lousy job, and she had a point there.*
> *S: So, he doesn't know what to do with his 12 year old son. Maybe she has something to do with that?*
> *T: OK, I see your point. Mom has been in the middle; keep her away and they will develop their own relation.*
> *S: That is right. If you keep telling yourself that he may be incompetent, you are stuck. Now, if you look at her intrusiveness as a complement to his lousiness, what could you do?*
> *T: Stop her.*
> *S: How? Remember, she has a point.*

T: Well, I would be appreciative of her desire to help but I would explain that she needs to let them fight their own battle.
S: Fine. Do you think that you could go as far as to blame her for his poor performance? Or could you ask him to take care of her discomfort? Put her down a little bit?
T: No, I wouldn't go that far.
S: Why?
T: I guess I really am not convinced that he can do it.
S: That is the point. How are you going to challenge her if <u>you</u> are not convinced about him? If you don't really see his incompetence as part of a complementary pattern, you cannot expect him to become more competent, and then you will not support his relationship to his son with enough intensity.

Supervisor and trainee then went through a review of past incidents in therapy, where the father's strength had been more apparent, and eventually the therapist went back to the therapy room and produced a successful intervention.

Walk In

In the case of the forgetful mother, however, the supervisor did not call the therapist out, because he could not figure out how to dialogue with her in a way that would be helpful to correct her perceptions. (It is irrelevant whether this was related to the insufficient development of a common code, or to the supervisor's untimely lack of imagination):

> The alternative chosen by the supervisor in this particular instance was to walk in the therapy room, joining the session in progress and demonstrating the kind of process that he had in mind. He attacked mother for presenting herself as a joke and for communicating in so many ways to her children that they should not take her seriously. Both the content of what he was saying and his attitude were expressing his conviction that mother could do better, that her helplessness was a myth. Turning to the boy, he explored where he was expecting help from, and found out that the son thought that he would eventually go to live with his father. This came as a surprise to mother, but the supervisor pointed out the many ways in which she was signaling that her son was too much for her to cope with, and that she was ready to give up; no wonder the boy would not take her seriously. The supervisor's intervention mobilized mom, who ended the session with an intense statement to her son to the effect that she would not give up on him, he would not go to live with his father, and she would straighten him up. There was a lot of street language in this speech, and none of the previous middle-class talk.
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> In the post-session discussion, the therapist was most impressed by mother's resourcefulness, which she had not suspected, and by the supervisor's apparent conviction that the resources were there. While trying to learn from the supervisor how to mobilize this mother, the therapist inadvertently learned the more important lesson that it was truly possible to mobilize her.

More than the effectiveness of any specific technique, the demonstration highlighted the effectiveness of the structural paradigm in fueling a successful intervention. The therapist also noticed that mom could more easily be one up to her son when she used street language and values than when she mimicked the therapist's own middle class culture —an instructive observation on the differences between content and pattern. The

supervisor then encouraged the therapist's curiosity about mom's street wisdom and how this could help a son whose problem was his frequent fighting. In the next session mother lectured, to an attentive audience composed of son and therapist, on street brawls, gang laws, what to do when a bully steals your quarter at the arcade, and why it is not wise to have a knife when you are 10 years old. Rules of etiquette for addressing the teacher could wait.

Priorities in Training

As previously indicated, these efforts to modify a trainee's paradigmatic perceptions and attitudes in the course of live supervision can generate confusion. The trainer who wishes to utilize live supervision in this way must be aware of this eventuality, and accept that confusion may be a legitimate moment in learning. Some degree of disruption in thought processes is necessary in taking the leap to a new paradigm.

There are other objections to this kind of approach. Many supervisors and trainees think that it goes too far in undermining the therapist's feelings of competence and, particularly in the case of walk-ins, that the therapist can be disqualified in the eyes of the family. There is also concern about the deteriorating impact on the supervisor/trainee relationship.

My own bias is that the therapist's learning experience should take priority over his feelings of competence: training is primarily an opportunity for learning, not for feeling good. This does not mean that the trainee must necessarily feel incompetent in order to learn, but that the trainer should not withhold a learning-producing intervention just because the trainee might be hurt. If the training experience is successful, the therapist will have multiple opportunities of feeling competent afterwards.

The supervisor's intervention does not need to diminish the therapist in the opinion of the family, if it happens within the context of a team approach. Once more, this kind of risk needs to be weighted against not only the best interests of the family, but even those of the therapist who is in training in order to learn, rather to look good to the family or to enjoy an amiable relationship with his supervisor.