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# STRUCTURAL FAMILY THERAPY

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approach minimizes exploration and manipulation of the present life context.[1]

The boundaries imposed by the artificial dichotomy between internal and external processes and influences limit the child therapist. If a child is referred to treatment because of a school phobia, the 1966 Group for the Advancement of Psychiatry report said "the child has unconsciously displaced the content of his original conflict onto ... a situation in the external environment that has symbolic significance for him. . . . Thus the child avoids those . . . situations that revive or intensify his displaced conflict.. . ." The focus of this diagnosis does not take into account the environment of the child or the target of the phobia. But looking at the child with school phobia in his current life contexts broadens possible points of entry. The problem and/or an area available to therapeutic intervention might be found in the school, the home, or at the interface between school and home.

In exploring the school context for possible points of entry, the therapist would look at the child's perception of himself as a learner and his performance as a student. He would explore the child's position in the peer group and his self-perception as a member of this peer group, his relationship with the teacher and the ways he perceives the teacher as similar to or different from other significant adults, the teacher's view of the child and how correct and differentiated that view is, and how the child and the teacher

work together.

Both home and school have, in a broad sense, an educational style and expectations of the child. The child can be seen as operating at the interface of two socializing institutions. Are the two syntonic, or do they interact with him in conflicting ways?

Exploring the family context, the therapist would look for the possibility that dysfunctional sets in the family are rewarding the child's phobia. The needs of the mother, creating dysfunctional sets in the mother-child dyad, might be keeping the child at home. Or there might be a conflict between the parents in which the child's symptoms are useful; if so, dysfunctional sets in the triad might be reinforcing his not going to school. Or the school phobia could be supporting the child in a position of strength in his sibling group. Or the siblings might be supporting his symptoms as part of a scapegoating process.

Given this expanded focus of observation, the family therapist can look at the multiple forces impinging on the child in his current contexts and select areas for intervention that his analysis and goals have highlighted as promising.

These concepts could only be a product of twentieth-century philosophy and technology. The old idea of the individual acting on his environment

becomes the concept of the individual interacting in his environment. As Bateson writes:

> Consider a man felling a tree with an axe. Each stroke of the axe is modified or corrected, according to the shape of the cut face of the tree left by the previous stroke. This self-corrective . . . process is brought about by a total system, tree-eyes-brain-muscles-axe-stroke-tree; and it is this total system that has the characteristics of immanent mind.

In nineteenth-century thought, actions were expressed simply: "The boy chopped the tree down." But twentieth-century cybernetic thought recognizes that a human being is controlled, in Bateson's words, "by information from the system and must adapt his own actions to its time characteristics and to the effects of his own past action. Thus in no system . . . can any part have unilateral control over the whole." The individual influences his context and is influenced by it in constantly recurring sequences of interactions.

The broadening of focus implied by this approach affects every aspect of therapy, including its diagnostic categories. A diagnosis is no longer a non-evolving label pasted on a contextless intrapsychic entity. It is an evolving, broader description of relevant sequences. Furthermore, it includes implications for therapeutic interventions. The diagnosis of encopresis implies only that the child should be cleaned up. The diagnosis of a child's responding to unresolved conflict in the family's spouse subsystem, or the

diagnosis of sequences of enmeshed interactions between mother and child that isolate the husband-father, contain the germ of possible therapeutic interventions.

Another implication of this broadened theory is the recognition of diagnosis as something achieved by therapeutic strategy. In a systems-oriented framework, the entrance of the therapist into the family group is recognized as a massive intervention in itself. He becomes part of a new system—the therapeutic unit [family + therapist]—and he acts and reacts as a subsystem of that system.

His diagnosis is an evolving analysis. For example, a family comes into therapy with a teenage girl because she is shy and withdrawn and has difficulties in her social life. The therapist notices that when the family enters the therapy room, the girl moves quickly to sit next to her mother and pushes the two chairs close. The therapist asks what the problem is, and the mother responds. When the daughter tries to add something, the mother continues talking about her as though she had not spoken. There is a great deal of noise and confusion in the family, with the girl's siblings talking while the mother talks. The mother's knowledge of her daughter's life is intimate, going far beyond material usually shared by adolescent girls. Four minutes after the beginning of the session, the therapist makes his first intervention, asking the mother and father to change chairs. This intervention tests the flexibility of

the family, suggests to the family an interpretation of pathology in the mother-child dyad, and brings the father into the picture, in general providing a reframing of the problem with a larger focus.

The idea that the child responds to stresses that affect the family, which is accepted by both child and family psychiatry, is the basic tenet of family therapy. It has largely been a clinical supposition, based on observation, but recent family research gives it experimental grounding.

For example, in one psychophysiological research project, parents are subjected to a stress interview while their children observe them through a one-way mirror. Blood samples are taken from all family members at fifteen-minute intervals for later analysis of the free fatty acid level changes at different times in the interview.[2] The children can see and hear their parents, but they are physically unable to take part in the conflict situation. Nevertheless, their free fatty acid levels rise as they observe their parents under stress. The cumulative impact of current psychological stress is powerful enough to cause physiological changes, even in children who are not directly involved.

This experiment also shows the utilization of a child in dysfunctional sets. In the T family interview, for instance, the parents were engaged in their usual spiral of non-resolving conflicts, with the wife blaming her husband and

her husband apologizing but indicating no intention of changing. During this period the parents' free fatty acid levels increased significantly. The identified patient, a nine-year-old diabetic boy who was having trouble in school, was observing their bickering. His free fatty acid level rose almost twice as much as those of his parents.[3]

When this boy was brought into the therapy room, each parent tried to entice him into a coalition against the other parent. The spouse conflicts were submerged in the sequences of triangulating the child. In the half hour of this situation the parents' free fatty acid levels returned to their basal levels. The child's increased and remained high.

The stress associated with chronic non-resolved spouse conflicts was lessened for the parents by the possibility of triangulating the child. The stress associated with this type of position in the family system is shown by the child's large rise in free fatty acid, poignantly demonstrating the price paid by what Ackerman calls the "family healer." The family healer's instability is necessary to lessen the stress in another subsystem. The triadic dysfunctional set operates at his expense.

## Techniques of Family Therapy

Family therapy is not a technique to be defined by the number of people in a therapy room during a session. It is an interactional theory, which

encompasses any number of techniques.

Bell is generally considered the therapist who first treated families as a group. He originated a distinct procedure for treating disturbed children, seeing first the parents and then the parents and child, emphasizing the refocusing of the problem from the child's behavior to parental conflict.

As the concept of family therapy began to gain currency in the 1960s, interventions directed toward every conceivable unit were tried. There have been experiments with different locations. Different time units have been used. Different co-therapists have been utilized. Various mechanical devices have been used; and total-family diagnostic tools have been developed.

When a child is brought into therapy by his family, he has already been diagnosed by the school, his pediatrician, the court, the police, or his peers. This diagnosis reinforces the family's labeling of the child as a problem.

The family therapist's initial objective is to transform this individual label into a diagnosis that includes the family. For example, if the child is caught in enmeshed interactions between his parents, either trapped in the position of a go-between, as in the previous example, or used as the battleground, the diagnosis will reflect this dysfunctional set. The therapeutic goal will be to achieve a family organization in which the spouse dyad can function without triangulating the child.

In order to work toward this goal, the therapist will look at the sets of spouse interaction, pinpointing the ones that seem to have to utilize the child's symptoms. These will be the targets of his change-producing interventions.

## Therapeutic Tactics

Therapeutic tactics will in general fall into two categories: coupling and change production. Coupling can be defined as everything the therapist does to enhance his therapeutic leverage within the therapeutic unit. Change production is the stratagems directed toward changing dysfunctional sets.

### Coupling[4]

When two different systems adjust themselves in terms of direction and become one system, this is coupling. The union in space of a lunar module and the command ship is an example. The therapist, one system, joins the family system, and the two become one therapeutic system. The therapist facilitates his entrance into the family by accepting the family organization. Coupling operations are obviously vital to therapy. If the family drops out or the therapist loses the leadership of the therapeutic unit, nothing can be accomplished. There are three types of coupling interventions.

1. Maintenance involves supporting the family structures. A family

system is governed by rules that regulate the behavior of its members. The therapist joining the family feels the pressure to behave according to these rules. He may accept them in the beginning as a way of gaining entrance to the system. For example, if the mother is the central pathway by which family communication is routed, the therapist also talks to her and allows her to mediate his communications to the family. The therapist must be aware of the family's threshold of stress. When family members need support, he will provide it. When change-producing stratagems are pushing the family toward its threshold, he will use maintenance techniques to move back to a point where the family is more comfortable. Other examples of maintenance operations are supporting areas of family strength, rewarding or affiliating with a family member, supporting an individual member who feels threatened by therapy, and explaining a problem.

2. Tracking[5] is a method of adopting the content of family communications. As a phonograph follows a record's grooves, producing sound, the therapist takes over the family content and uses it in a therapeutic maneuver. For example, a family may be complaining about the father's authoritarian stance. The father says, "I want to be a leader, but I want to be a democratic leader. I want to be the president of this family." The therapist says, "okay, if you want to be a democratic leader, let's hold an election." In tracking, the therapist does not challenge the family. It is a method that has its roots in hypnotic suggestion, in which the patient is never confronted. If the patient refuses a suggestion, the hypnotist accepts his refusal but manipulates

the situation so that the refusal is a form of obeying the hypnotist's command. As in the technique of jujitsu, one uses the opponent's own movement to propel him. With a family, the therapist utilizes the family's movement to propel it. But he maintains the framework that he is propelling it in the direction it wants to go in. He seems to enter the family as a supporter of family rules. But he makes the family rules work in the direction of his goals for it.

3. Mimesis is a coupling technique aimed at the family's style and affect, as reflected in the members' activity and mood. The therapist may use the tempo of family communications. If the family is restricted, his communications may be sparse. He may adopt the family's affective style. In a jovial, expansive family he may use expansive body movements. He pays attention to their language and begins to use some of their terms. If they discuss a bar mitzvah, he may use a Yiddish word. If a Puerto Rican family is urging a daughter to find a husband, he may suggest that she turn St. Anthony's statue upside down. Mimetic operations are mostly non-explicit and quite spontaneous. Experienced therapists perform them without realizing it. In one family, a father who was derogating himself took his coat off. Immediately, the therapist took his own coat off. But he did not recognize this as an intervention until an observer pointed it out in a post-session discussion.

**Change Production**

Unlike coupling, change production involves some form of challenge to the family's natural style, in order to change dysfunctional sets. It is helpful in conveying this to picture the family as a jazz group. Music is produced by improvisation, but the tempo, the order the instruments will solo in, and sometimes the key are firmly predetermined. The many improvisations open to the individual player are chosen according to his mood and the possibilities of his instrument. There are areas of great flexibility within a strictly patterned organization, but they are governed by the sets.

Change-producing interventions will be directed toward the sets, or the system "memory," which dictates the repetition of accustomed interactional patterns. Coupling operations will continue throughout, but they are not to be confused with the change-producing operations that will be directed toward pathogenic sets. Therapy is often unnecessarily long because therapists waste their effort on areas in which flexibility is already possible, instead of identifying and concentrating on pathogenic sets.

The following example may help present some of the clinical consequences of family therapy theory. The presenting problem was a serious case of anorexia nervosa in a ten-year-old girl. The priority of intervention was, obviously, the abandonment of the symptoms in the child. Once this had been accomplished, we embarked on a nine-month course of family therapy, vital to the continued change of the family patterns, which had generated and

supported the anorexia nervosa.

The following data are presented in terms of an analytic schema, rather than in process recording form. When one thinks of therapy as a process involving a system's needs, interventions oriented toward a goal, and outcome, this organization of data becomes cogent. It is not sequential. Much of the material in the diagnostic formulation, for instance, was explored only after the anorexia symptoms had been abandoned. But it is a logical course of phases that the family therapist must think through.

The schema divides therapy into four phases:

1. Determination of family structure, areas of strength, and dysfunctional sets. Assignment of priorities for intervention (diagnosis).

2. Determination of objectives, or goals for change. This will be closely related to the diagnostic assessment, but will evolve through therapy.

3. Assessment of therapeutic options and selection of strategies. Given a diagnostic assessment that includes objectives, there are many possible strategies. The therapist must assess the potential impact of each option in terms of its power, its type, and its cost. In terms of power, does it mainly affect the individual, another subsystem such as the spouses, the entire family, two interlocked systems such as family and classroom, and so on? In terms of its type, is it change

production or prevention? What will it cost in therapeutic time and input, psychological pain and financial burden to the family? Stratagem selection takes into account the family's assessment of its needs, the therapist's assessment of priority, the pathways open within the limitations imposed by the family's style and the therapist's style and capability.

4. Evaluation. Periodic evaluation of the results of stratagems leads to the reassessment of priorities, new evaluation of therapeutic alternatives, the selection of further stratagems, and further evaluation of implementation.

## Case Example

The Smith family is composed of the father, a successful architect in his mid-forties, the mother, and four daughters, Helen, fourteen and one-half, Barbara, twelve, Sally, ten, and Jane, eight. The family was referred to family therapy by its pediatrician.[6] Sally had been hospitalized, diagnosed as suffering from anorexia nervosa, after losing fifteen pounds during two and a half months. On her arrival in the hospital she had weighed forty-two pounds; after a week in the hospital, she weighed forty pounds. The family assessed itself as a "normal American family." Its goal was that Sally eat.

### Diagnostic Formulation

The priority of therapy was obvious—the abandonment of the anorexia symptomatology. In priority, the therapist's assessment coincided with the family's. But because he saw the anorexia syndrome as a response to family organization, rather than as an individual's illness, his diagnostic formulation of needs was much broader than the family's perceived needs. Both the immediate and long-term objectives depended on a broader diagnostic formulation.

The therapist's assessment of the family was that they were operating in a tight, enmeshed system. Dyadic transactions rarely occurred. They became triadic or group transactions. These interactions were characterized by a rigid sequence that promoted a sense of vagueness and confusion in all family members. A parent criticized one of the girls. The other parent or a sibling joined in to protect the child. Another family member joined the critic or the criticized. The original issue would be diffused, to start again through a similar sequence, to be similarly unresolved. There was a helpful, protective quality to the enmeshed interactions. The avoidance of aggression or even disagreement was striking. The family described all interactions as harmonious.

In the therapist's assessment, there were many unnegotiated husband-wife conflicts. Such conflicts were submerged and never allowed to become explicit. They were expressed in a family organization in which the mother

joined the daughters in a coalition of females that left the husband-father trapped in a position of helpless isolation. He was perceived by the women as an absolute despot. In reality, his power within his family was negligible. The mother parented the daughters; the husband-father was disengaged and peripheral. Only in the area of parenting were spouse disagreements expressed. The father felt the mother was too lenient with the girls.

Another expression of disagreement that might have been related to the selection of the anorexia symptom was the mother's constant attempts to improve the father's table manners. This was a disagreement that had run throughout the twenty years of the marriage and was now discussed with bantering by all the family members, particularly at mealtime.

The boundaries of the spouse subsystem were very weak. The peripheral husband-father had strong ties to extrafamilial systems, particularly his business and his own family of rearing. The mother was firmly bound in the female subsystem, which was an enmeshed, high resonance system. Small movements by members of this system brought countermovement from the other members. The mother was the main point of contact between this system and others. The father communicated with the girls through the mother. Therefore, the mother controlled the nature of their communication, screening out nurturant elements of the interactions but letting controlling elements pass, thus strengthening the coalition of the girls

with her against their father. Her relationship with the girls was over-controlling, intrusive, and over-nurturing. The close communication, appropriate with younger children, had led to difficulties beginning a number of years before when the older daughter, emerging into adolescence, had begun to make demands for age-appropriate increased autonomy. At this point, the relationship of mother and oldest daughter was fraught with demands for autonomy, countered by the mother's demands for obedience. Barbara was allied with her older sister in this conflict.

This family malfunctioning was affecting all the family members. The symptomatology of anorexia nervosa overshadowed the symptomatology of the parents and the "well" siblings, but clinical scrutiny of the total group showed each member responding to the family stress in idiosyncratic ways. The anorexia nervosa syndrome was deeply imbedded in the family's pathogenic sets.

The Smiths, like other pathologically enmeshed families, were highly resistant to change. When a situation that required family change occurred, they typically insisted on retaining their accustomed methods of interaction. Consequently, situations of chronic imbalance were maintained for long periods.

When significant members of a pathologically enmeshed family system

feel that the family can neither withstand change nor adapt to it, the system demands that particular family members change in a way that will maintain the malfunctioning homeostasis. A symptom bearer is selected (and self-selected) as a conflict-avoidance circuit. Whenever the rather low perceived danger point of family stress is approached, the symptom bearer will be activated for use in conflict-detouring sequences. The family system reinforces the development of symptomatology and rewards its continuance because the symptomatology is necessary to the conflict-detouring sequences that maintain the status quo of the family system.

In the Smith family, Sally was functioning as the chief conflict-detouring pathway. Her most important use and source of reinforcement was in the spouse subsystem, but the symptomatology was, of course, multideterminate.

### *Spouse Subsystem*

The never negotiated conflicts between the parents were perceived as a particular danger area. All the children were involved in keeping these submerged; but when one arose, it was most often Sally who crossed the generational boundary to diffuse the parental conflict. Her function was to allow her parents to detour their conflict via concern for her.

Furthermore, the symptom defined one safe area in which spouse conflicts could surface. The father thought the mother should make Sally eat.

The mother, though very worried, thought that Sally should not be forced to eat.

The coalition of the mother and daughter against the father was explicitly manifested in the mother's protecting Sally against the father's assertion that she should eat. At the same time, the selection of the symptom was an implicit coalition with the father, whose fight with the mother had also been allowed to surface in the area of eating.

### *Sibling Subsystem*

Sally was the least powerful member of the rather undifferentiated group. She was isolated and excluded. The sibling subgroup, of course, conformed to the family style. Whenever conflict arose, there was immediate bunching in coalitions. Sally was always excluded from these coalitions, and was often their target. Since open disagreement was to be avoided, her isolation took the form of tomboy interests. The girls said Sally did not want to play with them because she preferred boys' games, and Sally agreed.

The anorexia nervosa kept the structure of the sibling subgroup intact, but it improved Sally's position. She was still isolated, but the coalitions against her became coalitions of concern and protectiveness.

### *Individual Subsystem*

The anorexia syndrome was a means of self-assertion. By not eating, Sally was asserting herself in a way that was permissible within the value system of the family. She was disagreeing, but not openly. The family's priority of avoidance of conflict was maintained because her not eating was not an explicit confrontation or rule breaking.

The symptom, then, was being reinforced by the spouses as a conflict-avoidance circuit, by one spouse in coalition against the other, by

Sally's experience of "legal" self-assertion, and by Sally's being able to protect her family and even ally herself, on an implicit level, with her father. The siblings also reinforced the symptom as part of a protective and scapegoating system.

### *Objectives Posed by Diagnostic Formulation*

The objectives posed by diagnostic formulation were:

1. The disappearance of the anorexia nervosa symptomatology.

2. A change in the spouse subsystem. Supportive, complementary transactions between the spouses must increase. A strongly bounded subsystem of mother and father, parenting their children in a mutually supportive relationship, must appear. The mother must be disengaged from parenting to give her more space for spouse subsystem operations and for clear

supportive parenting operations. The father must be more engaged in parenting, able to contact his daughters directly without going through the mother; the mother's function as contact must disappear.

3. A change in the sibling subsystem. The enmeshed functioning of the subsystem must decrease. The boundaries must be weakened so that the girls can interact with their parents and with the extra-familial world without choosing a representative of their needs. There must be clear differentiation, with clear age-appropriate increased autonomy for the adolescents and a change in Sally's powerless, scapegoated position.

4. The possibility of effective dyads and triads in the total family system. The degree of flexibility must increase, and enmeshment must decrease. Flexible alliances and coalitions, capable of shifting, must be possible.

5. Clear communication among all family members. This must be fostered, so that the real nature of transactions can be recognized.

It will be obvious that these objectives are mutually interdependent. All changes are predicated on generic change in the family's enmeshed style and the degree of flexibility possible. Furthermore, the goals are interlocked within the system just as the pathology is. The older daughters cannot become adolescents until the mother becomes a wife. The mother cannot be a

wife until her husband pulls her away from her daughters. The daughters will not let their mother go until the mother has some support from the father as a husband in the areas of spouse support and tenderness. As long as contact between the father and daughters has to go via sequences that include the mother, the father cannot get his wife into his own orbit. While the mother and father are divided, the girls will have to struggle with the mother's intrusive over-nurturance and over-control. As long as the girls remain part of an undifferentiated, highly enmeshed sibling subgroup, they will struggle through the use of the anorectic sibling, further reinforcing the symptomatology.

**Assessment of Therapeutic Options and Stratagem Selection**

It is clear from the diagnostic formulation that only an approach to the whole family system will respond to family needs. If an option directed toward only part of the family system, such as individual therapy, were selected, this would still be an intervention affecting the total family (whether or not the therapist recognized and utilized this impact). Working with the child on an outpatient basis brings the therapist into the family system. He uses the therapeutic relationship to block the child's participation in the family interactions as a conflict-avoidance circuit; and he attempts to use the changes in the child as a modifier of family transactions. Furthermore, in working with the parents as part of the treatment of the child, the therapist

has another handle in changing family organization. When the child is hospitalized, the forced separation of the child from the family joins the factors that can help mobilize family conflicts that will have to be dealt with in the absence of the anorectic child.

But therapeutic interventions directed toward an anorectic child without explicit attempts at changing the family organization of which she is a subsystem would be expensive. Even if they were successful, they would be costly in terms of psychological pain for the identified patient, the pain of duration of the anorexia symptomatology, financial burden on the family, and lack of preventive qualities for siblings and parents. The family therapist is particularly aware of the parents and three siblings, each of whom is currently showing responses to family stress and might become the new scapegoat if the presenting problem were dealt with without change in the family system.

Accordingly, the option chosen for the Smith family was family therapy. Sally had already been hospitalized prior to referral. The therapist's preference was to work with the child in her family, shortening the period of hospitalization insofar as this was consistent with medical needs. The pediatrician and family therapist collaborated in a strategy of iatrogenic family crisis, designed to break the symptomatology so that Sally could return home quickly.[7]

Change-producing strategies are always predicated on the therapist's opening up repetitive vicious pathogenic sets as he joins the family system. Though he does not have absolute freedom to manipulate the system in the ways he wants, he does have several options within the mode of family therapy. He can, for instance, elect to defuse the stress that brought the family into therapy, returning the family to a sort of status quo ante and continuing long-term therapy to change the pathogenic sets. But in working with a rigidly dysfunctional family system such as the Smiths', this approach would only reinforce the dysfunctional organization. A return to the status quo ante would not be even an interim solution.

When working with pathologically enmeshed families with psychosomatically ill children, it is preferable to work in the development of crisis, organizing the family transactions in such a way that the family is forced to deal with the stresses it has been submerging. The therapist monitors the resulting crises, creating experiential situations in which the family members can and must learn to deal with one another in new and different ways. In a family that insists on defining itself as perfectly normal, except for one member's medical problem, a medically induced crisis opens up the significance of family sets which have created and supported the symptom. The symptom area offers the obvious route to this crisis. During the first session with the Smith family, the signs of pathological enmeshment were obvious.

Since the first step in iatrogenic crisis is to observe the family's reaction to and handling of conflict, the therapist searched for an area in which a conflict could be framed. But the family was extremely resistant to attempts to elicit conflict. Only after an hour and a half of probing was an area of difficulty brought out—the mother's constant attempts to nag her husband into improving his table manners. This provided a cue for asking the family to order lunch.[8] The session stopped while sandwiches were brought in and a lunch table was set up in the therapy room.

The technique of having lunch with an anorectic family is valuable for several reasons. For one thing, it makes things happen in the session with the therapist. When a conflict around eating can be enacted in the session, talking about anorexia nervosa would be a waste of time. Furthermore, organizing a family crisis around the anorexia symptom makes it available to direct intervention. Interventions on an individual level directed at the anorexia symptomatology, such as exploration of the anorectic's ideation about food and the like, might only serve to reinforce and further crystallize the symptom. But when a family crisis is organized around the syndrome, it is the interpersonal negotiation of parents and child around the eating that gains salience, rather than the symptom itself. Not eating becomes "ground" instead of "figure" because of the dramatic emergence of interactional factors, which then become available for change-producing interventions.

During the session with the Smith family, the crisis was produced by directing the parents to demand that Sally eat. They were unable to state their demand clearly or to get her to eat. The results highlighted their powerlessness, the anorectic's power over her family, and the family members' lack of negotiation skills within their web of enmeshed protectiveness and caused an experimental, here-and-now crisis in which the therapist could intervene.[9]

**Evaluation of Implementation**

The strategy of increasing stress between parents and daughter around the anorexia syndrome yielded immediate results. Sally started eating during the session, continued to eat during two more days in the hospital, and kept .eating after her return home. In a month her weight had returned to normal.

Once the dramatic presenting symptom had disappeared, the needs of other family members came more sharply into focus, forcing a reassessment of therapeutic goals. Since the core of the problem was the inability of the spouses to negotiate together, the next therapeutic priority became change in the spouse subsystem.

Sessions with the spouse subsystem were interspersed with total family sessions. Once the facade of mutual agreement had been broken, the spouse sessions dealt with the wife's sense of being unacceptable to her husband, her

sense of being in competition with her mother-in-law, her complaints of her husband's not supporting her in parenting and not respecting her as an adult. The husband brought issues of being isolated in the family, being needed to intervene with his daughters only when the wife failed, and feeling that his wife was not interested in him as a sexual partner. Therapeutic interventions in these subsystem sessions were addressed to facilitating the negotiation and resolution of disagreements and encouraging the experience of mutually supportive and pleasurable non-parenting interactions.

Meanwhile, total family sessions continued. Various stratagems were utilized in the intra-familial sphere. During total family sessions, communication style was challenged. When a conflict between two members developed, the therapist made them continue until they achieved a resolution or until a third member could join in explicit form, either asking to be included or being invited by the original dyad. Members of the family changed chairs so that the two or three people involved in a discussion sat next to each other; the others moved out of the circle and observed.

This technique was particularly useful in differentiating the siblings. For example, as the eldest girl's conflicts with the mother became prominent, the father was requested to intervene. The three brought their chairs to the center of the room while the other girls moved out. With the mother strongly supported by her husband, negotiations ensued that gave Helen much more

autonomy, explicitly related to her status as the eldest. The therapist increased this differentiation by treating her as an adult. He also assigned a task to the mother. She was to watch for actions Helen performed that deserved her approval and reward them. This was directed to a double audience. Helen heard the task assignment and increased the type of actions that her mother could reward. Helen began to emerge as a teenager.

The individuation and disengagement of Helen from the sibling subsystem left Barbara the playmate of Jane; Sally was excluded. Now the three girls occupied the center of the room, with the mother and father helping them from outside the circle. Jane and Barbara were directed to play with Sally. The three played a board game together, and the game became enmeshed and chaotic. Therefore, the girls were assigned the task of playing board games at home. The parents bought the games, helped select them, and saw that the rules were followed.

Barbara, the brightest and most psychologically minded of the family, began to ally with the therapist, sitting near him and commenting on family functioning. She began to have more school friends, spending more time with them in an age-appropriate process of contacting the extrafamilial. Sally and Jane became closer.

In one session, Jane complained that Sally played roughly and

threatened her with frightening fury. Now Jane and Sally took the center, with Helen asked to act as the mediator, helping Jane to understand Sally's explanation. Her role as eldest sister was buttressed by participation in a play that differentiated her two youngest siblings.

In all these sessions, the clear demarcation of the parties in a negotiation and the resolution of clearly stated conflicts were emphasized. This use of space to create explicit proximity and distance, delimit subgroups (actors and observers), intensify affect, potentialize the enactments of fantasies or roles, and so on is useful in rigid, deeply enmeshed, undifferentiated families. It enables the therapist to function like the director of a play, setting the stage, creating a scenario, assigning a task, and requiring the family members to function within the new sets that he has imposed.

Therapy with this family terminated successfully after nine months.

## Conclusion

The Smith family case demonstrates that a child presenting a symptom is presenting a symptom of family stress. If one broadens the focus, the forces within the family that maintain the symptom will appear and can be dealt with.

It will be obvious that the case example concentrates on the change-

producing interventions done with this family. Change-producing stratagems can best be conveyed by describing family members and the therapist as though they were cybernated robots. The inaccuracies of this approach in describing human beings and describing therapy with human beings are too obvious to need elaboration. But coupling operations are so idiosyncratic to a therapist's style, a family's style, and the way the two interact that a description of them would simply be case recording. Change-producing interventions can be described in more generic fashion.

In conclusion, an orientation that takes the child's ecosystem into account will combine the possibility of maximally potent interventions with preventive operations. This approach involves the least possible psychological pain for the people involved, and therefore becomes the most humanitarian as well as the most effective way of approaching a problem.

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## Notes

1 The Group for the Advancement of Psychiatry report10 contains innumerable examples of this point of view.

2 Free fatty acid level is a biochemical variable that rises within five to fifteen minutes in response to stress. It is used in this study as a physiological indicator of emotional arousal.

3 In a non-stressful control period his free fatty acid level remained close to his basal level.

4 I am indebted to Braulio Montalvo for labeling this operation. An elaboration can be found in his film, "Analysis of a C. Whitaker Consultation Interview," which is available from the Philadelphia Child Guidance Clinic.

5 I am indebted to Mariano Barragan for labeling this operation and for the example.

6 Robert Kaye was in charge of the pediatric aspects of this case and was a member of the family therapy team.

7 A pediatrician may be reluctant to allow an anorectic child to return home to the family, fearing the medical consequences. The family therapist may find himself in the position of having to educate both the family and the pediatrician, so that the pediatrician does not unwittingly reinforce the family's labeling of their symptom bearer.

8 Initial sessions with anorexia cases start at eleven A.M.

9 A film of this session is available from the Philadelphia Child Guidance Clinic.