Murray Bowen
(1913–1990)
Courtesy of Bowen Family

Salvador Minuchin
Courtesy of Dr. Salvador Minuchin
The Minuchin Center

Virginia Satir
(1916–1988)
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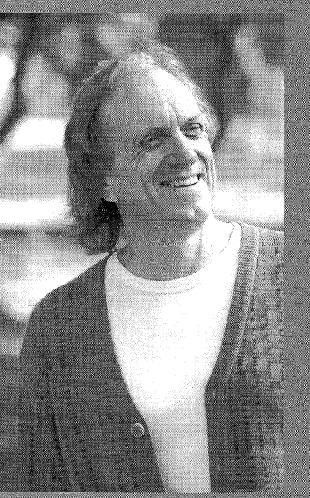

Michael White
(1948–2008)
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12 FAMILY THERAPY

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Family therapy is both a theory and a treatment method. It offers a way to view clinical problems within the context of a family's transactional patterns. Family therapy also represents a form of intervention in which members of a family are assisted in identifying and changing problematic, maladaptive, repetitive relationship patterns, as well as self-defeating or self-limiting belief systems.

Unlike individually focused therapies, in family therapy the *identified patient* (the family member considered to be the problem in the family) is viewed as manifesting troubled or troubling behavior maintained by problematic transactions within the family or perhaps between the family and the outside community. Helping families to change leads to improved functioning of individuals as well as families. In recent years, therapeutic efforts have been directed at broadening the context for understanding family functioning, adopting an ecological focus that takes the individual, the family, and the surrounding cultural community into account (Robbins, Mayorga, & Szapocznik, 2003).

OVERVIEW

Basic Concepts

When a single attitude, philosophy, point of view, procedure, or methodology dominates scientific thinking (and thus assumes the character of a *paradigm*), solutions to problems are sought within the perspectives of that school of thought. If serious problems arise that do not appear to be explained by the prevailing paradigm, however, efforts are made to expand or replace the existing system. Once the old belief system changes,

perspectives shift and previous events may take on entirely new meanings. The resulting transition to a new paradigm, according to Kuhn (1970), is a scientific revolution.

In the field of psychotherapy, such a dramatic shift in perspective occurred in the mid-1950s as some clinicians, dissatisfied with slow progress when working with individual patients or frustrated when change in their patients was often undermined by other family members, began to look at the family as the locus of pathology. Breaking away from the traditional concern and investigation of individual personality characteristics and behavior patterns, they adopted a new perspective—a family frame of reference—that provided a new way of conceptualizing human problems, especially the development of symptoms and their alleviation. As is the case with all paradigm shifts, this new viewpoint called for a new set of premises about the nature of psychopathology and stimulated a series of family-focused methods for collecting data and understanding individual functioning.

When the unit of analysis is the individual, clinical theories inevitably look to internal events, psychic organization, and the patient's intrapsychic problems to explain that person's problems. Based on a heritage dating back to Freud, such efforts turn to the reconstruction of the past to seek out root causes of current difficulties, producing hypotheses or explanations for *why* something happened to this person. With the conceptual leap to a family framework, attention is directed to the family context in which individual behavior occurs, to behavioral sequences between individuals, and to *what* is now taking place and *how* each participant influences, and in turn is influenced by, other family members.

This view of *reciprocal causality* provides an opportunity to observe repetitive ways in which family members interact and to use such data to initiate therapeutic interventions. Family therapists therefore direct their attention to the dysfunctional or impaired family unit rather than to a symptomatic person, who is only one part of that family system and, by his or her behavior, is seen as expressing the family's dysfunction.

The Family as a System

By adopting a relationship frame of reference, family therapists pay attention both to the family's *structure* (how it arranges, organizes, and maintains itself at a particular cross section of time) and to its *processes* (the way it evolves, adapts, or changes over time). They view the family as an ongoing, living system, a complex, durable, causal network of related parts that together constitute an entity larger than the simple sum of its individual members. That system, in turn, is part of a larger social context, the outside community.

Several key concepts are central to understanding how systems operate. *Organization* and *wholeness* are especially important. Systems are composed of units that stand in some consistent relationship to one another, and thus we can infer that they are organized around those relationships. In a similar way, units or elements, once combined, produce an entity—a whole—that is greater than the sum of its parts. A change in one part causes a change in the other parts and thus in the entire system. If this is indeed the case, argue systems theorists, then adequate understanding of a system requires study of the whole rather than separate examination of each part. No element within the system can ever be understood in isolation since elements never function separately. The implications for understanding family functioning are clear: A family is a system in which members organize into a group, forming a whole that transcends the sum of its individual parts.

The original interest in viewing a family as a system stems in part from the work of Gregory Bateson, an anthropologist who led an early study in which he and his colleagues hypothesized that schizophrenia might be the result of pathological family

interaction (Bateson, Jackson, Haley, & Weakland, 1956). Although not a family therapist himself, Bateson (1972) deserves special credit for first seeing how a family might operate as a *cybernetic system.* Current views of the origins of schizophrenia emphasize genetic predispositions exacerbated by environmental stresses, but Bateson's team should be recognized for first focusing attention on the flow of information and the back-and-forth communication patterns that exist within families. Rather than studying the content of what transpires, family therapists were directed to attend to family processes, the interactive patterns among family members that define a family's functioning as a unit.

A Cybernetic Epistemology

A number of significant shifts in clinical outlook occur with the adoption of a cybernetic epistemology. For example, the locus of pathology changes from the identified patient to the social context, and the interaction between individuals, rather than the troubled person, is analyzed. Instead of assuming that one individual causes another's behavior ("You started it. I just reacted to what you did"), family therapists believe both participants are caught up in a circular interaction, a chain reaction that feeds back on itself, because each family member has defined the situation differently. Each argues that the other person is the cause; both are correct, but it is pointless to search for a starting point in any conflict between people, because a complex, repetitive interaction is occurring, not a simple, linear, cause-and-effect situation with a clear beginning and end.

The simple, nonreciprocal view that one event leads to another, in stimulus-response fashion, represents *linear causality.* Family therapists prefer to think in terms of *circular causality:* Reciprocal actions occur within a relationship network by means of a network of interacting loops. From this perspective, any cause is seen as an effect of a previous cause and becomes, in turn, the cause of a later event. Thus, the attitudes and behavior of system members, as in a family, are tied to one another in powerful, durable, reciprocal ways, and in a never-ending cycle.

The term *cybernetics,* based on a Greek word for "steersman," was coined by mathematician Norbert Wiener (1948) to describe regulatory systems that operate by means of *feedback loops.* The most familiar example of such a mechanism is the thermostat in a home heating system; set to a desired temperature, the furnace will turn on when the heat drops below that setting, and it will shut off when the desired temperature is reached. The system is balanced around a set point and relies on information fed back into it about the temperature of the room. Thus, it maintains a dynamic equilibrium and undertakes operations to restore that equilibrium whenever the balance is upset or threatened.

So, too, with a family. When a crisis or other disruption occurs, family members try to maintain or regain a stable environment—*family homeostasis*—by activating family-learned mechanisms to decrease the stress and restore internal balance.

Families rely on the exchange of information—a word, a look, a gesture, or a glance that acts as a feedback mechanism, signaling that disequilibrium has been created and that some corrective steps are needed to help the relationship return to its previous balanced state. In effect, information about a system's output is fed back into its input, to alter, correct, or govern the system's functioning. *Negative feedback* has an attenuating effect, restoring equilibrium, whereas *positive feedback* leads to further change by accelerating the deviation. In negative feedback, a couple may exchange information during a quarrel that says, in effect, "It is time to pull back or we will regret it later." In positive feedback, the escalation may reach dangerous, runaway proportions; the quarreling couple may escalate an argument to the point when neither one cares about the consequences. In some situations, however, positive feedback, though temporarily

destabilizing, may be beneficial if it does not get out of control and if it helps the couple reassess a dysfunctional transactional pattern, reexamine their methods of engagement, and change the system's rules. That is, a system need not revert to its previous level but may instead, as a result of positive feedback, change and function more smoothly at a higher homeostatic level (Goldenberg & Goldenberg, 2008).

Subsystems, Boundaries, and Larger Systems

Following largely from the work of Minuchin, Nichols, & Lee (2006), family therapists view families as comprising a number of coexisting subsystems in which members group together to carry out certain family functions or processes. Subsystems are organized components within the overall system, and they may be determined by generation, sex, or family function. Each family member is likely to belong to several subsystems at the same time. A wife may also be a mother, daughter, younger sister, and so on, thus entering into different complementary relationships with other members at various times and playing different roles in each. In certain dysfunctional situations, families may split into separate long-term coalitions: males opposed to females, parents against children, father and daughter in conflict with mother and son.

Although family members may engage in temporary alliances, three key subsystems will always endure: the spousal, parental, and sibling subsystems (Minuchin, Rosman, & Baker, 1978). The first is especially important to the family: Any dysfunction in the spousal subsystem is bound to reverberate throughout the family, resulting in the scapegoating of children or co-opting them into alliances with one parent against the other. Effective spousal subsystems provide security and teach children about commitment by presenting a positive model of marital interaction. The parental subsystem, when effective, provides child care, nurturance, guidance, limit setting, and discipline; problems here frequently take the form of intergenerational conflicts with adolescents, often reflecting underlying family disharmony and instability. Sibling subsystems help members learn to negotiate, cooperate, compete, and eventually attach to others.

Boundaries are invisible lines that separate a system, a subsystem, or an individual from outside surroundings. In effect, they protect the system's integrity, distinguishing between those considered insiders and those viewed as outsiders. Boundaries within a family vary from being rigid (overly restrictive, permitting little contact among the members of different groups) to being diffuse (overly blurred, so that roles are interchangeable and members are overinvolved in each other's lives). Thus, the clarity of the boundary between subsystems and its permeability are more important than the subsystem's membership. Excessively rigid boundaries characterize *disengaged families* in which members feel isolated from one another, and diffuse boundaries identify *enmeshed families* in which members are intertwined in one another's lives.

Boundaries between the family and the outside world need to be sufficiently clear to allow information to flow to and from the environment. In systems terms, the more flexible the boundaries, the better the information flow; the family is open to new experiences, is able to alter and discard unworkable or obsolete interactive patterns, and is operating as an *open system.* When boundaries are not easily crossed, the family is insular, is not open to what is happening around it, is suspicious of the outside world, and is said to be operating as a *closed system.* In reality, no family system is either completely open or completely closed; rather, all exist along a continuum.

Cybernetics Revisited and the Postmodern Challenge

The early, radical assumptions proposed by systems theory (circular causality, feedback loops, boundaries, subsystems) were groundbreaking in their relationship-focused and

holistic character but were limited because they were confined to outside observers attempting to describe what was occurring within a system (Becvar, 2003). A later refinement, sometimes called second-order cybernetics, acknowledged the effect of the observer (the family therapist) on his or her observations; by helping define the problem, the observer influences goals and outcomes. Each family member's perceptions of the presenting problem began to be acknowledged as important and valid, because how each member constructs reality influences and is influenced by a larger social context. Postmodern views, popular today, are especially rejecting of the systems metaphor as based on mechanistic models. Postmodernists argue that our notion of reality is inevitably subjective; there are no universal truths out there ready to be described by "objective observers" (Gergen, 1999).

All family systems thus are influenced by one or more of society's larger systems—the courts, the health care system, schools, welfare, probation, and most currently the psychological challenges inherent in the cybersystem. This frontier presents new challenges to therapists who must be aware and understand the complications of virtual relationships and boundaries. Untangling the web of relationships, both perceived and real, can be difficult for the practitioner and presents both legal and ethical issues. (Pelavin & Moskowitz-Sweet, 2009).

Although such contact with the larger system may be time limited and generally free of long-term conflict, numerous families become entangled with such systems, and this entanglement sometimes impedes the development of family members. Family therapists today pay close attention to such interactions, looking beyond the dysfunctional family itself and integrating the recommendations of the various agencies in order to provide a broad, coordinated set of interventions to achieve maximum effectiveness.

Gender Awareness and Culture Sensitivity

Challenged by postmodern inquiries into the diversity of perspectives for viewing life, as well as by the feminist movement, family therapists have begun to look beyond observable interactive patterns within a family, and today they examine how gender, culture, and ethnicity shape the perspectives and behavior patterns of family members. Indoctrinated early into gender-role behavior in a family, men and women have different socialization experiences and as a result develop distinct behavioral expectations, are granted disparate opportunities, and have differing life experiences. Work and family roles and responsibilities have changed dramatically in the last 30 years, requiring new male–female interactions and family adaptations (Barnett & Hyde, 2001).

Gender, cultural background, ethnicity membership, and social class are interactive; one cannot be considered without the others. As Kliman (1994) notes, the experience of being male or female shapes, and in turn is shaped by, being poor or middle-class or wealthy, or being African American, Chinese, or Armenian. Contemporary views of family therapy emphasize taking a *gender-sensitive outlook* in working with families, being careful not to reinforce (as therapists sometimes did in the past) stereotyped sexist, patriarchal attitudes, or class differences. Today, family therapists pay more attention to differences in power, status, and position within families and in society in general.

Similarly, family therapists today believe a comprehensive picture of family functioning at the minimum requires an understanding of the cultural context (race, ethnic group membership, social class, religion, sexual orientation) and the form of family organization (stepfamily, single parent-led family, gay couples, etc.) of the family seeking help. Adopting a broad, multicultural framework leads to a pluralistic outlook, one that recognizes that attitudes and behavior patterns are often deeply rooted in the family's cultural background. That pluralistic viewpoint also enables therapists to better understand the unique problems inherent in the multitude of families today that do not fit the historical model of the intact family (Sue & Sue, 2007).

Developing a *culturally sensitive therapy* (Prochaska & Norcross, 1999) necessitates moving beyond the white, middle-class outlook from which many therapists operate (prizing self-sufficiency, independence, and individual development) and recognizing that such values are not necessarily embraced by all ethnic groups. For example, many clients from traditional Asian backgrounds are socialized to subordinate their individual needs to those of their families or of society in general. In developing a multicultural framework, the family therapist must recognize that acculturation is an ongoing process that occurs over generations and that ethnic values continue to influence a client family's child-rearing practices, intergenerational relationships, family boundaries, and so forth.

A culturally competent family therapist remains alert to the fact that how he or she accesses or counsels a family is influenced not only by professional knowledge but also by his or her own "cultural filters"—values, attitudes, customs, religious beliefs and practices, and (especially) beliefs regarding what constitutes normal behavior (Madsen, 2007). To ignore such built-in standards is to run the risk of misdiagnosing or mislabeling as abnormal an unfamiliar family pattern that might be perfectly appropriate to that family's cultural heritage (McGoldrick & Hardy, 2008). Similarly, the culturally sensitive therapist must be careful not to overlook or minimize deviant behavior by simply attributing it to cultural differences. According to Falicov (2000), the family therapy encounter is really an engagement between a therapist's and a family's cultural and personal constructions about family life. This includes the role of spirituality on the part of both the clinician and the client, tapping spiritual resources for coping, healing, and resiliency (Walsh, 2009). If religious or previously established family rituals do not satisfy the system's needs, creating collaborative rituals can be healing to the family (Imber-Black, Roberts, & Alva Whiting, 2003).

Therapeutic intervention with a wide variety of families requires the therapist to help family members understand any restrictions imposed on them as a result of such factors as gender, race, religion, social class, or sexual orientation. Cultural narratives (White, 2007) specifying the customary or preferred ways of being in a society are sometimes toxic (racism, sexism, ageism, class bias) and thus inhibiting and subjugating to the individual, family, and group. Here the therapist must provide help in addressing the limitations imposed by the majority culture if the family is to overcome societal restrictions.

Other Systems

Differences between family therapy and other therapeutic approaches are less clear cut than in the past, as systems ideas have permeated other forms of psychotherapy. Although therapists may focus on the individual patient, many have begun to view that person's problems within a broader context, of which the family is inevitably a part, and have adapted family systems methods to individual psychotherapy (Wachtel & Wachtel, 1986). For example, *object relations theory* has emphasized the search for satisfactory "objects" (persons) in our lives, beginning in infancy. Practitioners of psychoanalytically based object relations family therapy, such as Scharff and Scharff (2006), help family members uncover how each has internalized objects from the past, usually as a result of an unresolved relationship with one's parents, and how these imprints from the past—called *introjects*—continue to impose themselves on current relationships, particularly with one's spouse or children. Object relations family therapists search for unconscious relationship-seeking from the past as the primary determinant of adult personality formation, whereas most family therapists deal with current interpersonal issues to improve overall family functioning.

Conceptually, Adlerian psychotherapy is compatible with family therapy formulations. Far less reliant on biological or instinctual constructs than is psychoanalysis,

Adlerian theory emphasizes the social context of behavior, the embeddedness of the individual in his or her interpersonal relationships, and the importance of present circumstances and future goals rather than unresolved issues from childhood. Both Adlerian psychotherapy and family therapy take a holistic view of the person and emphasize intent and conscious choices. Adler's efforts to establish a child guidance movement, as well as his concern with improving parenting practices, reflect his interest beyond the individual to family functioning. However, the individual focus of his therapeutic efforts fails to change the dysfunctional family relationships that underlie individual problems.

The person-centered approach developed by Carl Rogers is concerned with the client's here-and-now issues, is growth oriented, and is applicable to helping families move in the direction of self-actualization. Its humanistic outlook was particularly appealing to experiential family therapists such as Virginia Satir (1972) and Carl Whitaker (Whitaker & Bumberry, 1988), who believed families were stunted in their growth and would find solutions if provided with a growth-facilitating therapeutic experience. Experiential family therapists are usually more directive than Rogerians and, in some cases, act as teachers to help families open up their communication processes (for instance, using methods developed by Virginia Satir).

Existential psychotherapies are phenomenological in nature, emphasizing awareness and the here and now of the client's existence. Considered by most family therapists to be too concerned with the organized wholeness of the single person, this viewpoint nevertheless has found a home among some family therapists, such as Walter Kempler (1991), who argues that people define themselves and their relationships with one another through their current choices and decisions and what they choose to become in the future rather than through their reflections on the past.

Behavior therapists traditionally take a more linear view of causality regarding family interactions than do most systems theory advocates. A child's tantrums, for example, are viewed by behaviorists as maintained and reinforced by parental responses. Systems theorists view the tantrum as an interaction, including an exchange of feedback information, occurring within a family system.

Most behaviorists now acknowledge that cognitive factors (attitudes, thoughts, beliefs, expectations) influence behavior, and cognitive–behavior therapy has become a part of mainstream psychotherapy (Dattilio & Epstein, 2005). However, rational emotive behavior therapy's view that problems stem from maladaptive thought processes seems too individually focused for most family therapists (Ellis & Dryden, 2007).

HISTORY

Precursors

Freud, Adler, Sullivan

Family therapy can trace its ancestry to efforts begun early in the last century, led largely by Sigmund Freud, to discover intervention procedures for uncovering and mitigating symptomatic behavior in neurotic individuals. However, although Freud acknowledged in theory the often-powerful impact of individual fantasy and family conflict and alliances (e.g., the Oedipus conflict) on the development of such symptoms, he steered clear of involving the family in treatment, choosing instead to help the symptomatic person resolve personal or intrapsychic conflicts.

Adler went further than Freud in emphasizing the family context for neurotic behavior, stressing the importance of the family constellation (e.g., birth order, sibling rivalry) on individual personality formation. He drew attention to the central role of the

family in the formative years, contending that family interactive patterns are the key to understanding a person's current relationships both within and outside the family.

Harry Stack Sullivan, beginning in the 1920s, adopted an interpersonal relations view in working with hospitalized schizophrenics. Sullivan (1953) argued that people were the product of their "relatively enduring patterns of recurrent interpersonal situations" (p. 10). In spite of not working directly with families, Sullivan speculated on the role that family played in the transitional period of adolescence, thought to be the typical time for the onset of schizophrenia. Sullivan's influence on Don Jackson and Murray Bowen, two pioneers in family therapy who trained under Sullivan, as well as on his colleague Frieda Fromm-Reichmann, is apparent both in their adoption of Sullivan's early notion of redundant family interactive patterns and in their active therapeutic interventions with families.

General Systems Theory

Beginning in the 1940s, Ludwig von Bertalanffy (1968) and others began to develop a comprehensive theoretical model embracing all living systems. General systems theory challenged the traditional reductionistic view in science that complex phenomena could be understood by carefully breaking them down into a series of less complex cause-and-effect reactions and then analyzing in linear fashion how A causes B, B causes C, and so forth. Instead, this new theory argued for a systems focus in which the interrelations between parts assume far greater significance: A may cause B, but B affects A, which in turn affects B, and so on in a *circular causality.* General systems theory ideas can be seen in such family systems concepts as circular causality and the belief that symptoms in one family member signal family dysfunction rather than individual psychopathology.

Group Therapy

John Bell (1961) developed a therapeutic approach called *family group therapy,* applying some of the social psychological theories of small-group behavior to the natural group that is the family. Adopting group therapy's holistic outlook, family therapists involve entire families in the therapeutic process, believing that kinship groups are more real situations and provide a greater opportunity for powerful and longer-lasting systems changes as a result of family-level interventions.

Beginnings

Research on Schizophrenia

A number of researchers, working independently, began in the 1950s to zero in on schizophrenia as an area where family influences might be related to the development of psychotic symptoms. Taking a linear viewpoint at first and seeking causes of the schizophrenic condition in early family child-rearing practices, the researchers ultimately branched out into a broader systems point of view. Early efforts by the following are particularly noteworthy: Bateson's group in Palo Alto, Theodore Lidz's project at Yale, and the efforts at the National Institute of Mental Health (NIMH) of Murray Bowen and Lyman Wynne. The idea of seeing family members together for therapeutic purposes came later, as a result of research discoveries and subsequent theorizing.

A landmark paper by Bateson, Jackson, Haley, and Weakland (1956) speculated that *double-bind* communication patterns within a family may account for the onset of schizophrenia in one of its members. Double-bind situations exist when an individual, usually a child, habitually receives simultaneous contradictory messages from the same

important person, typically a parent (verbally, "I'm interested in what you are telling me" but nonverbally, by gesture or glance signaling, "Go away, you are bothering me, I don't care about you") who forbids comment on the contradiction. Compelled to respond, but doomed to failure whatever the response, the child becomes confused and ultimately withdraws after repeated exposure to such incongruent messages, unable to understand the true meaning of his or others' communications. Schizophrenia was thus reformulated as an interpersonal phenomenon and as a prototype of the consequences of failure in a family's communication system.

Lidz and his colleagues (Lidz, Cornelison, Fleck, & Terry, 1957) hypothesized that schizophrenics did not receive the necessary nurturance as children and thus failed to achieve autonomy as adults. According to this premise, one or both parents' own arrested development was responsible, especially because the parents were likely to have a conflict-ridden marriage, providing poor role models for children. These researchers distinguished two patterns of chronic marital discord that were common in schizophrenic families. In one, labeled *marital skew,* extreme domination by one emotionally disturbed partner is accepted by the other, who implies to the children that the situation is normal. In the *marital schism* scenario, parents undermine their spouses, threats of divorce are common, and each parent vies for the loyalty and affection of the children.

Bowen was especially interested in the symbiotic mother-child bonds that he hypothesized might lead to schizophrenia. Hospitalizing entire families on the research wards for months at a time in order to observe ongoing family interactions, Bowen (1960) broadened his outlook, observing emotional intensity throughout these families. As a result, he moved from his previous psychoanalytic viewpoint to one that emphasized reciprocal functioning, in what he labeled the *family emotional system.*

Lyman Wynne, who succeeded Bowen at NIMH, turned his attention to the blurred, ambiguous, confused communication patterns he and his associates found in families with schizophrenic members (Wynne, Ryckoff, Day, & Hirsch, 1958). Wynne coined the term *pseudomutuality* to describe a false sense of family closeness in which the family gives the appearance of taking part in a mutual, open, and understanding relationship without really doing so. The members of these families have poorly developed personal identities and doubt their ability to accurately derive meaning from personal experiences outside the family, preferring to remain within the safe and familiar family system with its enclosed boundaries.

Psychodynamics of Family Life

Trained in psychoanalytic work with children, Nathan Ackerman nevertheless saw the value of treating entire families as a unit in assessing and treating dysfunctional families. In his landmark book *The Psychodynamics of Family Life,* often considered the first text to define the new field, Ackerman (1958) argued for family sessions aimed at untangling interlocking pathologies, thus endorsing the systems view that problems of any one family member cannot be understood apart from those of all other members.

By working therapeutically with nonschizophrenic families, Ackerman demonstrated the applicability of family therapy to less disturbed patients. By 1962, he in New York and Don Jackson on the West Coast founded the first journal in the field, *Family Process,* with Jay Haley as editor. This periodical enabled researchers and practitioners to exchange ideas and identify with the growing field of family therapy.

Delinquent Families

One project combining theory and practice was led by Salvador Minuchin (Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967) at the Wiltwyck School for Boys in

upper New York State, a residential setting for delinquent youngsters from urban slums. Recognizing the limitations of traditional methods for reaching these boys, who were generally from poor, underorganized, fatherless homes, Minuchin developed a number of brief, action-oriented therapeutic procedures aimed at helping reorganize unstable family structures.

Current Status

The current trend in family therapy is toward eclecticism and integration of therapeutic approaches (Lebow, 1997) since no single technique fits all clients or situations. Multisystemic approaches, research-based whenever possible, are being used to treat a variety of behavioral and emotional problems in adolescents and entire families as therapists select and borrow from one another's theories to address a current therapeutic problem. However, according to Goldenberg and Goldenberg (2008), eight theoretical viewpoints and corresponding approaches to family therapy can be identified.

Object Relations Family Therapy

The psychodynamic view is currently best expressed by object relations family therapists (Hughes, 2007 Scharff & Scharff, 2006), who contend that the need for a satisfying relationship with some "object" (i.e., another person) is the fundamental motive of life. From the object relations perspective, we bring *introjects*—memories of loss or unfulfillment from childhood—into current dealings with others, seeking satisfaction but sometimes "contaminating" family relations in the process. Thus, they argue, people unconsciously relate to one another in the present largely on the basis of expectations formed during childhood. Individual intrapsychic issues and family interpersonal difficulties are examined in a therapeutic setting. Helping family members gain insight into how they internalized objects from the past and how these objects continue to intrude on current relationships is the central therapeutic effort, along with providing understanding and instigating change. Treatment is aimed at helping members become aware of those unresolved objects from their families of origin and at increasing their understanding of the interlocking pathologies that have blocked both individual development and fulfillment from family relationships.

Experiential Family Therapy

Experiential family therapists such as Satir and Whitaker believe that troubled families need a "growth experience" derived from an intimate interpersonal experience with an involved therapist. By being real or authentic themselves, and often self-disclosing, experiential therapists contend that they can help families learn to be more honest, more expressive of their feelings and needs, and better able to use their potential for self-awareness to achieve personal and interpersonal growth.

For Virginia Satir, building self-esteem and learning to communicate adequately and openly were essential therapeutic goals. Calling his approach *symbolic—experiential family therapy,* Carl Whitaker gave voice to his own impulses and fantasies and depathologized human experiences as he helped family members probe their own covert world of symbolic meanings, freeing them to activate their innate growth processes. Currently, experiential family therapy is best represented by *emotion-focused couple therapy* (Greenberg & Goldman, 2008), an attachment-theory-grounded experiential approach based on humanistic and systemic foundations that attempts to change a couple's negative interactions while helping them cement their emotional connection to each other.

Transgenerational Family Therapy

Murray Bowen argued that family members are tied in thinking, feeling, and behavior to the family system and thus that individual problems arise and are maintained by relationship connections with fellow members. Those persons with the strongest affective connections (or *fusion*) with the family are most vulnerable to personal emotional reactions to family stress. The degree to which an individualized, separate sense of self independent from the family (or *differentiation of self*) occurs is correlated with the ability to resist being overwhelmed by emotional reactivity in the family; the greater the differentiation, the less likely the individual is to experience personal dysfunction.

Bowen (1978) believed that the child most vulnerable to dysfunction is the one most easily drawn into family conflict. He maintained that the most attached child will have the lowest level of differentiation, will be the least mature and thus have the hardest time separating from the family, and is likely to select as a marital partner someone who is also poorly differentiated in his or her family. The least differentiated of their offspring will marry someone equally undifferentiated, and so forth. In this formulation, problems are passed along to succeeding generations by a multigenerational transmission process. Bowen maintained that schizophrenia could result after several generations of increased fusion and vulnerability.

Another transgenerational family therapist, Ivan Boszormenyi-Nagy (1987), emphasizes the ethical dimension (trust, loyalty, entitlements, and indebtedness) in family relationships, extending over generations. He focuses on the relational ethics within a family aimed at preserving fairness and ensuring fulfillment of each member's subjective sense of claims, rights, and obligations in relation to one another. To *contextual therapists* such as Boszormenyi-Nagy, the patterns of relating within a family that are passed down from generation to generation are the keys to understanding both individual and family functioning.

Structural Family Therapy

Minuchin's (1974) structural view focuses on how families are organized and on what rules govern their transactions. He pays particular attention to family rules, roles, alignments, and coalitions, as well as to the boundaries and subsystems that make up the overall family system. Symptoms are viewed as conflict defusers, diverting attention from more basic family conflicts. Therapeutically, structuralists challenge rigid, repetitive transactions within a family, helping to "unfreeze" them to allow family reorganization (Minuchin, Nichols, & Lee, 2006).

Strategic Family Therapy

This approach involves the designing of novel strategies by the therapist for eliminating undesired behavior. Strategists such as Jay Haley (1996) are not particularly interested in providing insight to family members; they are more likely to assign tasks to get families to change those aspects of the system that maintain the problematic behavior. Sometimes indirect tasks, in the form of *paradoxical interventions,* are employed to force clients to abandon symptoms. Therapists at the Mental Research Institute in Palo Alto believe families develop unworkable "solutions" to problems that become problems themselves. Consequently, these therapists have evolved a set of brief therapy procedures employing various forms of paradox aimed at changing undesired family interactive patterns (Watzlawick, Weakland, & Fisch, 1974).

In Milan, Italy, Mara Selvini-Palazzoli and her colleagues (Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1978) developed *systemic family therapy,* a variation of strategic family