

CHAPTER 13

Structural Couple Therapy

George M. Simon

Strictly speaking, structural couple therapy (SCT) does not exist as a distinct approach for the treatment of couples. Structural family therapy, the “parent” model from which SCT derives, was developed (as its name indicates) as a treatment for families, not couples. As I detail here, SCT’s application of the conceptual apparatus and interventive technology of structural family therapy to the treatment of couples entails some distinct strengths for the model, but at least one weakness as well.

BACKGROUND

Structural family therapy emerged during the 1960s and 1970s out of the dissatisfaction with psychoanalysis experienced by Salvador Minuchin in his attempts to treat children. As Minuchin and his colleagues began to meet with the families of troubled children, they began to question the core psychoanalytic assumption that human behavior is driven from the inside out, by internal psychodynamics. Joining other early systems theorists, they began to experiment with an “outside-in” understanding of human behavior. For example, rather than viewing a child’s impulsive, acting-out behavior as a response to internal dynamics, Minuchin and his colleagues began to experiment with seeing the behavior as a child’s response to, say, a parent’s overly controlling, intrusive behav-

ior. However, the parent’s intrusive behavior could equally be viewed as a response to the child’s acting out. Thus Minuchin and his colleagues found themselves migrating from a psychoanalytic world of “linear causality” (A causes B), in which each person’s behavior is caused by his or her internal psychodynamics, to a systemic world of “circular causality” (A causes B, which causes A, which causes B, . . .), in which each person’s behavior, at one and the same time, is both an effect and a cause of the interactional partner’s behavior.

As promising as Minuchin’s group found the new systemic perspective forged by theorists like Don Jackson and Gregory Bateson to be, they were dissatisfied with the focus on the interactional dynamics of dyads that had characterized the work of these theorists up to that point. Minuchin’s group found the concepts developed by these theorists unequal to the task of comprehensively describing the interactional dynamics in systems consisting of more than two people. With no published literature to guide them, Minuchin and his colleagues undertook to develop concepts of their own that would bring a systemic way of thinking to bear on whole families, rather than just dyads.

In the theory that they developed, the family is depicted as a system that comprises “subsystems,” which arise in families as a result of differences (Minuchin, 1974). Generational differences, for example, produce parental and sibling subsystems.

Precisely because they are produced by differences, subsystems were conceived by Minuchin's group as being surrounded by "boundaries," which demarcate subsystems one from another.

The internal differences that give rise to subsystems are potentially a good thing for the family. That this is so becomes clear when we realize that the family is itself only a subsystem—of an extended family, possibly, but certainly a subsystem of the broader society in which it is immersed. A family is functional to the degree that it nurtures in its members the ability to negotiate well the demands of the world outside the family (Minuchin & Fishman, 1981). Performing this task of socialization requires that the family be able to adapt itself to changes in its social environment. However, it also requires that the family, when necessary, be able to exercise some agency in changing its environment, with an eye toward rendering the environment more supportive of the family's functioning.

The family system is better equipped to engage in this kind of complex interaction with the outside world if it has access to as many internal resources as possible. This is why the presence of internal differences that give rise to subsystems is potentially good news for the family. A family with a significant array of complexly cross-linked subsystems should find itself richly endowed with resources to manage its dealings with the outside world. Such will be the case, however, if, and only if, the various subsystems interact with each other in a way that allows the family as a whole to benefit from the resources contained in each subsystem.

To describe and to assess how adaptively family subsystems interact with each other, Minuchin (1974) proposed that we think of the boundaries that demarcate subsystems one from another as varying in permeability, from diffuse to rigid. A "diffuse" boundary between two family subsystems is one that does not adequately differentiate the functioning of the two subsystems, resulting in a deprivation of resources to the family as a whole. The presence of a diffuse boundary can be assessed when two family subsystems have no clear division of labor and/or focus between them. Subsystems separated by a diffuse boundary are said to be "enmeshed."

Equally debilitating to the family is the presence of "rigid" boundaries between subsystems. Here, differentiation has been carried to the point that resources in one subsystem are unavailable to the other. Subsystems separated by a rigid boundary are said to be "disengaged."

The constellation of subsystems in a family, along with the boundaries, whether diffuse, adaptive, or rigid, that separate the various subsystems from each other, are collectively referred to as the "structure" of the family. It must be kept in mind that in devising the heuristic metaphors of family structure, subsystems, and boundaries, Minuchin and his colleagues remained anchored in the assumptive world of systems thinking. Thus circular causality was seen as governing transactions both within and between subsystems.

FUNCTIONAL–DYSFUNCTIONAL COUPLES

Most readers no doubt realize that this brief overview of structural family therapy's foundational concepts does not include the couple as an explicit unit of analysis. This omission was not an oversight. To reiterate the point made at the beginning of this chapter, structural therapy is, first of all, a therapy of families, and only derivatively a therapy of couples.

When structural theorists consider couple functioning, they do so after having first articulated a view of family functioning. Inevitably, then, structural theorists' view of couples, both functional and dysfunctional, is set against the background of the theory's view of families. The couple is viewed as a family subsystem, no more and no less, and assessment of how well or poorly a couple is functioning is based on the theory's notion of what constitutes adaptive functioning for any and all family subsystems.

This conceptual arrival in the world of couplehood, after a journey through the world of family life, entails a distinct theoretical strength and one practical weakness for SCT. I describe the deficit—and, I hope, begin to remediate it—later in the chapter. Here, I briefly describe the strength.

Because SCT views the couple as a subsystem (perhaps of a family including children, perhaps of an extended kinship network, certainly of numerous societal-level systems), the approach does not base its understanding of the couple on a notion of romantic love. Structural theorizing about the couple recognizes that the ways people form couples and their expectations in doing so have varied dramatically from time to time and from place to place over the course of human history (Minuchin, Lee, & Simon, 2006). The notion that optimal couple relating is based on mutually experienced and reciprocally expressed romantic love is of rather recent vintage. Although this notion has

almost unquestioned currency among the middle classes of the developed nations of the West, basing an approach to couple therapy on this notion runs the risk of unnecessarily limiting the applicability of the approach.

Precisely because it evaluates couple functioning generically, utilizing the same conceptual repertoire that it employs to evaluate the functioning of any family subsystem, SCT is applicable to couples that have come together and remain together, or perhaps are coming apart, for a whole host of reasons. It can certainly be applied to couples whose members understand their relationship in what is considered the “traditional” way among the middle classes of the West (i.e., as being based on romantic love and as finding formal expression in the institution of marriage). However, it can also be applied to couples whose members, while speaking the language of romantic love, do not intend ever to marry. Equally, it can be applied to couples whose members, while choosing to marry, do not expect romantic love to play a significant role in the way that they relate to each other. It can be applied to couples whose members seek therapy to facilitate their uncoupling, as well as to couples whose members desire to remain together.

What, then, in the view of SCT, characterizes a functional couple? Like any functional subsystem, a functional couple is surrounded by a boundary sufficiently defined to demarcate the couple from its environment, yet sufficiently permeable to allow for adaptive exchange with the environment. Functional couples also share with all other functional subsystems the kind of internal differentiation associated with the presence of a significant array of resources. Thus functional couples not only tolerate but also actively encourage differences between the partners. They are marked by an ethos and a style of interaction that invites each partner to see the other partner’s differences as a resource rather than as a threat.

The dysfunctional couple, in distinction, is one whose external boundary is excessively diffuse or rigid. A diffuse boundary deprives the couple subsystem of integrity, resulting in partners’ lack of identity as a couple. A rigid boundary, on the other hand, cuts the couple off from its environment. The couple behaves not as a subsystem, but as a world unto itself. This results inevitably in functional and emotional overload, and perhaps in debilitating lack of fit between the couple and its social environment as well.

The dysfunctional couple also displays extremes in its approach to internal differentiation. Differ-

ences between the partners either are not tolerated or are rigidified into warring positions (or at least into positions in which partners do not engage in significant dialogue with each other). In both scenarios, the couple subsystem is deprived of resources.

Cultural Considerations

It is likely that in reading the description just given of SCT’s notion of functional and dysfunctional couples, many of you noted how abstract and vague the description is. The dysfunctional couple is defined as having “excessively” rigid or diffuse boundaries. “Excessive,” you might well ask, in whose estimation? The therapist’s? If so, how does the therapist avoid imposing his or her own aesthetic preferences regarding how human beings should relate when judging that a given couple’s boundaries are “too rigid” or “too diffuse”? Since such preferences are, to a degree that frequently escapes our awareness, conditioned by culture, class, and gender role socialization, this last question might aptly be recast as follows: How does the therapist avoid engaging in some form of cultural colonialism when he or she assesses the structure of a client couple (cf. Paré, 1996)?

In collaboration with my colleague Daniel Sciarra, I have proposed a means by which the heuristically useful structural notions of “boundaries,” “enmeshment,” and “disengagement” may be retained, while avoiding the pitfall of cultural colonialism (Sciarra & Simon, 2008). We propose that couples themselves must make the determination that their subsystem boundaries are dysfunctional. We consider that a couple communicates such a determination when it defines into existence a problem that it judges merits therapeutic attention. Following the collaborative language systems model of therapy pioneered by Anderson and Goolishian (1988), we assume that problems do not have any kind of objective existence: “Like everything else in the human world, a problem exists only when it is consensually defined into existence by members of a system” (Sciarra & Simon, 2008, p. 64). To use Anderson and Goolishian’s felicitous phrasing, a couple’s defining into existence of a therapy-meriting “problem” constitutes an “alarmed objection” by the couple—their way of signaling that they have determined that there is something amiss within the system.

Of course, the SCT therapist has a predetermined notion of where to look for what is “amiss” in the couple that presents itself to him or her for

treatment: The problem lies in a structure characterized by boundaries, within and around the couple subsystem, that are maladaptively diffuse and/or rigid. There is no camouflaging the fact that this notion of where to look for malfunction in the couple is brought to the therapy by the therapist, not the clients. What the clients do bring, however, is their own assessment that there is, in fact, something malfunctioning in their life together, expressed in their self-generated defining into existence of a “problem” that they judge merits the commencement of couple therapy.

In order for these ideas to provide the buffer against therapeutic colonialism that they are intended to provide, the very first thing that the SCT therapist must determine when meeting a new client couple is whether their presenting problem is genuinely self-defined by the couple, or has been defined for them by some external agent, who also has the power to coerce them into therapy (e.g., a family court judge or a child protective services worker). Thus, before engaging in the project of assessment, it is incumbent on the therapist to join with a client couple sufficiently to allow its real customership for therapy to be revealed (Sciarra & Simon, 2008).

If it becomes clear to the SCT therapist that the couple's presenting problem has been defined for the partners, rather than having been self-defined, he or she should not proceed into therapy-as-usual mode. In particular, the therapist should assiduously avoid assessing the couple, using the model's structural notions. Instead, the therapist can offer his or her services to help the couple members remove themselves from the supervision of the outside agent who has pushed them into therapy (Sciarra & Simon, 2008). Therapy “proper,” and with it, the use of SCT's notions of functional and dysfunctional couple structure, commences if and only if the couple members at some point volunteer to the therapist that they do, in fact, have a self-defined problem that has been a concern to them and that they would like to make the focus of treatment.

Development of Dysfunctional Structure

So what is SCT's explanation for the fact that whereas some couples crystallize an adaptive structure, others drift into an organization characterized by the dysfunctional features just listed? Structural theory has something to say about *when* couples are susceptible to developing a dysfunctional structure. Periods in a couple's life when

partners experience a press for change, originating either from a normative life cycle transition (e.g., the arrival of a first child, the leaving home of a young adult child) or from some acute stressor (e.g., the occurrence of a natural disaster, extended unemployment of one of the partners), are seen in structural theory as periods when the couple is at risk of developing a dysfunctional structure. However, as regards *why* some couples respond to such periods adaptively, while others do not, structural theory is relatively mute.

In large measure, SCT's silence on this matter reflects the model's nondeterministic outlook on the development of human systems. Precisely because human systems are *human*, they are complex, multifaceted entities, whose development over time cannot be subjected to the kind of rigorous modeling that is required to make accurate predictions. The structure exhibited by any given couple subsystem at any given point in its development is the product of the complex and largely idiosyncratic interplay of numerous factors, including the family-of-origin histories of the individual partners, the partners' respective biological endowments, the sociocultural environment in which the couple is immersed, chance events that have influenced the couple's life, and (not least) the couple's decisions about how to deal with all of these factors.

A corollary of SCT's nondeterministic outlook on couple development is the belief that a given couple's structure at any point in its development could always have turned out to be something different from what it is. A different decision made by the couple, a different response to some exigency of the couple's life, would have resulted in the crystallization of a different structure. This belief entails a crucial implication for the way SCT is conducted. Structural therapy is thoroughly informed by what I have termed an “assumption of competence” (Simon, 1995). No matter how dysfunctional the structure that a couple exhibits at the outset of treatment, it is never assumed that this structure reveals some essential, core quality of the couple. *Because SCT assumes that the couple could have evolved a structure different from the dysfunctional one now being displayed, it also assumes that the couple possesses in its relational repertoire adaptive resources that currently lie dormant.* SCT is not, therefore, an attempt to put something new into a couple viewed as deficient; rather, it is an attempt to activate what is already there, but latent, in a couple viewed as fundamentally competent. I soon demonstrate what a thorough-going

influence this assumption of competence has on the way SCT is practiced.

THE PRACTICE OF SCT

As is the case with every model of psychotherapy, the process of therapy prescribed by SCT follows rigorously from the way the model conceptualizes human functioning. The mechanism of therapeutic change in SCT, the structure of the therapy process, the way assessment is conducted and the goals set, the role of the therapist, and the therapeutic techniques employed all flow from the model's systemic conceptualization of couple functioning.

Mechanisms of Change

As noted earlier, structural therapy fully endorses the concept of circular causality. In the view of SCT, *the most therapeutically relevant cause of a couple member's behavior is not that person's history, biology, thinking, or feeling. Rather, the most proximal cause is that person's here-and-now experience of the partner's behavior.* And, of course, the partner's behavior is itself primarily caused by his or her here-and-now experience of the other's behavior.

In the conceptual universe of SCT, here-and-now relational experience elicits and maintains couple members' patterned behavior. Thus it follows that a therapist who wants to change behavior must change how couple members experience each other. *The mechanism of change in SCT is the production of new relational experiences for clients.* It is the experience of receiving different behavior from the partner that induces a couple member to behave differently toward the partner, and vice versa. In SCT, clients change each other by behaving differently toward each other. The job of the therapist is to facilitate this internal change process within the couple subsystem.

It is precisely because SCT is focused entirely on the production of novel, in-session relational experiences for its clients that *enactment* constitutes the centerpiece of the therapeutic process prescribed by the model (Aponte, 1992; Simon, 1995). "Enactment" refers to those moments in therapy when couple members interact directly with each other. It is in this direct interaction with each other during sessions that clients have the new relational experiences constituting the mechanism of change in SCT.

I have much more to say about enactment later, at various points in this chapter. Here, I want to

make clear that enactment is more than simply one technique among many utilized in the practice of structural therapy. Directly linked as it is to structural therapy's understanding of the mechanism of therapeutic change, enactment is better conceived as a leavening agent that is mixed into every aspect of the therapy process, from assessment to termination. Minuchin, Nichols, and Lee (2007) express this idea by asserting that enactment is more an attitude of the structural therapist than a technique that he or she utilizes. Everywhere, and at all times, the SCT therapist is oriented toward having couple members enact their relational life in the here-and-now of the therapy session, rather than talk about the relational life they live outside the session. Thus enactment organizes the therapy session as a setting in which couple members *have experiences*. Via enactment, couple members experience the futility and dysfunctionality of their current way of relating, and the possibility of relating in new, more functional ways.

Structure of the Therapy Process

SCT's understanding of the mechanism of therapeutic change dictates the manner in which the therapist manages the nuts-and-bolts details of how the therapy process is structured. Matters such as who should attend therapy sessions, how often sessions should occur, and whether referrals for medication evaluation should be made are all decided in light of SCT's understanding of the nature of couple dysfunction and how such dysfunction is remediated via the therapy process.

As I have just described, SCT aims entirely at changing how couple members experience each other. Obviously, one couple member cannot experience the other differently if that person is not in the therapy room with him or her. Thus, in general, both couple members are expected to be present together in every session of SCT.

Even when the SCT therapist succeeds in getting couple members to experience each other differently during sessions, he or she fully expects that during the early phase of therapy, those novel relational experiences are going to "wash out" during the period between sessions, as the couple subsystem's structure reasserts itself and the couple members return to their usual way of relating to each other. (I have more to say about this "relational inertia" later in the chapter, when I discuss goal setting and technical aspects of the therapeutic process.) Since the therapist wants the novel relational experiences produced in session to build

in intensity to the point where definitive restructuring of the couple subsystem occurs, whenever possible he or she structures the therapeutic process so that sessions occur, at least during the early phase of treatment, on a weekly basis.

While conjoint sessions are the rule in SCT, there is one important exception to this rule. It occurs when the therapist suspects that one couple member is behaving violently or abusively toward the other, and that this fact is not being reported openly in sessions. Under such circumstances, the therapist arranges individual sessions with each partner, thereby providing the abused partner a safe forum to talk about the violence and/or abuse that is occurring. Because violence or abuse that cannot be talked about openly in a conjoint session is likely to be the kind that is not amenable to change via conjoint treatment, if individual sessions reveal that abuse or violence is occurring, then couple therapy is not continued beyond that point. Rather, the abused partner is referred to services that help to ensure his or her safety. The therapist also provides an appropriate referral to the abusing partner, provided that, in the therapist's judgment, doing so will not place the abused partner at heightened risk of receiving some kind of retaliatory response from the abuser.

Whereas the SCT therapist readily makes referrals in the situation just described, he or she is slow to see the need to refer a client for a medication evaluation. It is not that that the structural therapist does not recognize the influence of genetics and biology on human behavior. The contribution of genetic endowment to human behavior has by now been too well documented to be ignored. However, structural theory has always assumed that family structure plays a crucial mediating role between genes and their behavioral expression. Adaptive family structure, the model assumes, works to suppress whatever genetic tendency family members might possess to become psychiatrically symptomatic; likewise, maladaptive family structure works to activate such genetic vulnerabilities. This assumption of structural theory has been validated a number of times by research designed to tease out the interaction between genetic endowment and family dynamics (e.g., see Wynne et al., 2006).

Recognizing the power of relational dynamics both to activate and to suppress psychiatric symptoms, the SCT therapist responds to the presence of such symptoms in one or both members of a client couple by doing what he or she would do with any couple: begin to work to restructure the

couple subsystem. The therapist does so, confident that an adaptive restructuring of the couple relationship will result in a significant abatement or even the remission of whatever psychiatric symptomatology was present at the outset of the therapy.

The SCT therapist only sees a need to make a referral for adjunctive treatment in circumstances in which a client's symptoms entail an imminent and substantial threat to harm self or others. Under such circumstances, the therapist cannot wait until an adaptive restructuring of the couple subsystem has ameliorated the client's symptoms. Such circumstances require the more or less "quick fix" that medication might provide. Thus, under these circumstances, the therapist refers the symptomatic client for a medication evaluation.

Whereas relational dynamics play a crucial role in the activation-suppression of biology-involving psychiatric symptoms, they are not the only contributing factor. Thus, even at the end of a successful course of SCT, some residual expression of such symptoms might remain in one or both couple members. If, at this point, the clients express the desire to see whether psychopharmacological treatment might produce a further reduction in symptoms, the SCT therapist gladly provides a referral for a medication evaluation.

Assessment

What the SCT therapist primarily assesses during the initial encounter with a client couple is, of course, the structure of the couple subsystem. However, it is important to recall that the SCT therapist will enter upon the process of assessment only with a couple that has presented itself for treatment with a problem that its own members have defined into existence.

Structural assessment of the couple subsystem entails an assessment of the permeability of the boundary surrounding the subsystem and the way differentiation is handled within the subsystem. The SCT therapist expects that most couples presenting for treatment are surrounded by an external boundary that is either excessively diffuse or excessively rigid. The model also predicts that most client couples either avoid differentiation between the partners—"We think alike on almost everything"—or exaggerate differentiation to the point that the only conceivable alternatives for the couple members are to live in a state of perpetual conflict or to avoid significant interaction with each other altogether.

The client couple carries its structure with it into the therapy room. The unarticulated rules and expectations that organize the couple's relational life outside the therapy room also organize how the partners behave in the therapy room. Thus all the SCT therapist need do to bring the couple subsystem structure to the fore is to invite the partners to begin interacting with each other in the therapy session. Such direct interaction between couple members is, of course, what SCT refers to as "enactment." Just as enactment, later in the therapy process, will be the SCT therapist's primary medium for changing the couple subsystem structure, so too is it the therapist's primary tool early in the therapy process for assessing that structure.

Any enactment the therapist elicits during the first session will probably provide a glimpse into the couple subsystem structure. However, because the SCT therapist is particularly interested in how the couple subsystem handles internal differentiation, and how this differentiation is circularly linked to the permeability of the subsystem's external boundary, certain kinds of enactment are likely to have more assessment value than others. Specifically, enactments in which couple members air and explore differences between them are likely to provide the therapist with the clearest view of the couple subsystem structure. Therefore, relatively early in the first therapy session, the SCT therapist looks for an opportunity to elicit an enactment between the partners on some matter on which they appear to differ.

Some couples cite intractable differences as precisely the problem that led them to seek therapy. Eliciting an enactment focused on differences is usually easy in such cases. After allowing each partner to articulate his or her position on the controversial issues(s) in question, the therapist merely directs the clients to continue their discussion with each other.

The situation is different when a client couple identifies symptoms in one partner as the presenting problem for therapy. In such circumstances, the partners frequently are in substantial agreement about the nature of the symptoms, and even about possible causes of the symptoms. More often than not, they agree in citing the identified patient's biology and/or developmental history as the cause of the symptoms.

Because enactments focused on presenting symptoms are not likely to expose differences between the partners, the therapist needs to broaden the focus of exploration during the first

session beyond the symptoms. The therapist can do so by interrupting the client couple's familiar narrative about the presenting symptom. By asking questions about the symptom that are not addressed by the couple's "official" narrative—questions framed in relational terms—the therapist can turn the presenting symptom into a portal into the couple's relationship (Minuchin et al., 2006, 2007): for example, "When she is depressed, are you left feeling high and dry, alone on a desert island?" or "Does his preoccupation with Internet porn sites feel more to you like a camouflaged kick or an abandonment?" As the therapist moves the conversation toward relational themes, differences between the partners that were papered over by their consensus about the presenting symptom are likely to emerge. Once they have emerged, the therapist can elicit enactments focused on these differences.

Wherever they occur in the therapeutic process, enactments are not so much observed by the therapist as they are experienced. There is no one-way mirror between the therapist and the clients as the latter engage in enactments. The therapist is very much present during an enactment, precisely as a third party within easy reach of the clients as they interact with each other. As such, the therapist occupies the same position during enactments that salient third parties occupy in the couple's natural ecology. Thus how the clients include or exclude the therapist during first-session enactments provides important information about the permeability of the couple subsystem's external boundary, and about how that permeability is circularly linked to the way differentiation is handled within the subsystem.

For example, a couple might respond to the therapist's repeated requests for enactment with exceedingly brief conversations, followed invariably by one couple member's attempt to engage the therapist in an extended dialogue about a matter not pertaining to the couple relationship. Situated at the receiving end of this transaction, the therapist might find him- or herself being pulled into a focal awareness of the couple member who keeps soliciting attention, and into a forgetfulness of the other member. Several repetitions of this pattern suggest to the therapist that the members of this couple are underinvolved with each other, and that this underinvolvement is circularly linked to enmeshment between at least one of the partners and one or more parties outside of the relationship.

If some kind of symptom in one or both partners is presented by a client couple as the reason

for seeking treatment, first-session enactments also provide the SCT therapist with the means to assess that aspect of the symptom, apart from possible threat to harm self or other, in which he or she is most interested: the manner in which the symptom “fits” into the couple subsystem structure, maintaining—and, at the same time, being maintained by—the structure.

For example, married partners inform a therapist early in their first session that they have sought therapy because of the wife’s depression. The therapist notes near-complete agreement between the spouses as they respond to her questions about the particulars of the wife’s symptomatology. Differences, however, begin to emerge when the therapist asks whether they have always agreed about how best to handle the depression. The therapist highlights the differences and asks, in an offhand way, what else the spouses disagree on. “Nothing, really,” the wife replies. “Well, I have told you repeatedly that I think you spoil the children,” the husband says tentatively. The therapist invites the spouses to talk together about this matter.

As the resulting enactment proceeds, the therapist notes that the husband builds gradually from a halting, tentative presentation of his ideas about parenting to a vigorous, increasingly angry presentation. The wife responds to each increase in her husband’s anger by becoming ever more derogatory of his character: “Well, I may spoil the kids, but you’re a socially inept jerk.”

The cycle of escalation continues for several moments until the wife suddenly falls silent and visibly begins to withdraw. Quietly, and, at least as the therapist experiences it, quite pathetically, she begins to cry. The therapist recognizes that the wife is beginning to enact in session that particular combination and sequence of behaviors that the couple has described earlier in the session as constituting her depression. The husband notices the change in his wife. He reaches out to her with a tissue in hand and gently wipes away her tears. Turning to the therapist, he says, “I think she handles the kids just fine. She’s right; I’m really something of a jerk when it comes to dealing with people.”

The therapist uses her experience of this enactment to construct the hypothesis that this is a conflict-avoiding couple, hypothesizing that the wife’s depression functions effectively to ward off the outbreak of conflict between the spouses, and to quickly short-circuit any episode of conflict that does manage to break the surface of the couple’s life. Because the couple subsystem struc-

ture, aided and abetted by the wife’s depression, does not permit the airing of differences, resources within the subsystem are not being utilized. The wife cannot benefit from her husband’s perspective on parenting, and the husband cannot benefit from his wife’s insights about his social skills. Meanwhile, the assiduous avoidance of conflict has had the paradoxical effect of causing considerable unresolved conflict to build up within the subsystem. The more conflict builds below the surface of the couple’s life, the more necessary the wife’s depression becomes to forestall its outbreak. The longer the depression succeeds in forestalling the airing of conflict, the more firmly rooted within the couple subsystem structure the depression becomes.

Goal Setting

A couple enters therapy with the goal of alleviating whatever it is that the members have identified as their presenting problem. The SCT therapist thoroughly accepts this goal and considers the therapy successful only if the couple members are satisfied that their presenting problem has been resolved.

The SCT therapist’s intention of realizing the couple’s goal of alleviating its presenting problem encounters an immediate impediment in situations where the couple members articulate very different notions of what such alleviation would look like. Such divergence in couple members’ conceptions of a solution to their presenting problem occurs most frequently when the presenting problem is one of relational dissatisfaction. In cases such as this, it happens with some regularity that one partner’s notion of a solution involves a more harmonious life together, while the other partner openly expresses ambivalence about the continuation of the relationship, wondering aloud whether the only solution is dissolution of the relationship. The SCT therapist’s first response to this situation will be to question the latter partner as to why, given this expressed ambivalence about the future of the relationship, he or she is sitting in a couple therapist’s office. Any of my readers who have had the least experience doing couple therapy are probably already mouthing the two answers most frequently given to this question:

1. “I’m here because he [or she] wants me to be.”
2. “I’m here because I want to make sure that I try everything before I decide to leave the relationship.”

The first of these two answers reveals the same lack of customership for therapy that I have previously indicated should alert the SCT therapist to avoid entering into “therapy-as-usual” mode. The same danger is operative here as in the situation where both couple members lack customership and are presenting for therapy at the behest of a powerful outsider: If the therapist launches into therapy-as-usual, he or she will be entering into a coalition with the person who is the real customer for therapy, and in the process will be disempowering the “visitor,” who is presenting for therapy under duress.

The problem facing the therapist is a different one when one of the couple members gives the second answer to the therapist’s question. Here the risk entailed is one of a self-fulfilling prophecy. If one member of the couple has already determined that he or she wants to leave the relationship, but feels the need to “go through the motions” of therapy to provide justification (to self and/or to others) that leaving the relationship is warranted, the therapy is almost fated to fail in a way that provides this couple member with the justification he or she is seeking. The client’s lack of motivation and resulting lack of work done in the therapy will almost certainly produce this result.

Faced either with imposing therapy on a client who does not want it, or with engaging in a “pretend” therapy fated to fail, the response of the SCT therapist is to postpone the commencement of therapy proper. In its place, the therapist will highlight during the first session the discrepant goals for the therapy being presented by the couple members and will “problematize” the situation, explicitly refusing on ethical grounds either to subject an unwilling couple member to a therapy that he or she does not really want, or to engage in a therapy that is fated to fail. The creation of this existential mini-crisis in the first session almost invariably has the effect of ferreting out the genuineness of the ambivalent partner’s rhetoric of ambivalence. If the expressed ambivalence is not genuine, but rather part of the dysfunctional, circular interactional loop between the partners, the prospect that therapy might not in fact commence usually moves the “ambivalent” couple member to disown his or her rhetoric of ambivalence, and perhaps to replace it with some novel means of expressing discontent with the relationship. If, on the other hand, the expressed ambivalence is genuine, the ambivalent partner will reassert his or her ambivalence, even in the face of the therapist’s “problematizing” of the situation. In such a case,

the commencement of couple therapy is not indicated, and the therapist will refer the motivated client to an individual therapy designed to help him or her discern how to respond to the situation.

Even when both couple members articulate the same or similar notions of what a resolution to their presenting problem would look like, the matter of goal setting in therapy is complicated by the fact that, more often than not, couples enter therapy with not only their presenting problem, but also a theory about why the problem is occurring. When the presenting problem is a symptom in one or both partners, clients frequently ascribe the problem to the symptom bearer’s biological makeup and/or developmental history. When the presenting problem is defined in relational terms, each partner usually sees the other as the cause of the problem: “We don’t have sex because he’s preoccupied with work,” or “We don’t have sex because she’s such a nag. Who would want to have sex with a nag?”

The difficulty that such clients pose for the SCT therapist is that their causal theories are at odds with the therapist’s own causal theory. It is a rare occurrence, indeed, when partners enter therapy subscribing to SCT’s assumption of circular causality, and seeing their presenting problem as rooted in the dysfunctional structure of their relationship.

This dissonance between clients’ causal theories and those of the SCT therapist presents a problem for the therapist because causal theories necessarily entail therapeutic goals. If clients believe that a symptom is caused by biology or developmental history, then the “fix” that they look for is a distinctly individualistic one. Similarly, if each partner believes that a presenting problem defined in relational terms is caused almost exclusively by the other, then they expect the therapist to proceed by evaluating their competing claims of causality, deciding which of the couple members is “really” at fault, and then whipping the “offending” partner into shape.

Rooted as it is in its own systemic theory of circular causality, SCT will little resemble the therapy that clients’ own linear, individualistic causal theories lead them to expect. Thus, as soon as the therapist has formulated a working hypothesis about the structure of a given couple subsystem (typically late in the first session), he or she must address the likely dissonance between the partners’ causal theory about the presenting problem and his or her own. The therapist needs to communicate his or her thorough acceptance of

the partners' overarching goal of alleviating their presenting problem. However, he or she needs also to communicate an "explanation" for the presenting problem that orients the clients away from whatever expectations about the therapeutic process they might have carried into therapy, toward at least an inchoate grasp of what the process will in fact look like. The provision of such an "explanation" is what SCT refers to as "reframing" (Minuchin & Fishman, 1981).

The "explanation" provided by reframing is in no way conceived of in SCT as an educative intervention. The causal theories endorsed by most clients who enter therapy are not "incorrect" in any absolute sense. To be sure, these linear, individualistic theories do not fit with SCT's circular, systemic worldview. However, there is nothing self-evidently true about that systemic worldview. The linear thinking that underlies clients' causal theories is every bit as intellectually credible as the circular thinking underlying SCT. Indeed, such thinking is more representative of the mainstream of the mental health professions than is systemic thinking.

Thus the SCT therapist is not trying to educate clients when, late in the first session, he or she offers a reframing of their presenting problem. Rather, the therapist uses reframing as an exercise in informed consent. In the reframe, the therapist shares with the couple his or her preliminary view of the structural features implicated in the genesis and/or maintenance of the presenting problem. Perhaps more importantly, the reframe also provides clients a glimpse into their therapist's systemic worldview.

A very small percentage of client couples respond to the therapist's reframing of their presenting problem in the first session by leaving therapy. These are clients who presumably find the causal theory about their presenting problem conveyed in the reframe—and, perhaps furthermore, the systemic worldview informing the reframe—too foreign to be entertained. The therapist who conceives of reframing as an exercise in informed consent is not disheartened by the exit of these couples from therapy. Having found the SCT therapist's view of their situation unacceptable, these couples, in leaving therapy, are doing exactly what they should be doing: rejecting a treatment whose rationale they find spurious, and mounting a search for a treatment whose underlying worldview fits more closely with their own.

Although the clients who remain in therapy following the reframing—and these comprise the

vast majority—presumably do not experience the causal theory expressed in the reframing as being toxic, as do the clients who leave, it would be incorrect to assume that they simply accept the reframe; quite the contrary, in fact. Most couples devote the bulk of their energy during the next few sessions to attempts to refute the reframe. Some do so explicitly, trying to engage the therapist in a debate about the view of the presenting problem contained in the reframe. Most do so behaviorally, continuing to act in ways that are consonant with their original, linear view of their situation.

The SCT therapist not only expects this response from clients, but actually welcomes it. Clients' "resistance," not only to reframing but also to the therapist's ensuing interventions, helps to shape and to particularize treatment that the SCT therapist delivers.

In addition to its assumption of competence, SCT is also characterized by an "assumption of uniqueness"—an assumption that "whatever characteristics it may share with other [couples], each [couple] is fundamentally unique" (Simon, 1995, p. 20). The SCT therapist welcomes clients' struggle against reframing and ensuing interventions because he or she sees this struggle as representing (at least in part) clients' assertion of their uniqueness. Seeing "resistance" in this way allows the therapist to think of interventions as tentative probes that provide feedback on a given couple's uniqueness, rather than as specifically targeted change attempts that, because of their very specificity, can only be evaluated either as having "succeeded" or "failed" (Minuchin & Fishman, 1981).

Because, under the influence of the assumption of uniqueness, the SCT therapist conceives of interventions as probes, he or she allows the particular ways a couple struggles with and against interventions to shape the next series of interventions he or she delivers. Without doubt, that next series of interventions will continue to be guided by the therapist's overarching, generic goal of changing the couple subsystem structure. However, by struggling against interventions, client couples progressively "teach" the therapist, as they simultaneously discover for themselves, what idiosyncratic arrangement drawn from their reservoir of unutilized resources they will crystallize as an adaptive alternative to the dysfunctional structure being challenged by the therapist's interventions. It is by struggling with and against the SCT therapist's interventions that the client couple collaborates with the therapist in guiding therapy toward an outcome that, in the end, will be as

much informed by the couple's idiosyncratic style, outlook, values, and relational resources, as by the therapist's therapeutic ideology. It is by struggling with and against the therapist's interventions that the client couple participates in setting goals for the therapy.

Role of the Therapist

The fundamental task of the SCT therapist is to help the client couple replace its dysfunctional structure, which is maintaining the couple's presenting problem, with a more adaptive structure. SCT's assumptions of competence and uniqueness lead the therapist to expect that this new structure will emerge from the wellsprings of clients' latent, idiosyncratic resources. Thus the SCT therapist does not function in the change process as a supplier of adaptive alternatives to the couple, but rather as an *activator* of relational resources that are assumed to lie latent in the client couple's repertoire as the couple enters the therapy.

As highlighted earlier, SCT's assumption of circular causality leads to the view that the most therapeutically relevant cause of human behavior is here-and-now relational experience. Thus the SCT therapist considers the mechanism of change in therapy to be the production, via enactment, of new relational experiences for clients. By providing the opportunity in session for couple members to experience each other in new ways, the therapist acts to dislodge the self-reinforcing, circular interactional loops that maintain the couple's presenting problem, and to help the couple stabilize more functional, problem-free loops.

The desire to make enactment the centerpiece of the change process in therapy places stringent requirements on both the level and the kind of activity in which the SCT therapist should engage. As regards level of activity, the therapist certainly needs to be active enough to induce clients to begin using relational competencies that are currently being suppressed by the couple subsystem's dysfunctional structure. At the same time, however, the therapist must avoid becoming so active as to centralize him- or herself in the therapy process, with the result that clients spend more time talking with the therapist than with each other.

As regards the kind of activity in which he or she should engage, the SCT therapist is once again guided by the assumption of circular causality. Because SCT assumes that here-and-now relational experience is primarily responsible for eliciting and maintaining human behavior, the

therapist uses *how clients experience him or her* as the chief means to activate their latent relational resources.

A concrete example helps to illustrate how the SCT therapist functions to elicit change in therapy. Let us imagine a hypothetical couple subsystem whose lack of internal differentiation manifests itself in a rigid overfunctioning-underfunctioning role structure. This couple's therapist notes how the complementary role structure informs in-session enactments, with the overfunctioning member invariably taking the lead to organize and to keep on task any conversation that the therapist elicits between the partners. The therapist also notes how the underfunctioning member invites and reinforces this behavior on the part of the partner—by never taking the lead in conversations, and never objecting when the partner leaps in to “help” when the underfunctioning member pauses (even briefly) in what he has to say.

In order to elicit a change-producing enactment for this couple, the therapist needs to do something in session to induce the underfunctioning member of the couple to surrender the passive posture that he invariably assumes when dealing with his partner. Structural theory informs the therapist that there is little chance of succeeding in this endeavor if the underfunctioning partner experiences the therapist in the same way he experiences his partner. So the therapist enters into a conversation with the underfunctioning partner, working hard as he or she does so to maintain a low-key posture, always following the client's lead rather than leading in a manner that is isomorphic with the way the partner usually behaves.

After a few awkward moments, the underfunctioning client begins to increase his activity level in the conversation. Soon, he is leading and organizing the conversation in a way he almost never does when interacting with his partner.

The therapist does not consider this shift in the client's behavior all that newsworthy. SCT's assumption of competence predicted that the client would be able to behave in this way. What the therapist needs to do now is to produce an interaction between the partners in which the underfunctioning client behaves toward the partner as he has begun behaving toward the therapist. Thus the therapist allows the conversation with the underfunctioning client to continue only long enough for the client to develop some momentum in the exercise of the new relational behavior displayed toward the therapist. After a couple of

minutes, the therapist elicits an enactment, asking the client to continue the conversation with his partner. Once the enactment begins, the therapist falls silent and begins to observe.

The therapist pays very careful attention to the ensuing enactment. Of course, the therapist is interested to see whether the couple's interaction in the enactment becomes informed by a new, more adaptive structure, or reverts instead to its old, dysfunctional organization. However, of far greater import to the therapist than the gross "success" or "failure" of the enactment are the details of *how* it "succeeds" or "fails." SCT's assumption of uniqueness leads the therapist to consider the enactment an opportunity to learn about the idiosyncratic features that render this client couple different from all others. Regardless of whether the enactment "succeeds" or "fails," the therapist uses what he or she gleans from the enactment about this couple's uniqueness to refine the next attempt to activate the couple's latent relational resources.

As illustrated in this hypothetical vignette, the SCT therapist's role as an activator of latent resources causes his or her behavior in therapy to become organized into an oscillating pattern, in which periods of relatively high activity level alternate with periods of relative inactivity (cf. Simon, 1992, 1993). During the former periods, the therapist strategically presents him- or herself to the couple in a manner designed to induce one or both partners to behave differently than they do when they interact with each other. During the latter periods, the therapist functions as observer of enactments in which one or both partners attempt to extend the novel behavior begun during their interaction with the therapist into their relationship with each other.

The SCT therapist's oscillation between engaged activity and relatively disengaged inactivity may aptly be compared to the behavior of a person who is directing a play in which he or she also acts. The therapist functions much like the director of a play when eliciting enactments between couple members. The therapist functions as an actor during those moments in therapy when he or she strategically assumes a certain relational posture toward one or both couple members, in an effort to elicit novel behavior from them.

The SCT therapist will not be able to exercise the role as director-actor of the therapeutic drama unless the clients, who are the "stars" of that drama, allow it. Thus, like therapists of all persuasions, the SCT therapist must devote effort to forging an alliance with clients. How the therapist

goes about creating this alliance bears the unmistakable imprint of SCT's fundamentally experiential nature. The therapist connects with a couple by modifying his or her manner of self-presentation in such a way that he or she is experienced by the couple as an "insider"—someone whose bearing, language, pacing, and all-around "style" fit with that of the couple subsystem.

Achieving this stylistic fit with the client system is what SCT therapists refer to when they talk about "joining" (Minuchin, 1974; Minuchin & Fishman, 1981). This word has come to mean many things, as it has gained widespread currency beyond the borders of structural therapy in the mental health field. In common clinical parlance, "joining" frequently means being supportive and/or empathic. However, being supportive and empathic will only join a therapist to a couple subsystem in which supportive and empathic transactions are the coin of the realm. Such behavior will not join a therapist, for example, to couple members who maintain their connection to each other via endless rounds of debate and refutation. To join with such a couple, the therapist needs to join in the debating—with the understanding that in this system, disagreement, far from being an indicator of disconnection, is rather a mechanism for connection.

Comparing, as I have done, the SCT therapist to the director-actor of a play not only illuminates the role of the therapist, but also provides insight into the clinician attributes required to practice this model successfully. The SCT therapist needs to possess components and qualities of both the "director" and "actor" roles.

Though the SCT therapist will certainly get a chance to act in the therapeutic play that he or she is directing, the therapist's "onstage" moments are distinctly those of supporting cast. The couple members have the starring roles in the therapeutic play. As a result, the SCT therapist needs to be comfortable spending much of the therapy "off-stage," exercising his or her role as director by quietly monitoring enactments between the couple members.

As an actor in the therapeutic drama—albeit in the role of supporting cast—the therapist needs to be able to manipulate the presentation of him- or herself to clients, varying this self-presentation deliberately and strategically according to the exigencies of the current moment in a given therapy. The therapist needs to be a person who can present him- or herself as either proximal and soft or as distant and critical, as expert or as confused, as

jocular or as serious, as vulnerable or as impassable. The SCT therapist needs, therefore, to be in possession of a complex and varied interpersonal repertoire. Moreover, the therapist, just like an actor, needs to be able (or to develop the ability) to activate, more or less on demand, that element in his or her repertoire that fits the “scene” in which he or she is acting (Minuchin et al., 2006).

SCT makes one more crucial demand on the clinician who wishes to implement this model successfully—one that has more to do with the therapist’s intellectual outlook than the stylistic attributes just described. Like every other approach to therapy, SCT is founded upon a set of philosophical assumptions about what it means to be human (Simon, 2003). Prominent among these is SCT’s collectivist, systemic assumption that the group, rather than the individual, constitutes the fundamental unit of the human universe. This assumption is manifest in SCT’s contention that it is the structure of the couple subsystem, and not anything internal to its members as individuals, that primarily drives the way the members relate to each other. I have argued elsewhere that it is reasonable to hypothesize that a therapist’s therapeutic effectiveness will be greatest if his or her practice is consistently guided by a model whose underlying philosophical assumptions provide a close fit with his or her own personal worldview (Simon, 2006a, 2007, 2012a, 2012b). In a related vein, a preliminary study has shown that therapists with a collectivist worldview adhered more closely to structural family therapy, SCT’s “parent” model, than did therapists with an individualist worldview (Ryan, Conti, & Simon, 2012, 2013). Thus it may very well be the case that in order for it to be implemented faithfully and effectively, SCT needs its practitioner to share its assumptive view of the human world, and perhaps especially its collectivist outlook. Therapists with an individualist worldview might do well to avoid SCT in favor of a model that provides a better fit with their view of the human condition.

Technical Aspects of the Therapeutic Process

Because each client couple is unique, every course of SCT is in some ways also unique. Nonetheless, there is sufficient resemblance among successful courses of SCT to allow me to make some generalizations about how a “typical” course of SCT evolves over time. To make these generalizations, I return to the theatrical metaphor I have employed

in the preceding section to illuminate the role of the therapist in SCT. If a course of SCT is thought of as a play, in which the therapist functions as director and supporting actor, then it typically is a play in two acts, with a brief prologue.

Prologue: The Director and Actors Meet

The curious thing about the SCT “play” is that it is already in progress when the director comes on the scene. The script for this play has been provided by the couple subsystem structure, and the couple members have been following this script for an extended period of time prior to the commencement of therapy. The script has given rise to a problem that has motivated the couple to seek treatment.

As the couple members enter the first session, they are substantially focused on their presenting problem, and only minimally (if at all) on the structural script that has elicited and/or is maintaining the problem. The SCT therapist, in distinction, is primarily focused on the couple subsystem structure because it is by means of a change in that structure that the therapist undertakes to alleviate the clients’ presenting problem. Thus, in most cases, the first meeting finds the director and the actors of the therapeutic drama looking in different directions. This state of affairs needs to be rectified quickly, if the therapeutic play is to move toward a satisfying end.

The primary agenda of the first session in SCT is construction of a consensus between director and actors regarding what the therapeutic play is going to be about. Not only is the pending therapeutic drama talked about during the first session, the session itself constitutes the opening scene of that drama, functioning as its prologue.

For the first session to perform its function as prologue to the therapeutic play, the therapist must execute several tasks during the session, many of them simultaneously. The therapist opens the session by asking the couple members to inform him or her about the problem that has brought them into therapy. As the clients begin to tell the story about their presenting problem, the therapist immediately begins the process of joining, allowing him- or herself to feel the “pull” exerted by the couple members, by their pacing, their use of language, and their demeanor and carriage. The therapist accommodates, in his or her own idiosyncratic way, to the couple’s style, hoping that the couple members quickly begin to experi-

ence him or her as someone who “fits” who they are as a couple.

After giving the clients ample time to narrate their view of the presenting problem, but long before a focus on the problem is allowed to dominate the session, the therapist moves the session toward an assessment of the relational structure that, in the view of SCT, is circularly linked to the couple’s presenting problem. The therapist looks for and/or creates opportunities to elicit enactments focused on the partners’ differences, using his or her experience of these enactments to begin constructing hypotheses about how internal differentiation is handled within the couple subsystem, and how this differentiation is circularly linked to the permeability of the boundary surrounding the couple.

During this middle part of the first session, almost all client couples allow themselves to be nudged by the therapist away from a focus on their presenting problem and toward an exploration of their relational structure. However, most clients expect (and, in my view, have the right to expect) that the therapist will make clear sooner rather than later the connection between the relational structure he or she has been exploring and the presenting problem that the clients entered therapy to resolve. Thus the necessary finale to the first session is the provision of the therapist’s preliminary formulation as to how the client couple’s presenting problem is being elicited and/or maintained by the couple subsystem structure. The therapist provides this formulation in the reframe, as described earlier.

Act I: Destabilizing the Old Structure

The return of the client couple for the second session marks the opening of Act I of the therapeutic play. The fact that the actors show up for the second session indicates that they have agreed to “play” with the dramatic script proposed by the therapist-director in the reframe. This is certainly not to say, however, that the actors have accepted their director’s script lock, stock, and barrel. Many couples enter the second session with revisions to the therapist’s script in hand—revisions that render that script less discrepant with the script they have already been following: “You don’t understand. It really *is* all her fault that we argue so much,” or “You don’t understand. In the face of his obsessiveness, I *have* to act the way I do.” Even couples who enter the second session expressing

complete acceptance of the therapist’s reframe have, in all likelihood, spent the entire time since the first session living out their old structural script with little, if any, change.

The SCT therapist is not in the least surprised by or chagrined at the structural inertia that the client couple almost invariably displays at the beginning of the second session. The therapist, after all, did not expect the reframe to have a substantial impact on the structure of the couple subsystem. As noted earlier, the SCT therapist conceives of reframing as an exercise in informed consent rather than as a restructuring intervention.

The therapist begins in the second session, and in the several sessions that follow, to provide couple members with opportunities to enact in session new, more adaptive structural arrangements. Inevitably, however, this experimentation with a new relational script occurs in the context of clients’ long experience of having lived out their old script. As problematic as that old script might be, it is familiar and predictable to the client couple. The partners know their lines well, and the long run that their play has had has given them confidence that they can act their assigned parts to perfection.

As a result, clients’ predominant experience during the first several sessions of SCT is the unsettling one of being asked by their therapist to leave what is relationally familiar to them. Almost invariably, clients respond to this unsettling experience with attempts to hold on to their old relational structure. Thus a polemic of sorts develops between director and actors—a polemic that quickly comes to dominate the first act of the therapeutic play. Whereas the therapist continually asks clients to experiment with new relational arrangements, the clients continually (sometimes subtly and sometimes not so subtly) try to alleviate their discomfort by reverting to their old relational arrangement. As I demonstrate shortly, this polemic usually builds until a crisis point is reached.

Enactment is the primary tool used by the SCT therapist during the first act of the therapeutic play to begin changing the structure of the couple subsystem. Depending on how it is used, enactment can target for change either the external boundary or the internal structure of the couple subsystem.

Recall that an excessively rigid or diffuse external boundary is a common structural characteristic of dysfunctional couple subsystems. During enact-

ments, the permeability of the external boundary of the couple subsystem is manifest in the manner in which the partners include or exclude the therapist from their interaction. Thus by strategically varying how much he or she enters (or refuses to enter) into enactments, the therapist can begin to influence the permeability of the couple's external boundary. Declining frequent "invitations" from a couple's members to enter into their enactments will function to strengthen an excessively permeable boundary around the couple. Conversely, forcefully and frequently inserting him- or herself into enactments between couple members whose enmeshment with each other makes them oblivious to the world around them will serve to modify the rigid boundary surrounding such a couple.

By simply regulating how much he or she enters into enactments, the SCT therapist can, during the first act of therapy, exert a direct influence on the external boundary surrounding the client couple. Because all structural elements of a system are linked by loops of circular causality, in the process the therapist also exerts an indirect influence on the internal structure of the couple subsystem. However, the therapist can also use enactments to exert a direct influence on this internal structure.

I have already described, in the section on the therapist's role, the way the SCT therapist uses enactment to exert direct influence on the internal organization of a couple subsystem. Functioning briefly as a supporting actor in the therapeutic drama, the therapist strategically manipulates his or her manner of self-presentation to the clients, with an eye toward inducing one or both of them to begin utilizing relational competencies that are currently suppressed by their maladaptive structure. Once such competencies have been activated in the interaction between therapist and client(s), the therapist, functioning now as director, elicits an enactment so that the competencies can be extended into the clients' dealings with each other.

Because each client couple is unique, the way the therapist needs to "act" to activate latent relational competencies varies considerably from case to case. Still, there is sufficient commonality among cases to allow the identification of two "supporting roles" the SCT therapist plays with some regularity during Act I of the therapeutic play.

Although it might, at first blush, seem counterintuitive, the SCT therapist frequently sees the need to elicit enactments that provide the partners with an experience of adaptive, produc-

tive conflict. Such enactments may be of use, for example, in restructuring an enmeshed couple subsystem whose enmeshment takes the form of assiduous conflict avoidance. Enactments of conflict may also serve as a means to engage members of a disengaged couple subsystem with each other. Eliciting enactments of this kind requires the therapist to instigate a fight that the clients have been avoiding. To "incite" this kind of conflict, the therapist needs to act in a manner designed to "lend" indignation to one of the partners. This manner of self-presentation by the therapist has been termed "unbalancing" in the literature of structural therapy (Minuchin & Fishman, 1981).

Unbalancing is illustrated by the following dialogue between a therapist and a woman whose conflict-avoidant marriage has deteriorated to the point that both spouses have begun to consider divorce. The woman typically assumes a one-down posture vis-à-vis her husband. The therapist begins the dialogue by inserting himself into an enactment in which the one-up-one-down complementarity between the spouses has played itself out, with the husband lecturing his silent wife on how she has brought their marriage to the brink of demise.

THERAPIST: Denise, may I ask you something? I was just listening to the conversation that you and your husband were having. Do you get the impression that he thinks that he's more intelligent than you? It seems to me that he was just lecturing you as if you were his student.

WIFE: (*Speaking to husband*) You see, other people see it, too!

THERAPIST: I find it curious that you allow him to speak to you that way. As I see you, you are every bit as intelligent as he—in some ways, more so. It seems to me that you have greater awareness of what's going on in your marriage than he does.

WIFE: (*Visibly blushing and looking away*) Well, maybe.

THERAPIST: The thing is, the way you deal with your husband allows him to continue in the mistaken impression that he has more on the ball than you. And that is clearly a mistaken notion. Why aren't you more vocal in telling him your point of view?

WIFE: He won't listen.

THERAPIST: I know that you're right because I have seen him dismiss you. But I think that

the survival of your marriage depends on your perspective becoming as visible as his. You need to get him to listen to you. Talk with him now and see whether you can get him to take you seriously.

Having endeavored to “lend” the wife some indignation over her one-down status in the couple subsystem, the therapist elicits an enactment, hoping to see in this enactment the beginning of an airing of the conflict that has been driving the spouses apart but has rarely emerged into the open.

Unbalancing is a difficult “role” for the SCT therapist to play well (Minuchin & Fishman, 1981). To begin with, its implementation is at odds with SCT’s core assumption of circular causality. In the previous vignette, for example, structural theory assumes that each spouse elicits the behavior of the other. The wife is as responsible for casting her husband in the one-up position he occupies as he is for casting her in the one-down position. Yet to produce an enactment in which the currently avoided conflict is aired, the therapist needs to act as if the husband is the sole culprit. Since the therapist does not believe that such is the case, acting in this way does indeed require quite the job of “acting.”

In addition, unbalancing, if it is effective, inevitably disrupts the therapist’s alliance with the “target” partner. To appreciate this fact, just put yourself in the shoes of the husband in the previous vignette, and fantasize how you would feel about the therapist at that moment. Thus effective unbalancing requires of the therapist an exquisite balancing act: to maintain the unbalanced posture long enough to produce the desired effect of eliciting or prolonging in-session conflict, but not so long as to disrupt irreversibly the alliance with the “target” partner. Indeed, to reestablish equilibrium within the therapeutic system, the SCT therapist frequently follows a period of extensive unbalancing on one partner’s behalf with a period of unbalancing on behalf of the other.

Avoidance of couple conflict is a common structural characteristic of families with a child as the identified patient. Because structural therapy was devoted almost entirely to the treatment of such families during the first decades of its development, unbalancing occupied a prominent place in the structural therapy literature of that period. However, when therapists began to apply structural therapy to couples presenting themselves for treatment precisely as couples rather than as parents of a child identified patient, they found them-

selves facing the need to supplement unbalancing with another kind of intervention.

Many couples that SCT therapists encounter are characterized by conflict that is vigorously aired rather than avoided. Indeed, for many of these couples, it is precisely their chronic and intractable conflict that is the presenting problem in the treatment they are seeking. Although unbalancing might be of some use in the treatment of these couples, genuine restructuring of these couple subsystems requires not the amplification of conflict, which is the goal of unbalancing, but the replacement of conflict with more supportive modes of transaction. To elicit this relational competence, the SCT therapist needs to soften the typically harsh transactions between these partners. “Softening,” then, constitutes the second “role” that SCT therapists play with some regularity during Act I of the therapeutic drama.

Examples of softening can be cited from the earlier structural therapy literature (e.g., see Minuchin & Fishman, 1981, p. 167). However, due to the limited call for the use of this intervention with the families that were the focus of structural therapy at that time, softening never developed into an explicit category of intervention in this literature. This lack of a detailed understanding of softening as an intervention in structural therapy is what I have mentioned early in this chapter as the model’s practical weakness when it is applied to the treatment of couples.

Although softening is not discussed thematically in the literature of structural therapy, it is the centerpiece of another approach to couple therapy, emotionally focused therapy (EFT; see Chapter 4, this volume). Despite some similarity between the two interventions, significant differences in underlying worldview between structural therapy and EFT render softening in SCT a substantially different intervention from softening in EFT (Simon, 2004, 2006b).

Softening in SCT begins with the therapist’s assuming a soft posture to induce—almost hypnotically—one or both couple members to begin acting softly. Just as the SCT therapist “lends” indignation during unbalancing, he or she “lends” vulnerability during softening.

As the SCT therapist engages in a soft exchange with one or both couple members, he or she looks for the first opportunity to move offstage and to cede the therapeutic drama back to its stars. The therapist maintains the dialogue with one or both clients during softening just long enough to produce the kind of soft, affiliative atmosphere that

he or she would like to see stabilized within the couple subsystem. Once that atmosphere has been established, the therapist elicits an enactment between the partners, asking them to maintain the softened mood in their interaction with each other. The therapist then retreats offstage to observe the scene.

The following vignette illustrates the use of softening in SCT. A young married couple requested therapy to address the problem of episodes of intense conflict, followed by extended periods of disengagement from each other. The couple entered the fourth session of the therapy in the midst of one of these conflictual episodes. The therapist elicited an enactment, so that the episode could play itself out in the therapy room.

During the enactment, the wife kept talking about how “concerned” she was about her husband’s drinking. Her manner as she used this word bespoke fury rather than worry. The therapist interrupted the enactment after it had proceeded for about 5 minutes.

THERAPIST: (*Softly, rolling his chair closer to the couple*) Trish, you’ve been telling Kevin how concerned you are about his drinking. Tell me what scares you about his drinking.

WIFE: (*After a brief pause, looking a bit nonplussed*) It concerns me that he needs to drink to have a good time.

THERAPIST: Do you think he knows how much seeing him drink frightens you? Do you think he knows how scared you get?

WIFE: (*Appearing to struggle to hold back some emotion*) No.

THERAPIST: He certainly knows how angry his drinking makes you, but I don’t think he has a clue how much it terrifies you. Do you know why it scares you so much?

WIFE: (*Wrapping her jacket tightly around her as she begins to cry softly*) My father was an alcoholic.

THERAPIST: Ah, now I see why his drinking scares you so. Can you tell him now about the fear that you feel when you see him drinking?

The wife stared speechlessly at her husband for about 30 seconds, while she continued to cry softly. Finally she began to tell him how frightened she felt when she saw him drinking, even though she never really had seen him drink to intoxication. As she spoke with him in this vein, he tentatively reached out and took her hand in his.

Whether they occur in the context of unbalancing, softening, or some other “role” played by the therapist as supporting actor in the therapeutic drama, enactments during Act I of this drama inevitably have the effect of introducing a wedge between the partners and the familiar structure that informed their transactions when they entered therapy. This is so, despite the fact that the couple subsystem usually reverts to its old structure—sometimes during the enactments themselves, and almost invariably between sessions. However, even when the partners revert in this way, they generally find that they simply cannot play out their old structural script in the same un-self-conscious way they did prior to the onset of therapy, due to the fact that they are now playing it out in the context of having enacted alternatives to the old script. Their experience during the first act of therapy is thus one of living in a kind of limbo. A new structure has not yet stabilized within the couple subsystem, and the old structure has begun to feel a bit alien.

Living in this limbo is a disorienting experience for clients. In most cases, somewhere around the fourth or fifth session, this experience of disorientation exceeds clients’ capacity to bear it comfortably. Most couples at this point seek to relieve their discomfort by making a last-ditch attempt to retrieve their old relational structure. This attempt at retrieval is usually enabled by a crisis, marked by the resurgence (perhaps beyond baseline levels) of the presenting problem that served as the occasion for the commencement of treatment. Recall that in the systemic universe of SCT, a loop of circular causality exists between the presenting problem and the couple subsystem structure, each eliciting and maintaining the other. Precisely because their presenting problem was intimately linked to their old relational structure, a resurgence of the problem provides clients with an opportunity to retrieve the “gusto” in playing out their old structural script of which the therapy has deprived them.

A crisis occurring around the fourth or fifth session of therapy is generally a sign of a course of SCT that is on its way to succeeding. Interestingly, in their research project designed to test the efficacy of structural therapy in the treatment of young adult heroin addicts, Stanton, Todd, and Associates (1982) found that a characteristic shared by most failed cases was the therapy’s failure to generate such a crisis.

Although the occurrence of a therapeutic crisis during Act I of the therapeutic drama enhances

the prognosis for the therapy, such an occurrence is not sufficient in and of itself to ensure a positive outcome. How the therapist responds to the crisis is a crucial factor in determining whether the therapy proceeds to a successful outcome. Should the crisis manage to deter the therapist from continued efforts to dislodge the old structure of the couple subsystem, the therapy is likely to fail. If, on the other hand, the therapist continues restructuring efforts in the face of the crisis, then the development of the therapeutic drama toward a successful outcome is likely to continue. Indeed, an appropriate response of the therapist to the crisis usually ushers in the end of Act I of the therapeutic play. Somewhere around the sixth or seventh session, Act II begins.

Act II: Nurturing the New Structure

The therapist-director's maintenance of dramatic vision in the face of the Act I crisis has an important effect on the therapeutic play's actors. Within a few sessions of the occurrence of the crisis, the actors finally surrender whatever "nostalgia" they retained for their old structural script. Freed from their lingering loyalty to the old script, clients begin to devote their undivided attention to exercising their competence and uniqueness in the crystallization of a new relational structure that, while different from the one that organized the couple subsystem at the outset of therapy, still expresses those idiosyncratic elements that make this couple different from all others. This disappearance of the actors' divided loyalty between their old script and their director's vision marks the start of Act II of the therapeutic drama.

Several behavioral indicators signal the therapy's transition to Act II. The most telling of these is a palpable shift in initiative between director and actors. During Act I, the client-actors' inertial tendency back toward their old script required that the therapist be prominent in functioning as both director of and as a supporting actor in the therapeutic play. While maintaining an overall posture of moderate activity level, the therapist did engage with some frequency in episodes of relatively high activity, as described in the previous section. When Act II begins, on the other hand, clients' heightened commitment to the therapeutic process reduces the therapist's need to operate as either director or supporting cast. Couple members begin to engage spontaneously in enactments during this act, without the therapist's having first to set the mood and to choreograph

the scene. During these self-initiated enactments, couple members engage in a kind of self-propelled search for alternative ways of relating—a search that occurs rarely, if ever, during Act I. With the clients' having claimed the initiative for the development of the therapeutic drama, the therapist is able to leave aside much of the directorial and acting responsibilities, and to assume instead the position of "audience."

This is not to say, of course, that the therapist is entirely inactive during Act II. However, although the therapist does intervene, this intervening has a very different tonality than it had during the first act. Functioning primarily as audience during Act II, the therapist does what audiences do: applaud. Indeed, applause is the main way that the therapist influences the shape of the play during Act II. Some of the enactments in which clients spontaneously engage during Act II clearly represent adaptive new structural arrangements for the couple subsystem. The therapist occasionally punctuates such enactments with "applause," congratulating the clients for the wonderful job they did during the enactments and noting how adaptive their interaction was in the enactments.

Some of the enactments occurring during Act II are organized by structural arrangements that, though different from the couple's original structure, are, in the therapist's estimation, not adaptive for the couple in the long run. However, the therapist does not overtly criticize or challenge these enactments. The fluid state of the couple subsystem structure during the second act renders such "gross" interventions unnecessary. All the therapist need do to reduce the chances that the maladaptive structure informing these enactments will become stabilized within the couple subsystem is to withhold applause at the end of the enactment. Such silence on the part of the therapist is a powerful intervention in the climate of Act II.

The diminished posture of the therapist during Act II makes termination in SCT a relatively brief and uncomplicated process. After the second act has gone on for a few sessions, it becomes obvious to all members of the therapeutic system that the therapist has grown more or less superfluous to the couple's already incipiently successful efforts to crystallize a new, more adaptive structure. Thus it feels like an organic development to all involved when, somewhere around Session 8–10, the therapist or the clients wonder aloud whether the termination of the therapy might be imminent. With some couples, termination occurs during the very session that the issue is raised; with others, agree-

ment is reached that the next session should be the last.

Common Technical Errors

As is probably the case in every model of couple therapy, a therapist can make a large number of errors in the implementation of SCT. A couple of common threads run through many of these errors, however. Given the significant differences I have just described between Act I and Act II of SCT, it should come as little surprise that the thread that runs through the errors commonly made during Act I differs appreciably from the thread running through the errors common to Act II.

Recall that the leitmotiv of Act I of SCT is the tension between the therapist's agenda of eliciting a new structure for the couple subsystem, and the couple members' preference to continue relating to each other according to the script provided by the subsystem's old structure. The sessions that constitute Act I will only achieve their overarching goal of restructuring the couple subsystem if the therapist prevails in the inevitable struggle with the couple's structural inertia that dominates these sessions. In order to prevail in this way, the therapist's interventions during these sessions need to be characterized by what in SCT parlance is termed "intensity" (Minuchin & Fishman, 1981), which refers to the therapist's resolute maintenance of behaviors designed to elicit enactments in which the couple members relate to each other differently. The common thread running through most errors made by SCT therapists during Act I of therapy is a lack of this intensity.

Due to widespread misunderstanding of intensity in SCT, it is necessary at this point to detail some things that intensity is not. It is not, for example, loudness, or even less, irascibility. Nor is it simply the repetition of the same failed intervention over and over again. As described earlier, SCT's assumption of uniqueness leads the therapist to view "resistance," at least in part, as a couple's way of asserting its unique identity as a couple. "Resistance," therefore, provides the therapist with an opportunity to learn more about what makes a given couple unique, and to respond to this learning by modifying his or her interventive strategy accordingly. What the SCT therapist should never modify during Act I, however, is the overarching goal of restructuring the couple subsystem. Intensity, then, refers to the therapist's single-minded focus on and commitment to achieving this goal.

Why do therapists sometimes fail to generate sufficient intensity during Act I of the therapeutic drama? Several factors might come into play, but one in particular is worth mentioning here. Intensity is founded upon SCT's assumption of competence. It would be neither therapeutic nor ethical for a therapist to resolutely undermine a couple subsystem's existing structure if he or she did not dogmatically believe that the couple members were fully competent to crystallize an adaptive structure in its place. SCT therapists who fail now and then to generate sufficient intensity during Act I may be therapists who are induced by the particulars of certain cases to temporarily "forget" the model's assumption of competence. Losing sight of the fact that the clients in these cases are fully capable of generating a new, adaptive structure, the therapists lose nerve in maintaining their challenge to the old, dysfunctional structure. Such occasional lapses in the generation of intensity can usually be redressed by good supervision.

Intensity is the sine qua non of therapeutic success in Act I of SCT. It is, however, the enemy of such success in Act II. As noted earlier, the therapist goes from being a challenger of entrenched, dysfunctional structure in Act I to being a nurturer of fragile, emerging, functional structure in Act II. Such nurturing does not require a therapist with the single-minded purposiveness that characterizes intensity. Rather, it requires a therapist who is observant and curious, providing ample space for the client couple to experiment with novel structural arrangements. Thus the thread that runs through the errors most commonly made by therapists during Act II of SCT is an inappropriately high level of therapeutic activity. Such a level of activity during this portion of the therapeutic drama tends to direct the couple members' attention away from each other and toward the therapist. Precisely at the point where their confidence in their ability to generate and maintain functional ways of relating to each other should be steadily increasing, the couple members instead become increasingly dependent on their overactive therapist to guide them in the crystallization of a new structure. Rather than quickly tending toward termination, Act II begins to drag on, with no clear end in sight.

Once again, it is usually a failure in regard to SCT's assumption of competence that is implicated in the generation of this common therapeutic error. The therapist who loses touch with this assumption may well find it difficult to make the transition from the more therapist-driven action

of Act I to the more client-driven action of Act II. Failing to believe that the clients can stabilize an adaptive structure on their own, the therapist “helps” in a way that ultimately is unhelpful.

APPLICABILITY AND EMPIRICAL SUPPORT

SCT, like all psychotherapeutic approaches, is not effective in all cases. It would be convenient if the cases in which the model is not helpful shared some easily discernible demographic or clinical characteristics. Then, referral to some other, more applicable form of treatment could be made before clients and therapist had devoted effort and resources to a failed course of therapy. Unfortunately, at this time, no research identifies readily observable characteristics shared by failed cases of SCT.

It is certain that the nature of a couple's presenting complaint is not correlated with the outcome of SCT. Couples in which one or both partners describe discrete symptoms as their presenting complaint are no less likely to benefit from SCT than couples who define their presenting problem in relational terms. Likewise, demographic variables are not correlated with outcome. Structural therapy developed out of Minuchin and colleagues' work with urban, poor families. However, over the years the model has proven helpful in work with clients at all socioeconomic levels, with families and couples representing numerous ethnic groups, with both homosexual and heterosexual couples, and in numerous countries (Greenan & Tunnell, 2003; Minuchin et al., 2006, 2007).

SCT is also not limited in applicability to couples whose members define themselves as having a shared future. Because the goal of SCT is to produce an adaptive structure for the client system, the model can be applied to divorcing and divorced couples as well as it can to engaged and married couples, and to unmarried couples whose members' mutual commitment is not in question. To be sure, an adaptive structure for a divorced couple little resembles that of a married couple, with the result that the therapy of a divorced couple is likely to have a very different feel from that of a married couple. However, one of the strengths of SCT's single-minded focus on systemic structure is that it renders the model applicable to couples at every stage of coming together, staying together, or coming apart.

The claims that I have made for the broad applicability of SCT find indirect empirical sup-

port in the extant outcome research literature about structural therapy. This literature provides only indirect support because, like the model itself, research on structural therapy's efficacy has tended to focus more on the model's application to family treatment, in which a child, adolescent, or young adult is presented as the identified patient, than on its application to couple therapy.

This limitation having been noted, however, the results of outcome research on structural therapy still deserve to be characterized as impressive. Research to date suggests that structural therapy is effective with widely varying populations in the treatment of a host of widely varying presenting symptoms, including psychosomatic symptoms in children (Minuchin et al., 1975); anorexia nervosa in children and adolescents (Eisler, Simic, Russell, & Dare, 2007; Minuchin, Rosman, & Baker, 1978); heroin addiction in young adults (Stanton et al., 1982); school adjustment, anxiety, depression, and withdrawal in adolescents diagnosed with attention-deficit/hyperactivity disorder (Barkley, Guevremont, Anastopoulos, & Fletcher, 1992); conduct-disordered behavior in adolescents (Chamberlain & Rosicky, 1995; Santisteban et al., 2003; Szapocznik et al., 1989); and drug use in adolescents (Santisteban et al., 2003).

The treatment administered in all of these studies was based on the same theoretical assumptions and constructs, utilizing to a large degree the same interventions, described in this chapter. Moreover, in the treatment of two-parent families, the therapy almost invariably attempted to restructure the parental subsystem in ways very similar to the ways that SCT attempts to restructure the couple subsystem. Thus it is reasonable to conclude that these studies provide indirect evidence of the efficacy of SCT intervention principles across a broad range of presenting problems and client populations. However, indirect evidence is hardly sufficient in the face of the current quest for empirically supported psychotherapeutic practice. The field of couple and family therapy stands in need of well-constructed research studies that provide a direct test of structural therapy's efficacy when applied to the treatment of couples.

CASE ILLUSTRATION

Session 1: The Prologue

“I still can't believe that he would do that to me!” Kayla was frenzied as she said this to me, 5 minutes into my first session with her and Peter, her

husband of 22 years. What she was referring to was Peter's involvement with Internet pornography sites, which, though apparently of rather recent vintage, had quickly become intense to the point of preoccupation.

Kayla had accidentally discovered the involvement about 3 weeks prior to my first meeting with the couple. During that time, she had been acting "like a lunatic," to use Peter's colorful description. "She's been screaming, crying, running around the house like a madwoman." Kayla had seen her internist not long after making the discovery, and he had prescribed anti-anxiety medication, which, she said, "has helped calm me down a lot."

"It has not calmed you down in the least," was Peter's immediate response. His tone was detached, almost clinical. "How can you say that?" Kayla shouted back. "Did that sound calm to you?" asked Peter, his tone unchanged.

I saw in this exchange a ripe opportunity to elicit this therapy's first enactment, which would help me get a sense of this couple subsystem's structure. So when the partners turned to me after Peter's comment, I simply directed them to continue their conversation, "since I'm curious about your different views on this issue."

I was struck during the ensuing enactment by the complementarity between Peter and Kayla's behavior. Peter, to my eye, kept trying to tamp down the intensity of the interaction by logically focusing on what he repeatedly called "the facts." However, rather than tamping down the intensity, Peter's logical, detached tone seemed to have no other effect than to enrage Kayla, whose responses to him showed little concern for what he deemed to be "the facts." And, of course, with every incremental increase in her emotional intensity, Peter responded with a comparable increase in logic and detachment.

Of equal interest to me in the enactment, however, was how brief it was, given its emotional intensity. Normally when I see that degree of reactivity in a subsystem, enactments develop so much momentum that it is I who have to end them, or run the risk of having the enactment eat up the entire session. Kayla and Peter, however, were done in under a minute. The enactment ended with Kayla turning to me with a sudden onrush of tears, and with Peter staring at a painting on the wall of my office as if he had suddenly recognized it to be a long-lost masterpiece by a Dutch master.

My attention in that moment was riveted on Kayla, who was tearfully pleading with me to understand how lonely she felt in her marriage:

"Even before this thing with the pornography, I just never felt sure that he loved me." Typically I would be glancing at the other partner after a remark like that had been made, to see what the comment was triggering in him or her. However, I found myself so filled with sympathy for Kayla that, for a moment, I forgot that Peter was even present in the room. Interestingly, I got the impression that in that moment, Kayla, too, was more interested in being understood by me than in "getting to" Peter.

Luckily, I did not forget that my task at that moment was to use what I had just observed and what I was now experiencing to construct a map of this couple subsystem's structure. Despite the brief intensity of the exchange I had seen between the spouses, my overall impression at this point was that they were disengaged from each other. Partners who are disengaged frequently are enmeshed with third parties outside the relationship. Right now, Kayla was far more engaged with me than she was with Peter, and he was far more engaged with that painting on my wall than with either one of us. Did the way in which the therapeutic system was structured at this moment correspond with the structure of their lives outside my office? I suspected it did.

When I asked how things had been between them prior to Kayla's discovery of Peter's involvement with Internet porn, they answered simultaneously, "Distant." In turns, they went on to describe a life together organized around Peter's time- and energy-consuming career, and around Kayla's utter devotion to the task of parenting their daughter. Each depicted the other's involvement outside the marriage as excessive. "She uses my 15-year-old daughter as a confidante," Peter said. "Do you know that she has told her every detail about what has been happening in the past 3 weeks? My daughter told me to my face 3 days ago that I am a pervert."

So these spouses were indeed disengaged from each other, and the couple subsystem was surrounded by an excessively permeable external boundary. Insufficiently engaged with each other, each spouse was maladaptively seeking a sense of connection and validation from sources destined in the long run to leave them dissatisfied: Peter, from his work, from Internet porn sites, and from the painting on my wall; Kayla, from her daughter, and already, this early in the therapy, from me.

The structure of this subsystem was fairly easy for me to discern. We were not too deeply into the first session, however, before I realized that it was not going to be correspondingly easy for me

to deliver a reframe that would orient this couple's attention toward the structure that I had so easily discerned. When, about 15 minutes into the session, I tried to use the complaints that each had made about their relationship—Kayla's persistent feeling of being unloved, Peter's obvious discomfort with Kayla's overpowering emotional intensity—to begin constructing a story that would set the presenting problem of Peter's Internet porn involvement in the context of the subsystem's structure, those relational complaints instantly disappeared from their narrative and were replaced by a narrow focus on the presenting problem itself. Kayla anxiously insisted that I focus my therapeutic attention on ferreting out what she was sure was a vast pattern of duplicity on Peter's part, of which his Internet porn involvement was simply the tip of the iceberg. Peter responded by dispassionately reiterating and offering what he considered incontrovertible proofs of "the facts" of his involvement. The first several attempts I made during the session to move toward a reframing had this same unhelpful effect of triggering a hasty retreat from their tentative airing of relational complaints to a collusive, narrow focus on the presenting problem.

Such had been my lack of success in offering a reframe when, with about 10 minutes remaining in the session, I responded—not, perhaps, without a degree of frustration—to yet another demand from Kayla to Peter that he tell her "everything else you have been up to," by asking her, "Why do you keep lobbing those softball pitches for Peter to hit out of the park?"

"What do you mean?"

"I mean that you're making it easy for Peter to avoid confronting what is absolutely clear to me: That you are a very lonely woman, who needs and deserves more from her husband than she is getting. Peter can comfortably spend from now until doomsday dispassionately reiterating 'the facts' to you, without having to come to grips with 'the fact' that the woman he claims he loves feels utterly unloved. And while he is doing that, he can avoid admitting to himself and to you that he has had to seek from a two-dimensional computer screen the sense of connection and satisfaction that he does not experience in his marriage. No matter what 'the facts' about Peter's duplicity might or might not be, your shared unhappiness about the way you are—or rather, are not—connecting is the one big 'fact' that neither one of you, if you are being honest, can deny."

Both of them were staring at me in what I can only characterize as a stunned silence. It was time

to end the session, and although they scheduled a second appointment, it felt to me as if the session I had just conducted was as likely to prove to be a show prematurely canceled during previews as it was to be the prologue of a full, two-act therapeutic drama.

Sessions 2–7: Act I

Given my lack of confidence about the usefulness of the first session I had conducted with them, I was heartened when Kayla and Peter showed up for the second session. I was even more encouraged when they told me that the first session had convinced them it was useless for them to keep spinning their wheels in conversations focused on "the facts" of Peter's Internet porn involvement ("and," Kayla threw in, "whatever else he has been keeping from me").

I saw in this report from them an opening to begin the Act I task in SCT of destabilizing this subsystem's dysfunctional structure. The map of this structure that I had constructed for myself during the first session suggested in broad outline the direction in which I needed to push my restructuring effort: I needed to increase engagement between these disengaged spouses. Recursively linked to this structural agenda would be efforts on my part to strengthen the diffuse boundary around this subsystem. In session, this would require that I find a way to seduce Peter away from his fascination with the painting on my wall, and that I decline Kayla's overtures to spend the session speaking with me rather than her husband.

My SCT toolbox offered me two broad strategies for increasing engagement between Kayla and Peter: I could either use unbalancing to promote extended conflict between them, or I could use softening to elicit extended affiliative transactions between them. What engagement the spouses had had with each other during the first session had in fact been conflictual, albeit extremely brief, so I knew that this subsystem was able to "do" conflict. An unbalancing tack would involve simply getting them to do more of what they already did. However, I had also seen during the first session that the way in which they "did" conflict, with Peter and Kayla functioning in the complementary roles of "logical one" and "emotional one," functioned to prematurely terminate their conflict and keep them at arm's length from each other. As a result, I decided to go the softening route in my first effort to destabilize this subsystem's structure.

The next decision facing me was whether I should soften Peter or Kayla, in preparation for eliciting enactments in which I would invite the “softened” spouse to maintain that posture in transaction with the other. The experience I had during the first session of how easy it was for Kayla and me to become involved in long, intense interactions that excluded Peter persuaded me to avoid this pitfall by focusing my softening efforts on him.

Since he had decided to return for a second session, I assumed that Peter had “bought” my description of him in my reframe as a man who felt acutely a lack of desired connection with his wife. And so, early during the second session, I launched into my effort to soften him, hoping to elicit from him some congruent expression of pain or sadness over his disconnection from his wife. I reminded him of his characterization of his relationship with Kayla as “distant.” Assuming a soft, evocative posture myself, I asked him to tell me about what this distance does to him emotionally. “I would imagine that you, too, are quite lonely.”

Nothing! The stare that came back to me from Peter was utterly blank. Undeterred, I continued my softening effort for a good part of the session, ultimately to no avail. Not only was I unsuccessful in inducting Peter into a softer posture, but I provided Kayla with an opportunity to reprise her role in this subsystem’s script: “Do you see what a cold fish he is? Can you imagine how unloved I feel as a result of dealing with him?” There followed the same torrent of tears from Kayla that I had seen in the first session. With the tears, Peter went back to examining what I was now sure was an unrecognized artistic treasure on my wall.

As I reflected on this session and began planning for the next, the conclusion I reached was that the session had failed not because I had decided to make Peter my “gateway” into restructuring enactments between the spouses, but because, in employing a softening tack, I had reached for an element in his interpersonal repertoire that proved to be not so easily accessible. Therefore, I decided to continue to use Peter as my “gateway” in the next session, though this time I would utilize an unbalancing strategy.

I was not at all surprised when the spouses began the third session by telling me that things had been status quo between them during the previous week. “She is still acting like a madwoman,” Peter said, with an unmistakable undertone of anger. I saw in that undertone a foothold from which I could launch my unbalancing strategy.

“Peter, I don’t think that Kayla cares one bit for how difficult it is for you to be with her when she acts like that. If she did, she would be trying to change her behavior. I think you should demand from her right now that she begin changing the way she deals with you.” I delivered this directive in a tone that I hoped Peter would experience as righteous indignation on his behalf.

The initial results of my intervention were promising. Peter took up my indignation and began to assertively demand that Kayla “stop acting like a lunatic.” As I hoped, she strenuously objected to this characterization, and for a couple of minutes the two of them engaged in a rather spirited, angry exchange—which, precisely because it was spirited and angry, entailed greater interpersonal proximity than was typical for them. Then I could see the energy precipitously bleed from the transaction. To provide a boost, I reentered the action, once again trying to lend Peter indignation. However, his response to this second unbalancing intervention was decidedly different from his response to the first. Back into the room came “logical” Peter: “There is no use; a leopard cannot change her spots. She is what she is.” In several ensuing exchanges with him, I repeatedly upped my own expression of supportive indignation in his behalf, but now every increment of increased indignation I made was being matched by an increase in dispassionate detachment by Peter. In a flash, it occurred to me that the interaction we were having had become informed by a complementarity isomorphic with the one that organized transactions between Peter and Kayla. I had become “the emotional one” who allowed Peter to operate in his accustomed position of “logical one.”

Having now failed twice to elicit restructuring enactments by attempting to induce a changed posture in Peter, the obvious alternative that remained for me was to use Kayla as my “gateway” into such enactments. However, as I prepared for the fourth session, I had to admit to myself that I had no good ideas how to do so. Utilizing a softening tack with Kayla did not seem promising, since I could not envision how any further amplification of her cries of sadness and loneliness would elicit anything novel and useful from Peter. Nor did I have much hope that utilizing unbalancing to amplify the rage that she certainly was capable of showing, albeit in relatively short bursts, would lead to enactments in which the spouses extended their engagement with each other beyond its baseline level. Of the two possible strategies, however, the outcome of unbalancing appeared more prom-

ising than that of softening, so I decided to go that route.

During the fourth session, I opened my unbalancing gambit by asking Kayla, “Don’t you find it enraging that during our three meetings together, you have received more empathy and support from me, a stranger, than you have from your husband of 22 years?” Not surprisingly, she did allow that she found this enraging, and she was more than happy to accommodate my request that she spend the next few minutes telling Peter just how enraged she felt. In the enactment that followed, Peter began by giving as good as he got, countering Kayla’s expressions of anger with his own. However, following upon my experience during the preceding session, I was not surprised when, after a couple of minutes, I saw his anger begin to wane. Determined not to have another session end in futility, I responded by quickly switching my “allegiance” from Kayla to Peter, in an effort to bolster his anger sufficiently to keep him engaged in the conflictual transaction with his wife.

For the next several minutes, I became a “serial unbalancer,” stoking the anger of whichever spouse appeared on the verge of exiting the enactment. This manner of intervening did succeed in keeping the spouses engaged with each other longer than they had been in any previous session. However, the strategy entailed a fairly high degree of activity and centrality on my part. This is always risky in SCT, privileging, as it does, the actor part of the director-actor mix that is the therapist’s proper role in the therapeutic drama. A play without a director is almost certain to wind up a failed play, and this session soon began to exhibit the unmistakable signs of yet another failed session. The more active I became in the session, the more dependent on my high activity level the action in the session became. Sensing this, I throttled back my activity level about halfway through the session. Predictably, my exiting of center stage brought the scene to a screeching halt. Peter and Kayla stopped engaging with each other. Peter returned to staring at the picture on the wall, and Kayla stared at me, clearly waiting to see what I would do next.

At that moment, I experienced an emotion that I rarely, if ever, experience while doing therapy: I felt utterly worthless. To be sure, my career as a therapist has been peppered with moments in which I felt stuck, frustrated, annoyed, or sad. This, however, was an emotion of an utterly different kind. It had, for want of a better term, an almost existential quality. I felt, quite simply, worthless.

I had “caught” this unusual emotion from this couple subsystem by an overzealous emphasis on the actor component of the SCT therapist’s role, which had placed me in an excessively proximal position to the subsystem’s internal workings. Now I needed to retrieve the middle distance of the director component of the therapist’s role, to make sense out what I was experiencing, and to utilize it (if possible) to make my next move.

Since the emotion I was experiencing was so unusual for me, it was clear to me that I had tapped into the emotional undercurrent of the couple subsystem itself. A very deep undercurrent it must have been, since the emotion I was feeling was nothing like what Peter and Kayla exhibited in their business-as-usual dealings with each other. Suddenly I realized why my interventions to that point of the therapy had failed to destabilize this subsystem’s structure. Compared to the emotion that I was experiencing, the emotions elicited and/or amplified in Kayla and Peter by my interventions had been “thin” and insubstantial, simply more of what these people experienced on a day-in, day-out basis. There was nothing in the experiencing and communicating of these emotions that was sufficiently novel to destabilize the structural status quo of this subsystem and to open the possibility of restructuring.

Thrust to the therapeutic foreground, the emotion I was experiencing seemed to me to contain the possibility of creating the structural instability that my previous interventions had failed to achieve. I knew that my next intervention needed somehow to utilize what I was experiencing; however, I had, in the moment, no clear and distinct idea precisely how to craft the intervention. So I simply said:

“Right now, I am feeling utterly worthless—not just as a therapist, but as a person—and I am pretty sure that this is the way the two of you feel deep down, most of the time. And I am guessing that you have felt this way throughout your time together. The fact that you have stayed together despite feeling this way makes me think that you were used to feeling this way before you ever met each other. I wonder how you came to believe that you were unlovable.”

They were thunderstruck. For what felt like several long minutes, we all stared at each other silently. Then Kayla said, “I don’t think my parents loved each other,” and began to cry with a cry that was nothing like what I had seen from her before.

I could tell from Peter’s reaction that something new and consequential was occurring. He was giv-

ing his wife the kind of rapt, commiserative attention that I had not seen him give her at any prior point in the therapy. "I am stunned," he said in a tone that I can only characterize as tender and compassionate. There followed a long enactment between the two of them, in which Kayla admitted that she had been selling Peter a bill of goods all these years in characterizing her parents' marriage as a good one. (It turns out that both of Kayla's parents had died before she and Peter had become a couple, with the result that his only knowledge of their relationship was based on what Kayla told him.) When he asked her why she had not told him the truth, she recalled a chance remark he had made when they were dating that he would never marry someone who had not come from a happy family. The regret on Peter's face when Kayla said this was truly heart-wrenching for me to witness.

Throughout this enactment, I did nothing because there was no need for me to do anything. Gone, for the moment at least, was the disengagement between the spouses, as well as their recursively linked enmeshment with someone or something outside their relationship. During the enactment, I was invisible to Kayla, and Peter had completely forgotten the art treasure on my wall. The session ended with them still rapt in conversation with each other.

As I reflected on the session, the irony was not lost on me that the restructuring enactment at its center had been triggered by the one "gateway"—a softening of Kayla—that I had rejected as holding next to no restructuring potential. I also saw in hindsight the usefulness of the position from which I had delivered the intervention that had elicited Kayla's softening. Precisely because this intervention had been addressed, so to speak, to the couple subsystem as a whole, and not in particular to either one of its members, the intervention had succeeded in marking the adaptive boundary between me and the subsystem that all of its predecessors had failed to mark.

Because the fourth session had produced a significant undermining of the structural status quo in the couple, I expected the spouses to report and/or evidence a homeostatic rebound in the fifth session. As I entered the session, I readied myself for this therapy's Act I crisis. It did not occur. They began the session by reporting that the week had been like no other in their memory. "We feel more connected to each other than we ever have," Peter said, while Kayla nodded enthusiastically. They spent the entire session oscillating between tell-

ing me how wonderful it was to feel close to each other, and engaging in spontaneous enactments in which they continued the process of increased engagement.

Having experienced the utter futility of planning and predicting in this case, I entered the sixth session with no idea of what they would present me with and with no plans as to how to proceed. The first few minutes of the session presented clear evidence that the restructuring of this couple subsystem instigated during the fourth session had held. However, evidence was also forthcoming that its stability was being threatened, and from a source that I had not anticipated. Kayla reported, "Things remain great between Peter and me—but out of the blue, our daughter, Samantha, has begun to act out this week. She cut school one day, violated her curfew last weekend, and seems spoiling to have a fight with me. Call me crazy, but I think she's pissed that I have stopped complaining to her about Peter."

I did not call her crazy. Here was the Act I crisis that I had anticipated would occur the week prior. It differed from most crises that occur during SCT, in that the "location" of the crisis was not within the couple subsystem itself, but within the broader family system. However, despite its atypical location, the crisis clearly had as much homeostatic potential as would a crisis located within the couple subsystem itself. Kayla and Peter were quick to report that their growing preoccupation with their daughter's unusual behavior had begun to erode a bit their nascent focus on each other.

Despite the fact that this therapy's crisis was emanating from the child subsystem of this family, I did not see any reason why I could not counter its homeostatic effects while continuing to work with just the couple. However, Kayla caught my attention when she said, "I am terrified that I will not be able to resist the bait my daughter is throwing in front of me. Do you think that we can include her in the next few sessions, to help her adjust to the changes that have occurred between Peter and me?" One of the benefits that accrue to SCT from its having been derived from a family therapy approach is that it enables a seamless transition from couple to family therapy in the (relatively infrequent) situations that call for it. After determining that Peter, too, favored the inclusion of his daughter in the next few sessions, I acceded to the request.

The next session, the seventh of the therapy, turned out to be a classic session of structural family therapy. Kayla was a different woman in the

presence of her daughter than she had been during the previous three sessions. Having renounced the use of Samantha as a confidante and ally, she clearly did not know how to relate to the girl, and like any teenager worth her cell phone, Samantha was using her mother's discomfort to advantage, glaring at her in a menacing way. My intervening in the session was organized into two major "movements." First, I elicited an enactment between Kayla and Samantha, in which Kayla apologized for having inducted Samantha into the inappropriate role of confidante. In the enactment, Samantha gave impressive expression to her anger over the fact that "I now have to change the way I relate to you just because you've now decided he's a good husband." In response to a softening intervention from me, her anger became transmuted into sadness, as she told her mother how uncomfortable she had been for a long time "being your therapist."

In the second part of the session, I elicited an enactment between Peter and his daughter, using this frame: "I think the organization of your family has kept the two of you from knowing each other that well. Why don't you talk together about how the two of you can get to know each other better?"

Sessions 8–9: Act II

Given how long-standing the baseline structure of this system had been, I would not have been surprised to have found that structure more or less intact when the family showed up for Session 8. However, this system's penchant for thwarting my expectations continued: There was a relaxed conviviality to all three family members as they entered my room. Un-self-consciously, Samantha chose a seat that allowed her parents to sit in close proximity to each other, and equally un-self-consciously, they took each other's hands as they did so. Ensnared in this highly symbolic seating arrangement, they continued the light banter in which they had been engaged in the waiting room, seemingly unconcerned about my presence and whatever agenda I might have at hand. When Peter jokingly said, "Maybe we should find out if George has something he wants us to talk about," I replied, "Nope. Just keep doing what you're doing." And they did, spending the session talking together in various combinations of twos and threes about various aspects of their life together, with an emphasis on "how things were" and "how they are now." If I said 20 words during the session, it was a lot.

Since I had so little to do in the session, I mused about "how this therapy had been" and "how it was now." Specifically, I noted that the session had the unmistakable feel of an Act II session of SCT, with the client system exercising almost complete initiative in structuring the session. I also noted the adaptiveness of the subsystem boundaries that were being manifested in the session's enactments. It was clear to me that if the next session looked like this one, the therapy was nearing its end.

In fact, the next session was nearly identical in form and tone. Just as I was about to raise the matter of eventual termination, Peter said to me, "You know, as much fun as it has been working with you"—sarcastic laughter from all, including me—"Kayla and I were wondering if this shouldn't be our last session." I wholeheartedly agreed that it was time to end. I was surprised one last time in this therapy when, with about 10 minutes remaining in the session, Samantha said, "I'm going to go to the waiting room. Mom and Dad started this therapy together, and I think they should finish it together. Maybe they have something they want to say to you that wouldn't be appropriate in my presence." I could not have scripted a better end to the therapy.

SUGGESTIONS FOR FURTHER STUDY

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