FAMILY PROCESS

Techniques of Structural Family Assessment: A Qualitative Analysis of How Experts Promote a Systemic Perspective

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The trajectory of assessment in structural family therapy moves from a linear perspective, in which problems are located in the identified patient, to an interactional perspective, in which problems are seen as involving other members of the family. Minuchin, Nichols, & Lee (2007) developed a 4-step model for assessing couples and families consisting of: (1) broadening the definition of the presenting complaint to include its context, (2) identifying problem-maintaining interactions, (3) a structurally focused exploration of the past, and (4) developing a shared vision of pathways to change. To study how experts actually implement this model, judges coded video recordings of 10 initial consultations conducted by three widely recognized structural family therapists. Qualitative analyses identified 25 distinct techniques that these clinicians used to challenge linear thinking and move families toward a systemic understanding of their problems. We discuss and locate these techniques in the framework of the 4-step model.

Keywords: Family Assessment; Systemic Family Therapy; Structural Therapy; Techniques

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Every first session presents the fundamental challenge of being a therapist: A group of strangers walks in and hands you their most urgent problem and expects you to solve it. "My fifteen-year-old is failing tenth grade. What should I do?" "We never talk anymore. What's happened to our marriage?" "It's me: I'm depressed."

There are landmines in these opening presentations: "What should we do?" "What's wrong with Johnny?" These people have been asking such questions for some time, maybe years—and they usually have fixed ideas about the answers, even if they do not always agree. Furthermore, they have typically evolved strategies to deal with their problems, which, even if unsuccessful, they insist on repeating. In this they are like a car stuck in the mud, with wheels spinning while they sink deeper into the mire.

The stress of life's problems makes for anxiety, and anxiety gives rise to rigid thinking. And so families who come to treatment tend to hold tenaciously to their assumptions: So and so is "lazy," "angry," "withdrawn," "disloyal," "weak," "passive," "childish," "rebellious"—or some other negative quality residing in the complicated mechanisms of the stubborn human psyche. These days this kind of thinking is reinforced by the medical model: He or she is "hyperactive" or "bipolar," or both, has "Asperger's disorder" or "OCD."

The point of structural family therapy is not to dispute that problems exist in individuals or even that such problems are sometimes rooted in biological disorders. Rather the

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premise is that focusing exclusively on individual patients and their problems often obscures the influence of family interactions in perpetuating such problems—and their underutilized potential for helping to resolve them (Hoffman, 1981; Nichols, 2013).

A FOUR-STEP MODEL OF FAMILY ASSESSMENT

Most guidelines for assessment focus on collecting facts about the presenting problem (Williams, Edwards, Patterson, & Chamow, 2011). These inquiries take the form of any visit to the doctor: What are the symptoms? How long have they persisted? What brings them on? Even texts on assessment in family therapy advocate a thorough assessment as a necessary precursor to intervening effectively (Taibbi, 2007; Williams et al., 2011) and advise clinicians to explore potential issues of harm, such as suicide, drug or alcohol abuse, violence, and sexual abuse (Patterson, Williams, Grauf-grounds, & Chamow, 1998). William Pinsof and his colleagues recommend that assessment continue with treatment to determine when it might be useful to shift therapeutic approaches (Pinsof, Breunlin, Russell, & Lebow, 2012). Thus, assessment and intervention are usually seen as distinct enterprises: Assessments are about information gathering; interventions are about problem solving.

Rather than thinking about assessment as merely a process of gathering information, we recommend a more active, dynamic form of assessment in which exploring the presenting complaint does not mean accepting it at face value but rather actively investigating the possibility that the presenting complaint might be significantly influenced by family interactions. We do not advocate an *either/or* stance—focusing on the presenting problem (e.g., de Shazer, 1988; Watzlawick, Weakland, & Fisch, 1974) *or* focusing on underlying dynamics (e.g., Ackerman, 1966; Bowen, 1978; Minuchin, 1974). Instead, we recommend a *both/and* approach, in which therapists explore the presenting complaint from the family's point of view *and* challenge the family to consider possible systemic contributions to their problems.

For a systems-oriented therapist, the art of assessment is to explore a family's perspective on their problems, *and* to expand that perspective to include the interactional context. Salvador Minuchin and his colleagues (Minuchin, Nichols, & Lee, 2007) described this process as requiring four steps: (1) opening up the presenting complaint, (2) highlighting problem-maintaining interactions, (3) a structurally focused exploration of the past, and (4) developing a shared vision of pathways to change.

The first step in this procedure often entails questioning a family's conviction that the primary problem is located exclusively in the internal machinery of the identified patient. A therapist broadens the focus from the identified patient to relational patterns of the family through a process of probing but respectful questioning. Even in cases where the primary complaint is relational—"We have a communication problem"—there is usually an assumption that someone else needs to change. Yet for meaningful change to occur, the essential systemic insight that clients need to achieve is not only that "our interactions are part of the problem," but also that "*I* must change some aspect of what I'm doing to make things better."

When clients come in with a problem to be solved, they usually expect a therapist to accept that problem at face value and to prescribe a cure. This works fine for medical or mechanical problems, but the problems families bring to therapy are rarely medical or mechanical. Therefore, the first challenge for a systems-oriented therapist is to move families from linear ("It's Johnny") and medical-model thinking ("he's hyperactive") to an interactional understanding. To initiate this shift, a therapist begins by asking questions about the presenting problem. These questions are not merely to get details about the condition as described but also to open up and challenge the family's fixed certainty about what is the problem and who has it.

According to the Minuchin et al. (2007) model, a therapist's opening questions should give family members a chance to tell their stories and express their feelings to help them feel understood and gain their trust. Indeed, being listened to and taken seriously are apparently essential to making clients feel involved in a collaborative therapeutic relationship (Hammond & Nichols, 2008). On the other hand, a therapist should not simply accept a family's description of their problems as residing entirely within one person. Questions limited to the presenting symptoms and their history only serve to confirm fixed, linear notions about a family's problems (Miles, 2004), while helpful questions convey respect for family members' feelings, but skepticism about accepting the identified patient as the sole carrier of problems. Helpful questions also continue to explore and open things up, while unhelpful questions accept things as clients describe them and concentrate only on the identified patient. To be effective at this stage, a therapist conveys the attitude, "I don't quite understand, but I'm interested and curious about how you understand things." The therapist who too readily ingratiates himself or herself by saying, "Oh, yes, I understand!" closes off exploration.

The second step in this systems-oriented assessment is exploring how family members may be responding in ways that perpetuate the presenting problem. This is not a matter of shifting blame—say, from a misbehaving child to an indulgent parent. Nor do we mean to suggest that family problems are typically *caused* by how other people treat the identified patient. In fact, what family therapists call "circular causality" is a misnomer because the shift from linear to circular thinking not only expands the focus from individuals to patterns of interaction but also deliberately avoids cause-and-effect explanations. Instead of joining families in a logical but unproductive search for who started what, circular thinking suggests that problems are sustained by an ongoing series of actions and reactions. Who started it? It rarely matters.

By helping family members see how their actions may be perpetuating the problems that plague them, a therapist empowers them to become their own agents of change. A woman who recognizes that scolding her husband to spend more time with her only drives him further away is now in a position to consider more effective ways of getting the affection she longs for. A father who realizes that nagging his son to wake up in the morning allows the boy to avoid taking responsibility for himself can stop acting as his son's alarm clock.

Talking with family members about how they may be contributing to the presenting problem requires overcoming a natural resistance to being blamed. No one wants to be told that they are responsible for their mate's neglect or their child's irresponsibility. While there is no magic formula for avoiding making people defensive, it may help to keep in mind that circular thinking is not designed to spread blame for causing problems; it is designed to discover who is in a position to resolve them.

The third step is a brief, focused exploration of the past to help family members understand how they came to their present, not always productive, assumptions and ways of responding to each other. One thing that distinguishes therapy from advice giving is trying to uncover why people do things that are not good for them, rather than merely telling them to stop. The rationale for exploring family members' past experience is to help make their current behavior intelligible—not to debunk their beliefs, but to put them in a more understandable context.

The fourth step in Minuchin et al.'s model is what makes family assessment not just informative but useful. After developing a clear and thorough picture of what's keeping a family stuck and how they got that way, the therapist and family talk about who needs to change what—and who is willing or unwilling to do that. Without this step, which turns the process of assessment from an operation performed *on* families into an operation performed *with* them, therapy often becomes a process of pushing people where they see no reason to go. No wonder they resist.

As every therapist knows, it is not always easy to translate the broad strokes of a conceptual model into practical interventions. "Our theories produce a working environment, not a roadmap to actual intervention" (Beels, 2011). Moreover, while it is possible to generalize about overall strategies, specific interventions must be tailored to the specific requirements of the situation, and they are often a unique expression of the therapist's personal style. Nevertheless, therapists do learn from each other, and in that spirit we set out to study video recordings of how three highly experienced family therapists actually implemented Minuchin et al.'s four-step model. Of particular interest were the specific techniques these expert clinicians used to challenge family members' linear views of the problems they came in with and to promote a more systemic perspective.

METHOD

In this small-scale qualitative study, three investigators (an experienced clinical psychologist/family therapist and two graduate students) systematically reviewed 10 assessment sessions conducted by three well-known structural family therapy experts well versed in the four-step model. (These experts had been involved in discussions over the course of several years that led to publication of this model in 2007.) The videotaped assessments were all first sessions conducted by the experts, who served as consultants to other therapists who conducted the remainder of the therapy. The presenting complaints included child behavioral problems, posttraumatic stress disorder, marital problems, major depression, and heroin addiction. There were five two-parent families, two blended families, and three couples. Six families were Caucasian, three were Hispanic families, and one was African American. On average, the assessment sessions lasted 1 hour (range 50–75 minutes).

The three judges watched each assessment session together and identified discrete segments of therapist behavior (usually two or three sentences but sometimes more than one utterance) that they would describe as an intervention (Miles & Huberman, 1994). We did not record instances of simple questions ("What brings you here?" "How long have you had this problem?" and so on) but rather categorized only those interventions that challenged clients to move beyond linear explanations to consider the interactional contributions to their problems. The judges discussed each intervention, reached a consensus on how to describe it, and used a category-based filtering method (Rennie, Phillips, & Quartaro, 1988) to add new categories until each new intervention could fit into the existing categories of techniques. To track the context of these interventions, the judges also noted which step in Minuchin et al.'s model each intervention appeared to support.

To assess inter-judge reliability in assigning interventions to categories, the three judges independently viewed three assessment sessions and assigned interventions to the 25 categories they had previously identified in the other seven sessions. There was full inter-judge agreement (all three judges making the same classification decision) for 89% of the interventions observed during these three sessions.

RESULTS

Table 1 lists the 25 systemically oriented techniques we identified through the qualitative category-based filtering method by order of their frequency. This table also lists the relevant stages in the assessment process during which these interventions were most frequently used.

The most frequently observed systemic techniques were direct and challenging (initiating enactments, commenting on problematic interaction patterns, suggesting what family members should do differently), but other, less direct intervention strategies were evident

TABLE 1
Categories of Therapist Intervention

Interventions	Number of times observed	Most relevant stages
Initiates an enactment (directs family members to talk with each other)	31	2, 4
Describes an organizational problem in the family (a structural problem involving more than two persons)	24	2, 4
Describes a family member's role in an interactional problem	19	2
Describes a problematic interactional pattern involving the roles of two family members	17	2
Suggests how family members should behave differently to improve their interactions	13	4
Asks family member what other family member does to provoke a certain response from him or her	12	1, 2
Praises family member(s) for behaving productively in the session	11	2, 4
Asks family member if he or she responds in a certain way to certain behaviors from other family members	11	2, 1
Asks about the emotional feeling behind a family member's actions	11	3, 2
Asks family member(s) how they will change to improve an interaction in the family	9	4
Asks family member if he or she wants other family member(s) to behave differently toward him or her	8	2, 1
Blocks third parties from interrupting	5	1, 2
Points out that the identified patient has behaved in the session more productively than the presenting complaint would have suggested	5	1
Tells family members that they must be doing something wrong that is perpetuating the presenting problem (they are stuck in a rut)	5	1, 2
Asks family member(s) what were the intentions that made them act in a certain way	4	1, 2
Asks for past history about how family member learned to respond in a problematic way	3	3
Tells enmeshed family member that he or she should allow disengaged members to develop more of a relationship	3	2, 4
Asks family member how he or she tries to get a desired response from other family members	3	2
Describes how the presenting complaint is a function of interactional problems in the family	3	2, 4
Points out (to an enmeshed family member) that he or she has a resource (a disengaged member) who could be approached more	2	2, 4
Tells disengaged family member that he or she needs to initiate contact with someone	2	4, 2
Asks family members what they are doing that might be contributing to a problem	2	2
Asks family member(s) if they play specified roles in a problem dynamic	2	2
Describes how enmeshed family member invites interference	1	2
Tells enmeshed family member that he or she should develop more outside relationships	1	2, 4

as well. To evaluate whether the techniques might have been therapist specific, we cross-tabulated the intervention categories by expert and found no evidence (via chi-square tests) of disproportionality. In other words, none of the three family therapy experts appeared to use particular techniques any more or less than the other experts.

Although the interventions we observed did not fall neatly into mutually exclusive steps of our assessment model, certain interventions were more common in different stages of assessments. In step one (opening up the presenting complaint), consulting therapists

frequently pointed out that the identified patient behaved in the session more productively than the presenting complaint would have suggested. For example, when parents sought help for what they described as an out-of-control 10-year-old, the consultant engaged the boy in conversation about his interests and friends, which encouraged the boy to respond in an appropriate and respectful manner. This gave the consultant leverage to suggest that since the boy *could* be well behaved, something must be going on in the family that provoked or allowed him to misbehave. Again, the point was not to shift blame but to open a discussion about how family members' interactions are influencing each other.

Perhaps the most common technique used in opening up the presenting complaint was asking a family member what another family member does to provoke a certain response from him or her. In one case, when a husband described his intolerance as the primary problem, the consultant asked, "What does she do that's hard to tolerate?" This intervention led to the recognition of a pursuer–distancer dynamic in the couple, and subsequently to the husband recognizing that his distancing only drove further pursuit, while the wife's pursuit only drove more withdrawal.

In another case, a family was seen in conjunction with treatment for the father's heroin addiction. When the father was asked what happened in the family that made him feel like giving up and getting high, he described how he felt that his wife undermined his relationship with their daughters. This led to an emotional but productive discussion about what she wanted from him and what he wanted from her, which set the stage for the couple experimenting with different, more direct ways of negotiating their differences.

Consultants often blocked third parties from interrupting and asked family members if they wanted others in the family to behave differently toward them. Thus, in the opening stage, there was a consistent attempt to shift the focus from personalities to patterns of interaction.

It should not be surprising that therapists can use most of the techniques our study identified in more than one stage of the family assessment procedure. The four steps are a way of conceptualizing strategy, not a lock-step formula for intervening. Thus, asking a family member what another family member does to provoke a certain response often served as a bridge from the first to the second step: exploring how family members may be perpetuating the presenting problem. Among the techniques commonly used in this second step, consultants often asked family members if they responded in a certain way to certain behaviors from other family members, asked family members if they played a role in a problematic dynamic, initiated an enactment, described the dynamics of a problematic interaction, or simply told family members that they must be doing something to perpetuate the presenting problem.

As noted above, some of these techniques are fairly blunt. What we observed, however, was that the consultants had prepared the way for this kind of directness by gentle questioning in step one. When the consultants described a problematic pattern of interaction, that pattern had generally become clear after exploring the context of the presenting complaint, so that intervention was less a matter of interpreting something the clients did not see than of putting into words something that had become apparent. In the case of the "intolerant husband," for example, the consultant began by asking questions about the husband's and wife's complaints, which turned out to be mirror images of each other: he wanted more independence, she wanted more togetherness. Only after initiating an enactment and observing how the pair interacted did the consultant point out to the woman that she "was coming on like the North Wind, blowing and blowing, which only made the man bundle up his coat more." The consultant then pointed out to the man that by "bundling up his coat," rather than taking it off, he was only encouraging "the North Wind" to bluster more to win her bet with the sun about which could make the man take off his coat first.

In the third step (a brief exploration of the past), consultants often asked about the emotional feeling behind a client's (problematic) actions and asked how the client learned to develop those feelings and that kind of response. These interventions reflect how structural family therapy has evolved from a strictly action-oriented approach to one that explores the emotions and cognitions behind family members' actions. Early on, family therapy pioneers such as Haley, Jackson, Weakland, and even Minuchin differentiated themselves from psychoanalysts by ignoring both cognition (what family members think about what they do) and the past (how they learned to act that way) to focus on interactions in the present. In retrospect, we see this rejection of history as part of a myopic focus on behavior to the exclusion of emotion and cognition.

What we observed about the third step in Minuchin et al.'s model is that it only made sense to ask family members how they learned a certain way of behaving *after* helping them realize their behavior was in fact counterproductive. In one case, for example, a mother complained that her 14-year-old daughter was a pathological liar. Only after almost an hour of careful questioning did the mother begin to see that her overprotectiveness might be playing a role in the daughter's lying to her. Then, and only then, was the mother open to the therapist's question about how she learned to be overprotective.

At the same time, our data indicate that the experts used techniques to explore cognitions and emotions relatively infrequently. Thus, although we see the inclusion of these important realms of experience as expanding the behavioral focus of the structural family therapy model, the majority of interventions used by these experts still focused on the dynamics and organization of family interactions (Favero, 2002; Fellenberg, 2003; Minuchin & Fishman, 1981).

The techniques most commonly observed in the fourth step (engaging families in a collaborative search for solutions) were fairly straightforward. By this point in the assessment process, family members had generally come to realize that their behavior was in some respects counterproductive, and they were often ready to consider making changes. To our surprise, the most common technique observed in this step was suggesting how family members should behave differently to improve their interactions. While this may seem like the kind of directive advice giving that families often resist, our observations suggest that in most cases, after having gone through the previous three steps of assessment, client families were often quite receptive to such recommendations. We observed no instances of expert therapists offering this kind of direct suggestion earlier in the assessment process, when we suspect the suggestions would have been resisted.

The second most common technique used in this stage was asking family members how they would be willing to change to improve interactions in the family. This kind of intervention was more in line with what we expected from experienced therapists, who seemed to intuit when it was important to allow family members to come up with their own solutions—in light of what they had learned about their family's dynamics.

Some of the interventions employed in this fourth stage, as well as in earlier stages, were specific to the structural model and tailored to the unique organization of individual client families. Examples of such interventions included describing how enmeshed family members invited interference, describing organizational problems involving three or more family members, pointing out to family members enmeshed in one relationship that they had a potential resource in a disengaged member that they could approach more, and telling disengaged family members that they need to initiate contact more often.

DISCUSSION

The data in this study show how experts in family therapy implemented Minuchin et al.'s four-step assessment procedure with specific interventions. We see this assessment

process, with its attention to cognition and emotion as well as behavioral interaction, as an extension of the classic model of structural family therapy. Although the consultants in this study all happened to be structural family therapists, we think the four-step assessment strategy and the techniques we identified to implement it would be useful to any family therapist with a systemic orientation. This assessment process is focused on helping clients expand their focus from the person with the presenting problem to its systemic context, and as such, its applicability is not limited to any one specific model of therapy.

Although the consulting therapists in this study were able to move through all four steps of the assessment process in one session, less experienced therapists may not always be able to move so quickly. While it is advisable even for beginners to take an active stance in assessment—not just gathering information but also exploring family interaction patterns—we recognize that moving through all four steps often (perhaps usually) takes more than one session.

Because the assessments in this study all occurred in one initial session, readers may wonder what comes next. Indeed, it is probably easier to describe the process of assessment than to describe the ongoing course of therapy, where the therapist's orientation and personal style, as well as the distinct characteristics of each family, will shape the therapy in unique ways. We suspect that follow-on sessions, even those conducted by experts, typically involve a process of working through issues uncovered in the assessment.

In a well-conducted family assessment, key dynamics often become very clear: Dad is neglecting his duties and needs to get more involved with his wife and children; daughter spends too much time fighting with her mother and needs to invest more energy in making friends and succeeding in school. Nevertheless, although family members may seem to agree with the goals outlined in an assessment, their silence may mask significant disagreement. Subsequent sessions give therapists a chance to find out what family members thought of what emerged in the assessment. Asking "How did you feel about what happened in the last session?" gives clients a chance to ask questions and raise objections. Finding a mutually agreeable formulation and working collaboratively through the process of change is what makes subsequent sessions interesting, challenging, and ultimately rewarding.

A systems-oriented assessment in family therapy must accomplish two things that may appear antithetical. First, to create a therapeutic alliance, a therapist must understand family members' complaints from their perspective. Unless they feel that the therapist hears them and appreciates their point of view, few families will be prepared to accept a collaborative relationship with the therapist (Sundet, 2011). At the same time, it is equally important not to accept uncritically family members' presentation of one person in the family as the problem. Individualistic views of human problems, like the medical model, continue to hold a tenacious grip on the mental health professions: If someone has a problem, there must be something wrong with him or her. Because this way of thinking is so pervasive, therapists may find it useful to arm themselves with strategies and tactics for expanding the field of assessment to include the systemic context of their clients' problems. We hope that the four-step family assessment model and the 25 related intervention strategies identified in this study will help practicing therapists turn assessments from a passive process of cataloging symptoms to an active process of cocreating a systemic understanding of clients and their interpersonal contexts.

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