Chapter 1

INTRODUCTION

At times, the pain of separation seems more than we can bear; but love and understanding can help us pass through the darkness toward the light.
And in truth, grief is a great teacher, when it sends us back to serve and bless the living. . . .
Thus, even when they are gone, the departed are with us, moving us to live as, in their higher moments, they themselves wished to live.
We remember them now; they live in our hearts; they are an abiding blessing.

~Jewish mourners' Kaddish (Central Conference of Rabbis, 1992)

According to the U. S. Department of Commerce (1991), almost 2 million children from birth through 18 years of age become bereaved siblings each year. Although homicide is the least frequent form of violent dying, it may have the most profound and lasting impact on surviving family members (Rynearson, 2001). Since the mid-1980s, the rate of murder committed by youth has doubled, increasing by 102% (State Legislative Responses to Violent Juvenile Crime, 1996-1997). Homicide survivors are defined as significant others who are left behind to mourn victims of homicide. While society recognizes that the violent loss of a child is one of the most devastating experiences a parent can confront, there is little societal recognition of the impact of such a loss upon surviving siblings (Fanos, 1996).

Despite the large number of adolescents and young adults who are faced with this catastrophic personal and family crisis, there is a lack of theoretical constructs and systemic treatments from which to generate a theory of sibling bereavement (Walsh &

McGoldrick, 2004). The loss of a brother or sister has a lasting effect on the overall development of the surviving sibling and the family system, and it is extraordinary that so little attention has been directed at understanding the impact of loss in young adulthood upon both individual and family life cycles (Carter & McGoldrick, 1999). The role and function sibling relationships play in identity formation is becoming recognized as a powerful force in personality development (Provence & Solnit, 1983).

Complicated grief is often part of the clinical picture with sibling survivors of homicide (Rando, 1993). In this paper, complicated grief is defined as involving an intensity of symptoms that affect people over an extended length of time or as barriers to daily living caused by grief (Weiss, 2000). Green, Lindy, Grace, and Gleser (1989) found that the experience of surviving the homicide of a loved one frequently led to complicated grief reactions. Rynearson (1984) pointed out that "the manner of dying rather than the event of death determines the meaning of death, which in turn influences the form and cause of bereavement" (p. 1452). Allen (1991) noted that surviving the homicide of a family member was detrimental to the survivors' psychological well being because homicide is "stigmatizing, unnatural, especially burdensome, and unexpected" (p. 18). Parkes and Weiss (1983) empirically supported their belief that the mental health effects of homicide on survivors were more pronounced than those experienced by individuals who lose a loved one because of an anticipated death. Furthermore, Allen (1991) noted that "the closer the survivor and the victim were, the more difficult the bereavement" (p. 20). Raphael's (1983) summary seems the most appropriate to conceptualize the severity of the grief experienced by relatives of a homicide victim: "First degree family members are the ones who are the most impacted by the death, and

the greater a family member is involved with the deceased, the more deeply the loss is felt" (p. 67).

Kubler-Ross's (1969) stage model of grieving has not been useful in helping these forgotten grievers to feel validated in their need to remain spiritually and emotionally connected to their deceased loved ones and to surviving family members (Walsh & McGoldrick, 2004). Instead, a model of treatment that has a deeper perspective and that examines multigenerational and emotionally interdependent functioning is needed (Bowen, 1976; Walsh & McGoldrick, 2004).

Chapter 1 has four sections: (a) An overview of the project, (b) the background of the problem, (c) a statement of the problem, and (d) the purpose of the study.

Overview of Project

This case study involved treatment of a 34-year-old, Caucasian mother of two infant sons. For the purpose of this study, the fictional name of "Cynthia" was used to refer to the subject, and fictional names were also used to identify family members. Cynthia is a sibling survivor of a homicide that occurred approximately 13 years ago. When she was 21, her brother, Josh, who was 19, was shot in the chest with a sawed-off shotgun by "the Skinheads who invaded our community." Recently divorced, she rekindled her relationship with Steve, her high school sweetheart, because he "offered me my dream of motherhood and family on a silver platter." Cynthia and Steve had recently begun living together at the beginning of therapy and had an infant son (referred to as Adam) together with another child (referred to as Timmy) on the way. Steve was still in the process of a divorce, and had a 3-year-old daughter, Abbie, from that marriage.

Cynthia presented with depression, stating:

> I have a problematic relationship with Steve, my boy's father, but I have known for a long time that I need to work through grief resulting from the murder of my brother. I want to go back and work through all my sadness and confusion in therapy.

From a systemic perspective, it is assumed that increased resolution of attachment issues in the family of origin will either improve attachment relationships in the nuclear family or alter past decisions in favor of healthier mate selection (Kerr & Bowen, 1988). Following from this theoretical lens, a therapeutic focus on Cynthia's family of origin issues would have a beneficial affect on her relationships in the present. Thus, grief work would be coupled with family of origin work, with the overarching goals of decreasing chronic anxiety and increasing differentiation.

As Cynthia worked on resolving attachment with her parents and Josh, her lower anxiety and increased differentiation would empower her either to have an improved relationship with Steve and/or to gain clarity as to whether the relationship should continue. Additionally, by uncovering new, hidden resiliency themes in old stories and by identifying multigenerational patterns of transmission, Cynthia stood to gain a revised image of herself. Instead of being a passive victim, she could become a survivor who could transcend her troubled family and offset her pain with pride (Wolin & Wolin, 1993). Most importantly, she could interrupt maladaptive patterns in her own generation, and in so doing, change the course of family life for generations to come. As she developed an increased ability to think systemically about her family, Cynthia would make new meaning out of her trauma. Her broader perspective would allow her to forge strengths *because* of, not in spite of, her adversity. Her increase in differentiation,

decreased anxiety, and meaning-making efforts would allow her to integrate the meaning of her brother's death into her life in a more adaptive way (Bowen, 1978; Frankl, 1959; Kerr & Bowen, 1988; Wolin & Wolin, 1993).

Cynthia lost her brother, Josh, in a gang-related homicide and had no previous therapy to work through her grief. She was approximately 20 months older than Josh. Cynthia and Josh shared the most unique of histories and were closer to one another than they were to anyone else. When Cynthia lost her 19-year-old brother to homicide, her life was unalterably changed. Because his death was by violent means, the grief would be more complicated.

Until approximately 1 year prior to Josh's death, Cynthia assumed he was her only sibling. However, about 2 years before he died, she discovered that a school friend of hers was, in fact, their half-sibling. This half-brother, Michael, was the product of an affair between Cynthia's father and another woman. Michael's wife, Tamara, a client of the author, referred Cynthia after her own treatment.

Cynthia was a high school graduate with 1 semester of college who worked part-time as a waitress, but was primarily a stay-at-home mother. She was bright, attractive, articulate, and demonstrated many qualities of resilience as defined by Wolin and Wolin (1993). Within the chaotic atmosphere of living in a home marked by the fallout of ongoing alcoholism and addiction of both parents, for example, this resilient woman managed to earn straight As in high school. She attended California State University at Humboldt for 1 semester at age 19 and earned straight As. However, she became homesick and dropped out of college to return home.

In high school, Cynthia had many friends, six of whom she was in close contact with. She was not an abuser of alcohol or drugs. Although she had experimented and used recreationally in the past, her insight resulting from growing up with alcoholic and drug-addicted parents was a protective factor in keeping Cynthia from becoming a substance abuser. Nevertheless, she had chosen mates in Tom and in Steve that allowed her to remain in her family-of-origin role as an over-functioner and as a rescuer.

Showing an innate quality of initiative, Cynthia managed to find substitute caregivers while in high school in order to study in a calmer environment. Showing her innate ability in relationships, she left home while still maintaining close contact with her parents and brother. She embraced her motherhood. Cynthia was eager and engaged in therapy. She enjoyed a close relationship with her mother, although Cynthia had had trouble differentiating her own voice from her mother's voice in thinking about the chaotic environment in which she was raised. Cynthia's initiative, engagement in relationships, morality, intelligence, creativity, efforts to make meaning, and sense of humor were apparent in many sessions. These are all resiliencies identified in children of alcoholics (Wolin & Wolin, 1993).

Like many children of addictive and divorced parents, Cynthia was parentified at a young age. In listening to her speak as she grieved her loss, one could imagine that she was a grieving mother rather than a grieving, older sister. The stigma of the homicide intensified an already closed communication system in her family of origin. Family secrets, addiction, alcoholism, emotional cutoff, and distance were used to manage problems of chronic anxiety within and between the generations (Kerr & Bowen, 1988).

Until the present, Cynthia described her paternal grandmother as "keeper of the family secrets."

This case provides a clear example of Bowen's (1978) emotional shock wave affect. Josh placed himself in harm's way and was killed on the night of his grandfather, Roger's, funeral. Bill, Cynthia's father, a heroin addict and alcoholic, died approximately 2 years after the deaths of Josh and Roger. Seemingly coincidental traumatic events followed the death of a very important family member who cut off from his son because of the latter's heroin and alcohol abuse.

The subject had been in therapy continuously for 1 and ½ years. The treatment goals for this case were complex and multidirectional. Working on increased resolution of complicated grief informed beginning, intermediate, and later stages of treatment. The treatment was conceptualized with the assumption that increasing resolution of attachment in family of origin relationships would improve the quality of life in the present. Thus, Bowen Family Systems treatment (BFST) informed therapy throughout treatment. Intervening successfully involved continuing family of origin work with an emphasis upon opening the communication system and examining the intergenerational ripple effects of three significant deaths within 2 years of one another. Alcoholism and addiction issues arising from within the extended and nuclear family systems were also examined from a BFST perspective. Additionally, treatment involved the client in the activity of meaning making from a resiliency perspective, including the development of a vocabulary of strengths.

The effort in BFST is to assess individuals through evaluating the effects of the multigenerational emotional processes running through generations of the family of

origin. By constructing a family diagram and returning to it to add family facts, the client is empowered to see how emotional patterns are unconsciously passed on from the family of origin, and how this has a profound impact upon functioning in present and future relationships. Change begins to occur even in assessment, when the family diagram is constructed, as the client gains an awareness of repetitive patterns in his or her family of origin. Over time and as work within the family of origin deepens, the client evolves into a more differentiated and less anxious self. The client becomes increasingly able to hold onto self in important relationships while at the same time being able to remain connected. The client learns to distinguish more clearly between his or her thoughts and feelings and can more frequently choose between using the thinking or feeling systems.

In recognizing multigenerational patterns, the client may eventually reject maladaptive roles, which she previously and unwittingly "inherited" and which affected her mate selection. Such an effort results in a client who has more control over his or her responses to external events and to relational stresses. BFST can be used to help the sibling survivor of homicide find a new way to view the multigenerational effects of trauma, and with this new understanding, grow and mature into a healthier and happier human being.

Background of the Problem

Death is a nodal event in the family system (Carter & McGoldrick, 1999). News of the loss of a family member sends many loved ones into a state of shock and numbness. Though initial reactions to news of death may be similar in all cases, the grieving process surrounding an unexpected and violent death, such as homicide, is complicated, painful,

and may generate a ripple effect of subsequent problems that interfere with healthy development over the individual and family life cycle (Walsh & McGoldrick, 2004). In fact, homicidal death has been associated with higher distress than suicidal or accidental dying (Murphy, 1999). While family members suffer bereavement symptoms as do survivors of those who die from more natural forms of death, bereavement is longer-lasting, more complicated, and may be more intense following violent deaths compared to other types of deaths (Redmond, 1989). In fact, it was noted by Redmond that it often took at least 3 to 5 years for the most intense grief symptoms to begin to subside. One woman described her reaction on learning of the murder of several family members:

> I remember dropping the phone and it was like my insides just totally erupted and I ran to the bathroom with diarrhea and I could still think straight, but I think my whole insides of my body were just going in...you know...in fits. (Asaro, 1992, p. 34)

The Federal Bureau of Investigation (1999) defined homicide as the "willful (non-negligent) killing of one human being by another" and reported that there were 15,561 homicides nationwide in 1999. Additionally, it has been reported that homicide causes 20% of all deaths among youth and young adults ages 10 to 24 in the United States (as cited in U.S. Department of Health and Human Services. Centers for Disease Control and Prevention [CDC], 1998). Spungen (1998), a trauma specialist whose daughter was murdered in 1978, defined homicide differently: "The blackest hell accompanied by a pain so intense that even breathing becomes an unendurable labor" (p. xix).

Statement of the Problem

Homicide survivors are significant others who are left behind to mourn victims of homicide. From an analysis of more than 300 family diagrams done with homicide survivor families, Redmond (1989) reported there were 7 to 10 close relatives who are left behind to mourn each victim. Spungen (1998) described surviving family members as *co-victims* of homicide.

While society recognizes that the violent loss of a child is one of the most devastating experiences a parent can confront, there is little societal recognition of the impact of such a loss upon surviving siblings (Fanos, 1996). Indeed, Cain, Fast, and Erikson (1964) reported, "Current studies showing a sharp awareness of the complex reactions of parents to the death of a child omit any mention of the impact of death upon other members" (pp. 741-742). Understudied by researchers and often neglected by grieving parents, surviving siblings of homicide may be conceptualized as co-victims left adrift at sea. There is a paucity of research to guide the treatment of these co-victims of homicide.

Complicated grief is often part of the clinical picture with sibling survivors of homicide. As Walsh and McGoldrick (2004) suggested, "The mental health field has not appreciated the impact of loss on the family as an interactional system" (p. 5). The narrow focus on the individual or dyadic relationship views the family system as a mere backdrop to pathological mourning. However, Kerr and Bowen (1988) emphasized that the family is emotionally interdependent and that vulnerability to physical and mental illness is likely linked to profound connections among members of the family system. Nevertheless, Walsh and McGoldrick noted that

> from Freud's (1957) treatise on mourning and melancholia and groundbreaking studies on bereavement (Bowlby, 1980; Engel, 1961; Glick, Weiss, & Parkes, 1974; Kubler-Ross, 1969; Lindemann, 1944; Parkes, 2001; Parkes & Weiss, 1983) to the extensive literature on loss in recent decades, the focus has continued to be on individual grief reactions (Doka, 1996; Rando, 1986b; Worden, 1996; 2002). (p. 5)

From a systems perspective, the death of a child may have a significant impact on remaining siblings by disrupting the internal balance of interrelated emotional roles in the family structure, which requires shifts in dynamics. Parents' unmet psychological needs can be transferred to survivor siblings, sometimes with disastrous consequences (Cain et al., 1964). Even more, in families in which parental under-involvement is high, the sibling bond assumes greater importance (Bank & Kahn, 1982). Secrecy, isolation, and closed communication channels may be part of the clinical picture following the stigma of loss through homicide and further exacerbate the traumatic effects of the loss (Walsh & McGoldrick, 2004). Seemingly coincidental subsequent traumatic events in the family system may reflect the emotional shock wave effect described by Bowen (1978) in his groundbreaking work on death in the family.

Kubler-Ross's (1969) emphasis upon a stage model of grieving ends with acceptance and resolution, as if a survivor should eventually move on and "let go." It may be more accurate to view bereavement as a transformation of the relationship from physical presence (Walsh & McGoldrick, 2004) to "continuing bonds" (Klass, Silverman, & Nickman, 1996). Even in death, cutoff can be the source of chronic anxiety (Bowen, 1978), and continuing bonds can be nurtured with ongoing family-of-origin work and meaning, making thorough the weaving together of stories, memories, spiritual insights, and generative deeds.

Walsh and McGoldrick (2004) noted that

> coming to terms with loss involves finding ways to make meaning of the loss experience, put it in perspective, and weave the experience into the fabric of life. The multiple meanings of any death are transformed throughout the life cycle, as they are integrated into individual and family identity, along with subsequent life experiences, especially other attachments and losses. (p. 9)

Additionally, Walsh and McGoldrick explained that there might never be a permanent resolution to loss. One does not ever get over it completely. Nor does resilience in the face of loss mean simply "bouncing back" by moving on or cutting off from the emotional experience. Rather, it involves active coping, struggling well, and forging strengths to meet the many challenges that present themselves over time (Walsh & McGoldrick).

Purpose of the Study

The purpose of this study was to identify implications for systems theory, research, and practice by presenting a single case study treatment of a sibling survivor of homicide dominantly informed by a resiliency-based application of BFST. Three research questions are posed in this qualitative study:

1. Is a resiliency-based treatment model dominantly informed by BFST useful with a sibling survivor of homicide?

2. Is the concept of resilience (defined as strengths forged through adversity) a valuable, supplementary framework for treating this population?

3. Is treatment informed by a framework of the impact of intergenerational transmission of trauma useful?

This integrative model is addressed through a literature review for each of the key concepts listed in the abstract. The study illustrates how each of these concepts are interrelated and utilized in the treatment. Such utilization is shown through a case history of a sibling survivor being treated in a continuing process over a 1½ -year period. This case study represents an effort to pave the way for a more effective approach in the treatment of siblings who have lost a brother or sister to homicide and who are, in a sense, co-victims.

The goals of psychotherapy will be threefold: (a) To help the client to increase her differentiation of self and to lower her level of chronic anxiety by applying BFST to the case, (b) to help the client to recognize and utilize her unique resiliencies by applying Wolins' Challenge Model to the treatment, and (c) to encourage the client to tell and re-tell her stories in session and with her family of origin in order to make interpersonal sense of her existential challenges.

Cynthia lost her 19-year-old brother when she was 21. Bank and Kahn (1982) have emphasized the critical nature of the sibling bond in human development. They asserted:

> The research for a personal identity emerges as the vital ground where brothers and sisters become significant to one another (p. 49)....Siblings, early in life, can acquire meaning for one another and become locked into a complementarity in which a vital part of one's sibling's core identity becomes fitted to deep parts of the other's core identity (p. 30)....Sibling relationships evolve to become a fitting together of two people's identity. (p. 15)

When a sibling dies, the constant, reciprocal interaction through which personal identity is learned is altered. Bereaved siblings who are just entering adulthood must cope not only with the developmental crisis in their individual and family life cycles, but with the horrendous stresses of sibling death and its aftermath (Carter & McGoldrick, 1999). If

the death has been a violent death, the experience of bereavement is compounded by the status of survivorship (Fanos, 1996).

The notion that trauma has an impact on mental health has long been recognized and is widely accepted. Similarly, the complex effects of intergenerational transmission of trauma have been widely addressed in the literature. However, the qualitative research literature on effective systemic treatments for sibling survivors of homicide is extremely limited. Clearly, more research is needed in this area, especially research that illuminates what this experience is like in a life as lived and in the context of multigenerational transmission of trauma.

This study is important because it may pave the way for researchers and clinicians to examine the efficacy of a broader, systemic treatment for the adult sibling survivor of homicide. The literature is scarce with regard to adult survivors of homicide, and this case study offers future researchers an opportunity to examine what worked in one case. The limitation of this study is that it has an N of 1. Although a positive outcome emerged from the treatment, such results must be viewed cautiously in the context of the narrowest of samples.

This case study is Cynthia's story—a recording of the journey that a sibling survivor of homicide and her therapist took together. In Chapter 2, this dissertation provides a literature review of the sibling relationship, sibling bereavement, especially in relation to homicide, resiliency in the individual and in the family system, and theory. Chapters 3, 4, and 5 respectively discuss assessment of the case, treatment goals and treatment, and the reasons why a resiliency-based, Bowen Family Systems treatment model can work well with this population of sibling survivors of homicide, including

implications for future research and practice. Excerpts from psychotherapy transcripts are included and analyzed as anecdotal illustration of theoretical concepts underlying the treatment.

Chapter 2

LITERATURE REVIEW

This chapter reviews the literature, including the sibling relationship, sibling bereavement, especially in relation to homicide, resiliency in the individual and in the family system, and theory.

The Sibling Relationship

The relationships in life that usually endure the longest are those between siblings (McGoldrick, Anderson, & Walsh, 1989). Most people experience the death of parents a generation before they die, and their children live a generation longer. Marital partners usually do not know one another until early adulthood. Friendships that last from earliest childhood till the end of life are rare. Thus, McGoldrick et al. noted that "our siblings share more of our lives genetically and contextually than anyone else" (p. 246). In this sense, the sibling relationship is distinctive from all other human relationships. Siblings have a shared personal and familial history, and this history includes experiences, values, and traditions. Brothers and sisters are each other's first playmates and confidants, even sharing 50% of their genetic composition (Wray, 2003). Carter and McGoldrick (1999) pointed out that "the more time siblings spend with one another and the fewer siblings there are, the more intense their relationships are likely to be" (p. 154).

In a longitudinal study of successful aging among men from the Harvard classes of 1938-1944, the single best predictor of emotional health at age 65 was having had a close

relationship with one's sibling in college. This was more predictive than childhood closeness to parents, emotional problems in childhood or parental divorce, and even more predictive than having had a successful marriage or career (Valliant, 1977).

Birth order has a significant role in later experiences with marital partners, colleagues, and friends (Toman, 1976). Because siblings are an individual's earliest peer relationship, he or she is probably most at ease in other relationships that reproduce familiar sibling patterns of birth order and gender (Carter & McGoldrick, 1999). Although not always honored or acknowledged as leaders, firstborn sisters are often assigned the role of caretaker of disabled family members (Carter & McGoldrick, 1999).

Bank and Kahn (1997) interpreted the sibling bond from a psychoanalytic perspective, basing their conclusions on an in-depth study of 100 clinical case histories in which the sibling relationship was problematic. They identified three conditions for the development of a strong sibling bond in childhood: (a) high access between siblings, (b) the need for meaningful personal identity, and (c) insufficient parental influence. Processes of identification with the sibling constitute the essence of the sibling relationship. According to Bank and Kahn, both close and distant sibling identification can lead to rigid relationships and clinical problems.

Teti (1992) noted the remarkable changes that occur in the life of the first-born child with the birth of a sibling. The older child must adapt to sharing parental attention with an infant. Teti found that older siblings might display increased anxiety and aggression toward either the new baby or their parents. Furthermore, Teti noted that older children frequently regress developmentally in areas such as toilet training. There are individual differences in how children adjust to this change, however. Two studies

found that in families in which parents involved the older sibling in the care of the baby and discussed the baby's needs and desires, siblings had particularly close relationships later (Dunn & Kendrick, 1982; Howe & Ross, 1990). Crouter and McHale (1989) noted that siblings spend a great deal of time together in early childhood, and, in fact, spend more time together than do parents with their children. In the early stages of the sibling relationship, the older sibling usually takes on a leadership role and teaches the younger sibling, while the younger sibling often imitates the older sibling.

In middle childhood, sibling relationships tend to be more egalitarian than those in early childhood. The younger sibling may become more cognitively sophisticated, allowing for a greater ability to communicate and negotiate with older siblings (Buhrmester & Furman, 1990; Vandell, Minnett, & Santrock, 1987).

As siblings enter the adolescent phase of development, their relationships become more distant than in childhood. Affection and hostility levels are lower in adolescence than in adulthood (Buhrmester & Furman, 1990; Stocker & Dunn, 1994). Additionally, siblings spend less time together as adolescents than they did as children. Supportive sibling relationships have been linked to decreased anxiety and greater maturity in young adolescents (East & Rook, 1992).

Research on sibling relationships in childhood and adolescence has shown that children's sociability is associated with sibling warmth, and emotionality is linked to conflict and rivalry in sibling relationships (Brody, Stoneman, & Burke, 1987; Stocker, Dunn, & Plomin, 1989). Furthermore, the match between siblings' temperaments is related to the quality of their relationship (Munn & Dunn, 1988).

The research on sibling relationships for individuals during late adolescence, a period characterized by increasing independence and identity formation, has received scant attention (Tseung & Schott, 2004). Tseung and Schott investigated late adolescents' perceptions of the quality of their sibling relationships in a British sample of 165 participants, using the Sibling Relationship Inventory. Significant correlations were found between sibling affection and the capacity to have close friendships.

Stocker, Lanthier, and Furman (1997) offer one of the few studies on sibling relationships in early adulthood. They found that such relationships, like those in childhood, varied in the areas of warmth, conflict, and rivalry. In another observational study, it was noted that young adult siblings who felt close to one another had fewer power struggles, more positive affect, and lower heart rate activity than siblings who rated their relationships as distant (Shortt & Gottman, 1997).

Recent research has found associations between the quality of the sibling relationship in young adulthood and affective-perspective taking. Young adults who rated their sibling relationships as close had higher scores on measures of emotional and cognitive empathy than did those who rated their sibling relationships as distant (Shortt & Gottman, 1997).

Scharf (2005) conducted a study with 116 emerging adults and adolescents. The subjects completed questionnaires and were interviewed about their relationship with a sibling. Emerging adults were found to spend less time and to be less involved in joint activities with their sibling than adolescents, but they reported being more involved in emotional exchanges with and feeling more warmth toward their siblings. Narrative analyses of the questionnaires showed that emerging adults had a more mature perception

of their relationship with their siblings. Unlike in adolescence, the researchers found that the quality of emerging adults' relationships with their siblings was less related to their relationship with their parents.

Many theorists and researchers have discussed the associations between sibling relationships and parent-child relationships. Dunn (1992) found that in families in which parent-child relationships are warm and supportive, high levels of affection also characterize sibling relationships. Conflictual parent-child relationships are associated with sibling relationships fraught with rivalry and conflict. In addition to associations between each sibling's relationship with his or her parent, differences in parents' behavior toward each sibling are related to the quality of sibling relationships. Siblings have more positive relationships with one another when parents treat them similarly (Brody, Stoneman, & Burke, 1987).

Associations between the quality of parents' marital or extra-marital relationships and children's' sibling relationships have been documented in the literature (Brody, Stoneman, McCoy, & Forehand, 1992; Kerr & Bowen, 1988; MacKinnon, 1989; Stocker, Ahmed, & Stall, 1997). Despite the positive links between marital conflict and hostile sibling relationships, some research suggests that siblings can act as supports for each other. For example, Jenkins and Smith (1990) found that in families with high levels of marital conflict, children with close relationships with brothers and sisters had fewer adjustment difficulties than those with conflictual sibling relationships.

One of the most consistent and striking findings about siblings is that they differ from one another on most measures of personality and psychopathology as much as any two people randomly selected from the population (Dunn & Plomin, 1990). Why should

sisters and brothers who grow up in the same family and share 50% of their genes be so different? Researchers have discovered that even though they come from the same family, siblings experience different environments within that family. Parents treat siblings differently, and these differences have been linked to differences in siblings' outcomes (Dunn & Plomin, 1990).

Murray Bowen (1978) offered a way to understand family emotional processes that create sibling differences. In a live-in family research project at the National Institute of Mental Health, he studied how it was that the same parents could raise one quite impaired child and another fairly normal child. He theorized that the unit of treatment is the family system, not the individual. He postulated that if parents do not work on difficulties they are having with each other in their marriage or relationship, then one or more children would be vulnerable to filling this breach in their relationship. The child who is fortunate enough to avoid intense focus by one or more parents is freer to grow and develop.

According to M. E. Kerr:

> The usual way that marital distance places one child in harm's way is that the mother focuses less energy on her husband and turns to the child to gratify desires for a comfortable emotional connection. In the process, the child becomes so important to her well being that he easily triggers her worries as well. This mix of needs and fears cements a powerful connection. The father invests much of his energy in work and is usually less entangled emotionally with the child. However, he participates equally in the child focus by playing his part in marital distance and getting anxiously entangled in his wife's relationship with the child. (personal communication, October 29, 2005)

M. E. Kerr explained:

> If one child fills the breach in the parents' relationship, his sibling is relatively off the hook. The parents expend their needs and fears on the overly involved child. It enables them to be more relaxed and at their best with his sibling. The sibling's reality needs rather than their anxiety largely govern their interactions with him. Developing in a less emotional climate, the sibling tunes into social cues, but

> without being programmed to overreact to them. (personal communication, October 30, 2005)

Kerr (personal communication, October 29, 2005) noted that functioning between an overly involved sibling and his brother or sister often become apparent during toddlerhood. One child may be more easily bored and depend more completely on his or her mother for direction. The freer sibling can entertain himself and manage himself more independently. By the time the child reaches school age, the freer child is not as dependent on his teacher for approval and direction. Peer relationships are freer and less of an issue for a child who is free of intense focus by one or more parents.

The overly focused upon child will be more prone to rebel or move into harm's way during adolescence, according to Kerr (personal communication, October 29, 2005). His rebellious streak parallels his or her difficulty in being an individual while the freer adolescent sails through this life cycle stage more easily. Kerr theorized:

> The overly involved child may function fairly well until stumbling badly in trying to make the transition into adult life. At whatever point problems surface, the parents intensify their focus on the child in an effort to fix him. This further escalates the tension, particularly if the child does not respond. (personal communication, October 28, 2005)

Kerr emphasized that

> a parent being overly involved with a child is harmful because the ongoing emotionally intense interactions over the years of his development program the child's well being and functioning to depend heavily on relationships....like a moth drawn to a bright light, he becomes preoccupied with [mother's] attention, approval, expectations, and distress. His mood and motivation become linked to how she and others view him. Being ensnarled in the emotionality constrains the child's instinctive urge to develop his individuality. (personal communication, October 29, 2005)

In the sections above, the nature of the sibling relationship has been explored from individual, systemic, and lifespan perspectives. Now a review of the literature on sibling bereavement, especially in relation to homicide, is investigated.

Sibling Bereavement, Especially in Relation to Homicide

When a young adult child dies, it is a crushing blow for the entire family and may result in highly distressing and lifelong grief (Gorer, 1965; Rando, 1986a). Parents and siblings may experience so much pain and guilt that they are blocked from continuing their own pursuits (Carter & McGoldrick, 1999).

When a brother or sister dies, bereaved siblings always remain. These grievers are large in number and often are overlooked, for society considers the parents to shoulder the greatest burden of loss (Hogan & DeSantis, 1992). Although young people's reactions to the death of a sibling have received scant attention, the conclusions of the few researchers who have studied the effects of this phenomenon point toward the traumatic nature of such a loss (Cain et al., 1964; McCown, 1987; McCown & Davies, 1985; McCown & Pratt, 1985). An Institute of Medicine report on bereavement published more than 20 years ago concluded that further research was necessary in the area of sibling bereavement, yet investigations of this phenomenon remain scarce and largely limited to pediatric and adolescent populations (Osterweis, Solomon, & Green, 1984). In fact, the first literature review with an exclusive focus on child and adolescent sibling bereavement was published in 1993 (Walker, 1993).

Major depression and post-traumatic stress disorder (PTSD) have been the psychiatric diagnoses most commonly associated with the experience of bereavement (Amick-McMullan, Kilpatric, & Resnik, 1991). *The Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition Revised* (*DSM-IVR*) (American Psychiatric Association, 1994) provides a list of symptoms that differentiate bereavement from major depression. Furthermore the *DSM-IVR* cautions against the major depression diagnosis for the bereaved unless the symptoms are still present 2 months after the loss. However, the symptoms of major depression and the experience of bereavement often overlap, and it is often difficult to differentiate their manifestations and criteria in order to make an accurate diagnosis (Lawrence, 2004).

Neidig and Dalgas-Pelish (1991) suggested that grief includes "the loss of interest in life, depressed mood, sleeplessness, appetite loss, social withdrawal, lethargy, anxiety attacks, and possible suicidal ideation" (p. 185). Several of these characteristics are also included, however, in the criteria of major depression and other mood disorders.

It is important for the clinician to remember that grief is not a mental disorder (Engel, 1961). The dictionary defines "bereavement" as the "state of being deprived of something," or the "state or fact of suffering the death of a loved one" (*Merriam-Webster*, 1993). In fact, the death of an important family member is an inevitable event in individual and family life cycles, and such an event may result in uncomplicated or normal grief (Carter & McGoldrick, 1999). However, death of a close family member such as a sibling may increase the risk for various psychiatric disorders (Altamirano, 2003).

The *DSM-IV-TR* (APA, 2000) specifies that if bereavement, or depressive-like symptoms, persist for more than 2 months, a diagnosis of Major Depressive Disorder may be warranted. Since bereavement often is accompanied by symptoms and features of a depressive disorder, as well as several other disorders, the development of diagnostic criteria for complicated grief is in the process of being articulated (Altamirano, 2003; Horowitz et al., 1997; Jacobs, Mazure, & Prigerson, 2000). Such research is long overdue, as complicated forms of grief have been so blatantly neglected by the mental health community that bereavement is merely mentioned in a short paragraph as a V code (v62.82) in the *DSM IV-TR* (Altamirano, 2003).

The diagnostic criteria for complicated grief as conceptualized by Prigerson (2003) include four clusters of criteria. In Criterion A, the person has experienced the death of a significant other, and responses may involve intrusive thoughts about the deceased, yearning for the deceased, searching for the deceased, and/or excessive loneliness since the death. In criterion B, the person may experience 6 of 11 listed symptoms at least daily or to a marked degree: (a) purposelessness, feelings of futility about future; (b) subjective sense of numbness, detachment, or absence of emotional responsiveness; (c) difficulty acknowledging the death (disbelief); (d) feeling life is empty or meaningless; (e) feeling that part of one's self has died; (f) shattered world view (lost sense of security, trust , control); (g) assumes symptoms or harmful behaviors of, or related to, the deceased; (h) excessive irritability, bitterness, or anger related to the death; (i) avoidance of reminders of the loss; (j.) stunned, shocked, or dazed by the loss; (k) life is not fulfilling without the deceased. In Criterion C, the duration of disturbance (symptoms

listed) is at least 6 months. In Criterion D, the disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning.
These symptoms were found to be salient predictors of morbidity, including increased substance abuse, cancer, cardiac disorders, and suicidal ideation above the range of symptoms associated with depressive disorders (Jacobs et al., 2000).

Farrugia (1996) added to the literature by noting that complicated grief reactions were also accompanied by the development of long-standing anniversary reactions, the displacement of grief onto other situations, and the development of family secrets related to the death. Additionally, the survivor may over-idealize the dead person, overprotect other surviving members of the family, develop obsessive-paranoid thoughts about death, or develop psychosomatic illness.

Sprang and McNeil (1995) suggested many outcomes for survivors following the trauma of homicide: (a) fear of trauma repetition; (b) guilt associated with being a survivor; (c) anger toward the deceased for putting himself/herself into harms way and/or toward God for allowing for such a senseless loss; (d) progression of losses following the murder, as in the case when survivors lose another loved one; (e) morbidity; and (f) insecurity about vulnerability to harm.

Robinson and Mahon (1997) conducted a concept analysis about the characteristics of sibling bereavement. They noted that metaphors of siblingship are indiscriminately applied and may compromise the integrity of theory development specific to sibling bereavement, especially as the knowledge base grows. Thus, the researchers attempted to expand the descriptive knowledge base for sibling bereavement beyond adolescence by analyzing the concept of sibling bereavement. The research focused upon a review of the

empirical literature, applying the Wilsonian Method (1963) of concept analysis. The researchers noted that the sibling relationship is unique among human relationships. Siblings can share biological and/or familial characteristics, values, and experiences. In comparison with other familial relationships, such as that between parent and child, siblings experience one another under relative egalitarian status. The death of a sibling marks an end to what is expected to be one of the longest and perhaps intimate relationships in one's life.

Robinson and Mahon (1997) conducted a purposeful sampling of studies examining sibling bereavement, seeking diversity in the variables of age and cause of death. They categorized their findings into bereavement reactions and self-perceptual outcome variables. In terms of bereavement reactions, they found a multidimensionality of reactions, including (a) physical reactions; (b) feelings of guilt, anger, anxiety and fear; (c) prohibited mourning; (d) social withdrawal from peers; (e) psychological growth; and (f) a marked lack of decrease in grief reactions over time. In terms of self-perceptual outcome variables, (a) increased resiliency; (b) a permanently changed reality; (c) an increased sense of others; (d) an increase or decrease in faith; (e) a change in world view, including one's roles and responsibilities; and (f) an ability to give and receive help were described.

Robinson and Mahon (1997) also found that the impact of life events (including but not limited to the death) on the sibling seems to result in a change in perception of boundaries. While this is sometimes seen as an increase in vulnerability, it can also be an increased awareness of or sensitivity to the experience of others. In conclusion, Mahon and Robinson emphasized that the bereavement response, change in self-perception, and

sensitivity to the experience of others all exist in the context of or with the foundation of the sibling relationship. It is the context as much as the above three effects that makes the sibling bereavement unique. The changes may be both positive and negative, and like bereavement reactions, appear to evolve over time.

Worden, Davies, and McCown (1999) found some gender-based differences in surviving siblings' responses to the death of a brother or sister. Girls with sibling loss showed more anxiety and depression, more thought problems, and showed more attention problems than boys who had lost a sibling. They also found that girls with sibling loss were typically more disturbed than girls with parent loss.

Family processes influence the adaptation of the child to the death of a sibling (Walsh & McGoldrick, 2004; Worden, 1996). Open communication, shared feelings, creative problem solving, flexible roles, utilization of available resources, adaptive reorganization to change, toleration of individual differences, and congruence between beliefs and actions all are instrumental in fostering healthy bereavement (Davies, 1998; Davies, Spinetta, Martinson, McClowry, & Kulenkamp, 1986). There is evidence that losing a sibling in adulthood may initiate an important search for meaning, and that the loss affected survivors on many different levels, including sense of self, relationships, and existential concerns (Godfrey, 2003).

Carter and McGoldrick (1999) noted that when a loss in young adulthood is in conflict with the developmental challenges of launching in the family life cycle, it can present problems. For example, at the launching stage, the family must renegotiate intergenerational relationships that are marked by a change from hierarchical authority of the adults to a more equitable balance between the generations. In the face of tragedy,

however, there is a familial need for togetherness that competes with the young adult's needs to establish independence. Furthermore, Carter and McGoldrick noted that society assumes that young adults should become independent of their families. This assumption may minimize the significance of the loss and contribute to complicated mourning (Carter & McGoldrick, 1999).

Many researchers have identified a conscious effort by surviving siblings to keep their feelings and other responses secret in an effort to protect their parents (Haase, 1989; Mahon & Page, 1995; Rosen, 1996). Rosen (1986) referred to this reaction as "prohibited mourning." This typical characteristic of sibling bereavement may reflect the societal belief that the death of one's child is the worst loss experience possible (Robinson & Mahon, 1997). Thus, whether externally imposed or self-imposed, the surviving sibling's expression of grief is often overshadowed by the grief of the parents and minimized. In buying into the social idea that their parents suffer more profoundly than they do, the surviving siblings assume a protective posture toward their parents. Such behavior may result in a sense of isolation, further complicating the mourning process (Carter & McGoldrick, 1999; Robinson & Mahon, 1997).

Many clinicians may assume that grief reactions decrease over time. But Fanos and Nickerson (1991) suggested that there was no significant relationship between grief reactions and time elapsed since the death of a sibling. Similarly, the persistent nature of grief reactions among sibling survivors has been corroborated in other research studies (Davies, 1991; Engel, 1975; Powell, 1991). It should be noted that the above studies have significant limitations in their use of small and self-selected samples, use of

nonreplicable measures, or reliance on parental perceptions to measure siblings' grief reactions (Robinson & Mahon, 1997).

While there is an abundance of research on grief, bereavement, and the loss of a loved one through death, most of the studies have focused upon death by illness and have been grounded in studying the effects upon survivors of terminally ill children or the elderly. The trauma of losing a young family member suddenly and accidentally has only begun to be explored (Rindt, 2001).

Sprang and McNeil (1995) stated that many survivors of murder victims viewed themselves as victimized twice, "first by the criminal and second by the criminal justice system" (p. 67). Young (1997) attributed the distress caused by the criminal justice system to its inequitable treatment of the survivors and the murderer.

In a pilot study describing the reactions of nine family members after homicidal dying, Burgess (1975) focused upon the long-term adjustment of the entire family to such an event. She coined the term "homicide-trauma syndrome" and suggested an underlying dynamic of "victim-oriented thoughts" or preoccupying identification with the manner in which the relative died. She offered no specific protocol for treatment beyond crisis counseling to support the survivors. Subsequent research is similar in its descriptive outline of the psychological effects of homicide (Amick-Mullen, Kilpatrich, Veronen, & Smith, 1989; Parkes, 1993; Rinear, 1988; Rynearson, 1988). It has been suggested that homicidal dying is associated with greater distress than suicidal or accidental dying, with Murphy's (1999) conclusions being the first study to document this difference empirically.

Davies (1993) emphasized that sibling bereavement cannot be studied apart from the context in which it occurs. When a young adult sibling's death is related to risk-taking, impulsive behavior, parents and siblings may experience intense anger, sadness, and frustration about the senseless loss (Carter & McGoldrick, 1999). If the victim and co-victims of the homicide live in neighborhoods threatened by gang violence, the experience of daily threat resembles living in a war zone (Garbarino, 1992). Feetham (1984) stated that the family is what the family defines itself to be. Sibling relationships exist on a continuum, so an individual must specify the nature of the relationship ahead of time, and it must flow from the research question and the theoretical framework. Kerr (personal communication, October 29, 2005) offered a BFST framework to explain how it is that siblings growing up in the same family turn out so differently. He suggested that the child who is freer of anxious, parental child focus might be more adaptive and free of symptoms over the life course.

Lethal firearms have caused a frightening increase in homicides of youths by youths (Carter & McGoldrick, 1999). Burton (1995) researched poor adolescents living in dangerous communities. The research concluded that these adolescents expected a shortened life cycle and experienced a sense of hopelessness about their future. Furthermore, the high risk of violent death led the young males who were the subjects of the study to doubt even reaching adulthood and contributed to a focus on early sex and parenthood, self-destructive drug abuse, and immediate gratification.

A survey of 116 homicide bereavement counselors reported that family therapy was the clinical technique they rated most highly, and they also endorsed existential and expressive, cathartic methods. Rynearson (2002), who developed a Violent Death

Support Service program, has helped family members cope with a violent death by using an approach called restorative retelling. This approach involves having co-victims, such as siblings, imagine and verbally describe the stories and images of the dying and the living of their loved one. To counterbalance traumatic mental pictures with those that reinforce the life the dead person has lived helps to decrease the distress responses of trauma and separation. Thus, many storytelling exercises focus on a retelling and commemorating of the living memory of the deceased, so that the survivors can re-engage in their own lives.

Although homicide occurs least frequently within the category of violent death (Rynearson, 2001), it has a cataclysmic effect upon sibling survivors (Asaro, 2001a, 2001b). However, Asaro concluded that loss of a loved one through sudden violence may result in posttraumatic growth, as well as posttraumatic stress. Similarly, Bank and Kahn (1982) suggested, "The dead sibling's legacy can be a force for sickness and stagnation or growth and creativity" (p. 271). Robinson and Mahon (1997) corroborated these findings, suggesting that long-term reactions to a sibling's death may include psychological growth and/or social withdrawal. However, Balk (1990) used cluster analysis to differentiate three distinct groups with low, average, and high scores on self-image, and his findings suggest, as with other types of death, that there is a wide range of effects on survivors. Such a wide range of outcomes points toward the need for broader descriptions of grief reactions characteristic of sibling bereavement in order to develop clinical practices that enhance positive growth and development in survivors.

The next section investigates a review of the literature on resilience in the individual and family system.

Resilience in the Individual and in the Family System

Webster's Dictionary (1974) defines resilience as "an ability to recover from or adjust easily to change or misfortune" (p. 596). Although this definition is widely accepted, resilience may be conceptualized as being more than merely bouncing back from setbacks. Resilience may also be the ability to bounce forward in the face of an uncertain future (Walsh & McGoldrick, 2004). Resilience has been conceptualized as the forging of strengths through adversity (Wolin & Wolin, 1993). Like the willow tree, people thrive if they have a strong, healthy root system. With branches flexible enough to bend with the storm and firm enough to weather strong winds without breaking, the willow tree can continue to grow despite being twisted into differing shapes. The willow tree may be a metaphor for the resilient individual and resilient family system. Resiliency is critical to mental health and healthy aging.

Bonanno (2004) defined adult resilience as a person's capacity to resist maladaptation in the face of risky experiences. Bonanno's individually based definition of adult resilience assumes that resilience resides in the person, an observation supported by the list of individual attributes that co-vary with resilient outcomes in Bonanno's work (hardiness, self-enhancement, repressive coping, and positive emotion.). Importantly, this definition of resilience does not identify the positive outcomes that can result from adversity in the hardy individual. Despite Bonanno's (2004) narrow definition, his analysis includes an interesting finding that loss and brief traumatic experiences, despite being aversive and difficult to accept, are normatively not sufficient to overwhelm the adaptive resources of ordinary adults. Bonanno's research calls into question the research

of Sameroff, Bartko, Baldwin, Baldwin, and Seifer (1998), which demonstrated in longitudinal analyses that as levels of adversity rise, and as resources fall, resilience becomes less tenable.

Rutter (1985) observed that strong self-esteem and self-efficacy make successful coping more likely whereas a sense of helplessness increases the likelihood that one crisis will lead to another. In a similar vein, Kobasa's (1985) research findings supported his hypothesis that people with resilience possess three general traits: (a) the belief that they can influence or control events in their lives, (b) an ability to feel deeply committed and involved in activities in their lives, and (c) a tendency to embrace change as an opportunity to grow and develop more fully. Thus, resilient children are more likely to have an inner locus of control (Seligman, 1990) or an optimistic belief that they can positively affect their fate.

Dugan and Coles (1989) suggested that individuals prevail over adversity more effectively if they have moral and spiritual resources. In a phenomenological study of nine subjects who had experienced such traumas as life in a concentration camp, disability, breast cancer, massive head injury, a life of violence and abuse, and loss of a child, Rose (1997) identified similar themes of resilience that emerged from individual interviews: (a) the role of supportive others, (b) empathy, (c) self-care, (d) faith, (e) action orientation, (f) moving on, (g) positive outlook, and (h) persistence. Rose identifies the foundational structure of resilience as (a) faith, (b) self-respect, (c) striving, (d) supportive others, (e) coping, (f) empathy, (g) self-reliance, and (h) moving on.

Closer scrutiny of children and families that are at risk reveals many exceptions to the "damage model" of development, which considers stress or disadvantage as

predictive of dysfunction. For example, Werner and Smith (1992) conducted an extensive longitudinal study of almost half a century of children from Kuai. The researchers found that in spite of early medical distress, poverty, school difficulties, teen pregnancy, or arrest, children were able to learn and persevere through difficulty, given adequate supports. In their analysis of how these impoverished children matured successfully, Vaillant (2002) noted that Werner and Smith emphasized "the importance of being a 'cuddly' child and of being a child who elicits predominantly positive responses from the environment and who manifests great skill at recruiting substitute parents" (p. 285). Werner and Smith pointed out that key turning points for most of these troubled individuals were meeting a caring friend and marrying an accepting spouse.

It is also salient that Werner and Smith found that more girls than boys overcame adversity at all age levels. Walsh and McGoldrick (2004) speculated that this finding reflects the notion that

> girls are raised to be both more easygoing and more relationally-oriented, whereas boys are taught to be tough and self-reliant through life...[and] often *because* of troubled family lives, competencies were built when early responsibilities were assumed for household tasks and care of younger siblings. (pp. 13-14)

Werner and Smith's study is especially important in reminding clinicians that early life experiences do not necessarily guarantee significant problems in later life. Walsh and McGoldrick (2004) suggested that their most significant finding was that resilience could be developed at any point over the course of the life cycle. Walsh and McGoldrick extrapolated from Werner and Smith's research that "unexpected events and new relationships can disrupt a negative chain and catalyze new growth" (p. 14). Favorable interactions with individuals, families and their environments have a systemic effect of

moving resilience in upward spirals, and a downward spiral can be reversed at any time in life (Walsh & McGoldrick, 2004).

In another longitudinal study, Felsman and Vaillant (1987) followed the lives of 75 males living in impoverished, socially disadvantaged families. People who suffered from substance abuse, mental illness, crime, and violence parented these men. Several of these men, although scarred by their childhoods, lived brave lives and became high functioning adults. Felsman and Vaillant concluded, "The events that go wrong in our lives do not forever damn us" (1987, p. 298).

Another study refuting the accuracy of the "damage model" was Kaufman and Zigler's (1987) finding that most survivors of childhood abuse do not go on to abuse their own children. Similarly, other research found that children of mentally ill parents or dysfunctional families have been able to prevail over early experiences of abuse or neglect to lead productive lives (Anthony, 1987; Cohler, 1987; Garmezy, 1987).

Werner (1995) identified clusters of protective factors that have emerged as recurrent themes in the lives of children who overcame great odds. The protective factors that were characteristic of the individual were myriad. Resilient youngsters are engaging to other people. Additionally, they excel in problem-solving skills and display effective communication skills. Problem solving skills include the ability to recruit substitute caregivers. Moreover, they have a talent or hobby valued by their elders or peers. Finally, they have faith that their own actions can make a positive difference in their lives.

From a developmental perspective, Werner (1995) emphasized that having affectional ties that encourage trust, autonomy, and initiative enhance resilience. Members of the extended family or support systems in the community frequently provide

these ties. These support systems reinforce and reward the competencies of resilient children and provide them with positive role models. Such supports may include caring neighbors, clergy, teachers, and peers.

In Vaillant's (2002) study of adult development at Harvard University, arguably the longest longitudinal study on aging in the world, it is suggested that resiliency researchers who focus on risk factors and pathology are mistaken in believing that misfortune condemns disadvantaged children to bleak futures. Instead, Vaillant calls upon clinicians to count up the positive and the protective factors when conducting assessments. Vaillant cites Sir Michael Rutter (1985), who reminds clinicians, "The notion that adverse experiences lead to lasting damage to personality 'structure' has very little empirical support" (p. 598).

Vaillant (2002) identifies four protective factors in the individual's potential to age well: A future orientation, a capacity for gratitude and forgiveness, a capacity to love and to hold the other empathically, and the desire do things *with* people instead of *to* people are personal qualities identified as resiliency factors. He posited that "marriage is not only important to healthy aging, it is often the cornerstone of adult resilience" (p. 291).

Furthermore, Vaillant (2002) described resilience as being a combination of nature and nurture. Both genes and environment play crucial roles. He explained:

> On one hand, our ability to feel safe enough to deploy adaptive defenses like humor and altruism is facilitated by our being among loving friends. On the other hand, our ability to appear so attractive to others that they will love us is very much dependent upon the genetic capacity that made some of us "easy" attractive babies. (p. 285)

An essential part of resilience is "the ability to find the loving and health-giving individuals within one's social matrix wherever they may be" (Vaillant, 2002, p. 286).

Thus, like Werner and Smith (1992), Vaillant's research identified extended families and friendship networks as key foundations to resilience in the individual and the family system.

American culture glorifies the "rugged individual." John Wayne, the personification of masculinity and strength, has been adored by generations of Americans as a hero. However, there is an inherent danger in the myth of rugged individualism, which implies that vulnerability and emotional interdependence are weak and dysfunctional (Walsh & McGoldrick, 2004). As Felsman and Vaillant (1987) noted, "The term 'invulnerability' is antithetical to the human condition....In bearing witness to the resilient behavior of high-risk children everywhere, a truer effort would be to understand, in form and by degree, the shared human qualities at work" (p. 304). Avoidance of personal suffering and the glorification of stoicism are hallmarks of American culture. Such cultural attitudes are typified by the call to "move on," to "cheer up," to get over catastrophic events, to put national and global tragedies behind, or to rebound (Walsh & McGoldrick, 2004).

Higgins (1994) noted that struggling well involves experiencing both suffering and courage, effectively processing and working through challenges from intrapersonal and interpersonal perspectives. In Higgin's study of resilient adults, it became clear that they became stronger *because* they were severely tested, endured suffering, and developed new strengths as a result of their trials. These adults experienced their lives more deeply and passionately. Walsh and McGoldrick (2004) observed that over 50% of the resilient individuals studied by Higgins were therapists. Egeland, Carlson, and Sroufe (1993)

offered an alternative approach to thinking about resilience as "a family of processes that scaffold successful adaptation in the context of adversity" (p. 517).

Important research conducted by Wolin and Wolin (1993) pointed toward the notion that although some children are born with innate resiliencies, resiliency can be modeled, taught, and increased. They emphasized that persons tend to seek healing from pain instead of holding on to bitterness. The researchers noted that the resilient person draws lessons from experience instead of repeating mistakes, and that they maintain openness and spontaneity in their relationships rather than becoming rigid or bitter in interaction. Wolin and Wolin also found that resiliency in individuals was strongly correlated with humor and creativity, as well as mental and physical health.

The Wolins (1993) identified seven traits of adults who survived a troubled childhood: (a) insight (awareness of dysfunction), (b) independence (distancing self from troubles), (c) relationships (supportive connections with others), (d) initiative (self/other-help actions), (e) creativity (self-expression, transformation), (f) humor (reframing in a less threatening way), and (g) morality (justice and compassion rather than revenge). Traits are viewed as dynamic processes by which resilient individuals adapt to and grow through challenge, rather than static properties that automatically protect the invulnerable. These observations are correlated with empirical studies of resilient children (Baldwin, Baldwin, & Cole, 1990; Bernard, 1991; Garbarino, 1992; Masten, Best, & Garmezy, 1990; Werner & Smith, 1992) and adults (Klohnen, Vandewater, & Young, 1996, Vaillant, 2002).

Walsh and McGoldrick (2004) argued that in the field of mental health, most clinical theory, training, practice, and research have been deficit-focused, implicating the

family in the cause or maintenance of problems in individual functioning. Under early psychoanalytic notions of destructive maternal bonds, the family came to be viewed as a pernicious influence. Even the early family systems theories focused upon dysfunctional family processes well into the mid-1980s.

The popularity of the Adult Children of Alcoholics Movement surged in the late 20th century and encouraged people to blame their families for their problems. This movement tempted the individual to make excuses for his behavior in terms of his dysfunctional family history instead of looking for family strengths that might help him overcome challenge and become stronger. Adult Children of Alcoholics "spend much of their time other-focused, and it is easy for them to become preoccupied with another group member's problem, take responsibility for it, and avoid the painful job of self-examination and taking responsibility for their own behavior" (Lawson & Lawson, 1998, p. 263).

In contrast to this damage model, the Wolins (1993) offered an alternative way to view challenging family backgrounds: a Challenge Model to build resilience, stating that "the capacity for self-repair in adult children of alcoholics taught [them] that strength can emerge from adversity" (p. 15). The Wolins reflected a paradigm shift in recent years, as family systems therapists have started to focus upon a competence-based, strength-oriented approach (Barnard, 1994; Walsh, 1993, 1995a). A family resilience approach builds on recent research, empowering therapists to move away from deficit and focus upon ways that families can be challenged to grow stronger from adversity (Walsh & McGoldrick, 2004). From the perspective of the Challenge Model, stressors can become

potential springboards for increased competence, as long as the level of stress is not too high (Wolin & Wolin, 1993).

Walsh noted, "The Chinese symbol for the word 'crisis' is a composite of two pictographs: the symbols for 'danger' and 'opportunity'" (p. 7). Wolin and Wolin (1993) observed that individuals may not wish for adversity, but the paradox of resilience is that the worst times can also become the best.

It is clear that the extensive research on resilient individuals largely points toward the social nature of resilience. However, most resiliency theory has approached the systemic context of resilience tangentially in terms of the influence of a single, important person, such as a parent or caregiver (Bowlby, 1988). Looking at resilient family functioning through a systemic lens calls upon the clinician to view individual resilience as being embedded in family process and mutual influence (Walsh & McGoldrick, 2004). Walsh suggested that if "researchers and clinicians adopt a broader perspective beyond a dyadic bond and early relationships, [they] become aware that resilience is woven in a web of relationships and experiences over the course of the life cycle and across the generations" (p. 12).

It has only been in the last 25 years or so that families that cope well under stress have been the subject of research (Stinnet & DeFrain, 1985; Stinnett, Knorr, DeFrain, & Rowe, 1981). A growing body of knowledge has pointed toward the multidimensional nature of family processes that distinguish adaptive family systems from maladaptive family systems (Walsh & McGoldrick, 2004). Walsh defined "family resilience" as "the coping and adaptational processes in the family *as a functional unit*," [and added that]...a

systems perspective enables us to understand how family processes mediate stress and enable families to surmount crisis and weather prolonged hardship" (p. 14).

Strong families create a climate of optimism, resourcefulness, and nurturance, which mirrors the traits of resilient individuals (Walsh & McGoldrick, 2004). In fact, research on family adaptation and on family strengths has suggested the following traits of resilient families: (a) commitment, (b) cohesion, (c) adaptability, (d) communication, (e) spirituality, (f) effective resource management, and (g) coherence (Abbott et al., 1990; Antonovsky, 1987; Beavers & Hampson, 1990; Moos & Moos, 1976; Olson, Russell, & Sprenkle, 1989; Reiss, 1981; Stinnett, Sander, DeFrain, & Parkhurst, 1982). Walsh and McGoldrick (2004) observed, "A family resilience lens fundamentally alters our perspective by enabling us to recognize, affirm, and build upon family resources" (p. viii). Rutter's (1987) research added further confirmation that resilience is fostered in family interactions through a chain of indirect influences that inoculate family members against long-term damage from stressful events. It is essential to consider family resilience as a major variable in a family's ability to cope and adapt in the face of stress (McCubbin, McCubbin, McCubbin, & Futrell, 1995).

Bennett, Wolin, and Reiss (1988) concluded from their research that children who grew up in alcoholic families that deliberately planned and executed family rituals, valued relationships, and preferred roles were less likely to exhibit behavior or emotional problems. They argued that families with serious problems such as parental alcoholism, which can still impose control over those parts of family life that are central to the family's identity, communicate important messages to their children regarding their ability to take control of present and future life events. These messages can determine

the extent to which the children are protected from developing future problems, including alcoholism in adolescence and adulthood.

It is only to the extent that significant stressors interrupt important family processes that children are affected (Patterson, 1983). Systemically, it is not only the child who is vulnerable or resilient; most salient is how effectively the family system can influence smooth adjustment (Walsh & McGoldrick, 2004). Even those family members who are not directly touched by a crisis are profoundly affected by the family response, with reverberations for all other relationships (Bowen, 1978). Thus, it is clear that "slings and arrows of misfortune strike us all, in varying ways and times over each family's life course. What distinguishes healthy families is not the absence of problems, but rather their coping and problem-solving abilities" (Walsh & McGoldrick, 2004, p. 15).

From an ecological perspective, Rutter (1987) suggested that it is not enough to take into account the sphere of the family as influencing risk and resilience in the individual and family life cycles. He emphasized that it is also incumbent upon therapists to assess the interplay between families and the political, social, and economic climates in which people either thrive or perish. Rutter's findings suggest that it is insufficient to focus exclusively on bolstering at-risk individuals and families, but there must also be public policy efforts to change the odds against them.

In the 21st century, it is apparent that the configuration of the family is shifting. Diverse forms of family systems do not inherently damage children (Walsh & McGoldrick, 2004). Walsh and McGoldrick emphasized, "It is not family *form,* but rather family *processes*, that matter most for healthy functioning and resilience" (p. 16).

One family process that governs how a family responds to a new situation is the way in which shared beliefs shape and reinforce communication patterns (Reiss, 1981). Hadley and his colleagues (1974) found that a disruptive transition or crisis could initiate a major shift in the family belief system, with both immediate and long-term effects on reorganization and adaptation. Additionally, Carter and McGoldrick (1999) suggested that how a family perceives a stressful situation intersects with legacies of previous crises in the multigenerational system to influence the meaning the family makes of the adversity and its response to it.

Walsh and McGoldrick (2004) explained that a concurrence of two or more stressors hinders adaptation as family members struggle with competing demands. Emotions can easily result in increasingly volatile conflicts. Over time, a cluster of stressors and losses can overburden a family's coping efforts. The overtaxing of the adaptive resources of the system can lead to family strife, substance abuse, and emotional or behavioral symptoms of distress (frequently expressed by children in the family).

Figley (1989) noted that catastrophic events that occur suddenly and without warning can be particularly traumatic. Bowen (1978) suggested that shock wave effects of a trauma might reverberate through the system and extend forward into multiple generations. Thus, Walsh and McGoldrick (2004) called upon therapists to take a systemic approach to intervention in the face of crisis, with interventions that "strengthen key interactional processes that foster healing, recovery, and resilience, enabling the family and its members to integrate the experience and move on with life" (p. 22).

To understand resilience, one must also look through a developmental lens (Carter & McGoldrick, 1999). Neugarten (1976) found that stressful life events are more apt to

cause maladaptive functioning when they are unexpected. Also, multiple stressors create cumulative effects, and chronic severe conditions are more likely to affect functioning adversely. However, Cohler (1987) and Vaillant's (1995) research found that the role of early life experience in determining adult capacity to overcome adversity is less important than was previously believed. Thus, discontinuity and long-term perspectives on the individual and family life cycle point toward the idea that people are constantly "becoming" and have life courses that are flexible and multidetermined (Falicov, 1988). Furthermore, Walsh and McGoldrick (2004) suggested that "an adaptation that serves well at one point in development may later not be useful in meeting other challenges" (p. 13). Research has pointed toward a greater risk in vulnerability for boys in childhood and for girls in adolescence (Elder, Caspi, & Nguyen, 1985; Werner & Smith, 1982). All these variables highlight the dynamic nature of resilience over time.

In the field of family therapy, it is incumbent upon researchers and practitioners to recognize that successful treatment depends as much on the resources of the family as on the resources of the individual or the skills of the clinician (Karpel, 1986; Minuchin, 1992). Family processes can influence the aftermath of many traumatic events, reverberating into the course of the lives of people in future generations. Individual resilience must be understood and nurtured in the context of the family and vice-versa. Both immediate crisis and chronic stressors affect the entire family and all its members, posing threats not only to the individual, but also for relational conflict and family breakdown in current and future generations. Family processes may mediate the impact of crisis on all members and their relationships. Protective processes build resilience by promoting recovery and buffering stress. Indeed, healthy family processes influence the

effects of present and future crises far into the future (Bowen, 1978; Kerr & Bowen, 1988). Since all families and their members have the potential to become more resilient, family therapists should work to maximize that potential by strengthening key processes within the system.

A review of the literature on theory applicable to the treatment of the subject of this case study is investigated in the following section.

Theory

William Wordsworth expressed the steadfast bond between siblings in his poem "We Are Seven":

> "How many are you," then said I,
> "If they two are in heaven?"
> Quick was the little maid's reply,
> "O Master, we are seven."
> "But they are dead; those two are dead!
> Their spirits are in heaven!"
> 'Twas throwing words away; for still
> The little maid would have her will,
> And said, "Nay, we are seven!"

Similarly, Klass, Silverman, and Nickman (1996) emphasized, "The grave does not obliterate the place of the sibling in the family" (p. 231). In fact, Hogan and DeSantis (1994) viewed the ongoing attachment between a living sibling and a deceased sibling as having the potential to provide an impetus to personal growth and increased resilience in the surviving sibling. They argued that it is in the ongoing attachment that transformation and increased maturity can grow.

Hogan and DeSantis (1994) may have been ahead of their time in associating a continuing bond between the deceased and the survivor with resilience because most

clinicians and researchers in the 20th century tended to view such a bond as an impediment to the grieving sibling who must adapt to the loss (Klass et al., 1996). Furthermore, the impact of loss on the family as an interactional system has been given short shrift during the 20th century (Walsh & McGoldrick, 2004). As Walsh and McGoldrick stated, "From Freud's (1957) treatise on mourning and melancholia and groundbreaking studies on bereavement (Bowlby, 1980; Engel, 1961; Glick, Weiss, & Parkes, 1974; Kubler-Ross, 1969; Lindemann, 1944; Parkes, 2001; Parkes & Weiss, 1983) to the extensive literature on loss in recent decades, the focus has continued to be on individual grief reactions (Doka, 1996; Rando, 1986b; Worden, 1996, 2002).

In the area of death and dying, Dion (2003) cited Ellis (1995) in suggesting that current literature on loss is primarily descriptive and disorganized in terms of having a theoretical context. In light of the deep and lasting connections among members of a family across time, it is easy to understand that loss by death may be more difficult than any other life change (Holmes & Rahe, 1967).

Bowen Family Systems Theory and Loss

A systemic approach that addresses the reverberating impact of death and loss on the family unit's emotional process in both the current generation and over time is essential to gain a broader understanding of the multigenerational family system (Bowen, 1976, 1978; Papero, 1990). Such an approach considers the family as the unit of treatment instead of the individual as the unit of treatment (Kerr & Bowen, 1988).

The premature death of a family member may have far-reaching effects for every member of the family and all other relationships (Bowen, 1978; Walsh & McGoldrick, 2004). A systemic perspective is necessary to understand the legacies of loss and chain of influences that ripple throughout the family across the generations and over the life cycle (Walsh & McGoldrick, 2004). The pain of the premature death of a young adult in a family system may find expression in continuing patterns of interaction and mutual influence among survivors over time, touching members' relationships with others who may never even have known the deceased (Walsh & McGoldrick, 2004).

Walsh and McGoldrick (2004) stated that although "family systems theory introduced a new paradigm for understanding family relationships...the field of family therapy was slow to approach the subject of loss, reflecting the cultural aversion to facing death" (p. 6). In fact, in his landmark work on loss, Bowen (1976) observed, "Chief among all taboo subjects is death. A high percentage of people die alone, locked into their own thoughts, which they cannot communicate to others" (p. 336). Bowen posed at least two emotional processes in operation: "One is the intrapsychic process in self, which always involves some denial of death. The other is the closed relationship system: People cannot communicate the thoughts they do have, lest they upset the family or others" (p. 339).

Walsh and McGoldrick (2004) credited Bowen (1976) with advancing our understanding of the experience of loss as deeply influenced by and, in turn, influencing family processes. In his paper entitled "Family Reaction to Death," Bowen (1976) provided a description of the disruptive impact of death or threatened loss on a family's functional adaptiveness. He argued that the intensity of the reaction is governed by the

level of emotional maturity in the family at the time of the loss and by the degree of influence held by the lost member (Bowen, 1976). The emotional shock wave may reverberate throughout an entire family system immediately or long after a death or threatened loss (Bowen, 1976). These shock waves may operate far beyond the usual grief reactions of members close to the deceased relative and operate through the underlying emotional interdependence of family members (Bowen, 1976).

Bowen emphasized that it is important for clinicians to assess for the emotional shock wave effect. To ignore such a nodal event may result in a misunderstanding of presenting symptoms that are relevant to the loss (Bowen, 1976). As he perceptively argued, symptoms that appear in a child or other vulnerable family member or conflict that festers may be covert expressions of unresolved attachments. In fact, such symptoms may be connected to the loss event, and the family may vehemently deny any such connection. Thus, it is imperative that therapists assess the total family constellation, the relative influence of the members who have died in both the current generation and the previous generation, and the family's overall level of adaptation to understand the meaning and context of presenting symptoms in order to guide a healing process (Papero, 1990).

In treating bereaved clients, it is important to use direct language about death and dying, to involve even very young family members in the grieving process, and to confront denial in every way that it rears its ugly head (Bowen, 1976). The emphasis is upon coming to terms with loss and addressing relational patterns associated with it (Walsh & McGoldrick, 2004).

Bowen Family Systems Therapy (BFST) Concepts

BFST is a useful way to conceptualize a case involving a sibling survivor of homicide. It is a natural systems theory that is based on evolution and biology (Kerr & Bowen, 1988). The theory is aimed at enlarging one's view of family functioning by exploring emotional processes over at least three generations (Bowen, 1978). Bowen (1978) introduced eight interlocking concepts that must be viewed in relation to one another to be understood properly. These concepts include (a) triangles, (b) differentiation of self, (c) nuclear family emotional process, (d) family projection process, (e) multigenerational transmission process, (f) sibling position, (g) emotional cutoff, and (h) societal emotional process. For the purposes of this case study, only those concepts that are most applicable to the treatment are discussed.

Triangles

Bowen (1978) originated the use of the concept of the triangle, a cornerstone of family systems theories (Papero, 1990). Bowen (1978) believed that the more anxious member of a two-person system will predictably and automatically pull in a third person to stabilize the relationship and calm down the dyad (Bowen, 1978). Contact with the third person tends to decrease the anxiety in one of the members of the dyad (Bowen, 1978). However, when anxiety is great, the basic triangle can no longer contain and dissolve the tension, which then spreads through a network of interlocking triangles (Papero, 1990). Papero (1990) explained:

> In a typical triangle, there are two relatively calm relationships and one anxious relationship. The intense relationship may shift around the three sides of the triangle, or it may become fixed in a particular relationship. When free of anxiety, the participants in the triangle may appear relatively autonomous and free from intense involvement with one another. As anxiety increases, however, the patterns emerge in their predictable patterns. (p. 50)

The greater the undifferentiation of the individuals and the family system, the greater is the level of chronic anxiety. In individuals and families that have low levels of differentiation, the clinician will find the triangles to be more intense, active, interlocking, and influential (Papero, 1990).

The most important triangle in terms of an individual's growth and development through the life course is referred to as the primary triangle, which is the position a child occupies between his or her parents (Bowen, 1978). In some families, the child's position in the primary triangle has a chronic regularity, and in other families, the child's position may be more fluid (Papero, 1990). The child who is most involved in the parental triangle is least free to grow and develop (Kerr & Bowen, 1988).

Importantly, when the family environment is relaxed, the comfortable and desirable position for an individual is to be on the inside position of the triangle (Papero, 1990). When the environment is anxious, however, the outside, uninvolved position is the desirable place to be (Papero, 1990). In conclusion, Papero (1990) clarified:

> The concept of the triangle addresses the automatic movement of individuals to maintain the degree of involvement or noninvolvement with another that allows them the greatest freedom from anxiety. It also addresses the mechanisms involved in anxiety transfer and arousal of the broader family group. (p. 51)

Nuclear Family Emotional Process

The nuclear family emotional process is another relevant concept in BFST. In explaining this process, Bowen (1978) observed that each spouse comes to a marriage with a certain amount of differentiation and a certain amount of emotional connectedness or undifferentiation (Papero, 1990). Bowen (1978) postulated that marital partners have similar levels of differentiation and undifferentiation. In their partnership, each spouse tries to deal with the emotional intensity of their relationship by using mechanisms similar to those he or she used in relationship to their respective parents and/or the parents used with one another (Papero, 1990). In order to survive the intensity of the relationship, the partners tend to use one or more of four patterns to cope: emotional distance, marital conflict, transmission of the problem to a child, or dysfunction in a spouse (Kerr & Bowen, 1988).

The concept of the family projection process describes the process by which parental problems can be projected onto a child or children (Papero, 1990). When the mother's emotional sensitivity to a child, for example, is greater than that to her partner, she projects her immaturity onto her child (Bowen, 1978). The husband may be sensitive to his wife's anxiety and supports her involvement with one or more of the children (Papero, 1990). In a family, it is common for a mother to be more emotionally sensitive to one child over the others. The anxiety within the marital relationship is ignored, but the anxiety increases her feeling for the child (Papero, 1990). She interacts with the child as if the anxiety were in the child rather than in her. The involvement often begins at birth, and the child becomes wired to become relationship sensitive throughout his or her life course (M. E. Kerr, personal communication, October 29, 2005). The mother's

emotions can be intense and range from a protective, overly positive posture to revulsion (Papero, 1990). It is the chronic anxiety of the parents within their marital relationship that leads to triangling the child into the emotional process between them (Papero, 1990).

Papero (1990) pointed out that the attachment is usually most evident between mother and child. However, the father is equally involved in the process. His own anxiety level and the mechanisms he uses to preserve his own functioning greatly affect the mother and child. If he withdraws, for example, the intensity between mother and child escalates. Neither parent nor child is viewed as being to blame in this process (Papero, 1990). Papero noted that such interlocking sensitivity and reactivity between mother and child is evident in other life forms, such as Goodall's (1979) chimpanzees. Such processes rarely represent the product of a single generation, and the intensity of the mother-child involvement reflects the cumulative effect of past generations (Papero, 1990).

With a concerted and structured effort, Bowen (1978) believed that it was possible to interrupt repeating patterns in the multigenerational transmission process. In a group of siblings, one child may be more involved in the multigenerational transmission process than another sibling. However, if it is intense enough, both siblings may be involved (Papero, 1990). The child upon whom there is the greater focus develops a heightened sensitivity to emotion in the parents, who in turn react with heightened emotionality (Bowen, 1978). The freer child tends to be less sensitive to parents' emotions, and he or she grows up with a level of differentiation that may be slightly higher than that of either parent or of the more focused upon sibling (Papero, 1990). Thus, the child who receives the most focus has the least amount of differentiation (Bowen, 1978).

In any particular generation, unfavorable circumstances can speed up decreasing levels of differentiation (Kerr & Bowen, 1988). From this perspective, all families have lines moving through time toward greater and lesser levels of differentiation. At extreme ends of undifferentiation, the clinician will find forms of chronic alcoholism, drug addiction, schizophrenia, and even chronic physical illness. Such outcomes are viewed as highly intense versions of the multigenerational transmission process (Bowen, 1978).

Toman's (1976) work on profiles of characteristics of people who occupy any of 10 sibling positions greatly influenced Bowen (Papero, 1990). Toman postulated that spouses have complementary, partially complementary, or non-complementary sibling positions (Papero, 1990). The degree of complementarity is related to the presence or absence of rank and/or sex conflict (Papero, 1990). Each spouse would attempt to occupy the same role that he or she occupied in the family of origin. For example, if a brother of brothers married a sister of sisters, the expectations and behavior each had for the other would not be complementary. Neither would have had the experience of a sibling of the opposite sex. Degrees of complementarity can also be applied to relationships between parent and child (Papero, 1990). Thus, each person comes to a marriage and to parenting with a series of expectations and types of behavior that are determined by one's own sibling position (Toman, 1976).

While Toman (1976) studied normal families (Papero, 1990), Bowen considered sibling birth order effects upon the family projection process. Toman's profiles allow for a reconstruction of relationship patterns in past generations, making it possible to investigate the evolving pattern of family interaction over time. As Papero (1990)

explained, “The knowledge of sibling position characteristics may provide a person with a first glimpse of his or her own reactive behavior and its impact on another” (p. 62).

Emotional Cutoff

The concept of emotional cutoff describes the way that people try to manage the emotional attachment to their parents and important other individuals in their adult life (Papero, 1990). A person may use intrapsychic mechanisms to deny any attachment or may actually separate him or herself physically from the family and reduce contact to infrequent, formalized interactions (Bowen, 1978). If a person uses intrapsychic measures, it is possible to manage the discomfort of attachment by remaining in frequent contact with important others and even live under the same roof (Papero, 1990). Still, the person manages to remain disconnected with those with whom he or she lives. Individuals who use intrapsychic mechanisms to cut off tend to blame themselves and carry internalized symptoms, ranging from depression to psychosis (M. E. Kerr, personal communication, October 29, 2005).

Another means of achieving cutoff is the person who uses geographical distance to manage the unresolved attachment to parents and important others. Individuals who use geographical distance to cutoff tend to blame parents, have impulsive behavior, and participate in serial relationships, and may become nomadic, as if occupying the role of refugee from the family (M. E. Kerr, personal communication, November 14, 2005).

Emotional cutoff is one way to handle intense relationships and reduce anxiety over the short term. However, in the long run, the pattern of cutoff is carried over into other intense relationships and leaves a legacy across the generations (Bowen, 1978).

Emotional cutoff may result in persons going from relationship to relationship, looking for the positive effects of closeness yet automatically cutting off when the intensity exceeds the tolerance level (Papero, 1990).

Chronic Anxiety

The central assumption underlying Bowen's (1978) thinking is that there is a chronic anxiety that exists in all life forms. BFST holds that "we have more in common with other forms of protoplasm than we differ from them" (Friedman, 1991, p. 135). Furthermore, biological evolution is viewed as the most important influence on how a family functions, and basic patterns are viewed as being the same across cultures (Kerr & Bowen, 1988). There is an inverse relationship between the level of chronic anxiety and the level of differentiation in an individual.

Bowen (1978) believed that there is an order and predictability to human relationships. The relative ease or dis-ease of a system is primarily determined by the emotional maturity of its leaders (Friedman, 1991). The more differentiated the leader, the lower the level of anxiety will be within the system. Thus, clinical work is conceptualized from the top down. Work on the self of the therapist begets improvement in clients, just as work on an important member of a family begets improved functioning in its members (Kerr & Bowen, 1988). By changing one's role in a system, one can improve one's situation (Bowen, 1978).

Differentiation of Self

Core to BFST is the concept of differentiation of self, and working to increase differentiation of self is viewed as a lifelong process (Papero, 1990). Differentiation of self is inversely related to chronic levels of anxiety (Bowen, 1978). The ability to choose between thinking and feeling and the ability to differentiate oneself from another person (i.e., knowing where one stops and the other begins) are the basic tenets that describe the emotionally mature or differentiated individual (Bowen, 1978). People with the least amount of self are less sure of their thoughts as distinguished from their feelings and operate with higher reactivity to others (Bowen, 1978). The fusion in the two parts of the brain (limbic/emotional and neocortical/thinking systems) parallels the fusion in relationships (M. E. Kerr, personal communication, November 14, 2005). Friedman (1991) explained that it is erroneous to equate differentiation with individuation, autonomy, or independence. Instead, "it has less to do with a person's behavior than with his or her emotional being...it has to do with the fabric of one's existence, one's integrity (p. 141).

BFST is unique in its tendency to think in terms of universal rather than discrete classifications (e.g., physical illness/emotional illness). From this perspective, functioning exists on a continuum as does intensity of interdependence among family members. In fact, what exists in extreme conditions such as schizophrenia exists, to a degree, in all families (Kerr & Bowen, 1988). Thus, BFST does not attempt to pathologize behaviors such as triangling and cutoff; instead, such mechanisms are viewed as coping mechanisms that may work to calm people in the short term, but that may have deleterious effects in the long term.

From Bowen's (1978) perspective, people have much less emotional autonomy than previously assumed. While Freud (1957) viewed humans as motivated by unconscious forces rather than by rational thinking (which limited their autonomy from their inner selves), BFST sees people as functioning in limiting ways that reflect their familial environment as manifesting in heightened reactivity (Kerr & Bowen, 1988).

From the perspective of BFST, the two vectors within the familial environment influencing chronic anxiety are people's reactivity to their personal space being intruded upon and their complementary fear of abandonment (Kerr & Bowen, 1988). The cliché "Can't live with them and can't live without them" describes this common dilemma. Patterns of emotional functioning are all related to the ways a family deals with its members impinging upon one another or, in reaction to impingement, disengaging from one another (Kerr & Bowen, 1988).

Thinking, Feeling, and Emotional Systems

It is important to emphasize that BFST does not deny emotions (Papero, 1990). It is quite the opposite. BFST is unique in that emotional, feeling and intellectual systems are differentiated from one another. Friedman (1991) explained:

> The term emotional—as in emotional system...is used to avoid a dichotomy between the psychological and the physical, and the emphasis on thinking is not to deny feeling but to emphasize the importance of self-regulation in the process of differentiation. (p. 136)

In a broader sense, the emotional system can be conceptualized as automatic functioning or as a kind of instinctual reaction (M. E. Kerr, personal communication, October 29, 2005). The emotional system is more than the brain. It also includes the mind, the body,

and our relationships, and it is that part that humans share with all other forms of life (Papero, 1990).

The feeling system involves the subjective experience that helps individuals be aware of what is going on in their bodies and in their environments (Papero, 1990). For example, the body system may become reactive, and this sets off a chain of events that becomes the subjective experience of pain. In contrast to emotions, which are not felt, people can be aware of feelings just by feeling them. Kerr and Bowen (1988) explained, "Feelings appear to be an intellectual or cognitive awareness of the more superficial aspects of the emotional system" (p. 31).

Bowen (1978) defined the intellectual system as that part of an individual that is unique. It is the system that allows individuals to reason and be objective. The intellectual system allows individuals to draw conclusions, gather facts, and observe. It is also the system that allows for the subjectivity that is illuminated by feeling states, such as racial bias. Furthermore, the intellectual system gives individuals the awareness that their reasoning can be clouded by subjectivity. To the extent that an individual's intellectual system can consider facts in spite of a feeling state is the extent to which he or she is able to process his or her experience from a differentiated position.

Bowen (1978) believed these three systems occurred not only within the individual, but also in the entire family system. Triangles in a family, for example, are anchored in the emotional system, in that there is anxiety around attachment and distance. What feeds reactivity in a triangle are universal needs: attention, approval, expectations, distress, and dependency (M. E. Kerr, personal communication, November 14, 2005). The person with greater differentiation of self may be more realistic as to what he or she

can do for others and what others can do for him/her in meeting those needs. The more differentiated individual is more capable of saying "no" without fear of reprisal and more capable of saying "yes" in a thoughtful effort to be connected. In other words, how well people manage the getting and the giving of these universal needs varies with level of differentiation of self (M. E. Kerr, personal communication, November 14, 2005). BFST attempts to use family relationships to help the individual to understand his or her intellectual, feeling, and emotional systems (Papero, 1990).

Certain phenomena in families illustrate the reciprocal nature of the family unit. For example, one individual may gain strength in relationship to another person having lost or given up strength (Kerr & Bowen, 1988). Thus, an individual can only comprehend functioning in the context of the functioning of the other people close to him/her. People may become reciprocally responsive to each other behaving in automatic ways (Papero, 1990).

The nature of the reciprocal response is emotional in nature and has an effect upon the whole organism (Papero, 1990). This interdependency can develop over time as a result of intense emotional processes between members of a family system in the current generation and across generations (Papero, 1990). Papero argued:

> The processes referred to as parent-infant bonding or falling in love, for example, lead to an interpersonal interlock, marked by preferential sensitivity and responsiveness, and the process known as grief may represent the adjustment of a person to the dissolution of such an interactional structure. (p. 30)

From a life cycle perspective, it is important to track family patterns over time, noting particularly those transitions at which families tend to be more vulnerable because of the necessary readjustments in relationships. Problems are most likely to appear when

there is an interruption or dislocation in the family life cycle, whether because an untimely death, a chronic illness, a divorce, or a migration forces family members to separate or because a family is unable to launch a child or tolerate the entry of a new in-law grandchild (McGoldrick, 1995, p. 31). It is important to be aware of the typical triangles and issues at each stage of family life (Bowen, 1978). Individual and family systems that possess higher levels of differentiation will adapt to change more easily across the life cycle (Kerr & Bowen, 1988).

Change

From the perspective of BFST, outcome is viewed very differently from other theories. A small change in one person may significantly change his or her life course, and such a small change cannot be implemented without therapy that may last several years (Kerr & Bowen, 1988). Also, a small change in one person may not be reflected in the family system for three or more generations (Kerr & Bowen, 1988). Kerr and Bowen (1988) stated, "The more generations of a family included in an assessment, the greater will be the divergence in functioning...Given sufficient generations, every family will produce people from the extreme of remarkably high functioning to schizophrenia" (p. 221). Kerr and Bowen clarified:

> The most extreme forms of manic-depression, alcoholism, and obsessive-compulsive neurosis, for example, develop over the course of at least several generations...Most distinctions between diagnostic categories may eventually be discarded in favor of a continuum ranging from mild occasional depression to chronic psychosis...so saying that the intensity of symptoms is generations deep does not necessarily mean that the actual symptoms have been present in preceding generations. It means that basic levels of differentiation are generations deep. (p. 241)

It is important to understand that all people diagnosed with a specific disorder are not the same emotionally (Kerr & Bowen, 1988). As Kerr and Bowen explained:

> There may be an inherited predisposition (genetic or otherwise) to [a disease like] manic-depression, but all people who have such symptoms are not equally adaptive. Those with low levels of differentiation have lives that are usually unstable in most aspects....Those with higher levels of differentiation may have only one or two [episodes] in a lifetime....The age of onset, severity and impairment of life functioning associated with all psychiatric diagnoses can be understood in the context of the multigenerational emotional process. (pp. 240-241)

Some instances involve a combination of markedly impaired adaptiveness and fairly minimal life stress and produce a psychosis. In other instances, a combination of strong adaptiveness and extreme life stress can precipitate a psychosis. Kerr and Bowen (1988) explained:

> Whether the potential for psychosis is actually part of everyone is difficult to determine...because there are so many other ways people manage anxiety. For example, there may be learned or genetically based psychological as well as biological tendencies that determine that a given individual will, when under stress, develop serious physical or social symptoms rather than emotional ones. This does not mean the potential for psychosis is absent...It just means [a person] manages [his or her] anxiety, even when under extreme stress, in a different way. (p. 240)

Unlike Freud (1957), Bowen (1978) did not consider the interpretation of transference as the way to change. Instead, Bowen thought that "the therapist should try to *stay out* of the transference as much as possible by functioning in a detriangled manner that kept it fulminating within the family in front of him" (Friedman, 1991, p. 154). Clients are coached to resolve transference directly with family members, especially within their primary triangles (Bowen, 1978). In clients' one-to-one meetings with siblings and parents, the effort is to develop an adult-to-adult relationship with each individual family member. By taking problems back to their original sources, the client is

on a direct route to altering the etiological factors giving rise to current problems (Bowen, 1978). Through a client's revisiting his or her position, especially in his or her primary triangle, and by reviewing childhood distortions, the client's perceptions become more realistic. In this way, family cutoffs can be repaired, and fused positions can be shifted, which diminishes family anxiety (Kerr & Bowen, 1988). It is in this context that the client can change from a focus on others to a focus on self-in-relation (Kerr & Bowen, 1988).

Bowen (Kerr & Bowen, 1988) believed that the process of change takes time. Change is not equated with symptom relief or even feeling better, but with an increase in the level of differentiation of the family. Long-term therapy increases the depth with which the client addresses multigenerational processes (Friedman, 1991), and this requires a commitment to therapy that may last several years (Kerr & Bowen, 1988). Change occurs outside of therapy, as the Bowen coach sends clients back to work with their families of origin (Kerr & Bowen, 1988).

To effect change in the system, the therapist should work with the person most motivated to change, who often is the over-functioner (Kerr & Bowen, 1988). The goal of the work with this person is to develop a differentiated leader, one who can lead the family in a way that will have a positive effect on all members.

Horizontal and vertical stressors challenge the system in varying degrees, depending on the level of differentiation in the individual and in the family. By raising levels of differentiation, more flexible and adaptive responses to change can increase (Bowen, 1978).

Marked upward or downward, changes in differentiation from one generation to the next are uncommon (Bowen, 1978). Each sibling may have a little bit more or a little bit less differentiation than might his or her parents. Children who are focused upon more heavily are not as differentiated as those left freer to grow and develop (Kerr & Bowen, 1988). Thus, the position of each sibling in his or her family of origin may be more or less fortunate, leading to small but varying differentiation in lines of the family (Bowen, 1978). Much as it takes several variables all lined up correctly to spawn a hurricane, so it is with negative outcomes in the human being and his or her family system. If only one variable is changed, it can prevent the storm that might otherwise have occurred (Bowen, 1978).

Bowen (1978) bypassed the marital fusion of the nuclear family in favor of focusing on at least three generations of the extended family (Titelman, 1987). Bowen (1978) concluded:

> Families in which the focus is on the differentiation of self in the families of origin automatically make as much or more progress in working out the relationship system with spouses and children as families seen in formal family therapy in which there is a principal focus on the interdependence in the marriage. (p. 545)

In the beginning stages of Bowen therapy, it is important to reduce reactivity as much as possible. Simply asking questions in a matter-of-fact manner can calm the environment. Papero (1990) emphasized:

> The effort of family systems therapy is to address the thoughtful capacity of the individual as much as possible. Engagement of the cognitive system can heighten objectivity and broaden perspective. When people begin to become more objective...anxiety is automatically lowered. (p. 68)

As treatment continues, the family diagram evolves to reflect newly collected family facts.

The Family Diagram

The family diagram is both an assessment tool and component of treatment. It can illuminate repeating patterns, identify nodal events, and highlight interlocking triangles. Within the construction of the family diagram, there is an exchange of ideas between the family and the therapist, which will highlight contrasts in how both of them view the nature of the problem (Papero, 1990).

The Bowen therapist is concerned with assessing intensity in relationship. Papero (1990) described an intense interaction in the following manner:

> One in which strong feeling states are produced and very rapidly transmitted among the participants to the exchange...intense anxiety is a strong fear of real or imagined events. The more intense an interaction, the greater the likelihood that individuals involved will behave automatically, that is in response to the intellectual system being overridden. (p. 41)

Such automatic behavior is viewed as reactivity.

Since Bowen family systems is based in natural systems (Bowen, 1978) rather than cybernetic systems, the focus in not on homeostasis so much as it is focused on reciprocity (Bowen, 1978). Thus, if one person's functioning declines, another person's functioning may rise. As such, it is possible, for example, that one sibling's success may predict another sibling's failure (M. E. Kerr, personal communication, October 29, 2005). Similarly, if an over-functioning spouse decreases his or her functioning, the under-functioning spouse should improve (Bowen, 1978).

Kerr and Bowen (1988) stated:

> It is the *basic* level of differentiation that is largely determined by the degree of emotional separation a person achieves from his family of origin...basic level is fairly well established by the time a child reaches adolescence and usually remains fixed for life, although unusual life experiences or a structured effort to increase basic level at a point later in life can lead to some change in it. (p.98)

A given sibling will have a slightly greater or lesser amount of differentiation than his or her parents.

As opposed to basic differentiation, *functional* differentiation is dependent on the relationship process. As such, people with very different basic levels can, under favorable circumstances, have similar functional levels (Kerr & Bowen, 1988). Related to functional differentiation is the concept of pseudo-self, which refers to "knowledge and beliefs acquired from others that are incorporated by the intellect and are negotiable in relationships with others. Pseudo-self is created by emotional pressure and can be modified by emotional pressure" (Kerr & Bowen, 1988).

Process of Therapy

Psychoeducation is a small part of most sessions (Bowen, 1978), introducing the client to the natural systems concepts that are applicable to the material the client brings to session. Broadening perceptions instead of getting stuck in linear, cause-effect thinking is an ongoing process, beginning early in treatment. Clients are taught that the tendency to blame escalates with increases in anxiety. However, in early treatment, when the anxiety is high, it may be more difficult to engage the client in the cognitive activity of increasing his or her ability to understand systemic conceptualization of the family of origin and extended families (Kerr & Bowen, 1988).

During the middle stages of therapy, therapy remains aimed at reducing emotional reactivity (Bowen, 1978). Continuing psychoeducation on the key constructs of BFST is accompanied by application of these concepts to the client's family of origin and nuclear families (Papero, 1990). As a coach, the therapist acts as a process consultant for the

family and teaches members how they can differentiate themselves from important others (Bowen, 1978). There is an ongoing effort to remain neutral (Papero, 1990). With a couple, for example, the therapist becomes the third part of a triangle, directing each partner to differentiate a self from his or her partner (Kerr & Bowen, 1988). The therapist takes his or her own "I" position stands, emphasizing that if each partner can calmly state his or her own position, without fear of criticism, then this can prevent him or her from getting stuck in competitive debates. It may be useful to use illustrative stories of fictional clients' success with a similar problem, use metaphor, or read a relevant adult fable (Friedman, 1990).

Since a healthy separation from an individual's family of origin contributes to healthy adult relationships, family members are coached to detriangulate from their families of origin (Bowen, 1978). To do this, it may be necessary to move in steps. Clients are encouraged to engage in one-to-one conversations with extended family members. The overarching goal in middle and later phases of therapy is to increase the level of differentiation of self in each family member, starting with the most differentiated. In this way, the system increases its ability to function, which will automatically reduce symptoms (Kerr & Bowen, 1988).

During later phases of treatment, the client is transitioned from therapy to other environments (Bowen, 1978). The client is educated that differentiation is a lifelong process. It is re-emphasized that the ability to think systemically is related to the ability to remain calm and to keep the focus on self-in-relationship instead of other. The therapist continues to coach toward the bridging of emotional cutoffs in a way that changes old patterns in a particular relationship (Bowen, 1978). Systemic

conceptualizations of the client's family continue to be discussed and applied. Clients should be able to make "I" statements and act independently of the emotionally fused forces of their families of origin and nuclear family. They should be capable of balancing rational and emotional responses and feel an internal sense of decreased anxiety.

There really is no termination phase in BFST (Bowen, 1978). Longevity is favored over frequency (Kerr & Bowen, 1988). It is not uncommon for a client to return for coaching even years later, if he or she gets stuck on an old or emergent issue (Papero, 1990). Just as the therapist reinforces the self of the client by asking at the beginning of each session how he or she would like to use the time, so the therapist honors the client's expertise as to when it is appropriate to stop therapy or see the therapist less frequently. By privileging the client's judgment at all times, the therapist sends the implicit message that he or she is fully capable of managing life (Kerr & Bowen, 1988).

The Self of the Therapist

BFST is unique in its emphasis upon the self-development of the therapist (Friedman, 1990). Thus, the Bowen therapist should continually work on an increasingly healthy separation from his or her own family of origin in a way that he or she still remains connected. Friedman (1991) pointed out that "Bowen has consistently maintained that it is hard for the patient to mature beyond the maturity level of the therapist, no matter how good his or her technique" (p. 138). In fact, Friedman explained that "in Bowen theory, *the differentiation of the therapist is the technique*" (p. 138).

A therapist cannot possibly be a Bowen therapist merely by reading about it or taking workshops (Kerr, 1981). The therapist must go through an emotional

transformation, which happens experientially after continued exposure to revisiting the family of origin while applying the complex ideas of the theory. Work with a family of origin and work with a supervisor are central parts of the therapist's development (Papero, 1990).

It is important to maintain a non-anxious presence (Kerr & Bowen, 1988). To be objective and to promote differentiation in others is directly related to the being of the therapist, not to his or her technical skills (Friedman, 1991). To be able to think in terms of the system and not the emotionality or content requires a high level of differentiation. Therapists must push themselves to work continually at separating thoughts from feelings and knowing where the therapist stops and the client begins (Papero, 1990).

The therapist should be warm, respectful, engaging, and matter-of-fact in asking questions (Papero, 1990). A collaborative atmosphere should be maintained in all stages of treatment (Bowen, 1978). The process of gathering family facts is, in itself, collaborative and inherently conducive to reducing anxiety (Papero, 1990). Additionally, the types of questions asked move the client toward a deepening appreciation for pattern and process, which is favored over content (Papero, 1990). In a sense, the therapist assumes the role of researcher and is always curious (Papero, 1990). One question leads to another, and the calmer the therapist is, the more he or she can call on his or her best thinking to expand the line of questioning into broadening perspectives (Papero, 1990). Eventually, clients begin to see replicating patterns from past to present and connections between events in their nuclear families and family of origin legacies (Papero, 1990).

Family members are encouraged to speak through the therapist rather than to each other (Kerr & Bowen, 1988). By remaining a non-anxious presence in a triangle, a

change can be induced in the relationship of the other two that would not occur if the same things were said in the absence of the therapist (Kerr & Bowen, 1988).

The Bowen therapist is a coach, in that he or she teaches differentiation moves or ways that the client can increase neutrality, especially in hot triangles (Kerr & Bowen, 1988). The Bowen therapist also acts as an educator in teaching the family about family systems dynamics (Kerr & Bowen, 1988). Often, BFST concepts are illustrated on a white board to increase clients' ability to think about their processes in a systemic way (B. Paul, personal communication, April, 2002). Homework may include relevant readings and letter writing assignments, which may or may not be mailed (Friedman, 1990). Clients may be asked to journal and/or generate questions to ask their extended family members. Photograph albums and videos brought to sessions touch the past, adding a rich layer of experience to the treatment and also enhancing the joining effort of the therapist. This material may also aid in the effort to bridge cutoff, resolve attachment, or make contact with the deceased. Socratic questions that highlight process over content challenge the client to engage his or her cognitive processes (Papero, 1990).

Kerr and Bowen (1988) encouraged therapists to use humor and playfulness where appropriate, but warned that the maturity and differentiation of the therapist is critical to communicating that what is taken so seriously by the family can be seen in a humorous light. The client is honored as the expert on his or her own family and is often asked questions that lead him or her to take responsibility for his or her part in a family problem. A helpful guideline is to work on making oneself "small" within the session (B. Paul, personal communication, April, 2002). Such an effort means that the therapist has succeeded in being a non-anxious presence who does not over-function for the client.

Kerr & Bowen (1988) suggested that a client who is able to apply the theory to his or her family of origin and collect new facts in a way to broaden understanding may surpass the therapist in his or her differentiation of self.

Bowen Family Systems and Increasing Resilience

An individual's family of origin has the potential to be both a resource and a support system (Kerr & Bowen, 1988). Emotional cutoff from an individual's extended family makes both of these things impossible. Kerr and Bowen (1988) suggested that resilience might be increased to the extent that individuals bridge cutoff in their original families as they emphasize that the family of origin is a resource and a laboratory for learning more about themselves and thus reducing their levels of chronic anxiety. Relationships with parents, siblings, and other relatives during the formative years are the template by which an individual manages himself or herself in marriage, in parenting, and with other significant people in life (Kerr & Bowen, 1988). In bridging cutoff, it is important to realize that "

> the goal *always* is to work on oneself, not to attempt to change one's family. The goal is not to get the family to 'accept' you, to 'love' you. The goal is to be more of a self, which is not contingent on acceptance. (Kerr & Bowen, 1988, p. 275)

Bowen and Kerr (1988) emphasized that if one is armed with some knowledge of theory and a willingness to observe and listen, one can learn more about the emotional process in his or her family and his or her part in it. By revisiting dormant triangles in the family of origin, the client gets clearer about his or her own immaturity and the immaturity of others. Kerr and Bowen (1988) offer a roadmap to increased resilience,

stating that "Changing oneself *while in relationship* to the past is a 'highroad' to increasing basic level of differentiation" (p. 276).

Broadness of Bowen Family Systems Theory

Bowen Family Systems is a theory, which is broad enough to incorporate existential efforts at meaning making into treatment. A core challenge lies in the individual and family efforts to self-define while at the same time remaining connected to one another. In order for a client to differentiate his or her voices from important others, it is necessary to increase the ability to tolerate anxiety and refrain from reactivity in emotional environments. In order to remain connected, at times it is necessary to prepare and then bridge emotional cutoffs. Such an ability improves with continued efforts to call upon an individual's best thinking while at the same time considering difficult questions.

Bowen Family Systems counters a preoccupation with the dysfunctional family with a description of healthy family functioning, which exists on a continuum. Bowen (1978) emphasized the importance of identifying reciprocity or polarizations in relationships. The idea is to improve the balancing process between polar opposites.

Similarly, in the Circumplex Model of assessing family systems, Olson (1989) proposed that family functioning is a matter of balancing polar opposites. The model is set up along two major dimensions. With the dimension of cohesion or emotional bonding, families need to balance separateness and togetherness. With the dimension of flexibility or the ability to adapt to change, families need to balance stability and transition. From this perspective, family health is not predicated by a finite list of

required qualities and necessary conditions. Optimally healthy families practice the art of balancing the various polarities of life into patterns that are attuned to the constantly shifting terrain of their family experience within and between the generations.

Conn (1998) noted the fundamental desire of the self to transcend itself in relationship to the family, to others, and to God. But only a developed, powerful self has the strength to realize significant transcendence. Efforts to do so must recognize two polarized points in fundamental human desire: the drive to be a self and the dynamics to move beyond self in relationship. Such an approach privileges the inextricable connection of these two paradoxical drives and the tension such polarization generates. Thus, the desire to be a self and to reach out beyond self must always be understood together. Efforts at making meaning require the client to work at increasing his or her ability to hold such ambiguity, which, in turn, is related to increasing the level of differentiation of self. Clients' efforts to make meaning will increasingly reflect an appreciation for and a toleration of the paradoxical condition of existence as they progress in treatment.

Bowen's (1978) biological theory of the emotional system describes the interplay of these two counterbalancing life forces—togetherness and individuality in couple, family, and social relationships. These two life forces, the one pushing towards attachment, the other pulling away in separation, constitute the two polar ends to be balanced in a relationship system. Bowen's' core concept of self-differentiation points to a state of perfect balance, something to aspire to though never to be fully achieved.

It is within the family that the individual mediates his or her world. Family can enhance or dampen an individual's interaction with him or herself and with others. In order to anchor the individual creatively in the sea of otherness through which he or she swims, efforts at making psychospiritual meaning may be another important way to enhance the differentiation of an individual's voice from important others. The effort to understand systems and the disruptive power of reactive anxieties and triangles requires careful, almost didactic preparation as clients work toward closing distance and bridging cutoff in their families of origin. The family diagram is used to instruct and apply cognitive skills, and this activity is assumed to have calming power in and of itself to interrupt maladaptive patterns that may be generations deep. In addition to the careful preparation of meeting a family armed with new systemic knowledge, a client may develop increasing ability to tolerate emotional environments in a way that does not shut down the capacity to think and reflect as the therapist accompanies the client on an examination of existential questions.

In the ensuing chapters, a case study of a sibling survivor of homicide, utilizing a resiliency-based, Bowen Family Systems approach to treatment, is presented. Chapter 3 discusses assessment of the case. Chapter 4 discusses the formulation of treatment goals and a description of the treatment, which spanned 18 months of weekly or biweekly sessions. A description of the treatment is divided into early, intermediate, and later treatment. Additionally, excerpts from transcripts are provided for each stage of therapy.

Chapter 5 discusses the treatment approach utilized in the case study in terms of efficacy with this population, as well as implications for future research and practice. Additionally, Chapter 5 examines the ways in which the writing of the dissertation

transformed the author. Finally, a discussion of the experience of supervision of the case is included.

Chapter 3

ASSESSMENT

This chapter presents an initial assessment of a 34-year-old woman (referred to as "Cynthia"), who is a sibling survivor of homicide. This section begins by printing a timeline that was created by Cynthia in response to collaborative early efforts to collect facts from her mother and to recall nodal events in her life. Next, a discussion is presented detailing what brought Cynthia to therapy at the particular point in time when she made the phone call requesting services. Additionally, the history provided in initial intake sessions is presented. It is important to note that family facts become added as information emerges over the course of psychotherapy. Following this introduction, the author assesses the loss and complicated grief experienced by Cynthia as a result of her brother's homicide (referred to as "Josh") and her father's subsequent death. Additionally, the author assesses Cynthia in relation to Wolin and Wolin's (1993) resiliencies. Finally, the author assesses the case through the lens of Bowen Family Systems therapy, using a family diagram to illustrate various theoretical concepts relevant to the case in visual form. Bowen Family Systems assumes that assessment and treatment is a fluid process, so that assessment is actually an ongoing part of the treatment plan (Bowen, 1978).

Cynthia's Time Line

Within the first few sessions of treatment, it became apparent to the author that Cynthia's three-generation family system was filled with intensity. It was difficult to understand the context and the timing of many events in constructing the family diagram. The author suggested to Cynthia that she interview her mother and collect more family facts in order to gain clarity. Cynthia was immediately responsive to this idea and earnest in her effort to dig deeper for information. In order to organize the information that she had gathered and to gain clarity, Cynthia took it upon herself to construct a timeline. She created this timeline based upon the information she gathered with her mother and brought it into session approximately 6 weeks into treatment. The creation of the timeline by Cynthia paralleled her early increasing engagement and curiosity about the intergenerational emotional functioning in her family system. The author and the client utilized this timeline at various times throughout the course of treatment. What follows is the timeline that Cynthia created, which she presented during her sixth session in treatment.

My Timeline

January 18, 1972

Age 1: Born in San Diego, CA, lived with Mom and Dad. We moved every six months in rented apartments. Mom and Dad took LSD and smoked pot on occasion. Dad would go on speed and heroin benders for days at a time. He would flip out after the benders. He suffered from depression and actually had an exorcism. Then he would get sober, go to County Mental Health, and get his medication. He would

feel better, take himself off the drugs, and go on another bender. This was a vicious cycle.

Age 2: There was a time that we were almost homeless. We lived in the Balboa Hotel for a week. Then we rented a duplex on Abigail Street and Josh is born.

Age 3: Dad did even more speed. Dad cheated on Mom, and she left him. She took Josh and me with her. Dad flipped out then. He did not like it when Mom took us. We hitchhiked as a family.

Age 4: Dad rented a house on Long Beach Street, where we all lived. Mom tried heroin twice. My paternal grandmother's boyfriend died. When Mom took Josh and me to visit her for a few days, the junkies sold all Mom's stuff. I was in preschool. Then we went to stay with my maternal grandmother for three months. She and my maternal grandfather were separated.

Age 5: My maternal grandfather divorced his wife. Mom, Josh, Grandpa, and I rented a nice, big house on Santa Barbara Street for about a year. My grandfather did not let Dad come around. I remember this to be the most relaxing, normal, and happy part of my childhood.

Age 6: My maternal grandmother died. My parents reconciled. We rented the Trolley Street house from a Hell's Angel. I remember disliking the house from the beginning. I knew this would be a hard time for us.

Age 7: The chaos started. People would come and not leave for months at a time. We didn't have much, but people still managed to steal things and eat our food. They would take our space and destroy our peace.

Age 8: There were scores of alcohol and drugs. Derelicts and druggies were around our house seven days a week.

Age 9: CPS removed Josh and me from our home. We were taken to Hillcrest Receiving Home, where we were placed in foster care for one week.

Age 10: My own depression started to set in. I did not like to play with neighborhood kids often, although I always had one best friend. I was more comfortable at home with the adults than running around the neighborhood causing trouble. I started to put on weight. I did enjoy and excel in school.

Age 11: Heavier drugs started to make way into our house. People were dying all the time—on our roof, in front of our house, in their cars, and in our backyard. It did not bother Josh the way it bothered me.

Age 12: Junior high was a difficult transition for me. I was put into all gifted classes. However, this intimidated me, so I pulled myself out. That was when the academic battle began. My new classes bored me because I was not challenged. I struggled with finding my place socially.

Age 13: I started to make more friends. I liked to stay out late. I partied with older beach people, like Dad's friends from high school. I was not really interested in boys, but I loved socializing. I experimented with different drugs out of curiosity. I knew I liked them, so I quit. Watching my parents taught me some hard lessons at a young age.

Age 14: High school starts, and I felt comfortable right away. Good grades were easy, if I applied myself just a little bit. The problem was I could not keep interested long enough, and I struggled deeply with my living situation.

Age 15: I got my first job. I moved out into Lynn's apartment. She was a woman I used to baby sit for. She was a tweeker that had two kids, ages 10 and 13. She started to fall downhill fast. Then I moved into the Taksa's residence. The father was a minister, and his daughter was one of my best friends. I did so well in school, that his daughter became jealous and wanted me out. I was devastated when I had to leave there. I think I have had trust issues since that day.

Age 16: I moved in with the Kramden family. They were deeply religious, wealthy Christians. It was an awkward fit.

Age 17: I moved in with the Butterworth's. I met Steve Vereen. We started to date exclusively and fell in love.

Age 18: The best year of my life! I graduated in 1990 and moved in with Miriam. I decided not to attend college for the first semester, so I could settle down. I just wanted to take a break and enjoy life. Steve, Josh, and I went to the beach a lot. I found out that Michael is my long lost brother. That was shocking!

Age 19: I enrolled in a massage college for one semester. Steve moved to Hawaii. My heart is broken. I moved to Humboldt and attended one semester of college. I did not fit in there, so I moved back to San Diego. My mom left my dad for Jim.

Age 20: I lived, I worked, and I had fun.

Age 21: I hung out a lot with Josh in OB. My paternal grandfather died from brain cancer. On the night of my grandfather's funeral, which was held one week after his death, Josh was murdered. His violent death devastated the family and the

entire community. Steve and I reconnected. We moved to Santa Barbara together to focus on building our relationship. I was really depressed about Josh. I needed to be looked after, but there was no time for that. I worked to keep myself afloat, and I resented Steve for not being more supportive.

Age 22: I worked and went to school. I dropped out, broke up with Steve, and moved in with Tom. Josh's son was born, and I wanted to be close with him. I was also worried about my dad because he had no one. I was very frightened that he would soon die. I wanted to move home alone, but Tom begged, pleaded, cried for weeks. Because I felt sorry for him, I reluctantly let him move back with me.

Age 23: My dad died. Even though I feared this, I was flattened. I felt emptied emotionally. It took several years for me to start grieving. I do not know that I ever really grieved his death. My half-sibling, Michael, did not come to the funeral. I eventually got Tom out of my life. I worked and saved money to go to New Zealand for one month.

Age 24: Tom and I got back together. We became engaged and have a great year.

Age 25: Tom and I got married.

Age 26: I worked and attended Massage School again. I sunk into a deep depression for awhile. I did not care to live or die.

Age 27: I quit working in restaurants and looked for a "real" job.

Age 28: I got an academic counseling position at a massage college. I loved the job, but we partied too much.

Age 29: I continued to work at the massage college, but I partied too much. My marriage started to unravel.

Age 30: I quit my job to start a family. Tom got fired and started dealing cocaine. I knew this spelled trouble. I left him July 5, 2002.

Age 31: I reconnected with Steve on February 15, 2003. He and his wife filed for divorce. He moved back to San Diego to be with me. We tried to get pregnant right away and succeeded. We struggled emotionally and financially. We changed jobs a lot and moved homes a few times. We gave birth to a beautiful, baby boy, Adam, on January 7, 2004.

Age 32: Our home was finally settled for the most part. But my relationship with Steve barely survived because of Steve's bad habits. In May, we found out that we were pregnant again. Steve took a turn for the better. He made great progress personally and professionally. Finally, we saw some relief on the horizon. Perhaps the past seventeen months of struggle, labor, and maintenance have paid off. Praise God!

Introduction to Assessment and Initial Intake Information

Twelve years following the violent, gang-related death of her brother, Josh, Cynthia called the author to make an appointment for counseling. She had been referred by another client of the author (referred to as "Tamara"), who was the wife of Cynthia's half-sibling (referred to as "Michael"). Cynthia grew up with Michael, and they attended the same schools. However, she did not find out that he was her half-sibling until she was 18, approximately 1 year before Josh's death. Michael was the product of an affair

between Cynthia's father (referred to as Bill) and a woman Cynthia described as "schizo, flamboyant, and on drugs" (referred to as Judy). Shortly after Josh's death, Cynthia made repeated efforts to go toward Michael in an effort to replace her loss. She experienced him as being distant, arrogant, and disinterested in cementing their relationship. However, she was able to cement a relationship with his wife, Tamara.

In her initial phone call, Cynthia explained that she was experiencing serious problems with her partner (referred to as "Steve"). Since April of 2003, Cynthia stated that she and Steve have been in a co-habitating relationship and that they recently had an infant son (referred to as "Adam"). She stated that their escalating relational problems seemed to be at the root of her increased sense of anxiety and depression. However, she knew that she had unfinished work to do in relation to her grief from her brother's death, which had occurred 12 years earlier. Therefore, she was interested in beginning individual therapy.

Steve and Cynthia were high school sweethearts and were the same age. They began dating when Cynthia was 17 years old and broke up when Cynthia was 19 years old because Steve moved to Hawaii. Steve and Cynthia reconnected when she was 21 years old and shortly after Josh was killed. They moved to Santa Barbara together soon after the homicide took place, for Cynthia stated that she needed to get away from the family and "that whole chaotic scene" following the homicide.

At age 22, Cynthia broke up with Steve. Shortly after the breakup, she met her future husband, referred to as Tom. She liked the way he made her feel, for he was very attentive and smitten with her. They married when Cynthia was 25. She and Tom lived a lifestyle that involved partying, the use of club drugs, and swinging. They remained

married for 5 years. Cynthia divorced Tom because she feared his heavy use of drugs would not allow her to remain healthy or to raise a healthy happy family. She was familiar with the fallout from chronic substance abuse and knew enough to get out of this marriage before she had children. Steve married a woman referred to as "Connie" at about the same time and had a daughter in that marriage (referred to as "Amanda," who was 3 years old when therapy with Cynthia began).

Cynthia's current relationship with Steve had a chaotic beginning that reflected the chaotic environment in which she had been raised. She moved in with Steve once again in April of 2003, soon after her divorce from Tom became final in March of 2003. Steve had been separated from Connie since September of 2002 and filed for divorce shortly after the separation. However, despite the fact that Steve and Cynthia were living together and had recently had a son, Steve's divorce was still not finalized when Cynthia began therapy. The divorce did not become finalized throughout the course of therapy.

Steve's estranged wife and daughter moved from Minnesota to Santa Barbara early in Cynthia's treatment, and this closer proximity stirred up the emotional field in these interlocking family systems. Cynthia experienced distress because Steve was dragging his heels in finalizing his divorce. Additionally, she was troubled because he smoked marijuana, had an intermittent gambling problem, had been secretive about his impulsivity in these areas, could be explosive, and did not share enough of the household and parenting duties in their home. Furthermore, Cynthia felt that Steve's mother favored his estranged wife and daughter and did not offer her enough practical or emotional support. She also resented the way Steve's mother "coddled him" and treated him as if

he were still her little boy. Thus, Cynthia occupied the outside position in a hot triangle between Steve and his mother (referred to as "Ilene").

In addition to the stress of having a new baby, this couple continually struggled to surmount the stress and anxiety from past, unresolved attachments. Steve's estranged wife and Cynthia's ex-husband remained a constant issue in their relationship. These issues were the backdrops to Steve's use of substance and gambling to bind his own anxiety. Similarly, these issues were the backdrops to Cynthia's propensity to try to control and over-function for Steve in her effort to bind anxiety.

During occasional couple sessions requested by the client in the early stage of therapy, it was apparent to the author that their repeating cycle was that Cynthia took on the role of distancer in response to Steve's propensity to pursue. Similarly, she over-functioned and Steve under-functioned. Little did Cynthia realize that learning the multigenerational patterns of transmission in her family of origin would lead her toward insights that would reconfigure the way she thought about her relationships in the present.

During the intake session, Cynthia stated that she had never been to therapy. She presented as focused, confident, articulate, and extremely attractive. She described life in her family of origin as chaotic. Both parents abused alcohol, and her father (referred to as "Bill") was a heroin addict since the time that she could remember. Similarly, both her maternal and paternal grandparents' families' histories were riddled with alcohol abuse, domestic violence, divorce, emotional cutoffs, and family secrets. She recalled her home as a place where "people lived and died in my backyard." She stated that her mother (referred to as "Winnie") was a "big, fat caretaker," who took in winos and homeless people in the community. Cynthia recalled tripping over derelicts upon leaving for

school each morning as they lay sprawled out on her living room floor. In her second session with the author, she reported having recent nightmares, where she was "a child tripping over dead people in my backyard." She then recalled her deceased brother and teared up, emphasizing the uniqueness of their bond.

Although she and her mother had always had a warm relationship, she resented the parental neglect that she and her brother, Josh, experienced as children. Cynthia took it upon herself to be a role model and perform parental duties for her brother. Whenever Cynthia complained of her parents' neglect and of the chaos, Winnie would tell her that she needed to be grateful for "how good you have it. You don't know how blessed you are." Winnie's minimization and denial of parental neglect created within Cynthia a sense of shame for her ungratefulness.

In describing her relationship with Josh as a child, Cynthia recalled that Josh had a defiant streak that reminded her of her father. Josh was less troubled by the chaotic environment that defined their home life than Cynthia was. Notably, he was a daredevil who was accident-prone. Conversely, Cynthia followed rules, preferred to relate to adults, and took it upon herself to be Josh's role model. She recalled how Josh would enjoy getting a "rise out of me, breaking the heads off my Barbie dolls and teasing me." Cynthia remembered keeping after him to stay out of trouble, disapproving of his rebellious ways, and making him school lunches each morning without being asked to do so by her parents.

Cynthia excelled in school. In the timeline that she created, she noted that she enjoyed school. Good grades were easy. Initiative is one of seven innate resiliencies identified in resiliency research by Wolin and Wolin (1993). Wolin and Wolin also cited

"insight" as one of the seven innate resiliencies on their resiliency mandala. Certainly, Cynthia reflected early insight when she noted that she experimented with different drugs at 13, but knew she liked them, so she quit. She stated, "Watching my parents taught me some hard lessons at a young age."

At the age of 15, Cynthia landed her first job and moved out of the family home. She decided that she needed to find a calmer environment if she were to focus on her schoolwork and continue to learn. Nevertheless, she stayed in close touch and on good terms with her mother. Cynthia's resourcefulness was apparent even at this young age, as she sought substitute caregivers who would not interfere with her ability to achieve her academic goals. Her ability to recruit substitute caregivers also reflected another innate resiliency: relationships (Wolin & Wolin, 1993).

When Cynthia's father, Bill, died in 1995 (1½ after Josh was killed), she recalled not being able to cry or grieve his death. She stated, "Even though I lived with a constant fear that my father would die from his drug abuse and alcoholism, I was flattened and emptied emotionally when he died. I could not grieve." It was as if she could not mourn what she believed she never had: a father who would be there for her and parent her. It is more difficult to grieve what you never had. However, an individual *can* grieve for the loss of the hope and the dream.

After the author collected initial facts about Cynthia's family of origin, marriage, divorce, and current nuclear family, Cynthia wanted to talk about her deceased brother, Josh. Striking is the fact that Josh placed himself in harm's way and was killed in a gang-related incident on the night of his own paternal grandfather's (referred to as "Roger") funeral. She described her father, Bill, as the black sheep in his family. As a result of

Bill's defiant streak and early use of alcohol and heroin, he and Roger had a distant and, at times, completely cut-off relationship. Roger and his wife (referred to as Anne) divorced when Bill was an adolescent.

Cynthia believed that Anne was strict, mean, and cold in her parenting style, in contrast to Roger's passive and kind posture. Furthermore, Cynthia stated that Anne had always been the "keeper of the family secrets" and that she guarded them as if they were precious possessions. She recalled Ann as a hard worker who did not hesitate to batter and hit her husband and/or her children if they disobeyed or did not cooperate with her wishes.

Cynthia emphasized that she always knew she needed to do grief work and that she was relieved that she had finally decided to seek therapy. She complained that she had lost touch with her spiritual side and that she no longer could hear God's voice. She still mourned her brother's death because his life gave her a sense of purpose. She no longer felt a sense of purpose in her life. She mourned the loss of her "creative spirit" and missed her hobbies of painting and writing. She regretted not finishing college. Her most important goal was to create a happy family and provide her sons with the calm, healthy environment that she never had as a child. When she talked about Josh's death, she teared up. She quickly recovered and was eager, engaged, and enthusiastic about embarking upon this psychotherapeutic journey. She was reflective, introspective, and ended the initial session exclaiming, "When my brother died, I felt as if I had been split in two." The closeness between Cynthia and Josh was unique because they had to cling to each other to survive. Their interdependent needs in the face of their parents'

dysfunction and resultant neglect might have further exacerbated the already intense fusion between them.

Assessment of Loss and Complicated Grief

Although the client came to therapy presenting with relational problems with Steve, it became apparent within the first session that the client suffered from symptoms of complicated grief. Cynthia met the diagnostic criteria for complicated grief as conceptualized by Prigerson (2003). In Criterion A, Cynthia felt excessive loneliness since Josh's death and had intrusive thoughts about her deceased brother. In Criterion B, she experienced 6 of 11 listed symptoms: (a) a sense of purposelessness; (b) a feeling that life was now empty or meaningless; (c) a feeling that part of herself had died; (d) a shattered worldview or lost sense of security, trust, control; (e) excessive anger related to the death; and (f) a sense that life was not fulfilling without the deceased. In Criterion C, the duration of the disturbance had lasted in excess of 6 months (12 years).

In Criterion D, Cynthia's disturbance had caused significant impairment in social, occupational, and other important areas of functioning. She never completed college. She regretted that some of her more gifted peers had progressed with occupational goals that had eluded her. Her relationships with her ex-husband and with her current partner and father of her children had been problematic. Furthermore, Cynthia experienced significant anxiety by her own self-report. Finally, Cynthia reported that she and her mother continued to experience long-standing anniversary reactions, becoming especially irritable, moody, and emotional during the month of Josh's homicide each year.

Cynthia stated that she had always known that she needed to do grief work, especially around her brother's untimely and tragic death, and that she had never had more than a few sessions of therapy at various periods of her life following the homicide. She stated that she never found a therapist with whom she felt a strong enough connection to continue with services.

Cynthia and Josh were each other's first playmates and confidants. Since they spent so much time together and were each other's only known siblings, their relationship was very intense. Cynthia noted that her brother's death made her feel alternately guilty and angry. When her brother died, she lost her sense of purpose, which had been to be a role model for him.

Cynthia remained protective of her mother, not wanting to expose the depth of her own grief for fear of exacerbating her mother's profound pain. This protective posture precluded Cynthia from engaging in her own grief work. Her brother's existence providing her own existence with a sense of purpose and her protective posture in relation to her mother both reflected the propensity toward fusion characterizing this multigenerational family. The fact that Josh knowingly placed himself in harm's way led Cynthia to be horrified at the senselessness of a death that was, for all intents and purposes, self-imposed.

Cynthia complained of losing her connection to God, and it could be inferred that her anger extended to God for allowing such a senseless loss to happen. To add to her injury, she wondered how God could allow Josh's death to affect her father's health in a way to create still another profound loss.

Cynthia moved away shortly after Josh's death. She stated that she had to get away from the chaos. She left to reunite with Steve, but they eventually broke up. Soon she began dating and married Tom, whose lifestyle replicated the lifestyle of her childhood. After divorcing Tom because he used drugs in excess and because she recognized the danger patterns from her own childhood, she reunited with and immediately moved in with her high school sweetheart, Steve. Steve did not yet seem as severe in his symptoms of impulsivity. Nonetheless, Steve smoked cigarettes and pot, used cocaine, gambled, had binge drinking episodes, and could become explosive. Whenever their relationship heated up with tension between them, life cycle changes, or various stressors, his symptoms became increasingly severe. Cynthia often demanded that he move out, and a breakup seemed imminent. Eventually, he would be allowed back into the home. There would be a honeymoon period during which time Steve would make amends. Then tension would rise, and the couple would again repeat this predictable dance.

In an important way, Tom and Steve exhibited certain behaviors typical of Cynthia's father and brother. Both men had a defiant streak and bound up their anxiety with substance. Both men under-functioned in relation to Cynthia's reciprocal over-functioning. Perhaps these men represented Cynthia's unconscious attempts to replace these important males in her life. In still another effort to replace her lost brother, the client moved toward her half-sibling, Michael, a classmate who was identified as her relative shortly before Josh's demise. She experienced distress at her perception of his repeated rejections of her efforts to bond with him. When her father, Bill, died approximately 1½ years after Josh was killed, she reported being unable to grieve. Instead she said that she felt numb and "emotionally flattened."

Her self-reports early in therapy pointed toward amplified anniversary reactions every year. She described family of origin issues that were fraught with intensity, and the chaotic environment in which she lived affected her sense of self over her life course. Importantly, Cynthia recalled that upon her brother's death, she lost her motivation to be creative, to return to college, and to enjoy the spirituality that had previously been a central part of her life. As she began therapy, she expressed regret and remorse at not being where she wanted to be in life. Finally, the death of her paternal grandfather occurred days before her brother's death. She explained that she still experienced distress when she thought about how her father's cutoff with his father precluded her ability to have a relationship with her paternal grandfather.

According to the research of Worden, Davies, and McCown (1999), girls with sibling loss were typically more disturbed than girls with parent loss. Since Cynthia experienced the death of her father as the loss of someone she had never really had and since Josh and Cynthia shared such an intense bond, it seemed most important to focus the grief work more heavily on the loss of her brother.

It is crucial to conceptualize this case as one that involved multiple losses. Cynthia mourned the death of her brother, a grandfather with whom she had a very limited relationship, and a father, whose use of substance made him as good as permanently lost before he even died. When the love for lost people is mixed with anger at the deceased relatives' lives as lived and/or a sense that the death was unnecessarily due to the negligence of the deceased, the work of mourning generally becomes more difficult (Toman, 1976). The ambivalence toward lost love objects that involves concomitant feelings of love and anger will prolong the work of mourning and may not lead to an

effective working through of grief (Freud, 1957; Toman, 1978). Thus, it is necessary to normalize the ambivalence and encourage the bereaved to give voice to his or her conflicting thoughts and feelings.

Assessment of Cynthia in Relation to Wolin and Wolin's (1993) Resiliencies

Anais Nin once said:

> One discovers that destiny can be directed, that one does not have to remain in bondage to the first wax imprint made on childhood sensibilities. Once the deforming mirror has been smashed, there is a possibility of wholeness. There is a possibility of joy. (as cited in Wolin & Wolin, 1993)

Similarly, the Victorian novelist George Eliot (1984) underlined the bittersweet paradox of adversity: "Deep unspeakable suffering may well be called a baptism, a regeneration, the initiation into a new state" (p. 403).

Instead of subscribing to a damage model of functioning, Wolin and Wolin (1993) called upon clinicians to use their Challenge Model to empower clients with adverse childhood backgrounds to prevail. Such a model honors and builds upon the resiliencies that are innate within clients. It also moves people to take misfortune as an impetus for increasing effort to set and reach goals. Although the researchers emphasize that no one is born with all seven resiliencies, some people are fortunate enough to be born with some of them. Such people tend to be more optimistic than pessimistic (Wolin & Wolin, 1993) and tend to have an internal locus of control (Lefcourt, 1982). Instead of encouraging a client to view himself or herself as a victim, clients' challenges may be reframed in such a way to highlight their innate resiliencies. Clients are directed away from believing that they suffer from a psychological sickness or addiction as a result of

growing up in a dysfunctional family. Instead, clients are guided toward an increased sense of responsibility in making their real-life canvas appear to look the way they envision it to look in their dreams. This posture is in contrast to the Adult Children of Alcoholics Recovery Movement, a disempowering movement that enjoyed popularity in the 1980s.

When a clinician utilizes Wolins' Challenge Model in conjunction with Bowen Family Systems, he or she continually remembers the Japanese proverb, "the reverse side also has a reverse side." Also, the Challenge Model therapist has a goal to find a telling of the life story that helps the client fix the broken mirror that reflects back at his or her fractured sense of self. Instead, the therapist offers a new mirroring that empowers clients from chaotic families of origin to live well in the present and look forward to the future with hope. Such perspective is congruent with the narrative school of thought, which takes the position that an individual's life story can be told in several ways (White & Epston, 1990). Some stories are healing in contrast to others, which are destructive (White & Epston, 1990). The use of Minuchin's (1974) technique of reframing is also used to replace clients' beliefs that they are victims or scapegoats with the belief that they have unique resiliencies that allow them to be heroes of their own life story.

Wolin and Wolin (1993) identified seven resiliencies gathered from clinical interviews with 25 resilient adult survivors. These clusters of strengths include creativity, humor, initiative, relationships, independence, insight, and morality. Within the earliest sessions of assessment, it became apparent that Cynthia's resiliency in the area of relationship was strong. She was engaging, attractive, articulate, intelligent, and positive in her attitude about embarking into treatment. She made friends easily and kept them.

For example, she still maintained very close relationships with six of her high school girlfriends. As a fifteen-year-old girl, she also showed remarkable initiative. She found substitute caregivers when she realized that she could not continue to excel in school in her chaotic environment.

Cynthia also demonstrated a strong sense of morality. She valued her relationship with God. After her brother's death and her father's death, she mourned the loss of that connection. She missed her ability to hear God's voice and missed the sense of purpose that she felt when Josh was alive. Her morality could also be seen in her sense of responsibility to her brother and in her wish to be an advocate for children who grew up in similar circumstances. Still another area of demonstrated resilience was underlined in Cynthia's statement in her timeline. She said that when she tried drugs, she realized that she liked them too much and quit. Such a statement reflects insight.

Cynthia came across as being independent. However, the assessment sessions revealed that Cynthia held a pseudoposture with regard to such independence, especially in relation to a romantic partner and/or spouse. Her ability to open her heart to another and be vulnerable would be a challenge for her as she moved through life.

Bowen Family Systems Theory Assessment

Theory is the key to the process of assessment using Bowen Family Systems Theory (BFST). Theory is essentially the way a clinician is thinking about the nature of emotional problems and about the factors that generate them. Thus, questions posed and data collected are driven by theory. In this way, the clinician asks about and focuses on the facts that are most salient to understanding the problem (Papero, 1990).

Even as the clinician begins assessment, it is important to represent the theory to the client as accurately and assertively as possible while at the same time not being dogmatic. From the start, the sole responsibilities of the clinician are to communicate theoretical ideas soundly in relation to the case and to manage self in session (Kerr & Bowen, 1988). A clinician's effort is to remain neutral while collecting facts and to monitor his or her own reactivity. If the clinician is unable to manage self, the clinician may inadvertently get "caught" in key triangles in the system. Such a pattern reflects the clinician's susceptibility to fusion and contaminates the therapy process (Bowen, 1978).

Clinical assessment assumes that emotional and feeling systems can sabotage the intellectual system of the client in terms of subjective biases (Kerr & Bowen, 1988). Emotional objectivity may be defined as the ability to describe factually the interplay between a person's emotional reactivity, feelings, subjectivity, and behavior and what is taking place in the client's most important relationships (M. Kerr, personal communication, October 29, 2005). Thus, the clinician is always making an assessment of the client's emotional functioning or those behaviors governed by the emotional system. It is important to note that the emotional system includes feelings and subjectivity, and it also includes biological functioning.

Assessing emotional functioning involves gathering what Bowen theory refers to as *facts* of functioning (Kerr & Bowen, 1988). Because the emotional system is reflected in functioning at levels all the way from biology to relationships, then data about all of these levels are assumed to reflect an individual's and family's emotional functioning. Thus, age, health, dates of births, marriages, divorces, deaths, level of education completed, occupation, and geographical moves are collected (Papero, 1990). Such facts are looked

at against the backdrop of family relationship shifts, the extremes of which may involve complete or partial emotional cutoffs.

Bowen theory places human emotional functioning on a continuum that ranges from highest to lowest levels of adaptation (Bowen, 1978). Individuals and family systems that adapt most effectively to life challenges, particularly to real or anticipated changes in key relationships, have the highest basic levels of differentiation (Kerr & Bowen, 1988). Such people may be viewed as having a well-developed self. At the other end of the continuum, are the no-selves (Bowen, 1978). People with the higher basic levels are most able to maintain fairly solid levels of emotional functioning. Therefore, if the facts of functioning about a person on a family reflect a stable and productive life, these facts suggest a high basic level of differentiation. In contrast, if the facts of functioning reflect an unstable and not very productive life, it may be assumed that the individual or family does not have as high a level of differentiation (Bowen, 1978).

A person's level of emotional functioning can increase or decrease depending on his or her level of chronic anxiety. The quality of a person's key relationships has the most significant impact on his or her level of chronic anxiety. A central facet of Bowen family assessment is determining how has the balance of relationships in a family system been disturbed to the point of someone developing symptoms (Bowen, 1978). Such a determination assumes a profound level of interdependence in human emotional functioning. In fact, it is often the case that one person can be carrying chronic anxiety for the system. Thus, it is essential to assess the level of emotional functioning of every key person in the system.

The family diagram is a method for recording the data about emotional functioning for the family as a whole (Papero, 1990). Once data are entered onto the diagram, the clinician may apply the concepts of the theory in his or her interpretation of the data. Most importantly, the clinician assesses whether relationships have been disturbed by key events and what the basic adaptive level of this family is within and between generations. In assessing a client using the family diagram, the clinician should look for repetitive strengths and symptoms, identifying relationship patterns seen across the family and over generations. Repeated triangles, coalitions, cut-offs, patterns of conflict, and over- and under-functioning are all areas that are important to identify.

Coincidences of dates may include the death of one family member or anniversary of death occurring at the same time as symptom onset in another. Similarly, the age of symptom onset may coincide with the age of problem development of another family member. Changes in functioning and relationship may correspond with critical family life events, such as deaths that occur "off schedule." The clinician should be alert for "missing" information or discrepancies in information. Such gaps frequently reflect charged emotional issues in the family (McGoldrick & Gerson, 1985).

Assessment also assumes that each sibling will have slightly more, slightly less, or the same amount of differentiation as the parents (Kerr & Bowen, 1988). Each sibling's position in the family triangle is different. The child who is most focused upon is less free to grow and develop (M. Kerr, personal communication, October 29, 2005).

A Bowen Family Systems Assessment of Cynthia

Cynthia's level of differentiation of self, sibling position, nuclear family process, family projection process, triangles, the multigenerational transmission process, and emotional cutoff are important areas to assess. Assessment of these theoretical areas provides insight into the client's level of chronic anxiety. Because the theme of loss is so dominant in Cynthia's history, the presence of emotional shock wave effects is also central to assessment. Seemingly coincidental problems and/or nodal events that follow the death(s) of important family member(s) must be considered as possible ripple effects resulting from deep trauma and grief (Walsh & McGoldrick, 2004).

By creating a three-generation family diagram in collaboration with the client during initial sessions, the clinician can begin to identify patterns within the client's family system. The family diagram is a graphic representation of the facts of the family system (Kerr & Bowen, 1988). It is a tool and resource to project a hypothesis regarding the family emotional system both in the present and in the past (Bowen, 1978). The diagram offers a pictorial representation of relationship patterns, utilizing symbols such as circles, squares, and lines to illustrate theoretical concepts highlighting relational functioning. This diagram becomes a work in progress, with new facts added as they emerge through the course of treatment.

Differentiation of Self

Cynthia's differentiation of self was probably slightly higher than that of either of her parents and higher than her deceased brother, Josh's, level of differentiation. It

appeared that Cynthia received less anxious focus than her brother received. However, patterns in her family of origin over the two preceding generations reflected a high degree of intensity. Domestic violence, alcoholism, drug addiction, divorce, and emotional cutoffs all reflected the low level of adaptivity to change across the individual and family life cycles.

Taking these family facts into consideration, it is likely that Cynthia's level of differentiation was probably on the upper end of the lower quadrant in the (theoretical) differentiation-of-self scale. This lower level of differentiation made it difficult for Cynthia to gain an objective view of herself. It was more difficult for her to wrap her mind around broad, systemic concepts because her anxiety got in the way of her ability to think in novel ways. It follows that when emotional issues in her relationships emerged, Cynthia became highly anxious and was unable to call upon her best thinking. Instead, her reactivity got in the way of her ability to take responsibility for her own functioning. Her propensity to blame others for the problems in her life was directly related to the high level of emotional intensity that had been experienced in her family of origin over many generations.

It can further be assumed that Cynthia's differentiation level influenced her mate choices, leading her to marry a husband with an equally low level of differentiation and have children with a man who also had a level similar to her own. The lower level of differentiation could also be observed in the emotional fusion between Cynthia and her mother, as well as between Cynthia and Steve.

In several respects, Cynthia's relationships with Tom and Steve replicated her parents' marriage, her position in the primary triangle, and her role in relation to her

brother and father. She attached herself to men whom she could save and rescue in much the same way as she attempted to save and rescue her father and her brother. She reacted to her unsuccessful attempts to do so by adopting a pseudo-independent posture and withdrawing from the relationships. Her withdrawal from important others reflected a multigenerational pattern of cutoff in her family of origin. Her effort to reform men was likely her emotional system's directive to attempt to succeed at what eluded her in her family of origin. Like her mother, she chose men who did not function at a high level. Her mates moved Cynthia to compensate and over-function, a behavior that reflected her attempt to reduce her chronic levels of anxiety when she experienced either real or perceived threats to her own emotional survival. The type of reciprocity of emotional functioning in relationships reflected Cynthia's "inherited" predisposition to fuse with important others in the position of over-functioner, a behavior that was also consistent with her birth order position of oldest daughter.

Sibling Position

As the older sister of a brother, Cynthia was 2 years old when her brother, Josh, was born. Because she was still in diapers, she might well have felt more threatened than overjoyed by his arrival. Toman (1976) posited that it may take up to her 5th year of life to become accustomed to her little brother before she is able to adopt a nurturing attitude toward him. However, Toman stated that it is not long before the older sister realizes that she can pretend to be mother to her younger sibling. She relishes the opportunity to take care of the younger one and is compensated by the fact that he will look up to her and even protect her in return as he matures. Toman also observed, "The older sister seems to

realize that her younger brother, being the first and only boy in the family, tends to be taken more seriously and to be valued somewhat higher than herself" (p. 13).

Cynthia eagerly adopted the maternal role and embraced the responsibility, as well as kept an abiding awareness of her somewhat lesser importance in the family, and this role and awareness stayed with her into adulthood. Within her maternal role, she developed an appreciation that she could handle boys anywhere, always striving to keep her brother and friends in line and out of trouble. As a reflection of her sibling role, Cynthia enjoyed giving her partner, Steve, comfort, consolation, nurturance, and care when tension between them was low. She performed her housekeeping and motherly duties with enthusiasm and with a certain satisfaction. When tension between Steve and Cynthia was high, she resented Steve for not helping her enough with her duties or appreciating all that she did for the household.

Although Cynthia discovered during her 18th year that she had a half-sibling, the relationship with Michael never materialized in the way she had hoped it would when she went toward him after Josh died. Thus, for all intents and purposes, Cynthia became an only child after she lost her brother, Josh. In many respects, Cynthia fit Toman's (1976) description of an only child, however, even before Josh died. She preferred the company of adults at the age of 10, according her own self-report in her timeline. She described herself as a do-gooder who struggled to find her place socially. She prided herself on her position of authority with her brother and his friends, always looking to see that they stayed out of trouble. Her reputation as a smart, "Miss Goody Two Shoes" seemed to compliment her need to take on a leadership role in her social group.

When Cynthia's father, Bill, died she was 23. In her timeline, she noted that Michael did not attend the funeral. His absence underlines her role as an only child. In a sense, Bill's death only highlighted to Cynthia the idea that she never really had a father who could parent her in all the necessary ways. With her father gone, this left her to console her mother, who was still grieving the loss of her only son. Although Winnie had left Bill to marry another man who did not have children of his own (referred to as Jim), Cynthia continued to view her role as her mother's primary emotional support. She recalled how she was the apple of her Dad's eye, and that Josh had a special place in her mother's heart.

Since Josh had academic and social problems from an early age, including a diagnosis of ADHD, it is easy to imagine that he was the recipient of more anxious parental focus than Cynthia was. Not surprisingly, Steve also received an early diagnosis of ADHD. When in conjoint session with Cynthia, he often showed the defiant streak so common in the men in Cynthia's family of origin. As the younger of two male siblings, Steve recalled, "My mother is a worrier with good reason. I put her through it."

Kerr and Bowen (1988) emphasized that a best sibling position does not exist. Each position comes with its own positive and negative aspects. For example, they pointed out, "The person who is an oldest child may feel he is doing all the work and that he is 'over used' and 'under appreciated'" (p. 316). On the other hand, an oldest child may accept leadership and responsibility easily without attempting to control or to intrude upon others. When the relationship between Steve and Cynthia heated up, Cynthia would complain bitterly that she did all the work and was underappreciated by Steve. During

calmer periods, she viewed her life with Steve as fulfilling her dream of raising a happy family in a wholesome environment.

Cynthia and Steve held complementary sibling roles. He was the younger brother of two boys, and she was the older sister of a brother. As such, each partner could assume roles and responsibilities familiar to them as a result of their sibling roles in terms of rank (Toman, 1978). However, they had differing sex roles, as Steve was the younger of two boys in contrast to Cynthia being the older sister to a younger brother. Thus, Steve was not accustomed to life with a sibling of the opposite sex. Similarly, Cynthia was not accustomed to life with a sibling of the same sex. Toman pointed out that in love and marriage, sex conflict may result in each partner's having trouble in his or her daily life trying to get used to the sex of his or her partner. Nevertheless, Toman's research showed that complementarity or partial complementarity has a better prognosis than other relationships. Cynthia and Steve had partial complementarity in their relationship.

In terms of sibling position as it relates to parent/child constellations, Cynthia probably would be most identified with her older son, Adam, since she was also an older child. However, she might be more protective toward her younger son, Timmy, who occupied the same rank and sex as her lost brother. Toman (1978) stated:

> A parent can be with and cooperate best with that one of his children whose sibling position is relatively most complementary to his own. In the most favorable case, that parent has neither a rank nor a sex conflict of sibling roles with that child. (p. 121)

Her younger son, Timmy, might thus be at risk for a higher degree of anxious maternal focus, which, in turn, may result in symptoms throughout his life course. Should Timmy

receive this focus, it would parallel the focus received by Josh in Cynthia's family of origin.

In assessing Cynthia's case, it is important to consider the entire constellation of the nuclear family. The sibling positions of each parent provide immediate information about some facets of the partnership. In Cynthia's case, she was an oldest sibling with a mother who was a youngest sibling and a father who was an oldest sibling. As an oldest sibling, Cynthia identified most strongly with her father and saw herself as "daddy's girl." She was a parenting partner with a father who was a younger sibling of brothers, who most closely identified with his mother. Her nurturing posture toward her partner alternated with her resentful posture that she did too much, both of which were consistent with her sibling position in relation to her parents, to her deceased sibling, and to her parents.

Nuclear Family Process

The nuclear family emotional process reflects the flow of emotional process or patterns of emotional functioning in a nuclear family (Kerr & Bowen, 1988). What is central to this concept is that the context of symptoms is broadened from the individual to the nuclear family relationship system (Kerr & Bowen, 1988). The key patterns of emotional functioning in a nuclear family are assessed on the basis of a careful history (Kerr & Bowen, 1988). The author assessed Cynthia's nuclear family process by using Bowen's (1978) four basic relationship patterns that govern relationships in a nuclear family when problems develop. In the ensuing paragraphs, the four basic relationship

patterns are identified, described, and related to the assessment of Cynthia's nuclear family process.

Marital conflict. The first relationship pattern is *marital conflict*. Although Cynthia and Steve were not married, it became apparent during intake sessions that each partner externalized his or her anxiety into their relationship as family tension increased and the partners became more anxious. For example, conflict escalated between them when Steve decided to take Cynthia with him on a trip to reunite with his 3-year-old daughter and estranged wife. The unresolved attachment in Steve's first family and interlocking triangles in Steve's two families placed stress upon his partnership with Cynthia. Similarly, conflict occasionally developed around Steve's jealousy of Cynthia's former husband. Conflict also escalated as Steve invested in and embarked upon a new business venture. As anxiety increased in their nuclear family system, Steve's mother would often become protective of her son and form an alliance with him, creating an interlocking triangle that reflected the increasing anxiety in the system. Cynthia resented being in the outside position of that hot triangle in much the same way that she felt left out when the couple visited his first family. Similarly, it is easy to imagine that Cynthia resented being in the outside position between her younger brother and her mother, especially when Josh became the focus of Winnie's anxious attention. Finally, conflict escalated in tandem with the adjustment involved in having an infant son and escalated further with the news that Cynthia was pregnant with their second child.

Dysfunction in one partner. The second relationship pattern is *dysfunction in one partner.* In this pattern, one partner places pressure upon the other to behave or think in proscribed ways and the other accommodates to the pressure in order to avoid making waves. Although both partners may alternate accommodating behaviors to preserve harmony, one partner does more of it. When the emotional atmosphere is calm, the interaction may be comfortable. However, when family tension rises, the subordinate partner may give up so much self that his or her anxiety escalates significantly. If other necessary conditions are present, this raised anxiety generates the development of a psychiatric, medical, or social dysfunction.

As family tension increased in Cynthia's nuclear family, each parent began to behave in more emotionally reactive ways. With the escalation of individual tension and anxiety, the couple experienced more relational conflict. Cynthia would withdraw from Steve when she perceived him to be less than appreciative of her homemaking efforts or when she resented the length of time he put into developing his new business. She would also withdraw from him when she experienced frustration that he was dragging his feet in his ongoing divorce or when she felt he placed his daughter's financial wellbeing over the needs of their own nuclear family. Steve at once admired Cynthia's independent posture and was threatened by it. When she withdrew from him emotionally, he worried that she would leave the relationship. He marveled at her ability to regroup if one of her friends should call, while he complained that it took him longer to get over an argument they were having. When Steve would reach a point of feeling undervalued by Cynthia, he would often careen out of control. He would go on drinking binges, sneak marijuana into

the house, or go on a gambling spree, losing large sums of money. His mother would blame Cynthia for upsetting her son and worried about his physical and emotional health.

The pattern of social dysfunction developed wherein Cynthia increasingly over-functioned and Steve under-functioned. Within this reciprocity, the clinician assessed that the level of family tension was high. Additionally, the level of emotional distance in the partnership had not changed and the partners were internalizing the anxiety within the system. Since Steve repeatedly was the one who regressed into impulsive behaviors when tension in the nuclear family system escalated, it can be assumed that he had given up more self than Cynthia in their relationship. Alcohol, marijuana, gambling, explosivity were alternatively present in Steve's behavior when anxiety rose to intolerable levels within himself. These behaviors are a way that Steve used to create distance and to bind his anxiety. Because Cynthia was the one who was apparently most motivated to change since she was the one requesting services, the clinician should coach her to tone down her over-functioning in order to empower Steve to raise his own functioning within the system.

Impairment of one or more children. The third relationship pattern is *impairment of one or more children*. One son was under 6 months at the time of initial assessment, and the second son was yet to be born. At this point, no impairment was present. However, if either Cynthia or Steve projected their anxieties from within their own relationship or from unresolved attachments within their respective families of origin onto one or both children, their sons might have been at risk for future impairment. Such a process sabotages the children's differentiation from the family and makes them

vulnerable to impaired academic performance, problems with physical or psychiatric health, and/or social symptoms.

Emotional distance. The fourth relationship pattern is *emotional distance*. In this pattern, each individual withdraws into himself/herself. Each partner becomes not only detached from his or her emotions, but the partners also become disconnected from each other. In order to reduce relationship intensity, people use distance for short-term relief. Over time, however, this distance shifts into anxiety over feeling too isolated. One or both partners may triangle in other people and/or substance to compensate for the lack of connection they feel with each other. In this pattern, partners achieve neither autonomy nor intimacy. Instead, the fusion created within the partners' respective low differentiation leads to an unhealthy attachment pattern, which, in turn, fosters clinical problems in the nuclear family system.

Cynthia would kick Steve out of the house when anxiety became too high for her to tolerate. Similarly, Steve would impulsively use substance, gambling, or explosivity to create distance as a way to bind his anxiety and get the distance he felt he needed from the intensity between them.

Family Projection Process

The family projection process describes the primary way that parents transmit their emotional problems to one or more of their children (Kerr, 2003). The projection process can create impairment in the functioning of one or more children and increase their

susceptibility to clinical symptoms. Children acquire many strengths as well as problems through their relationships with their mothers and fathers, but Kerr (2003) posited that the

> problems they inherit that most affect their lives are relationship sensitivities such as heightened needs for attention and approval, difficulty dealing with expectations, the tendency to blame oneself or others, feeling responsible for the happiness of others or that others are responsible for one's own happiness, and acting impulsively to relieve the anxiety of the moment rather than tolerating anxiety and acting thoughtfully. (p. 19)

The more intense the projection process, the stronger the relationship sensitivities the child develops that follow him or her throughout the life course (Kerr, 2003).

Kerr (2003) stated that the projection process follows three steps: (a) The parent focuses on the child because he or she fears something is wrong with the child, (b) the parent interprets the child's behavior as confirmatory of the fear, and (c) the parent interacts with the child in a way to communicate that something is really wrong with the child. Thus, the danger of the family projection process is that it becomes a self-fulfilling prophecy (Kerr, 2003). In the parents' efforts to try to "fix" the perceived problem they have identified in their child, they indiscriminately affirm the child. The child's low self-esteem is co-created with the parents, and the child's self-esteem grows dependent on their continuing affirmation. The parents often invest more time, energy, and worry in one child than in other siblings. As a result, the siblings less focused upon are more mature and have a more realistic set of expectations for relationships over the life course. Similarly, the sibling(s) less focused upon are less sensitive to their partners' perceptions of them and are more able to be a self in relationship.

In the case of Cynthia, one can look over three generations and speculate about the affects of the family projection process. As the black sheep in his family, Bill may have

received the highest degree of anxious child focus. It is likely that his anxiety resulted in acting out behaviors that emerged during adolescence when he became highly dependent on alcohol and drugs. Like Winnie, Bill was a child of divorce. Both Winnie and Bill were children of fathers who were alcoholic. Winnie witnessed domestic violence and knew that her father had been unfaithful to her mother. When Bill became very drunk, the family knew to be frightened when he put on his boots. Then he would become mean and violent, often throwing things and creating even more chaos in an already chaotic household. As Cynthia described it, "When my father put on his boots, all Hell would break loose."

As the only daughter and youngest sibling of three, Winnie's brothers were respectively gay and substance dependent. Winnie also was alcoholic and abused drugs. Even more pointedly, Winnie married and parented children with a man whom she could over-function for in much the same way that she saw her mother behave in response to her father. She might have slightly less differentiation than her parents, for Winnie believed that she grew up in a home that was more stable than the home she created with Bill.

Since Josh was diagnosed with ADHD, experienced problems in school, was accident prone, and often placed himself in harm's way, it can be assumed that he might have received more anxious focus from his parents than Cynthia did. His position as the only son and as the youngest child, coupled with his resemblance to his father, might have combined to increase his heightened vulnerability to the family projection process.

Cynthia and Steve's sons have not yet shown any symptoms of impairment. However, because Cynthia and Steve's relationship was fraught with problems, there is a

risk that Cynthia will become excessively involved with her children even beyond infancy when their needs shift from being based in reality to mother's projected anxiety onto one or both of them. The children stand to receive both the worry of the mother and the anger and frustration that both parents feel in their failure to connect with one another effectively and fulfillingly.

Triangles

The triangle consists of a three-person relationship system (Bowen, 1978) or two people and an issue or problem (A. Lawson, personal communication, April, 2005). Bowen viewed the triangle as the building block of the larger emotional system, seeing it as more stable than the dyad. The two-person system can tolerate only so much stress or tension before a third person is pulled in to spread the anxiety out among three people or two people and a problem such as substance abuse. A triangle can contain greater amounts of tension because the tension can shift around three relationships. The metaphor of the three-legged stool being more stable than a two-legged stool illustrates the concept (M. Kerr, personal communication, October 29, 2005). The result frequently involves one person being shoved into an outside position while the new twosome becomes fused. The shift in the emotional movement may contribute to the emergence of symptoms, as getting pushed from the inside to the outside position may be intolerable.

If the tension is too great for one triangle to contain, it may spread to a series of interlocking triangles. Although spreading the anxiety may stabilize a system in the short term, little gets resolved over the long term (Kerr, 2003).

The patterns in a triangle shift with increasing tension (Kerr, 2003). In calm periods, it is comfortable to be on the inside, and the third person is an uncomfortable outsider. However, if two people are in conflict, it may be preferable to be in the outside position. The important thing is that someone is always uncomfortable in a triangle and is pushing for change. Insiders affirm their bond by choosing each other in preference to an outsider. Within this choosing process, the outsider is usually aroused to suffer intense feelings of rejection. Triangles can be significant precursors to clinical symptoms. For example, if two parents intensely focus on what is wrong with a child, it can trigger defiance and serious rebellion in a child (Kerr, 2003). This child may go on to embrace his or her role as the black sheep of the family.

During initial assessment, Cynthia complained of discomfort in the triangle of Steve, Michael, and herself. She resented the fact that Michael was rude and unfriendly to Steve. Cynthia's family diagram showed that all parental relationships had a highly conflictual and fused bond. All parental bonds in Cynthia's family of origin had a father who was addicted to substance and a mother who focused anxiously upon the children. Similarly, Steve's father was alcoholic. Steve was not told of his biological father until he was older and only met him once at the age of 16. His mother married and divorced two more times. Steve took the name of her second husband, who became a father figure and role model. Steve took his name and stated that he abandoned the family when Steve was 16. He says, "It hurts that I never talk to him."

As Cynthia provided details of her family system, it became apparent that each system replicated the next. For example, each generation was peppered with domestic violence between the parents. Each generation had a child (male) that was more defiant

and rebellious than the other siblings. In fact, over the generations, a belief system evolved that affirmed people for flaunting their ability to bend and break rules in a blatant way and with attitude. Each generation showed an over-functioning mother and an under-functioning father. Each generation reflected divorce.

Cynthia's position in her primary triangle involved being on the inside position with her mother, with her father in the outside position. She and her brother Josh were alternately two insiders, or she would place herself on the outside between her brother and her parents. She noted that Josh was far more comfortable with the chaotic conditions in which they lived, and he did not suffer the shame she did among her peers with the homeless people being sprawled out in their yard and in their home.

In interlocking fashion, there was a current triangle of Steve, his estranged wife, and Cynthia. Cynthia became reactive when she felt on the outside position. Also, Cynthia became reactive when Steve's mother took her son's side in their relational conflicts, placing her in the outside position of that hot triangle. Most importantly, assessment of the three-generation family diagram pointed toward the risk of Cynthia's sons being anxiously focused upon in order to compensate for unresolved attachment in the parents' families of origin and with one another in much the same way that the family projection process operated in the generations before them.

Multigenerational Transmission Process

The concept of the multigenerational transmission process describes the inheritance of the family emotional field through the succeeding generations (Kerr & Bowen, 1988).

Physical, emotional, and interactional patterns are passed down through the generations via the multigenerational transmission process (Kerr & Bowen, 1978).

This process can graphically illustrate how small differences in the levels of differentiation between parents and their offspring and between members of a sibling group lead over several generations to significant differences in differentiation among members of a multigenerational family (Kerr, 2003). Children develop levels of differentiation of self similar to their parents' levels as a result of parents' actively shaping their children's development and children innately responding to their parents moods, attitudes, and actions (Kerr, 2003).

It is important to note that the relationship patterns of nuclear family emotional systems often result in at least one member of a sibling group developing slightly more "self" and another member developing slightly less "self" than his or her parents. Additionally, people will predictably choose mates with levels of differentiation of self that are stunningly similar to their own level (Kerr, 2003). In fact, the multigenerational transmission process programs the ways in which people interact with others, as well as the level of "self" an individual may develop. Both types of programmed wiring affect mate selection (Kerr, 2003).

Once reactivity is managed with a client, the clinician is encouraged to look at multigenerational patterns that may be playing out in the current system, often through the use of the family diagram. This educational component is extremely important to the therapy process as well, but can only be accomplished when reactivity is low. From a multigenerational perspective, the clinician looks for such patterns as triangles that block growth, cutoff, fusion, over-functioning/under-functioning, substance abuse, social

problems, pseudo-self, loss, and divorce. Problems that arise out of multigenerational patterns may be most easily seen in the context of the family of origin. The assumption is that gains made in understanding one venue will show up in other venues, such as in the nuclear family.

Multigenerational patterns of transmission in Cynthia's family diagram are intense. Patterns included divorce, cutoff, substance abuse, infidelity, domestic violence, over- and under-functioning, as well as defiant streaks in the males, reflecting a lot of pseudo-self. All marriages were conflictual and fused. Verbal abuse, explosivity, and anxiety also characterized the marital dyads. Such marital conflict predicted a greater likelihood of symptoms being exhibited in the siblings and/or a physical or psychological illness in a spouse or child. Both Cynthia and Josh exhibited stress and low levels of functioning due to the parents' marriage.

However, as the less focused upon child, Cynthia often showed marked resiliency in the face of her chaotic environment. For example, she accepted a leadership role with her peers, engaged well with people, and excelled in school. When her environment presented a threat to her ability to maintain her grades, she creatively sought substitute caregivers that could offer a calmer environment. Cynthia's innate resiliencies in relationship and initiative were apparent at a young age (Wolin & Wolin, 1993).

Cynthia's father had been on SSI since her earliest memory, and she believed that her father was diagnosed as borderline schizophrenic at one time. Cynthia's mother was an alcoholic and, along with Cynthia's father, neglected basic parental responsibilities. Homeless, drunk, and drug-addicted people were routinely invited into the family home, where they often stayed for indefinite periods of time. The children were allowed to play

by searching through trashcans, had no curfew, and no adequate supervision. The home environment was so chaotic that the client recalled being unable to study and waking up for school only to trip over bodies of derelicts sprawled all over the living room floor. Cynthia's father's behavior over his life course from adolescence forward was such an embarrassment to his parents that they cut him off almost completely, and he was the only sibling to be left out of his father's will. Cynthia could not remember one day that her parents were sober. Both of Cynthia's parents were children of divorce. Cynthia did not learn of her father's secret child till she was in her late teens.

In assessing for patterns of multigenerational transmission, it was obvious to the author that Cynthia came from a multigenerational family of very high intensity. Relationship patterns in her family of origin had developed over a long period of time that predicted Cynthia's challenges in her nuclear family.

Emotional Cutoff

The concept of emotional cutoff describes "the way people manage the undifferentiation (and emotional intensity associated with it) that exists between the generations. The greater the undifferentiation or fusion between the generations, the greater the likelihood the generations will cut off from one another" (Kerr & Bowen, 1988, p. 271). Emotional cutoff may be achieved through physical distance and/or through different forms of emotional withdrawal (Bowen, 1978). Cutoff and distance are interchangeably used in this paper. Assessing emotional cutoff from the past and reducing it in the present is one of the most important elements of therapy. Although

cutoff may provide a salve for immediate pressure, the person's vulnerability to intense relationships remains unchanged.

In Cynthia's family of origin, just as Bill was cut off from his father, so was Cynthia cut off from Bill. Similarly, Steve was cut off from both his father and his stepfather, whom he identified as his role model and mentor. Inconsistent and missing information reflected the extent of the family secrets, another indication that cutoff was massive within the system. Cynthia described her father, brother, and uncles as having a defiant streak. All the men in Cynthia's family thumbed their noses at authority and displayed a bravado that screamed pseudo-self. The ability to cut off from family as if to be autonomous only heightened the emotional ties to the family, expressed in dysfunctional styles of relating to partners.

Cynthia was wired to look to her partner to compensate for all the losses she experienced as the daughter of a man whose life was scarred by the use of substance. Her will to find compensation for her paternal losses in a mate intensified with the premature death of her brother. The instability of Cynthia's family of origin reflected low emotional functioning across the generations. Longevity, health history, occupational and educational performance, and marital history all provided a composite picture reflecting an outcome of a rapid downward multigenerational trend in functioning. The author considered the most important part of assessment to be the formation of an impression about the stability of the emotional process in the nuclear family and the extended system surrounding the nuclear family. Looking at the amount and intensity of emotional cutoff in Cynthia's multigenerational family provided an important lens through which to make this assessment.

Emotional Shock Waves

Events that result in major alterations in the functioning of a family become clearer when assessing to identify those who greatly influence a family and those who are more peripheral. For example, the death of an important family member may mark a turning point for a family (Papero, 1990). Such a death may usher in the beginning of a series of problems in a family, as if the death created ripples that undulate across the generations.

In the assessment of nodal events within Cynthia's multigenerational family, most striking is that Josh placed himself in harm's way and was murdered on the night of his paternal grandfather's funeral. The cutoff between Bill and his father, Roger, began in Bill's adolescence and lasted till Bill's death. It is highly likely that Bill's death, which occurred less than 2 years after Roger's and Josh's death, also represented the ripple effect of the deaths of two important family members.

Summary of Assessment

Cynthia's family diagram showed tremendous intensity in symptoms over three generations. Generational patterns of addiction, alcoholism, academic and occupational dysfunction, over-functioning and under-functioning, and divorce appeared on both her maternal and paternal sides. Infidelity, emotional cutoff, and domestic violence were yet other patterns used on both sides of her family to bind anxiety. Family secrets and complicated grief also combined to make it extremely difficult to collect certain information. Such a graphic picture leads the clinician to formulate modest goals, considering the fact that high levels of chronic anxiety have likely been present for many generations in this family system.

Although Cynthia probably had a higher level of differentiation than other members of her family of origin did, she was probably in the lower quadrant on Bowen's (1978) theoretical Scale of Differentiation of Self. She was less anxiously focused upon than Josh, so she had more freedom to grow and develop. Nevertheless, her position in her primary triangle and between her brother and her mother caused her to have high levels of chronic anxiety. Because of this anxiety, Cynthia exhibited a kind of allergic reaction to intimacy with adult partners over time. Through family of origin work, Cynthia would learn to move differently in the triangles in her life today.

An ability to understand systemic patterns was a major focus of therapy, as such insight will empower Cynthia to interrupt the toxic pattern of child focus in the parenting of her own children. Decreasing the fusion between Cynthia and her mother will empower her to grieve her many losses and move on with her life. Part of the work in decreasing fusion will empower Cynthia to honor her own voice, separating it from her mother's voice, and accepting her views as valid even when they differ from her mother's views. Decreasing the fusion between Cynthia and her deceased brother will allow her to view her life in a way to give it purpose beyond being a role model for him. Finally, Cynthia will continually be reminded of the emotionally interdependent nature of family systems and will be called upon to provide examples of this interdependence. Within her new understanding, Cynthia will realize that even in death, emotional cutoff might be prevented. It is important to honor the continuing bonds that exist in families within and across the generations.

In the ensuing chapter, a formulation of treatment goals and a description of Cynthia's treatment are presented. Transcripts that illustrate clinical application of theory are threaded throughout the chapter.

Chapter 4

TREATMENT GOALS AND TREATMENT

This chapter presents a brief review of treatment from a Bowen Family Systems perspective. Additionally, a brief discussion of treatment from the perspective of Wolin and Wolin's (1993) Challenge Model is presented. The author utilized both of these theories as guiding principles in treatment of Cynthia's complicated grief, anxiety, and relational difficulties in the present. Next, the beginning, intermediate, and later treatment goals for Cynthia are presented, all stages of which are informed by Bowen Family Systems and Wolin and Wolin's Challenge Model. Finally, beginning, intermediate, and later stages of Cynthia's treatment are described and illustrated with excerpts from selected transcripts relevant to stated goals within the respective stages of this client's therapy.

Treatment From a Bowen Family Systems Perspective

Bowen Family Systems treatment is aimed at making second order changes in the family system. Many theories of therapy and most self-help literature focus on change as a kind of shifted behavior to alleviate symptomatic distress. Such superficial treatment of a problem creates a first-order change, which usually leaves the underlying family structure giving rise to the problem unchanged. In contrast, BFST is aimed at gathering

historical facts relevant to the evolution of a problem and is respectful of the myriad factors perpetuating the problem(s) over time. The aim is to interrupt longstanding patterns that interfere with the client's ability to adapt to change.

Discomfort is a state that most humans automatically try to avoid. Uncertainty breeds such discomfort and leads clients to search for ready answers. Many clinicians are quick to offer such quick fixes, looking to reduce the client's discomfort as quickly as they can. In contrast, BFST does not offer quick fixes or ready solutions. Instead, this treatment modality offers a way to counteract multigenerational emotional forces that foster maladaptive behaviors in a permanent way. As such, the garnering of facts of relational functioning in a family system of at least three generations in order to gain clarity about repeating patterns and personal accountability are early emphases of treatment.

Life goals and decisions necessary to implement a client's goals may never come to be realized if a client does not identify and adhere to core principles that cannot be bent or broken from relationship pressure or from the "group think" so prevalent in severely fused families. Such work may initially increase rather than decrease immediate tensions in self in relation to important others. Outcome is determined in part by whether the client can hold on to self in the face of enormous pressure from the family to "change back." However, the long-term gain from tolerating this discomfort may lead to increased comfort with self, which in turn leads to greater adaptiveness to change in relationships and in work over the life cycle.

Thus, an overarching goal is to empower clients to realize that they are part of a larger, evolving system. They should come to realize that in order to improve functional

patterns in self, they must be able to see, recognize, and alter their part in repetitive, multigenerational patterns. As such, clients may emerge with a focus upon their personal responsibilities and accountability with regard to moving differently in their important relationships. For example, as a complex pattern of fusion between parent and child becomes clear, clients may be coached to broaden their thinking in a way to decrease blame and understand reciprocity. Clients may be called upon to differentiate their own thoughts and feelings from their parents' thoughts and feelings. Such change may result in the ability of a client to shift his or her position in the primary triangle, resulting in increased resolution of attachment, lower levels of chronic anxiety, and increased differentiation of self.

Bowen Family Systems is not a therapy that focuses on techniques nor does it provide specific descriptions of how to structure therapy sessions (Papero, 1990). Instead, there is an emphasis upon the therapist's continuing work with his or her own family of origin, which will result in a therapist who is less vulnerable to being "caught" and triangled into the emotional process of the family system he or she is treating. The therapist's resolution of family of origin issues is reflected in the

> ability to be in emotional contact with a difficult, emotionally charged problem and not feel compelled to preach about what others should do, not rush in to fix the problem and not pretend to be detached by emotionally insulating oneself. (Kerr & Bowen, 1988, p. 108)

It follows that the central role of the therapist is to manage self in session in a way to remain neutral while still connected to the client, to direct conversation in a way to increase objectivity, and to minimize focus on children in the process of therapy. The emphasis is upon the therapist's maintaining a differentiated posture. This results in a

therapist who is not drawn into an over-functioning/under-functioning reciprocity in efforts to be helpful. Instead, the therapist's calm, curious, respectful demeanor creates a research environment that moves the family toward the calmness necessary to study its own emotional system. Maintaining a differentiated posture in the anxious environment of a heated therapy session is a challenge to many therapists. In light of this common dilemma, Bowen (1978) calls upon therapists to investigate their own need to help, rescue, or heal, looking to their own sibling position, multigenerational legacy, and position in the primary triangle as precursors to this anxious behavior in session. Bowen (1978) coaches therapists to discourage clients from passively waiting to be healed. Instead, therapists should encourage clients to position themselves in a way that underlies their responsibility for their own change. The parallel process of the therapist who is able to make I statements as well as monitoring and managing self in session offers the client a model of what a differentiated self looks like.

In early treatment, the therapist builds trust, forms a therapeutic alliance, and begins to collect facts of family functioning in a three-generation family diagram. During the early stage of treatment, BFST is focused on reducing clients' anxiety about the symptom by teaching them how the symptom is part of their pattern of relating to important others. Intermediate treatment aims to clarify issues of self, so that clients may increase their levels of differentiation. Clients are coached to resist the pull of what Bowen (1978) referred to as the togetherness force in the family. In later stages of therapy, clients are coached in differentiating themselves from their family of origin. Clients become more active out of session and may come to therapy less frequently.

There is an assumption that gains in differentiation will automatically flow over into decreased anxiety and greater self-responsibility within the nuclear family system.

Treatment From the Perspective of Wolin and Wolin's (1993) Challenge Model

Treatment from the perspective of Wolin and Wolin's (1993) Challenge Model honors the remarkable accomplishments of people who have overcome tremendous odds. The therapist is an alternate mirror reflecting his or her validation of the client's newly discovered pride in overcoming enormous hardship (Wolin & Wolin, 1993). The Wolins called the particular brand of pride they heard in the 25 successful survivors they interviewed "survivor's pride." They defined it as an earned sense of accomplishment that results from withstanding the pressures of hardship and prevailing in ways both large and small. It is the bittersweet mixture of pain and triumph that is usually under the surface, but sometimes readily visible, in many adults and children struggling with adversity in their lives. This pride, developed over time in the course of a struggle, typically goes unnoticed in professional and lay circles. Unfortunately, adults who suffered great hardships as children are likely viewed by many mental health professionals as having deficits instead of being noticed for their strengths in the face of significant struggle.

"How did you do it in the face of such severe hardship?" is the question posed by the therapist practicing resiliency-based treatment with a client who presents with the assumption that something is wrong with her. The therapist attempts to rid the client of the false mirror image reflected back to her from her family of origin (for example, that

she is not worthy). The resiliency-oriented therapist works with the client to correct the false mirroring she may have received from parents who are themselves burdened with broken self-images and caught in a vicious cycle of substance abuse. The therapist proceeds on the assumption that the client was not given an accurate image of herself. She may have, for example, discounted her self-worth, because she was neglected. She may have an inaccurate sense of her strengths. The therapist may listen to the client's story, with a laser light aimed at highlighting her resiliencies. The therapist may repeatedly return to the story, incredulously asking, "How is it that you have overcome the ravages of your past as much as you have? How did you have the insight and initiative to help yourself as an adolescent?" Eventually, the client shifts her belief that she has been indelibly broken to an alternate belief. She is able to say, "I have been tested and I prevailed. I learned and grew despite the hardship that I suffered." She views the upside of loss as hope, the aphrodisiac of the soul. The healing of the client's scars is reflected in her new reality. She becomes saturated with new hope that extends to her children and to her children's children. It is a hope that is not based in fate, but is rather based in pride in the individual's strengths and ability to forge a positive future. Although Wolin and Wolin (1993) posited that the seven resiliencies are innate, they emphasized that these strengths can be identified, honed, polished, and even taught.

Thus, the focus of this approach is to apply a vocabulary of strengths to the client, which is a distinct departure from the traditional deficit model (Wolin & Wolin, 1993). The notion that hardship results in damage and vulnerability is acknowledged on the one hand; on the other hand, the paradoxical result of hardship's capacity to produce great strengths is emphasized (Wolin & Wolin, 1993). Reframing adversity in terms of its

capacity to stimulate resiliency and carve out opportunity is empowering (Frankl, 1959) and guides the client toward honoring her strengths. Additionally, the client is encouraged to take responsibility for applying her strengths in the face of challenge instead of curling up in a fetal ball of victimhood (Bowen, 1978). The resiliency-treated client may come to view her scarred childhood as an inoculation against repeating the mistakes of her parents as an adult (A. Lawson, personal communication, February, 2006). Because of her adversity (not in spite of it), the client has become stronger and less vulnerable to the "infection" she was exposed to as a child.

As opposed to deficits listed in the *DSM*, the seven resiliencies identified by Wolin and Wolin (1993) are defined in terms of behaviors instead of as abstract concepts. The person with insight can ask tough questions and give honest answers. The person with relationship strength is talented at making ties to other people. A client with initiative takes charge of problems, takes action, and demonstrates competence. The creatively resilient client appreciates beauty and can express herself through art. The client with the strength of morality can act on her conscience and may have a sense of transcendence through hearing the voice of a higher power. The client with the strength of humor can laugh at herself and her pain. The independent client can manage herself in relationships in a way to be separate while still being connected (Wolin & Wolin, 1993).

In using this vocabulary of strengths, the therapist may reflect back to a client the message that although she may have been scared and worried about her wellbeing and her family's wellbeing as a child and adolescent, she has resiliency. She has the initiative, creativity, insight, and relational intelligence to take action. This kind of resilience allows the client to wear her Survivor's Pride as a Badge of Courage. It is an essential

part of who she was as a child, an essential part of who she is today, and an essential part of who she will become in the future.

Treatment Goals

The overarching goals of treatment in BFST are grounded in three core assumptions. First, it is assumed that decreased anxiety in the emotional field of the multigenerational family system will increase the functional level of differentiation of self, which will, in turn, reflect a reduction of symptoms. Second, it is assumed that even a slight increase in basic level of differentiation of self will have a profound effect on the quality of an individual's life course. Higher differentiation and lower anxiety will result in an increase in a person's adaptability to intense emotional fields. Third, treatment is guided by theory and is not centered on interventions or techniques. It is the self of the therapist and his or her ability to manage self in the intense emotional field often permeating the therapy room that drives successful outcome.

The overarching goal in a resiliency-based treatment is to convey a message that validates rather than minimizes the well-deserved sense of "survivor's pride" that emerges when an individual overcomes tremendous odds (Wolin & Wolin, 1993). Thus, resiliency-based treatment empowers the client to become aware of and make greater use of his or her resiliencies. In heightening the client's awareness of his or her strengths, the client is more capable of stepping up to the plate and taking responsibility for creating a life of meaning. The client comes to appreciate that the meaning of his or her life is in part forged as a result of, rather than in spite of, the adversity. The art of therapy is to validate individual and family strengths in a way that is not based in the therapist's own

anxiety (Kerr & Bowen, 1988). In other words, the effort is not to "fix" the client by loaning her "self" when the client is dealing with difficult material; conversely, the effort is to get factual and objective about innate individual and multigenerational strengths as well as maladaptive, multigenerational patterns of functioning (Papero, 1990).

Beginning Treatment Goals for Cynthia

Goal 1: Establishing trust and building a strong therapeutic alliance to set the stage for long-term therapy.

Goal 2: Beginning collaborative construction of a four-generation family diagram to concomitantly set the stage for later identification of and recognition of patterns of multigenerational transmission and to reduce reactivity.

Goal 3: Introducing psychoeducational component by some discussion of core concepts of BFST in session as appropriately timed to call upon client's thinking and to cool the system. Additionally, introduction to systemic, broadened thinking includes assigned reading to be completed between sessions: *One Family's Story* (Kerr, 2003) and *Man's Search for Meaning* (Frankl, 1959).

Goal 4: Beginning work on resolving issues and considering emotional shock waves related to complicated grief from multiple losses, including her brother's homicide, her paternal grandfather's death, and her father's death. Honoring the ambiguous loss that Cynthia suffered, due to having parents who could not be emotionally present to meet her needs. Beginning work aimed at helping Cynthia give

voice to her grief in a way that gives her permission to differentiate her voice from her mother's voice.

Intermediate Treatment Goals for Cynthia

Goal 1: Continued reduction of emotional reactivity by encouraging thinking over feeling responses and by peppering the client with questions aimed at gathering and clarifying family facts around patterns apparent in the family diagram.

Goal 2: Prepared strategies to facilitate the client's efforts to detriangle and reduce fusion within family of origin and nuclear family, especially within the hottest triangles.

Goal 3: Continued psychoeducation on BFST concepts in order to gain insight into repetition of key maladaptive patterns. Coaching is accompanied by applying new concepts to the client's nuclear family and family of origin, especially what differentiation looks like, self-care in service of lowered anxiety, how to move more adaptively in triangles, reciprocity of over-functioning and under-functioning, the benefits of toning down Cynthia's over-functioning, the decreasing of fusion and the bridging of emotional cutoff, even in death, and the risks of child focus.

Goal 4: In the service of continued reduction of complicated grief reactions, open the family of origin's communication system, especially around Josh's death. Also, normalize ambivalence and anger toward living and deceased significant others. Tell and retell story of Cynthia's brother's death. Process feelings around father's death and grandfather's death. Emphasize the emotionally interdependent nature of family systems, teaching about the emotional shock wave effect in operation in her own family to

underline the concept (Roger and Josh dying within 1 week of one another, and Bill dying less than 2 years after his father's and son's death).

Goal 5: Coach client to position herself in a more neutral way in her primary triangle by decreasing fusion with mother and by coaching her to connect with more people on paternal side of family. In decreasing levels of fusion between Winnie and Cynthia and between Josh and Cynthia, as well as bridging cutoff with her deceased father, a greater resolution of attachment will occur and result in an increase in level of differentiation of self.

Goal 6: Encourage client to identify and articulate short-term and long-term goals and coach client to put a plan into place to achieve goals that have been identified as having the highest priority.

Goal 7: Coach client to take "I" positions with a focus on self rather than other.

Goal 8: In the telling and retelling by the client of her story, reframe challenges as opportunities and mirror back client resiliencies and family of origin resiliency processes, thus correcting the false mirror image the client has carried with her all her life as the core of her life story.

Long-Term Treatment Goals for Cynthia

Goal 1: Continued work on being a self in important family relationships, including increased and improved contact with extended family, as well as the writing of letters giving voice to Cynthia's thoughts and beliefs in relation to important others in her family of origin.

Goal 2: To restore Cynthia's sense of purpose in life, one based on building self rather than on binding anxiety by over-functioning for important others.

Goal 3: Continued work on resolving complicated grief by establishing a new support system that confirms the universality of a permanently changed reality as the result of the premature and violent loss of her sibling.

Goal 4: Increasing capacity for systemic thinking around family relationships will be reflected in Cynthia's awareness that she has the opportunity to shift the multigenerational patterns of substance abuse, child focus, cutoff, and mate selection. Client should become more active at returning to her family and moving differently in her important relationships.

Goal 5: Increased acceptance of losses, decreased anxiety, and appreciation for the process of self-differentiation as a lifelong process. Cynthia will have a greater ability to take responsibility for self. It follows that there will be a decreased focus on others and an increasing respect for the notion that blaming behaviors reflect heightened anxiety about self.

Goal 6: Cynthia will be able to think more broadly about her part in important relationships, always with an eye to reducing automatic behavior. She will view her family of origin struggles as the impetus that continues to make her stronger and appreciate her resiliencies. She will have resolved a great deal of her complicated grief, allowing her to go on with her life. She will become the hero of her own story.

Early Treatment

Cynthia began weekly treatment in May 2004 and continued in that mode until February 2005 when she decreased her therapy visits to the 2 times a month, which continues to the present. Cynthia was 32 years old and living with the father of her infant son when she presented for therapy. Unhappy with the way her relationship was progressing with Steve and a bit nostalgic about her former husband, Cynthia presented with symptoms of anxiety and depression. The conflict with Steve and idealization of her past relationship with Tom at once exacerbated her adjustment to the early family life cycle stage of having her first child, and the stressor of the birth of her baby may have reciprocally exacerbated her dissatisfaction with her current relationship. Cynthia preferred working individually, and most sessions did not include her partner, Steve. Bowen (1978) believed that a therapist could do family therapy or couples therapy with only one person to affect change, so individual therapy was congruent with theory.

Although Cynthia suffered with anxiety and problems in the present, she had the insight to know that her past unresolved grief significantly intruded upon her ability to adapt to change in her nuclear family. This insight reflected one of the core resiliencies identified by Wolin and Wolin (1993). As Gorer (1965) and Rando (1986a) emphasized, lifelong and highly distressing grief may affect the entire family when a young adult child dies. Similarly, research has shown that bereaved siblings may experience so much pain and guilt that they are blocked from continuing with their own lives (Carter & McGoldrick, 1999).

For Cynthia, the grief surrounding the murder of her brother 12 years before was pervasive and, at times, overpowering. Also, her sadness and anger at the parental

neglect that she experienced as a child permeated her narrative even in the first session of treatment. Thus, complicated grief from the ambiguous loss of parenting she never had and from the loss of her sibling interfered to some extent with all areas of Cynthia's functioning. Additionally, her unresolved attachment with her father led to complicated grief reactions. She remarked that she never cried about her father's death and remembered feeling emotionally numbed upon hearing the news even though she had feared that he would die for years before his death. She stated that she knew that she had many issues to resolve about her father and that she had been avoiding dealing with her pain before and after his death. She also deeply regretted never having a close relationship with her paternal grandfather.

Despite her presenting problems of anxiety and depression, Cynthia came to therapy sessions with an engaging smile, radiating a confidence and positive attitude that immediately impressed the author. Her sun-burnished, dirty blonde hair, natural beauty, and tanned, lanky body typified the stereotypical California girls decorating the covers of popular magazines. Her brown eyes alternately sparkled with pride and excitement about embarking upon a therapeutic journey and then went dark with the pain and suffering she had been carrying as so much heavy baggage for years. Cynthia projected warmth and knew how to connect with people. Her gift with words underlay her intelligent, reflective nature. Cynthia embraced her new motherhood, energized with hope that she could provide her own children with the kind of environment that she never had.

When Cynthia expressed fear that she would repeat maladaptive patterns in her own family after becoming familiar with the multigenerational patterns of alcohol and drug abuse in her multigenerational family system, the author emphasized that research

showed that many children of alcoholics have strengths and resilience (Werner, 1992; Wolin & Wolin, 1993). The author reiterated Wolin and Wolin's (1993) research on resiliency and continued to use a vocabulary of strengths that applied to Cynthia's coping style. Also, the author discussed Werner's (1992) research, which identified four qualities that make a difference: (a) social competence, (b) problem solving skills, (c) the development of autonomy, and (d) a sense of purpose and future. Cynthia resonated with Werner's (1992) finding that resilient people believed they had control over their lives, as opposed to feeling controlled by external factors. Cynthia viewed herself as self-reliant, yet able to ask for help when she needed it. Even at this early phase of treatment, Cynthia seemed active in her approach to solving life's problems. She exhibited a tendency to perceive her experiences constructively, even those experiences that had caused great pain and suffering. She appreciated her ability to gain other people's positive attention, even since she was a little girl. Cynthia yearned to regain her strong ability to use faith in order to develop a positive vision of a meaningful life.

Cynthia was committed to the psychotherapy process from the start. Nevertheless, she warned the author that one of her problems in life had been a lack of follow-through on goals and ambitions. Remarkably, however, Cynthia came to therapy punctually week after week, always eager to roll up her sleeves and dig into issues that she had written in list form throughout the week. Early on, her consistent attendance was noted by the author, reflecting back to her the early success. Affirming the smallest successes became building blocks for future honing of her resiliencies of relationship, initiative, and insight.

As Cynthia approached the end of the beginning phase of treatment, nodal events, multigenerational patterns of regulating closeness and distance (particularly with

substance and with child focus), and triangles became part of her new awareness. Cynthia repeatedly expressed a deepening pride in her commitment to the process of learning systems and taking care of her self with therapy. At a later date, she proudly remarked that she had been able to continue with therapy even into the final stage of pregnancy. Indeed, Cynthia attended regularly, until one week before delivering her second son. This consistent, weekly attendance continued despite the hardship of economic stressors.

Cynthia had been in ongoing treatment with the author for 1 year and 21 months at the time that the writing of this dissertation neared completion. The treatment was reviewed in individual supervision and occasionally in a peer supervision group. Early in treatment, the author received more supervision on this case than she did during the intermediate and later stages of treatment. As the author became more experienced and confident in her application of Bowen Family Systems to this case and others, the need for supervision decreased.

Case notes were detailed and used to document information about the client and the process of therapy. Legal and ethical issues regarding informed consent, fees, and release forms were kept in the file. Assessment information, including the presenting problem, history of the presenting problem, history of the nuclear family, and family diagram were included. BFST concepts such as fusion, triangles, differentiation, and emotional cutoff were discussed in the notes as they applied to the client. Case notes were reviewed before the start of each session in order to refresh the author's memory about content and to assist her in the identification of patterns related to emotional process in and out of session.

Most sessions were audiotaped. The author listened to the tapes driving to or from work within the week, and this review process enhanced the ability to conceptualize the case. Additionally, the audiotapes were used to guide supervision and for the writing of transcripts.

Establishing Trust From a Bowen Family Systems' Perspective

During the fourth session, Cynthia expressed her joy and relief in finding a therapist with whom she felt a strong connection and to whom she could relate. This feedback reassured the author that the trust-building effort had been successful. Trust-building proceeded upon the assumption that the therapist had a responsibility to remain in emotional contact with Cynthia, while at the same time remaining a neutral and objective presence (Bowen, 1978).

The aim of the therapist is to aid the client in self-definition without being invested in decisions made by the client (Kerr & Bowen, 1988). However, the therapist has a responsibility to communicate her thinking clearly and in a way that the client can hear the ideas presented. The client should become respectful of the power that reactivity has on making decisions, and the effort to become more thoughtful and less reactive about choices is appreciated as being a challenge throughout the client's life. Such a posture can only be assumed by a Bowen therapist who has achieved some mastery of the ability to differentiate a self from an anxious emotional field (Kerr & Bowen, 1988).

The therapist who continues to work on her own family of origin issues becomes more skilled at not getting caught in triangles and at managing her own tendency to fuse

with a client and her family (Bowen, 1978). In order to remain inoculated against the contagion of anxiety coming at the therapist, the therapist increased her own active efforts to work on her own family of origin issues throughout the writing of this dissertation. By doing so, the therapist was continually reminded that increasing differentiation is a challenging, lifelong process (Bowen, 1978). Throughout the dissertation process, the therapist gained increasing ability in choosing when to stay connected with the client and when to remain separate. Similarly, there was a consistent effort to remain highly attuned to the difference between her thoughts and feelings.

Building trust with the client is grounded in the therapist's ability to manage self in a way that contributes toward maintaining a calm environment. Calming the client's reactivity is a clinical skill that reflects the level of differentiation of the clinician (Bowen, 1978). The well-differentiated clinician does not get caught in the client-family's emotional system. She can be a self instead of getting fused into the emotionality of the system. As Papero (1990) pointed out, a therapist who is a good manager of self will have a better shot at engaging the client in her own thinking processes.

Honoring the ability of the client to become thoughtful about her feelings was often accomplished by the author's consistent habit of redirecting anxious questions asked of the therapist back to the client in a way to encourage thinking, discourage dependence on the therapist, and to model differentiation (Papero, 1990). Additionally, at appropriate times, the author consistently tried to define a self in session with regard to her own thinking about issues raised. The challenge for the author was to monitor when her "I"

statements reflected a need to "fix" based in anxiety and when such statements actually benefited the therapy effort (B. Paul, personal communication, September, 2005).

Even in the earliest sessions, the therapist was respectful of the selfhood of the client. For example, at the start of each session, the therapist asked the client how she wanted to use her time that day. This question heightened the notion that the client had the ability to self-manage and take responsibility for her therapy. She was the best judge of how to use her own time.

Thus, the trust building effort, which is a key focus in early treatment, involves calming the system and maximizing the potential of the client's thoughtful capacity (Papero, 1990). By engaging the cognitive system, Cynthia took baby steps toward becoming more objective and broader in her perspective. When Cynthia began to think more broadly and objectively about situations as well as important people and events in her extended family, it became apparent to the author that this effort automatically lowered her anxiety. To illustrate the logic in getting a broader view of her family, the author used a metaphor that a football game looks very different when viewed from the top bleacher in the stadium compared to viewing it from on the field (Kerr & Bowen, 1988). Later in therapy, Cynthia remembered this metaphor as she attempted to get more neutral instead of blaming in understanding the dynamics of her multigenerational legacy. Within this calm and safe environment, Cynthia developed a deepening trust in the therapy process as a vehicle that enhanced her ability to think and thus move toward an increase in her functional level of differentiation of self.

Constructing the Family Diagram

With the effort in mind to get clearer about who Cynthia was and from where she came, the author and Cynthia collaboratively began construction of her four-generation family diagram. Questions were first asked in the service of collecting facts. Vital statistics were key to the construction of the diagram. These included (a) birth date, (b) place of birth, (c) place and cause of death, (d) level of education, (e) brief history of employment, and (f) a survey of major health problems (Papero, 1990). Dates were also significant and were recorded for all events listed (Papero, 1990).

Beyond the presenting problem and vital statistics, the author queried Cynthia about the functioning of the nuclear and extended family systems (Papero, 1990). When were the good times and the bad times? During which periods was there a sense of tranquility and during which periods was emotional reactivity in the system high? How had deaths, births, and separations, divorces, and other changes affected the system? By which methods did people in the system regulate the competing life forces of closeness and distance? Which relationships were characterized by the fusion of cutoff? Which relationships were characterized by the fusion of over involvement? Were marriages conflictual, harmonious or distant? Which children received the greatest anxious focus of a parent or parents? How did the family make meaning of their worlds? Were there over-functioning and under-functioning dynamics in the marriages? (Papero, 1990).

In assessing the emotional field in the system, the author often prefaced questions with the phrase "What is your *thinking* about how this change affected the family?" By asking thinking questions, especially about the feelings within a relationship *system*, the therapist heightens the client's respect for the powerful force of emotional

interdependency. This approach also guides the client to use her feelings as a bridge to engage the intellectual domain (Kerr & Bowen, 1988). Such awareness increases the likelihood that decisions will more likely be made thoughtfully instead of reactively and that the client will as a result adapt to change more comfortably. Initially, Cynthia's ability to call on her best thinking was minimal, when she was most anxious. However, as construction of the family diagram proceeded, Cynthia almost always visibly relaxed and settled down.

Many Bowen therapists may rush to finish the diagram in the first few sessions. This style of collecting "the facts" may be perceived by the client as detached, cold, and clinically insensitive, thus detracting from the effort to build rapport, a strong connection, and trust. Instead, the author took her time in getting the facts. Conversations about one particular relationship often required several sessions and were often re-introduced in later phases of treatment. This relaxed pace in collaboratively creating the family diagram had an inherent calming effect on the client. The therapist asked questions in a relaxed voice and showed curiosity as well as respect for Cynthia's ideas.

Empathy From a Bowen Family Systems' Perspective

Empathy is an important quality for a therapist to possess in the service of creating a therapeutic alliance (Nichols, 1987). Empathy that is non-anxiously based is expressed without a desperate need to "fix it" or "make it go away" (Bowen, 1978). Instead, the therapist is curious, asks questions that open the client to new awareness of patterns and

important nodal events, and acts as a guide who gently leads the client back to the landscape of her family of origin (Papero, 1990).

At other times, the therapist may demonstrate empathy with a mischievous or playful remark (Bowen, 1978; Friedman, 1991). Only when the therapist has managed her anxiety successfully and only when the client and therapist have a strong bond borne of mutual respect can humor be used in the service of personal growth (Friedman, 1991). Reversals, paradox, and hyperbole are examples of the playful responses that a Bowen therapist may use (Friedman, 1991). For example, when Cynthia complained of Steve's reticence to come to a conjoint session, the author used humor and absurdity to detriangle herself. The author retorted, "Well, I guess we could gang up on Steve and make him feel guilty for not coming!"

A Research Perspective

Because Cynthia and the author established a strong connection early in treatment, together they embarked on a journey as two explorers, beginning research on a four-generation family diagram that would be returned to and referred to throughout the course of therapy. There was a continual search for ripple effects or "emotional shock waves," making the dates of deaths of important family members central to conceptualization of the case (Bowen, 1978). Academic functioning, occupational functioning, relational functioning, parenting styles, sibling relationships, family roles, rules, and values were explored carefully (Papero, 1990). Patterns of closeness, distance, conflict, child focus, and cutoff were examined superficially in the earliest sessions, only to be returned to in order to gather a more in-depth understanding later in treatment.

Early Grief Work

The work of grieving had begun within the process of creating the diagram, for this activity generated conversations about Cynthia's multiple losses. Thus, construction of the diagram itself became a tool to build trust, to open up communication about longstanding and complicated grief, to calm down the system, and to introduce the idea of multigenerational patterns and other systemic ideas. By peppering Cynthia with questions, the author continually encouraged her to engage her thinking process about her emotional losses. The questions asked during this construction process stimulated Cynthia's curiosity at the same time that it calmed down the reactivity that may have otherwise emerged from excavating the source of longstanding, frozen pain.

Without being directed to do so by the therapist, in the second month of therapy, Cynthia displayed her burgeoning involvement in intergenerational work by co-creating a detailed timeline of her own life with her mother (reproduced in Chapter 3). With the creation of the family diagram and with the additional tool of the timeline that Cynthia provided, the author noted profound emotional shock wave effects. However, the art of therapy involves timing, and it was too early to point out to Cynthia the extent of emotional interdependency and multiple traumas that might have resulted from her paternal grandfather's death.

Walsh and McGoldrick (2004) noted that there are profound implications in the activity of co-constructing a family diagram to alter a client's response to traumatic loss. As a therapist, creating the diagram meant that the therapist could think alongside Cynthia. This collaborative, respectful, and reflective process helped Cynthia connect to three important relatives that she had lost within the space of 2 years: her grandfather,

her brother, and her father. In utilizing the tool of the family diagram, we could approach the painful emotions from a cognitively based, curious perspective. This neutral posture seemed less threatening to Cynthia, and it opened the possibility of reconnecting with parts of herself that she had buried and avoided for years. By working in this way, her traumas were approached from the outside in, and it was touching to watch Cynthia's frozen emotions begin to thaw within our effort.

A Search for Patterns

In the process of creating the family diagram, the author searched for and reflected back to the client's individual and multigenerational strengths, as well as maladaptive patterns that she might want to interrupt. This strength-based focus, emerging even in the early work, became just as important to Cynthia's self-definition as her increasing ability to recognize maladaptive generational patterns. Cynthia's extended family reflected strengths such as affection, volunteerism, creativity, and community involvement. However, patterns of over-functioning and under-functioning, child focus, and substance abuse were prevalent. Family secrets were myriad, making it difficult to get a complete history. The closed communication in Cynthia's family system probably went back for generations, leading the family to have a difficult time being adaptive in the face of change.

Creating a Calm Environment

From the start, the author created an environment of ambiance to foster calmness and tranquility. Halogen lighting, lit candles, and the sound of a table water fountain

complemented the slow, relaxed pace of therapy. Cynthia needed to ease into the difficult work she had put off for most of her adult life. The work would be from the outside in. Thus, early goals for Cynthia were realistic and small. Building the therapeutic alliance, beginning conversations about her losses, talking about her immediate and pressing problems with her partner, assigned readings, and construction of the family diagram dominated the early phase of treatment. Although Cynthia requested a few sessions with her partner during early treatment, she decided that she would benefit more significantly in individual treatment. She had the insight to see that her reactivity in his presence precluded her ability to do her best thinking in her work of being a self (Bowen, 1978).

Bibliotherapy

Suggested readings were provided within the first 3 months of treatment to set the stage for the psychoeducation that would be a part of every succeeding session. These readings were invaluable in cementing the working relationship between the author and Cynthia. The reading material stimulated intellectual development and fostered the building of trust with the introduction of systemic ideas. Thus, *One Family's Story* (Kerr, 2003) introduced BFST concepts by providing an example of one family over time. Frankl's (1959) *Man's Search for Meaning* provided inspiration for creating new opportunities out of adversity. Cynthia devoured the readings, always returning with a list of comments, reactions, and reflections upon these new ideas.

In the beginning, Cynthia struggled with understanding the concepts. She asked repeatedly, "What does differentiation really mean?" or "Why is differentiation so important?" She questioned the value of bridging longstanding cutoff, especially with

her paternal grandmother. Frankl's (1959) emergence from the horror of concentration camps as a survivor thrilled her, but she was puzzled as to how a human being could ever triumph over such seemingly insurmountable odds. After reading this book, she began to talk about goals far into her future, such as reawakening her creative side and re-discovering her spirituality.

Heightening Respect for Emotional Interdependence

As the family diagram continued to evolve with new facts and events in the timeline being processed, Cynthia became stirred up and uncomfortable with the notion that she was not as autonomous as she had once believed. However, she worked hard to stay with it and never expressed any doubt about continuing, even though financial stressors pressed upon her throughout treatment. Little did Cynthia realize that her black and white world was about to explode into a world of color and pattern. At one point in early treatment, she asked, "Is there really such a thing as an individual?" This highlighted her growing appreciation for the emotional interdependence in family systems.

It was from this point that therapy progressed. What follows are excerpts from a transcript in the later stages of the initial treatment phase. By reading *One Family's Story* (Kerr, 2003), processing ideas in her own family that she could relate to the reading, and looking closely at the family diagram that the author and client had constructed, Cynthia already demonstrated a familiarity with a multigenerational pattern of over-functioning and under-functioning in her extended family. In a transcript excerpt from early

treatment, the author became impressed with Cynthia's dawning awareness of reciprocity in relationships. In a second transcript excerpt from early treatment, Cynthia gives voice to her grief about the homicide and considers differentiating a life purpose of her own, apart from overseeing her brother.

Transcripts From Initial Treatment Phase

Section One

Therapist: So how would you like to use your time today, Cynthia?

Cynthia: Well, I want to tell you that talking about my family of origin is really bringing a lot to the surface for me. I left session last week and felt very stirred up. My curiosity about dates and events became so great, that I asked my mother to sit down with me and help me to create a time line of my life. We never really talked about a lot of things like that before. It was very liberating for both of us.

Therapist: Did you bring it with you?

Cynthia: I am not finished with it. I'll bring it next week. But it was very calming to sit down and get it on paper.

Therapist: You have a right to find ways to get calmer. It seems like your journey of self-discovery is expanding. Can you describe what you mean by "liberating?"

Cynthia: Well, it is something that I guess I have always needed to do...I mean talk to my mother about things, try to understand. And now all these new ideas...Well, this week they have been constantly working in me. How the men used alcohol and drugs and how the women seemed to pick up all the pieces. My mother's and father's parents had the same habits as my parents.

Therapist: Hmm, almost as if your grandma and grandpa and mother and father defined each other's behavior by the way they interacted with each other? Each one just seemed to respond in an automatic way to what the other partner said or did? Kind of like that?

Cynthia: Exactly.

Therapist: Any other thoughts about your experience in making the family diagram and

timeline?

Cynthia: It's very enlightening. It has really helped me to move some of the responsibility that I've...um...worn on *my* back and that instead of taking all the responsibility for my family, I've been able to hold my father accountable for his mistakes and still see that my mother had an equal part in the way we lived. And if I hold myself responsible for other people, I will be just like the other women in my family.

Therapist: So they played opposite parts? Your dad kind of became useless from being drunk or high and your mom just got more useful in response?

Cynthia: Well, sort of. Yea, I guess so. I'm not sure what you mean though.

Therapist: They played opposite parts. Can you hear opposites as the same? Just different sides of the same coin—reactivity around relationship intensity? Either you use a substance or you over-function—either way you are just trying to find a way to survive. Unfortunately, neither way is very useful. And what person does habitually brings up a habitual response in the other?

Cynthia: Absolutely. That is the way it really was with my grandparents and my parents. Guess I do it too, with Steve and I did it with Tom. Wow.

Therapist: Yes, just like two sides of the same coin.

Therapist: So what would it look like when you would become anxious back then?

Cynthia: Barbara, I would try to take on everything myself as if I could fix the world somehow.

Therapist: Hmm, as if you could impose control on an uncontrollable situation. How do you know when you are anxious today?

Cynthia: I suppose I go into the same routine. Miss Fix-It. Do you know what I mean?

Therapist: Yes, I think so. But say some more.

Cynthia; Well, I know I'm anxious when I start doing all this stuff to keep a lid on it. I know it when I feel a lot of weight on me. I could never say, "Hey, you guys are screwing me up. You make bad choices. I suffer from this."

Therapist: So you were not willing to upset the boat for openness? Yes, I get it. It's a challenge to be a self with people you depend on, isn't it?

Cynthia: Yes, I just tried to impose my own control on my world.

Therapist: A world that felt out of control?

Cynthia: Yes, that is what I would do. I really believed I could rescue my father from his alcoholism.

Therapist: Is that right?

Cynthia: Absolutely.

Therapist: And that you would kind of take care of your brother, even though you were never asked to do so by your parents, you kind of took that on?

Cynthia: I *completely* took that one on. In getting him ready for school, and worrying about lunches and those kind of things. Absolutely.

Therapist: Almost as if you made yourself the parent you thought he needed to have.

Cynthia: Oh yea, we all knew that. With my parents, it was kind of a joke that I was in charge of the family, that I was the parent. That started in elementary school. Third or fourth grade.

Therapist: So what I hear you saying, Cynthia, is that you kind of were an over-functioner and a rescuer. That the way you manage anxiety is to get busy and do it all for everyone. I guess you learned that early on in your family. And that in your busyness, you could convince yourself that your world could be controlled if only you did everything just right for you and for anyone you loved who was in trouble. Is that right?

Cynthia: Yes, this work is making little balloons come up for me. And *this* is an issue that you buried with you. And this has come up and is always gnawing at your childhood. And now I am able to start processing what before I just held onto. And we look back and I see that both of my grandmas and my mom did it just like me.

Therapist: So in looking at this pattern, I am wondering how you conceptualize an individual's behavior as part of a system?

Cynthia: I think people do to each other things that make the other person respond in a certain way.

Therapist: So how do you get off this merry-go-round?

Cynthia: I guess I can only put people in charge of their own lives. I can only look at myself. I am realizing how important it is for me to have control. I think that's

been an issue when I am stuck in a difficult situation. I just want to control. I really want to keep a close reign on things. This is what I've noticed the most since I've been in therapy with you. I want to stop focusing on trying to control other people in my relationships. I act as if I am in charge of everybody else and that doesn't sit well with me. I see myself differently in this way compared to when I started therapy.

Therapist: It is easier said than done sometimes. Much easier to change our "automatic response" when we do not feel a threat to our security. And so much more challenging when our very survival—our sense of inner security—feels at risk. That is the work—to apply these concepts as much as we can when we recognize the anxiety coming on.

Section Two

Therapist: I am wondering how you think you have been able to integrate Josh's death into your own life.

Cynthia: Well, I had to find something positive that happened....I had to give it a reason. I had to give it a purpose.

Therapist. Say some more. hat was that purpose?

Cynthia: I don't know. To live with it. Things were getting so violent in our community. People running the streets...lots of bloodshed. Josh was killed, and no one thought it could happen to one of us. It straightened everyone up. I mean if it could happen to *him*, it could happen to any of us (begins to cry). After he died, a change came over the community. It just got quiet overnight. It shook everyone to the core. Nobody was out running the streets anymore. And now it's twelve years later, and it's still a really nice and safe place to live.

Therapist: That is a huge meaning you are giving to his death. That his death kind of shook some sense into the whole community to stop the insanity.

Cynthia: Yea, that's not a fantasy I made up. That is the truth (begins to cry).

Therapist: What are the tears?

Cynthia: I don't know.

Therapist: Cynthia, can you give yourself permission to grieve?

Cynthia: I just cannot let go of my brother (still crying).

Therapist: In a way, you never have to let go. Every time you talk about him—in here or

with your family, you are touching him. You can have a continuing bond with him in that way. Though he may be physically gone, you can keep the connection just by remembering things about him. You do not have to cut off your memories of him.

Cynthia: Well, when we talk about giving his life instead of his death a purpose, it helps me think I can live again. Before, when he left, I felt I had lost my own sense of purpose. I felt that my brother was so much more disadvantaged than I was. I felt I was smarter. I felt motivated to oversee him and show him a better life. That we could do things in life better than we had been given. So since he died, I've never had my own purposeful feeling.

Therapist: It's as if you and Josh were so fused together that life without him meant you could not over-function for him anymore, which left you bereft of meaning?

Cynthia: Yes, yes. I don't think anyone will ever give me that sense of purpose like I had with my brother. Not even my children will give me *that.*

Therapist: How about a sense of purpose about building self?

Cynthia: Well, I don't think anything will ever give me that sense of purpose like I had with my brother. At such a young age, I felt so responsible for him. I had to show him a way out of this.

Therapist: Where are you today in your work around your own life purpose today then?

Cynthia: I want to spend as much time as possible with my children. Give them a good foundation for when they start kindergarten. I know that to be the best parent I can be, I will have to have fun and be good to myself, too. To not live only to pick up the pieces for them and to be so focused on them, that I have nothing left for me. That will be hard for me, but I want to try. I want to go to church again. I have lost God's voice. I want us to have positive outlets.

Therapist: And how about long-term goals?

Cynthia: I want to go to college someday. I want to start writing again. I want to be involved in my community again. Maybe be a psychologist. I want to save children who grew up like I did from the streets or prison or a life on drugs. The social workers I had to talk to never knew what it was really like to grow up like I did. They only had the experience of dealing with someone like me through books. They never really had a hands-on experience with life, as I knew it. So someday maybe I can really talk to these children as an insider.

Therapist: It sounds like you carry a strength from your family of origin as I listen to

you articulate some of your dreams for the future.

Cynthia: Yes, I am proud that my family was a loving and nonjudgmental presence. Even though I hated the chaos—how they took in every derelict—there was a kind of ethic of caring about the less fortunate. I guess I have inherited that. Someday I want to be an advocate for those kinds of children. Even though I grew up with so much craziness, I was proud of the relationships we had with each other and the way our house was a welcome refuge for anyone who had lost their way.

Therapist: So in a way, you have to get clear when you are over-functioning to bind anxiety and when you are being helpful , just because of your ethical principles. When you are saving and being Ms. Fix-It and when you are acting on thoughtful reflection. Principles versus reactivity.

Cynthia: Exactly. It can be so damn confusing at times.

Therapist: Yes, not so neat and tidy to tease apart the motivation for your behavior, but well worth the effort, no?

Cynthia: Very much worth it.

Intermediate Treatment

There were three overarching goals of treatment during this phase: The first involved empowering the client to become more active in working with her extended family, which, in turn, opened up dialogue around sensitive issues such as the multiple losses suffered in three generations. In the second, the client needed to understand her part in relationship triangles and move differently in relation to the other two parts of the triangle. In the third, much time had to be spent reminding Cynthia of the concept of emotional interdependence defined at the beginning of treatment, especially during times of great reactivity.

Moving Differently in Triangles

Accomplishment of these goals first required an identification of Cynthia's hottest triangles. Once identified, Cynthia's coaching continued to emphasize that she should stay in good touch with each part, developing separate relationships with each person. She learned to recognize that the pattern of talking about an absent third member of a triangle reflected anxiety and that such a behavior actually rigidified dysfunction within a triangle (Kerr & Bowen, 1988). In her own life, Cynthia was distressed at her outside position in the hot triangle with Steve and his mother. Steve's mother was always sympathetic to her son and critical of Cynthia. Every time Cynthia was shoved into the outside position, she would become anxious and furious at both of them. Therapy was often directed at coaching Cynthia to insist on direct communication with each of them. She learned to discipline herself, so that she would not talk with Steve about his mother nor talk to his mother about Steve.

Cynthia was also coached to look for opportunities to develop more frequent and better communication with members from her father's side of the family. Even though her father had died, she could increase resolution of attachment with her father by getting to know his relatives better (Bowen, 1978). She initiated and continued a growing connection with her father's brother during this phase of treatment. She also planned a strategy to approach her paternal grandmother in an effort to learn more about her father.

During this phase of treatment, the author often diagrammed hot relationship triangles that Cynthia described on a whiteboard. Closeness and distance needs and how these needs were managed in her family of origin and nuclear family were addressed whenever relevant. The author coached Cynthia to stay in good touch with both sides of

the triangles, likening the effort to being in an emotional gym. Cynthia came to appreciate that the effort to increase differentiation of self was most likely to be successful when emotional processes were active within the family system, such as at nodal events like funerals, weddings, child births, or memorials (Bowen, 1978).

Increasing Responsibility for Self

Cynthia also learned to make "I" statements instead of blaming statements as she grew to understand that the only way to create changes in her relationships had to be from the changes she made in herself (Kerr & Bowen, 1988). For example, Cynthia became more adept at noticing when she felt anxious by monitoring the extent of her impulse to blame Steve, instead of examining her own role in their dynamic. When Cynthia would get focused on what was wrong with Steve in session, the therapist would gently, and sometimes playfully, guide Cynthia back to focusing on her part. Cynthia came to expect this redirection after a few months of treatment, and during calm periods, she would recognize her return to focusing on him as a red flag indicating that she needed to calm herself down.

One of the metaphors used in this context that Cynthia found helpful was the notion that even if the other person's side of the street was filled with 99% of the garbage, it was her responsibility to tend to the 1% of the garbage on her side. She was further coached to appreciate that even a tiny change in her behavior could result in a change in the system, as the system compensated for her change (Kerr & Bowen, 1988).

Cynthia also worked on holding on to herself in the face of fierce attempts by other members of the system to get her to "change back." The author coached her to keep in

mind that if she could tolerate efforts by others to get her to revert to her old styles of relating (such as her prior over-functioning), positive results would eventually follow (C. Jacobs, personal communication, February, 2006). The emphasis was consistently placed upon reminding Cynthia that a focus on "the other" blocked her own personal growth. In summary, the work during the intermediate phase prodded Cynthia to step up to the plate and take responsibility for herself instead of focusing on what she needed to do to change the other.

Theory-Driven Therapy

At all times, the therapy was driven by theory. For example, *Friedman's Fables* (1990) were occasionally read in session, including parables such as a retelling of "Cinderella" from the stepmother's point of view. Such stories helped Cynthia appreciate the need to get broader in considering the context of people's stories. The author did not rely on techniques per se. Instead, management of the self of the therapist was an ongoing effort that directly related to successful outcome in therapy (Bowen, 1978).

By applying concepts of triangles, fusion, cutoff, and differentiation to Cynthia's narratives in session, she became increasingly aware of the multigenerational patterns in her extended family (Kerr & Bowen, 1978). She recognized that divorce, domestic violence, alcoholism, and drug abuse passed on from one generation to the next generation (Bowen, 1978; Lawson & Lawson, 1998). She developed an increasing appreciation for the function such behaviors served in binding anxiety (Kerr & Bowen, 1988). She developed a dawning awareness that her own efforts to raise her differentiation of self could result in the interruption of patterns that may have been

centuries old (Bowen, 1978). She also learned that changes she made in herself resulted in a compensatory effort of the system to get her to return to old ways (C. Jacobs, personal communication, March, 2006). When Cynthia made changes in herself, the ferocity of the system's will to remain the same often presented a challenge. The author predicted these challenges to Cynthia when it appeared that she was feeling pressured to change back to old styles of over-functioning.

The Bowen (1978) model began to be discussed more openly and frequently during this phase. With respect to the multigenerational pattern of alcoholism, particularly in the males in her extended family system, Cynthia understood the defiant "I can do it myself" posture of her father and brother in a new light (Kerr & Bowen, 1988). She learned that the alcoholic individual conducts his life on a slippery slope between too much closeness and too much emotional isolation (Bowen, 1978). Within this knowledge, it made sense to her that in re-establishing more meaningful emotional contact with cutoff parts of the family, she could bring up the functioning position of herself and of members who were anxious about their lack of connection or their over involvement with one another (Kerr & Bowen, 1988). Eventually, she appreciated that toning down her over-functioning could predictably be followed by Steve's making a compensatory change in his functioning. The key variable in shifting their dynamic to a healthier one rested in Cynthia's ability to hold on to herself in the face of pressure to revert to old ways.

Giving Voice to Grief

Cynthia became more comfortable telling and retelling the story of Josh's life and death during this phase of treatment. Rynearson (2001) emphasized the restorative value in retelling the story of violent death. During many sessions throughout the intermediate stage of treatment, Cynthia often asked to talk about the circumstances leading up to Josh's death, the funeral, and their relationship through the years. She took comfort in the fact that they were closer than they had ever been at the time of his death. She recalled how she would hang out with his friends, and how she had been able to relinquish her parentified role in a way that allowed her to enjoy his company more completely during his final year. Instead of watching out for him, she acted like an equal during that last year. This meant that therapy had to provide a safe place for her to express her ambivalence around the circumstances of his death. Did she have part in his willingness to walk into harm's way because she had not been as hyper-vigilant with him in that last year? She stated that she had known for a long time that she had been putting off processing her feelings of anger, guilt, and grief about the loss of her brother. She said that the telling and the retelling of the violent loss liberated her, and that, as a result, she was experiencing a reawakening of creative and spiritual parts of herself that had long been numbed.

As Cynthia mourned the loss of her own sense of purpose since Josh was no longer around for her to watch over, she also developed a heightened sensitivity to the extreme fusion in their relationship. She came to recognize the concept of borrowing self from others or loaning self to others in other contexts in her current life. When she was calm

enough, she could wrap her mind around the idea that she and Josh had become like two cells that had merged with one nucleus.

Cynthia also started to honor the depth of the grief she had kept buried since losing Josh, realizing that her propensity to protect her mother from her grief meant that she had to minimize her pain. She realized that such a protective posture interfered in a way that led to her complicated grief reaction. She became committed to the idea that doing her grief work would allow her to go on with her own life in a more adaptive way. She also realized that in protecting her mother, she joined the "group think" that defined the closed communication system in the family, and that this closed communication prohibited both of them from resolving their grief and moving forward in their lives (Bowen, 1978).

The normalizing of her sense that she had lost a part of herself when Josh died and granting her permission to give voice to her pain and struggle within that loss became an ongoing part of therapy in the intermediate stage. By acknowledging that her life would never be the same since suffering the profoundly deep loss of her sibling, she could move forward in a way to carve out a life that had meaning beyond being appended to Josh. Such work opened up space for her to move toward realizing some of her future goals in a world without her brother. The work represented a shift from an avoidant sibling attachment script to a more secure one (Walsh & McGoldrick, 2004).

During this phase of therapy, Cynthia was also able to unlock and express her previously repressed anger. For example, she wrote her brother a letter detailing the causes of her anger after processing her anger in several therapy sessions. Research has shown that anger is a normal part of the grieving process when someone dies (Kübler-Ross, 1969; Walsh & McGoldrick, 2004). Cynthia learned that because it is difficult to

get mad at the person who has died, it sometimes comes out in anger toward someone else or toward oneself (Walsh & McGoldrick, 2004). Cynthia said that she was angry with Josh for leaving her and that he died due to his own irresponsible decision to place himself into harm's way. She mourned the fact that he would not be there for her, for her mother, for her children, and for his own child whom he had never met. Normalizing anger is a crucial aspect of grief work. It is essential that the client becomes aware of the many facets of his or her anger and is freer to express it. Such work reconnects the anger to its original source (Walsh & McGoldrick, 2004).

Because the pain Cynthia experienced was intense and complex, working with her in moving beyond her loss was one of the author's greatest clinical challenges. Cynthia often questioned whether life would hold any meaning for her without Josh, and she wondered if she could ever survive the pain of his loss in a way that she could lead a life of meaning. She described feeling a "hole in her heart" that could never heal. She felt alone and isolated in her grief because she always felt compelled to suppress her own grief in an effort to keep her mother protected. Sometimes the anger would be directed at her partner, and at other times, she became angry with Josh, her parents, God, and the government. More often, the anger turned in against herself. She would lament what she did not do to prevent his demise, saying, "If only I had...." The author needed to create an environment where Cynthia felt safe to express all aspects of her anger and fears without worrying about being judged. As Cynthia became clearer about the problems within her own propensity to over-function, her guilt about not over-functioning for Josh began to diminish.

Bowen (1978) cautions the clinician to establish the deceased member's functional position in the family, for not all deaths have the same impact. A search for emotional shock waves and a respect for emotional interdependency means that the Bowen-trained therapist is always mindful of the systemic implications of loss, as the family must reorganize itself with one less family member (Bowen, 1978). In reorganizing itself, it is healthy for the family to maintain a continuing bond with loved ones who are gone (Klass et al., 1996). Mourning rituals, memorials, and conversations that recall the deceased are healing (Walsh & McGoldrick, 2004). A focus on continuing bonds with the deceased as being healthier than cutting off ties with the deceased is congruent with Bowen's (1978) idea that emotional cutoff, even in death, may make an individual and a family system vulnerable to symptoms.

In creating new rituals, finding a support group of survivors of violent loss and establishing an annual memorial for her family and friends, an increased level of inner locus of control developed within Cynthia. Cynthia began to appear less anxious and depressed. Instead, she seemed more energized by her newly discovered sense of personal agency.

Learning new ideas within the Bowen (1978) Family Systems Theory engaged Cynthia's cognitive process, which inherently served to calm her reactivity. Working with the new, broader concepts also enhanced Cynthia's sense of self-responsibility and personal mastery. Looking at the deep ripple effects within her multigenerational system stimulated and developed Cynthia's innate resiliency of insight (Wolin & Wolin, 1993). It was inspiring to observe how the process of putting together old family facts in a broader, more objective way empowered Cynthia to become calmer and more focused on building

her idea of who she was and from whence she came. Within the process of struggling to apply new concepts within the Bowen model, Cynthia moved dramatically from assuming a pathetic posture to an empowered and responsible posture. Instead of seeing herself as a victim, she began to define herself as one who had the tenacity and discipline to prevail against Herculean odds.

Opening the Communication System

It is likely that the single most important task for the therapist is to provide a place for the bereaved to talk (Bowen, 1978). The Bowen-trained therapist is always mindful that it is difficult for people to use direct language when talking about death. He or she is also aware that opening up the relationship system so that people can communicate openly about their losses is an essential piece of family grief work. In severely fused families, members harbor many secrets (Bowen, 1978). Also, the fierce emotional process operating in the family system creates an environment that discourages individuality. Thus, it is common to find family members going silent in an effort to protect others or to avoid upsetting them (Bowen, 1978). Healing conversations with family members meant that Cynthia had to talk about her own feelings openly and directly in session, thus becoming familiar with her buried feelings and comfortable expressing them to the therapist. Similarly, a session with Cynthia and her mother had powerful healing effects. At all times, the author tried to use direct language rather than euphemisms about death and dying. This use of language underlined the therapist's comfort level with talking about death, a subject that Bowen (1978) called the greatest taboo.

Interrupting Multigenerational Pattern of Over-Functioning

With some introduction to systems thinking through work in and out of therapy, Cynthia also gained insight into her "inherited" propensity to bind anxiety by over-functioning for the men in her life. All of this preliminary work lowered Cynthia's reactivity for a time. She was engaged in *thinking* about her relationships and the part *she* played in them in a different way. Broadening her thinking and coaching her to tone down her over-functioning calmed Cynthia. This calming effect set the stage for Cynthia to begin approaching her family more frequently and in the role of a researcher. Thinking and applying new concepts to old traumas empowered Cynthia to make progress in recognizing when her reactivity interfered with her ability to make good decisions.

Increasing Client's Active Moves for Self Outside of Session

Psychoeducation accompanied strategy sessions in order to plan ways Cynthia could make her own active moves within her extended family. Such active moves were actually detriangling moves that supported her efforts to increase her level of differentiation of self and lower her anxiety. Bridging longstanding cutoff on her father's side of the family, for example, would help her achieve a more neutral position in her primary triangle. With this knowledge, Cynthia began to consider which relatives on her father's side might be useful to her effort to collect more family facts. She identified her father's brother as a good source and initiated conversations with him for the first time in many years. From this brother, she learned that her grandfather disowned her father, Bill, after years of substance abuse. In fact, he was the only sibling to be cut out of the will.

Cynthia learned that her paternal grandmother over-functioned in much the same way that her mother had over-functioned with Bill. She believed that her grandmother physically and emotionally abused her alcoholic grandfather. Cynthia viewed her grandmother as "cold," "mean," and "unapproachable." Grandfather was viewed as kind, gentle, and calm. Such polarizations are common in reactive family systems (Kerr & Bowen, 1988). Yet, it was difficult to help Cynthia get broader, since her grandmother was private and secretive about the past. Thus, it was easy to understand why Cynthia was reticent to approach her paternal grandmother in search of gathering facts from her perspective. She referred to her grandmother as "guarding the past like private property." Cynthia struggled. During intermediate treatment, she decided she did not want to talk to her grandmother. However, she would gain the courage to move toward her in later treatment.

Cynthia approached her half-sibling, but he rejected her advances toward him. In her efforts to continue to define a self, she was able to express her anger openly to him. Although she cut off from him emotionally in response to the rejection that she experienced, she formed a close bond with his wife and daughter as a way to stay in touch with him. She learned that she must sustain contact with him if only in a superficial way, however, if she were to move in a detriangled fashion. She also learned that in forming a closer relationship with her half-sibling's wife, she should not talk about her half-sibling in his absence. Instead, she should work to form a one-to-one relationship with each of them.

Detriangling Self Within Primary Triangle

In becoming more objective about her place between her parents by collecting more facts about them, Cynthia began to adjust her position in her primary triangle. She had meaningful conversations with her father's brother in order to collect more family facts. She began to see her parents more objectively and with less polarization. The blame she assigned to her father decreased, and the blame she assigned to her mother increased. Eventually, however, the blaming shifted to a realization that both parents had a reciprocal part in their dynamic that led to parental neglect, but that it was probably true that both mother and father were doing the best they could with what they had. This healthier re-balancing occurred after continued work on the diagram and on understanding the forces of closeness and distance, especially in relation to alcoholism, pseudo-self postures, and functioning positions. This adjustment prefigured her ability to move less reactively and more effectively in other important triangles in her nuclear family if external stressors were not too overwhelming (Bowen, 1978).

Increasing Differentiation of Self and Highlighting Resilience

Differentiating Cynthia's voice from her mother's voice was an important part of treatment during this phase. Giving voice to her own experiences when they differed from her mother's perceptions, which were likely based on defensive denial, served both to decrease the fusion between them and to honor Cynthia's resilience in prevailing over circumstances of neglect and irresponsible parenting. Her mother, Winnie, for example, had always minimized Cynthia's complaints about the chaotic atmosphere in her home. Winnie insisted, "You do not know how good you had it. You should be grateful."

Cynthia would then feel guilty and ashamed that she expressed such negative sentiments about her upbringing. She lamented that such reactions from her mother made her feel like an ingrate. Differentiating her own experience and reactions from Winnie's reactions helped Cynthia to self-define in a way that highlighted her courage and her resilience. This emphasis upon her resilience moved her from a position of victim to a position of proud survivor (Wolin & Wolin, 1993).

As Cynthia continued her work on differentiation, the author attempted to correct the broken mirror in which she viewed herself by offering an alternate reflection of her resiliency. Frequently, the author asked Cynthia, "How did you do it?" In the course of answering, Cynthia once responded, "Knowing what I went through as a child, I've devoted myself to being a good parent and to seeing that my children have a better life than I had." The author suggested that Cynthia might not be so much worried about her children as she was proud of how she herself had maneuvered around the formidable obstacles life had strewn in her own path (Wolin & Wolin, 1993). Following from this idea, Cynthia's early challenges were reframed thusly: "I have been tested, and I have prevailed. I learned and grew despite the hardship I suffered, and I wonder if my sons could do as well." Thus, the author suggested to Cynthia that she had couched an intended compliment to herself in a statement of parental concern (Wolin & Wolin, 1993).

The thrust of combining Bowen (1978) Family Systems treatment with Wolin and Wolin's (1993) resiliency theory means that the clinician should find myriad opportunities to reframe severe challenges from tragedy to opportunity. By exercising the responsibility for self that is congruent with Bowen theory, the client moves from

defining herself as a victim to a triumphant one who prevails. For example, the author affirmed the client's ability to persist by communicating to Cynthia that when life was falling apart because her parents were drinking and neglecting her, she could easily have been overwhelmed by feelings of helplessness and given up. But she didn't. She dug in and met the challenges, even finding a substitute caregiver at the tender age of 15 in order to change her chaotic environment into a calmer one. Such a change allowed her to continue to excel in school.

The author reminded Cynthia that if she could do that then, she had what it took to meet the challenges she was currently facing and would face in the future. Such a statement was empowering because it reminded Cynthia of her competence to act (Wolin & Wolin, 1993). She is full of hope and assurance that she is capable of succeeding in her current struggles. Most of all, because the affirmation is based on the specifics of Cynthia's life, it can be internalized more readily than the generic praise that might be offered by well-meaning therapists who do not have a way to think about the power of opportunity accompanying struggle (Frankl, 1959; Wolin & Wolin, 1993).

What is most salient is that within the author's consistent practice of heightening what Cynthia had been able to accomplish under severely challenging conditions at home, the client proceeded to work on increasing her differentiation and shifting her self-definition in a way that gathered momentum. There was a palpable shift as Cynthia moved away from thinking of herself as "damaged goods" to thinking of herself as a person who always landed on her feet and who became stronger, rather than weaker, in the face of real or perceived threats to her survival.

With Cynthia's growing appreciation for the notion that work on differentiation of self was a lifelong process and that a person with more self had a set of guiding principles that are non-negotiable in the face of relationship pressure (Bowen, 1978), she also decided that a reason to persist could become a guiding purpose in her life or the reward at the end of a trying experience (Wolin & Wolin, 1993). Thus, Bowen's (1978) emphasis upon clients' increasing responsibility for self by stepping up to the plate within their families worked well with Wolin and Wolin's (1993) emphasis upon reframing multigenerationally transmitted challenges into opportunities to overcome and to prevail. Synthesizing these two modalities appealed to the author, in that the client was not discouraged by a pathologizing of her place within an emotionally intense, multigenerational intense family system.

Intermediate treatment, therefore, emphasized the need for Cynthia to increase responsibility for self within her family of origin. One area in which Cynthia took an active role of leadership was in opening up the communication system in her family of origin. Healing conversations with Winnie included practice at having the courage to be a self in her mother's presence without blaming her mother while at the same time not striving to protect her mother by caving in to her or ignoring the expression of her own core truths. Such an ability to be separate while still connected to her mother had the positive benefits of interrupting the patterns of fusion, cutoff, and over-functioning with her own children.

During this phase of treatment, Cynthia decided to invite her mother into a session, where she could begin talking to her mother for the first time about her pain and about their mutual losses. Importantly, Cynthia's work in this area opened up the possibility of

interrupting maladaptive repetitive patterns in her generation and in future generations. If a daughter can talk to her mother in a way that honors her individuality even when there is pressure to not "rock the boat," hurt a loved one's feelings, or conform to "group think," she will likely carry this toleration for difference in being a self to other important relationships within her nuclear and extended family systems.

In summary, in a resiliency-based, Bowen (1978) Family Systems treatment, Cynthia recognized and honored her struggle instead of wallowing in self-pity (Wolin & Wolin, 1993). As an adult child of alcoholics, she came to appreciate her strengths and resilience.

Cynthia recognized within herself qualities that Werner (1992) believed make a difference: (a) social competence, (b) problem-solving skills, (c) the development of autonomy, and (d) a sense of purpose and future. Werner (192) found that resilient children believed they had control over their lives, as opposed to feeling controlled by external factors. They were self-reliant, yet able to ask for help when they needed it. Cynthia increased her ability to perceive her experiences constructively, even if they caused pain and suffering. She took a more active approach to solving her problems as she embraced this shifting locus of control. She came to appreciate that she had an ability to gain other people's positive attention since early childhood. She moved back into taking advantage of her innate resiliency of morality by returning to her faith. A re-involvement in church provided social support. Most importantly, her spiritual reawakening helped her gain a positive vision of a meaningful life for her and for her children (Wolin & Wolin, 1993).

Bowen (1978) Family Systems therapy's emphasis upon the notion that differentiation of self is a lifelong process gave Cynthia reason to persist in her struggle not to relive the horrors of her multigenerational past. In differentiating her voice from her mother's voice (Bowen, 1978), she could form a new bond with her mother rather than bear the burden of her mother's guilt (Wolin & Wolin, 1993). Taken together, Cynthia began to see herself as someone with strength, not as a person victimized by pathetic beginnings (Wolin & Wolin, 1993). She shifted her belief into the idea of honoring the struggle rather than bemoaning her fate. While she did not deny the reality of what she had lost, neither did she demean the efforts she had made. Within this resiliency-based, Bowen (1978) Family Systems approach, Cynthia affirmed her dignity while at the same time acknowledging her reality. Such a shift in her perspective served as an effective antidote to the lasting pain that resulted from standing in for her mother at a time when she should have been mothered herself (Wolin & Wolin, 1993).

Exploring Emotional Shock Waves

The later part of the intermediate phase of treatment focused upon ripple effects that occurred as a result of the deep cutoff between Bill and his family. The extent of the aftershocks was deep and exploded in two big ways upon her grandfather's death. For a long time into treatment, Cynthia did not believe that Josh's death and Bill's death could be connected to the impact of her grandfather's death. Accepting the idea that emotional cutoff had the power to create deep wounds between the generations presented a difficult challenge for Cynthia. It was only as she became more active in her efforts to bridge distance with her paternal relatives that her reactivity to the idea of emotional shock

waves decreased. The author struggled to remain neutral and not push Cynthia to make moves into the paternal emotional system before she was ready. Bowen (1978) cautioned clinicians to respect the idea that clients resist the idea that they are not autonomous and to take care to not push the idea of emotional interdependence too early in treatment (Bowen, 1978).

As Cynthia increased her appreciation of emotional interdependence and shock waves, she also began to wrap her mind around the workings of child focus. She began to see that mothers might try to compensate for the breach of connection with a partner by becoming overly involved with one or more of her children. Cynthia learned that the pattern of child focus in her extended family was long standing and became motivated to interrupt this pattern with her own children. As child focus was studied and as the author frequently used a white board to diagram how conflict and distance between Cynthia and Steve placed her sons in an at-risk position for symptoms, the client began to look around her world for ways to correct the way she was managing herself in relationships. Thus, at this point in treatment, Cynthia and the author began to generate ideas about ways in which Cynthia could balance her life with various support systems and creative endeavors. Unfortunately, her relationship with Steve started to unravel with the birth of their second son as the accompanying stressors of an already chaotic nuclear family system struggled to accommodate a new member.

Rising Anxiety and Interlocking Triangles

During the intermediate course of treatment, Steve's wife and daughter moved from Minnesota to Southern California, considerably closer to Steve and Cynthia. There were

attempts to get the families together. When extended contact uniting the two nuclear families occurred on two separate occasions, reactivity erupted each time. Inside of this severe emotional field, Steve and Cynthia used conflict to get distance from one another. In addition, Steve used alcohol to create distance. Cynthia increased her anxious focus on the boys and stepped up her over-functioning. It was obvious to the author that the interlocking triangles between the two nuclear families created chaos between Steve and Cynthia.

In periods of increased tension, triangles expand into interlocking triangles to contain all the anxiety (Bowen, 1978). Such a situation erupted as Steve's estranged wife and young daughter moved closer to his new nuclear family with Cynthia. Shortly after the second blending event of these two families, Steve's mother, who anxiously focused upon her son and rescued him from calamities repeatedly, took Steve's side after he relapsed into his biggest binge to date. She blamed Cynthia as the catalyst for Steve's relapse and placed her son into an inpatient rehabilitation hospital. Cynthia's mother took her own daughter's side, becoming angry with Steve and his family for being emotionally and financially unsupportive of Cynthia. In her reactivity within this force field, Cynthia moved to cut off from Steve permanently and kicked him out of the house. She had learned that kicking an alcoholic out of the house offered relief for Winnie, who repeatedly kicked Bill out of the house when he would "put his boots on" during an alcoholic binge and become abusive to his family. Despite repeated pursuits by Steve, Cynthia continued to distance and refused to reconcile. As of the time of this writing, the couple had still not reconciled.

Parallel Process

The author had to manage her own anxiety about separation (emanating from her own family of origin issues) carefully so that Cynthia could calm down enough to think for herself. This anxiety was addressed by the author in individual and group supervision. The author worked on her anxiety in a way that sent her back to shift her own position in her primary triangle and recall her own disturbing memories of overhearing her parents threaten to get a divorce. The author worked on getting more neutral and appreciative of the fact that both her parents played an equal part in their use of conflict to get distance. This parallel process must be recognized and addressed when a therapist finds herself taking sides and getting caught in the emotional process of the client's family system.

The author appreciated that many generations of alcoholic behavior in response to relationship anxiety did not afford Cynthia a positive prognosis in her ability to manage herself without cutting off in intimate relationships and in order to be in a relationship that did not generate her return to the comfortable role of over-functioning. Had she decided to get out of the relationship in order to draw her line in the sand so that she would no longer be with an under-functioner? Or was it possible that Steve's effort to get healthy threatened her ability to remain in the comfortable position of over-functioner? These questions were posed to Cynthia in session in a neutral and curious tone. Since she had trouble considering the possibility that it was not necessary to cut off from Steve, it seemed very likely that reactivity rather than thoughtful choice was driving her decision process. Nevertheless, Cynthia was coached to consider carefully how she might modify her part in their dynamic in order to stay together, especially since Steve was undergoing

treatment. The author had to take care to remain neutral about this issue. It was clear that her own anxiety around cutoff challenged her ability to remain a neutral and objective presence. Nevertheless, the author suggested that Cynthia at least consider her move as reactive. This aspect of treatment was a difficult challenge for the author.

Breaking Up With Steve: Reactive or Reflective?

It is possible that over-functioning became an ego-dystonic position for Cynthia. It is also possible that her insistence on kicking Steve out was merely a reactive move to create cutoff. Either position is arguable, and the therapist reflected this ambiguity back to the client, honoring her ability to decide for herself. Cynthia reactively insisted that she just "hated Steve," and that he was a self-absorbed "Mama's Boy."

In her propensity to blame Steve, the author reminded Cynthia that increases in blaming behavior reflect heightened reactivity that blocks an individual's ability to see his or her part. The author, therefore, coached her to focus on her own part in the binge outcome. The author presented a psychoeducational component examining reciprocity. Also, the author called upon Cynthia to think of ways she could prevent cutting off in the interest of her own growth and in the interest of not breaking up the nuclear family. However, the author also honored the client's ability to make decisions and reiterated that she was neutral about the outcome. Such a position might not have been based in reality, as the author was highly aware of her own reactivity to the idea that the nuclear family had been torn asunder.

In calmer periods, Cynthia could assume greater responsibility for her part in the relationship with Steve. The increase in blaming behavior was partly related to the stress accompanying the birth of a second child, a birth that occurred before the first child was not yet 2 years old. Her reactivity was also based on the fact that systems concepts altered her way of thinking about relationships. For example, intermediate work looked at the interlocking triangles created because Steve was still not divorced and had a 3-year-old daughter with his estranged wife. The chaotic manner in which Cynthia and Steve reunited after breaking up during earlier adulthood reflected anxiety from unresolved attachments from previous relationships. Cynthia was coached to form a cordial relationship with Steve's estranged wife. She was also coached to tolerate Steve's very real need to remain more connected with his daughter from that marriage. Finally, she was coached to take responsibility for the chaos that, in part, was a result of her own willingness to enter into co-habitation and parenthood with a former boyfriend who was still married and had a toddler.

In the early part of middle treatment, Cynthia struggled to understand the tension between the forces of closeness and distance in a relationship. She was coached to recognize that her inherited patterns of emotional process affected her mate selections. She learned to see how she used conflict, cutoff, and child focus as a maladaptive way to get distance when she felt intruded upon in her relationship with Steve. But in reactive periods, her thinking reverted to feelings that created blame and resulted in reactive decisions to cut off from important others.

Anxiety and Change

As Cynthia made progress in bridging distance with the paternal side of her family, she also became more anxious. As she stopped accommodating to Steve's binges and decreased her over-functioning, Steve and his mother pressured her to change back. As she developed an increasing awareness of multigenerational patterns, she recognized the interdependency as being much bigger than she realized. These active moves in the family and dawning realizations scared her, on one hand. On the other hand, she felt a greater sense of personal agency, knowing that if she learned to manage herself differently, she could make a better life for herself by moving differently in her relationship system.

When people realize that they are not in as much control as they thought they were and that great interdependence exists in a family between and within the generations, it is difficult to swallow. Systems education and active work continued to move Cynthia toward a growing realization that the only real control she had was in management of herself. This realization created both a sense of freedom and responsibility (Yalom, 1980). Inside of that responsibility lurked the existential angst (Yalom, 1980) that could be likened to what Bowen (1978) defined as chronic anxiety. Thus, the paradox of progress and regression being embedded in one another became apparent to the author. What that looked like during this phase of treatment was a "two steps forward, one step back" kind of movement. The author became humbled at the fierce intensity in Cynthia's multigenerational family. Essentially, the author realized that it was more realistic to be satisfied that Cynthia had made modest gains lowering her anxiety and increasing her functional level of differentiation of self.

Transcripts From Intermediate Treatment Phase

Section One

Therapist: How would you like to use your time today, Cynthia?

Cynthia: I want to continue with where we were last week. I mean last week was just so liberating. It was exactly what I came here to do. Remember how in the beginning I was in this desperate place? All I wanted was help in getting out of the Relationship with Steve. Well, working on my family of origin stuff has been calming. Sometimes it stirs me up. But the big thing is that I am more comfortable in my relationship with Steve now. I don't want to jump out of the relationship every time something goes wrong. I feel like when we work on my own stuff with my family, I get a fine foundation for what I need to do for myself.

Therapist: Do for yourself? Say some more.

Cynthia: Well, if I can get a better grip on the patterns in my family and change some of them, I will be able to be different with my boys. Also, I notice that I can focus on my part with Steve when I am not too nervous. But if I get really stressed, I start to blame him more. I start to do too much and then resent him for not doing more. I have to take care of myself.

Therapist: I hear you. You start to take on a lot to take your mind off your own stuff. Then you get mad at yourself and blame him instead. Are there other patterns you can identify in your family?

Cynthia: I want to parent my sons differently than how I was parented. I want to see that they do not grow up with parents who abuse drugs and alcohol. I want them to have supervision and responsibility. I want to go to a church as a family. Have them feel safe and secure, not neglected.

Therapist: So your priority is to get calmer by working on your family of origin issues and to give your boys a more stable home than the one you grew up in?

Cynthia: Exactly.

Therapist: Where are you in your work on that now?

Cynthia: Well, before therapy, I guess I was thinking that I could sort of get married and have this white picket fence life that would be so different from the chaos of homeless people stretched out all over my parents' living room and in my backyard. I figured I could minimize it in my mind, as if it did not matter.

Therapist: What function did it serve to minimize it for yourself?

Cynthia: Well, my mother tells me that I had it a lot better than I realized. I used to try\ to tell her that it wasn't right the way we could play in trash cans and never have a curfew. Then the guilt would come over me. She said that I needed to be more appreciative. So I started to minimize it. I wanted to please my mother, have gratitude, and put it all behind me.

Therapist: Were you able to put it behind you?

Cynthia: No. But now in therapy I am working to face down my denial. And in not denying the horror of what I went through, I have been able to give a value to the struggle I had as a child. I think I protected my mother in devaluing that for years. And yet growing up like that defined me for so many years. And somewhere along the line, I thought that my whole past would just disappear somehow. And I let go of what really defined me because my struggle did. Yet when it was happening, deep inside I was so proud that I could come out of it. And now in therapy, I am breaking a pattern of denial that defined my family. I don't want to go and cover up pain with drink or partying or drugs or by copping a defiant pose. Nobody in my family talked about our problems. There was affection and love. But so much denial of all the craziness in the house and of the irresponsible parenting that Josh and I had. It didn't seem to bother Josh the way it bothered me. I always did so well in school. He always had problems. He was fine with our house being full of derelicts and addicts.

Therapist: You have a right to be proud. You were strong and brave and found ways to thrive in spite of all the craziness. You also have a right to recognize your own truths, including the way you felt neglected as a child and teenager.

Cynthia: Well, I want to connect to my roots here. I want to kind of work through them in a healthy way, not trying to put them in a box and suppress them. Because I think that is what I had been doing all the years that I have felt so numb. I just did not realize it. I want to get to the point where I can actually start feeling that sense of pride. I want to face the pain that motivated me to get into therapy and then get over it, kind of use it to change the course of my family life with my own efforts. I am ready to dig in.

Therapist: Where will you dig first?

Cynthia: I want to talk about my brother and my father and my grandfather. Their funerals. My dad's family. I want to recap the pains that have brought me the motivation to change the course of my family life with my own efforts. Because I think that is honest, and I think that I want to work through that. I think that will give my life meaning because I have minimized a lot of things in the past ten years, including my relationships and my family...all the losses...one on top of the other on top of the other.

Therapist: Yes, I remember that your dad lost his father and his son within one week of each other.

Cynthia: Yes, that is the reason I was so worried about Dad's downward spiral.

Therapist: I can imagine. And do you think about the deaths as being connected in any way?

Cynthia: How do you mean?

Therapist: Do you think that one death had ripple effects? Could the death of your grandfather have had any affect on Josh walking into harm's way on that funeral night? Or could your father's declining health and death have been related to his multiple losses in such a short time? His wife? His father? His son?

Cynthia: Well, Josh did not know Roger very well. Remember, Dad and my grandfather had not been close since Dad started using in his teens.

Therapist: Right. I am curious. Was Josh aware that your dad was upset about not being on good terms with Roger till the day he died?

Cynthia: Absolutely.

Therapist: And do you think it is possible that Bill's health spiraled downward due to his losses overwhelming him...losing both father and son?

Cynthia: Especially since my mother had also left him. I worried about my dad all the time. I knew he would probably die soon.

Therapist: It is almost like there were shock waves when Roger died...ripple affects. Might have been more than coincidence. Do you think that is possible? Each of you is affected by and affects the other, you know.

Cynthia: Well, I don't know. I guess it's possible (cries). I felt so sorry for my father.

Therapist: You said Bill had a very cut off relationship with Roger.

Cynthia: Yes, Dad was the black sheep. That's for sure. He was so very, very sad and broken up at his father's funeral.

Therapist: How did you know that?

Cynthia: Just the sadness around him. It was just so heavy. He was so alone. He was ostracized from his family from a young age because of his drug habit. I don't know what happened between him and my grandfather to make them not speak for so many years. That was a deep dark secret. Your could almost feel the weight around my dad during my grandfather's funeral. He was completely left out of the will. That had to hurt. He didn't get even one dollar, you know.

Therapist: So he was the black sheep in the family.

Cynthia: Yes, but the whole family did not speak to each other on that side. It runs deep.

Therapist: Do you think it might run generations deep?

Cynthia: I think so. I want to try to crack my grandmother, but it is hard to talk to her. I will call her next month and see if I can go to lunch with her. I don't think I will get much information about her or her parents' generation though.

Therapist: Well, maybe we can get curious and plan some questions for her together.

Cynthia: Yes, and I want to talk to my father's brother, too. He will be able to give me different perspectives about my Dad and growing up together.

Therapist: That is a fine project. We will have a planning session next time.

<u>Section Two</u>

Therapist: Thank you so much for coming into Cynthia's therapy, Winnie. Did Cynthia explain to you the purpose of your coming here?

Winnie: She said she wanted me to talk about our family. She said you were interested in what I remembered about her relationship with Josh when the kids were little.

Therapist: Yes, it will be like a consultation that may push Cynthia along with continuing her research on family patterns through the generations.

Winnie: I brought a picture book along.

Cynthia: I brought pictures before, too.

(Therapist looks at photos as mother and daughter process the memories the photographs evoke)

Winnie: The pictures tell a lot. Josh and Cynthia were real close. We had a small house. But you know. It's like all brothers and sisters. They would fight like cats and dogs and then make up. They always had the same friends.

Therapist: They shared the same friends?

Winnie: Well, they did. Cynthia always preferred to be with adults though.

Therapist: She liked it better to be with the grownups?

Winnie: Yeah.
Therapist: Would it be fair to say that Cynthia was protective of her brother?

Winnie: Oh, always. And vice-versa. They picked on each other, but if anyone else hurt one of them, they would not stand for it.

Therapist: So they always stuck up for each other? Cynthia, are you thinking or feeling any emotions as you hear Mom talking? I see you have been holding her hand since the two of you sat down. Do you often hold hands?

Cynthia: I feel as if Mom is fragile. I know when we talk about Josh that it is hard for her.

Therapist: Is that true, Winnie?

Winnie: Very hard (crying).

Therapist: Your deep losses are important to honor. One way is to talk about him. When the two of you can call up memories together, it will comfort you both and help you heal. You will have a continual bond with him. Talking about pain is more protective for each of you than remaining silent and secretive. Being secretive may seem protective. But the family can only heal in direct proportion to its members' ability to be direct about death and loss in conversations with each other. You can learn to be a support system for one another.

Cynthia: Thank you, Barbara. I am thinking about what Mom said. Josh grew into being protective of me when he became a young adult. He was small for his age. When he got into his teens, he turned really good looking and strong. I remember his pride in being protective of me. He loved me so much. I got to witness that the last year he was alive. We both had so much pride about our relationship.

Therapist: Was "protection" a value in your family, Winnie? People protecting people they love? And even helping the less fortunate, like taking in homeless folks?

Winnie: I would assume it is like that in every family.

Therapist: Some families have a strong value of protecting others. Sometimes the kids become protective of the parents. Sometimes the parents are over-protective of the kids. Sometimes one spouse will do more in taking care of the household than the other. I agree that it can be a theme in every family, but it gets played out differently. So I am wondering how you see this theme as being played out in your own family?

Winnie: Well, Cynthia's dad was somewhat abusive. I had to protect them from the upset.

Therapist: Would that be scary to you and to the kids?

Winnie: Well, the kids finally got to where Josh would kind of step in. Once Bill put his boots on, we knew there was going to be trouble.

Therapist: Once he put his boots on, he would get mean?

Winnie: Well, once those boots went on, he just kind of changed. It wasn't fun. You just had to ride it out. There were times you just had to kick him out. You know, tell him, "You're out of here." It was like a vicious cycle.

Cynthia: Mom, I think that maybe you got more protective over us during that time. I know one thing. We sure did get more protective of you, when Dad got those boots on.

Winnie: Well, he would never hurt the kids, but something might get thrown.

Cynthia: Yea, he wasn't abusive with us. He didn't hit us or anything.

Therapist: You mean he was not physically abusive.

Cynthia: Not even verbally. He was neglectful, but not abusive to us intentionally. It's just that his first focus was on alcohol.

Therapist: Winnie, how would you describe growing up in your home in contrast and in comparison with Cynthia's years in your home?

Winnie: What do you mean?

Therapist: Well, for example, did your parents have a problem with alcohol?

Winnie: Oh, I'm sure. Dad drank a lot. My parents got divorced when I was 6 or 7. I seen my dad trying to knock my mom a couple of times. My brother hit my dad square in the face one time.

Cynthia: Timmy?

Winnie: Yes, and I saw my older brother take my dad and push him up against the wall one time. I'm sure alcohol was involved. My mom was having a lot of nervous breakdowns.

Therapist: Did she use alcohol?

Winnie: Yes, but she would never get drunk. She was like a Sherry sipper. With my Dad, you *knew* he was drunk. You couldn't tell with her.

Therapist: Cynthia, is this information helpful to you? Anything else you want to ask?

Cynthia: I am really finding this session to be freeing for me. I wonder what differences you saw between me and Josh when he was alive, Mom?

Winnie: Well, Josh was always in the hospital.

Therapist: Was he accident-prone?

Winnie: Always, because he was a daredevil. We knew the nurses in the emergency room by name.

Therapist: So was Cynthia more cautious than Josh?

Winnie: Way more.

Therapist: Was she always telling him to watch out, so he didn't get hurt again?

Winnie: I think so. She was watching out for him by telling on him. Like, "Hey Mom, Josh is doing this or that again."

Cynthia: I was a tattletale, Mom? (laughing)

Winnie: You were a big sister.

Cynthia: Sometimes I felt more like a little mama.

Therapist: How does it feel to be talking about Josh today, Winnie?

Winnie: Well, it is just not something I do. It is hard.

Therapist: Well, I want to be respectful. Are you OK right now?

Winnie: Just go ahead. Whatever you want to ask is fine.

Therapist: I am wondering if you could tell me a little bit about Cynthia as a little girl. What were her strong points?

Winnie: She was one of a kind. Cynthia had a tough exterior. My way or the highway. She was always a softie inside, but it's a hard front she put out. It was hard for anyone to get into her. But she could always thrive on her own.

Therapist: Did you have a part in raising her to be so independent?

Winnie: I don't think so.

Cynthia: Well, Mom, you did. I mean you gave me *too* much freedom to make my own decisions at times. I know that gave me a lot of confidence, but it was also hard to feel as if my Mom would just let me run the streets. Mom, you were always so patient and so loving to us. So gentle. I mean I really, really appreciated that, but the other side was that we had no rules or supervision. We had to sink or swim on our own. I want you to know that growing up with the chaos was not good for us. I am not being ungrateful when I say that. It gave me confidence and independence, but it was not right to let us play by digging around in trash cans.

Therapist: I hear you saying this to your mother now, and I hear a tone that is almost matter-of-fact. Is that right?

Cynthia: Well, yes. I do not blame her. She and my dad had the same kind of stuff in their houses growing up. I want it to be different for my sons. And it just feels like I have to tell her that I do not think it is good to tell me how much better we had it than others. I want to honor my struggle as a child. It feels more honest.

Therapist: Winnie, what's going on for you now, as you listen to your daughter?

Winnie: I will come back here if you want to talk to me again. I guess I am crying, because Cynthia is trying to make it different than it was for her. It is good, I guess. But she really did have it a lot better than a lot of people I know.

Therapist: How has it been for both of you to talk about Josh together?

Winnie: I miss him.

Cynthia: I do, too.

Therapist: You have a right to miss him and to be sad. Every time you reminisce about Josh, you comfort yourselves. You keep a continuing bond with Josh even when you laugh about happy times, cry about sad times. It is healing to talk openly with each other. Thank you, Winnie, for coming today. I hope that you each feel a sense of stronger connection with each other and with Josh as a result of our conversation today. I hope that this session will help you to open up these conversations with each other whenever you miss him or just want to feel him in your lives.

Late Treatment

During late treatment, Cynthia continued to work on resolving complicated grief reactions. As the anniversary of her brother's death approached this year, she exhibited diminished symptomology. Furthermore, Cynthia exhibited an excitement and sense of freedom within her increasing awareness that a focus on self rather than a focus on other enhanced her relationships. She continued to be challenged in being able to get calm enough to notice that when her focus shifted to others, she was reacting rather than responding with her best thinking. Cynthia could not always get objective enough to attribute her other-focus to increased anxiety. For example, she could not always recognize anxiety as the driving force behind her increased need to blame and/or to cut off from Steve. In less intense relationships, however, Cynthia improved her ability to move within relationships from a less reactive and more responsible position.

BFST posits that two factors influence levels of chronic anxiety. First, one inherits a level of emotional maturity from the previous generation, which is a vertical variable. Second, outside stressors, which include tasks that are a normal part of the individual and family life cycles, as well as unexpected changes such as premature illness, are horizontal variables. The degree of adaptivity to change reflects the level of basic differentiation of

self. Bowen (1978) believed that it was not possible to increase the basic level of differentiation very much over the life course. However, with prolonged and deep effort, it was possible to increase the functional level of differentiation. Cynthia was able to increase her functional level of differentiation significantly during the course of treatment, and in late treatment, she decided to reduce her therapy sessions from four times a month to twice a month. Such a decision underlay Cynthia's ability to become more independent in her efforts to build self. Her decision reflected the author's successful avoidance of utilizing the transference and sending Cynthia back to her own family to resolve attachment issues.

The Inverse Relationship Between Anxiety and Thoughtful Decision-Making

In Cynthia's case, not only did she come from a family of origin with generations of intensity (representing vertical stressors), but also horizontal stressors raised her anxiety to an even higher level. When horizontal stressors increased, her ability to make decisions based on her best thinking decreased.

Although she could not always do so, in late treatment, Cynthia frequently questioned whether her decisions were based on reactivity or on her reflective ability. In itself, this developing habit of self-monitoring represented a marker of progress. Since Cynthia was part of a family system that reflected a low level of differentiation and resultant high levels of reactivity, her ability to consider the possibility of reactivity driving her behavior was, in itself, an impressive gain.

Continued Work on Grief in Context of Emotional Interdependence

In the late phase of treatment, Cynthia understood the emotional interdependence of family systems more completely. For example, she became convinced of the power of the emotional shock wave effect in her family of origin. In gaining this insight, she became more sensitive to the extent of emotional interdependency in her family system. Cynthia's growth in this area was directly related to the therapist's own efforts to consider the emotional shock waves from her own father's death in her family of origin. As Bowen (1978) observed, if a therapist cannot stand the heat, he or she should get out of the kitchen. In order to work effectively with a client on complicated grief, the therapist must work on her own unresolved grief.

Opening the Relationship System and Toning Down Over-Functioning

Cynthia came from a closed relationship system. Members in her family of origin did not talk to one another about their feelings. In opening up the relationship system by coaching Cynthia to initiate conversations with her mother and other relatives, magical results began to manifest in late treatment. By using direct language about death and by coaching the client to make "I" statements to her mother and other important relatives with regard to her grief, sadness, positive memories, and negative memories, Cynthia moved forward in her ability to be a self. The heightened anxiety that she and her mother experienced around each anniversary of Josh's death diminished considerably during the second year of treatment. The suppressed anger toward her brother had been expressed in session, in keeping a journal, and in writing him letters about her love and her anger.

Cynthia became more connected to her brother in important ways. She became more able to be an adult with her own set of principles and beliefs in relation to her mother.

In later treatment, Cynthia reported more frequent efforts to tone down her over-functioning in her relationship with Steve. Also, she no longer viewed the need to protect her mother from the depth of her own grief as healthy for either of them or for their family system. She developed an increasing understanding that opening up the relationship system in her family of origin offered a big bang for her buck, especially in terms of interrupting maladaptive patterns for her two sons and for future generations.

Heightened Activity in Family of Origin
Work Outside of Session

Cynthia became very active in her work outside session during this phase of treatment. She wrote letters to her deceased brother, made contact with her paternal grandmother and uncle, and talked to her mother frequently in an effort to collect more family facts. This increase in activity outside of session reflected Cynthia's increased ability to take responsibility for self and systemic appreciation that she could change the course of future generations with her own efforts. She became less dependent on the therapist in her quest for personal growth and development.

In placing new facts alongside the existing information that she had, Cynthia was able to get more neutral and objective. In making contact with her father's side of the family, she was able to shift to a more neutral position in her primary triangle with her parents. To the extent that she became able to reduce her blame toward her parents, especially toward her father, she could keep focus on self and begin to understand her

part in other important relationships in her life. During this stage of treatment, Cynthia would come to session as if she were a reporter, bringing in new responses to old unasked questions and archival data. Her enthusiasm about her excavating efforts within her family of origin was palpable.

Realistic Expectations in Meeting Therapeutic Goals

Cynthia broke up with Steve as the author was writing the last chapters of this dissertation. Initially, this outcome disturbed the author. Was the treatment unsuccessful? How was it that the client would cut off just as her partner worked on rehabilitating himself from binge drinking? Was Cynthia leaving Steve only because he might be getting healthy, which would block her need to over-function for a partner?

Returning to the family diagram reminded the author that the potential for gains in therapeutic progress must be considered within the context of the family's intensity over time. Therapeutic goals must be formulated modestly, with the amount of intensity of a family over time figuring prominently in the assessment. For example, it was not surprising that Cynthia used the defense of denial when the author questioned Cynthia in terms of Steve's rehabilitation decreasing the need for her to employ her own anxiety-binding mechanism of over-functioning. Cynthia vehemently denied the possibility that Steve's rehabilitation disturbed her enough to cut off from him. Instead, she stated that Steve had other qualities that made it impossible for her to remain with him, especially his explosivity and his self-centered attitude.

Despite the client's insistence that cutting off from Steve was based in reflection rather than reactivity, it is the author's view that it is less likely that Cynthia's move to kick Steve out of the house was based on reflection. It is more likely that this move was reactively based. When looking at Cynthia's family diagram, it is apparent that the intensity is generations deep. Cynthia had only to consider the fact that like her mother kicking her father out of the house, she kicked Steve out of the house. Many individuals within Cynthia's intense, multigenerational family system used maladaptive mechanisms to bind anxiety and to get distance, including abuse of substance, conflict, domestic violence, divorce, child focus, and especially emotional cut off.

Over-functioning women married to under-functioning spouses was a part of the picture in every generation that is known in Cynthia's extended family. That Cynthia would not be able to tolerate an intimate relationship over time pointed toward her sensitivity to being a self in relationship. Cynthia, like other forms of protoplasm, had to manage the tension between a need to be separate and a need to feel connected (Bowen, 1978). The lower the level of differentiation, the higher the tendency toward fusion and/or cutoff (Kerr & Bowen, 1988). This meant that Cynthia's survival depended upon not feeling either swallowed up or too disconnected from other. In considering the traumatic series of losses in her own life course, it is easy to understand how difficult it was for Cynthia to sustain intimacy over time. Like the relatives who came before her, she was relationship sensitive. Perceived threats to her selfhood were often based on her undifferentiation rather than in reality.

Outcome

Cynthia made many positive gains in therapy, all of which pointed toward a rising level of functional self. As the writing of this dissertation came to a close, for example, Cynthia talked frequently about the ways in which the return of her creative juices manifested themselves. She was extremely proud to have completed a draft of a children's book on her own beloved community. She had recently begun to develop a tee-shirt line celebrating motherhood and hoped to give a percentage of profits from her sales to organizations helping battered women.

Cynthia grieved the loss of God's voice throughout much of her treatment. After working through many of her feelings of anger at a God who would take her brother and who would give her parents who could not parent, she joined a new church. Cynthia was very enthusiastic about her engagement in this new spiritual community. By reclaiming her spirituality, Cynthia experienced holiness in an unholy world (Wolin & Wolin, 1993). Starting out life essentially having to look out for herself, Cynthia still developed a compassion and concern for others. Yet she retained the necessary survival skill of watching out for herself. Her resilience represented the continuing search for answers to the core human questions posed by the sage Hillel in the first century B.C.:

> If I am not for myself, then who will be for me?
> If I am only for myself, then what am I?
> If not now, when? (Wolin & Wolin, 1993)

Cynthia also initiated a relationship with her paternal grandmother that reflected more frequent and more open lines of communication. Additionally, during late treatment, Cynthia increased the frequency of time spent with her brother's son. She developed an annual ritual on the anniversary of Josh's death, wherein her community

could celebrate with her the meaning of her brother's life. Working on differentiating her voice from her mother's voice and on understanding repetitive roles and patterns in her family of origin in a broader way profoundly affected Cynthia's ability to move forward in her life. All of these changes reflected Cynthia's higher level of functional differentiation of self.

The emphasis in late treatment was to coach Cynthia toward becoming more active in her own efforts (Kerr & Bowen, 1988). With increased activity and greater responsibility for managing herself in intense emotional environments, Cynthia could increase the resolution of attachment to her brother, to her mother, and to her father (Kerr & Bowen, 1988). In the service of these efforts, Cynthia worked outside of session to increase the frequency and quality of her contact with living relatives and with deceased relatives. Letters, conversations, visits, journal entries, and focused inquiries helped Cynthia to achieve this greater resolution. Thus, even in death, Cynthia found that she could maintain a continuing bond with important relatives. Indeed, the resolution of attachment concomitantly enhanced efforts to resolve complicated grief by enabling the bereaved to maintain spiritual bonds with those who were no longer physically present (Klass et al., 1996).

Cynthia's new awareness of the value of maintaining connectedness and her ability to do so more effectively served to decrease symptoms borne of the anxiety from emotional cut off in both life and death. Such a growing awareness was congruent with Bowen's (1978) groundbreaking insight that emotional cutoff between and within the generations can result in a legacy of severe symptoms in a family system.

In differentiating from her mother and in resolving large stores of complicated grief, it was important to Cynthia not only to tell her mother that she was sad about the loss of a father that she felt she never had, but to also express her anger at not being parented responsibly by her mother. Cynthia eventually gained the insight to realize that her parents did the best they could with what they inherited from their own pasts, and this realization was a core part of the healing that she experienced in treatment. It was challenging for Cynthia to prevail over the forces of fusion in her effort to honor her survivor's pride and utilize her childhood adversity in a way to make more opportunity for her and for future generations.

Thus, in late treatment, Cynthia was able to acknowledge her key resiliencies of relationship, initiative, insight, creativity, and morality (Wolin & Wolin, 1993). She shifted from her belief that she was damaged goods to a belief that she was a strong survivor who could prevail. Through the course of therapy, Cynthia had to give up her belief that there was something wrong with her, and if she could find the flaw, she could save her family. In giving up the deficit-based belief that she was damaged, Cynthia no longer had to over-function (Bowen, 1978) to save herself and her family. By identifying all the resources that Cynthia drew on in the past in order to survive and by conquering the past damage by naming it, she reshaped her self-image into one who prevails (Wolin & Wolin, 1993).

In late treatment, Cynthia also recognized that her desperate determination to provide her sons with a different home life than the one that she knew drove her efforts to find a husband. Even though she questioned her ability to choose a healthy mate because of the desperate quality to her search, she also stated that she could not help herself in

getting involved with someone who would hold her and be there with her family. At the time of this writing, she had already found a new boyfriend and discussed the possibility of marriage with him. Although the author coached Cynthia to sit with her anxiety within the aloneness of being without Steve and/or to work on self instead of focusing on what was wrong with Steve, the client could not do so. Whether this new romantic interest is healthier or more differentiated than her previous partners remains to be seen.

In summary, Cynthia made modest progress in treatment. Although her ability to sustain intimacy with a partner might not have been realized, she gained profound insight that in celebrating her childhood challenges, she could become motivated to seize opportunities to guide her future. At this late point in her treatment, Cynthia became determined to return to college with a goal of helping other children who came from backgrounds like hers. She knew that her insider's understanding of children suffering from parental neglect would be a career asset in her wish to help similarly challenged families emerge with an awareness of their strengths and ability to persevere. In this sense, a future goal of becoming a social worker was congruent with her multigenerational legacy, which embraced the value of giving back to the community from which you came. At the time of this writing, Cynthia was also excited about her entrepreneurial efforts and her efforts to publish her writing of a children's book. The church had become an integral part of her life, and her new boyfriend shared with her a re-entry into her dialogue with God. With a playful smile, Cynthia reminded the author that this move back to religion proved that she retained her innate resiliency of morality (Wolin & Wolin, 1993).

It is important to reiterate that all phases of treatment integrated psychoeducational material, coaching, therapist's monitoring of and management of self, resiliency work, and increasing fact-finding activity within the family of origin. In a parallel process, there were times that the therapist felt anxious about Cynthia's propensity to cut off her relationship with her sons' father. At the author's most anxious, for example, she over-functioned by frequently reminding Cynthia of the dangers of over-functioning! The author also continued to coach Cynthia about child focus and about how such behavior naturally evolves inside of the tension within closeness/distance forces between the parents (Kerr & Bowen, 1988). Thus, in late treatment, Cynthia had gained increasing clarity that when the parental/spousal subsystem becomes bereft of connection or too fused for one partner to believe he or she can survive without being swallowed up by the other, parents often fill the breach with conflict, distance, and/or in a focus on one or more in the sibling subsystem (Kerr & Bowen, 1988). She also developed an awareness that social symptoms such as drug and/or alcohol addiction were maladaptive attempts to bind anxiety around these same competing life forces of closeness and distance in important relationships (Kerr & Bowen, 1988).

It follows that as treatment continued, Cynthia became aware that it was essential to the well being of her nuclear family that she balance her life with more interests than her new motherhood. Resiliency work was continually aimed at helping Cynthia utilize her core strengths of initiative, creativity, insight, relationships and morality (Wolin & Wolin, 1993). As Cynthia became more engaged in these efforts, she appeared far less anxious and depressed than she had been in early and intermediate treatment. Cynthia is easier on herself today. She is able to articulate goals for her future and even put some of the

actions necessary to realizing these goals into affect. Cynthia enjoys her motherhood in a calmer way. Such gains were the result of the client's courageous and hard work. What follows are excerpts from letters that Cynthia wrote to important others during the late phase of treatment, and her words underline her core resiliencies of relationship, initiative and insight:

> Dear Grandma,
>
> Yesterday was the best day I ever remember having together. I feel like we connected on a real level with no pretentious barriers protecting our most vulnerable selves. We were simply hanging out together, free to talk about whatever came to mind. To me, it felt as if many generations of "cut off" were cut out of our family's future. I will always look back on my day with you and my little boys as one of my favorites. It was so honest and relaxed. That is how I want our new connection to be. I love you and hope we have many more days like yesterday.
>
> Love, your granddaughter,
>
> Cynthia

> Dear Josh,
>
> You know and I know the uniqueness, depth, and adversity defining our love. When you were alive, my life overflowed with purpose and confidence. I strived to be the best person I could be. I strived to be positive as well as strong. I prided myself on overcoming the hardships we were handed as children. Although there were many others who witnessed the chaos in our home—young and old—only you and I knew what it was like being raised on our little streets. Our house was the totally notorious household in our community.
>
> Over the years, I have been mad at you. We have been mad at each other. The tender moments were so natural that they would easily go unnoticed. Josh, my soul and spirit know that you are gone. In many ways, you lit up my life more than anyone. The depth of our mutual understanding of each other and the lives we lived is quite possibly what I miss the most.
>
> The purpose of this letter is not to make you feel good or reminisce as to what we have lost. I am angrier with you in your death than I ever was when you were alive. What right did you have to put yourself in harm's way like that? We all suffer now. My sons will not see how we related to one another as brother and sister. You robbed your own son of a father! You robbed all your nieces and nephews of the bond of having a phenomenal uncle. None of us can ever again laugh with you, cry with you, nor share our secrets with you.
>
> Josh, what right did you have to take away the apple of your mom's eye? How could you have left our dad? Now all my holidays and significant days are tinged with the sadness of your violent departure. Until now, I have never expressed my anger. I want you to know that I need you to be accountable for all

the pain you have caused me. I am mad that you made such a stupid decision, and I am mad that you were behaving in a selfish way to achieve a little bit of glory. And if you had not have died that night, perhaps my brother would have been a hero. But so what? You may have lasted a little longer, but your next decision may have been even riskier. Just know that you are missed and that your decision to walk into your own death has caused me the deepest pain I have ever known.

Love,

Cynthia

What follows are two excerpts from transcripts in later treatment. In the final chapter, the author discusses the treatment, the supervision, and the self of the therapist in relation to this case study. In addition, limitations of the case study and directions for further research are discussed.

Transcripts From Late Treatment Phase

Section One

Therapist: How do you want to use your time today?

Cynthia: Well, on the way in here, I was feeling pretty empowered and really good.

Therapist: Say some more.

Cynthia: Well, I was reading over the vocabulary of strengths, the seven resiliencies. I think I have all of them. I have insight, independence, relationship strength, initiative, creativity, humor, and morality.

Therapist: Remember, these are relative strengths. No one has all of them, although each of them can be taught and developed. Which ones do you think are strongest in you?

Cynthia: Definitely relationships. I made wonderful, fulfilling connections to a a beautiful, strong healthy group of people. I am connecting to my mother and grandmother on a more genuine level. I am even connecting to Josh in a more genuine way. Creativity is returning. I know I have talent, and now I am cultivating it again. My morality is based in my devotion to a God whose voice I could not hear for the longest time. I talk to him again and often.

Therapist: So you build support systems around yourself—that's one of your resiliencies that you see. Right? Like finding your own substitute caregivers as a child?

Cynthia: Absolutely. I never appreciated that about me before. It's big.

Therapist: Huge.

Cynthia: Yea.

Therapist: Any thoughts about the letter you wrote to Josh?

Cynthia: It was big to me to acknowledge my anger at my brother in writing. I can almost trace back the bad stuff in my life to when he was killed. Getting cognitive about it has helped me manage my emotions in a calmer way. I feel more empowered and able to be a self now. It is almost like taking the cork off of a bottle and being able to smell the aroma of life. I am not dulled in my senses. The numbness is gone.

<u>Section Two</u>

Therapist: How do you want to use the session today?

Cynthia: Well, I was thinking about a lot this week. I was thinking about how little I am aware sometimes of what's driving me in my current relationships. And how I interpret love sometimes in sort of twisted ways because we obviously love our parents at the same time that we hate them. So if I work on me instead of what's wrong with Steve or my ex-husband, I can begin looking a bit more critically at my familiar roles. I realize that grieving the loss of a father I never really had is as big as grieving the loss of Josh. And it seems as if I pick people to love that I can oversee, which just lets me do the same dance in life of overseeing just to calm me down.

Therapist: I hear you. How will you work on that?

Cynthia: I will have to keep shifting off others and working on myself. That is why I am here.

Therapist: Even more, that is why I keep coaching you back to your family.

Cynthia: Yes, but I am so driven to do this dance that I cannot seem to get past it.

Therapist: Aah, that over-functioning dance has its own rhythm.

Cynthia: I'll say.

Therapist: But you get exhausted from doing all that work, right?

Cynthia: Yea, after awhile, I say, "Get away from me. I've had it."

Therapist: And you are the one who gets to stay on the moral high road.

Cynthia: What do you mean?

Therapist: Well, you get to blame the other person and be righteous.

Cynthia: Yes, I guess so. I still like to be the perfect one.

Therapist: As you were the perfect child?

Cynthia: That way no one could leave me and I got to call the shots.

Therapist: Your attempts to control a world that felt out of control. Could you ever be with a man who did everything just the way you thought it should be done? Or respect his right to do it differently?

Cynthia: On one hand, I complain about how much crap I have to over manage and you are suggesting I would be lost without it. I know I have to stop for me and my sons' future.

Therapist: What if you began to learn to how to be a parent to yourself? What if what it took to calm you down was to be taking care of self instead of other?

Cynthia: What a concept. Sometimes I can't imagine that.

Cynthia: But now that I found a new potential partner, I worry that it's a reactive choice. But that doesn't seem to stop me.

Therapist: Can you stop and sit with that anxiety without moving?

Cynthia: I am praying on it. It is very hard.

Therapist: I hear you. Let's strategize some of your questions and work at observing in family that you will do over the next two weeks.

Chapter 5

CASE STUDY OF A SIBLING SURVIVOR OF HOMICIDE: DISCUSSION

This chapter addresses the results of the treatment, including the usefulness of this treatment model for a population of sibling survivors of homicide. Additionally, the chapter considers how the self of the therapist informed selection and treatment of the subject, as well as ways in which completion of this project transformed the author-therapist. The chapter concludes with a discussion of the supervision of the case, suggestions for future research, and limitations of the study.

Usefulness of Treatment Model and Results of Treatment

A resiliency-based Bowen Family Systems treatment proved to be useful throughout the course of therapy for a sibling survivor of homicide. Grief and loss therapy permeated all stages of treatment. There was an emphasis upon defining self and the normalization of anger in the face of senseless loss and in the face of a chaotic childhood. Additionally, there was an emphasis upon the healthiness of continuing bonds with the deceased that transcended physical loss. Such an emphasis is congruent with the concepts in Bowen Family Systems Theory that emotional cutoff causes symptoms and that differentiation of self involves finding an individual's unique voice amidst the "group think" pervading the undifferentiated ego mass of a distressed family system. Finally,

treatment continually highlighted the interdependent nature of family systems between and within the generations (Bowen, 1978).

From the perspective of this treatment model, a therapist must be able to remain separate yet connected to the client. In order to achieve this goal, the therapist must have the ability to manage herself in session without becoming fused into the emotional field. Techniquism is eschewed in favor of the therapist's ability to be a self in session. To the extent that the therapist continues to do her own personal work within her own family is the extent to which she can be a self. To be a self is to be less vulnerable to fusion. It is the ability to remain a neutral, objective, and connected presence in the emotional environment of a therapy session (Bowen, 1978).

Bowen Family Systems work that is successful results in a client's reducing his or her anxiety and increasing his or her functional level of differentiation of self. In order to achieve these results, the client is continually coached to engage his or her cognitive capacities in order to understand new concepts and to work outside of therapy sessions with his or her own family. It is believed to be inherently calming to the client to begin to understand and apply the challenging and interlocking concepts. Such work involves active work in the cognitive domain, which may calm the activity in the emotional brain (Kerr & Bowen, 1988).

Bowen Family Systems Theory assumes that by increasing the intellectual capacity to engage, especially in the emotionally taxing environment of an individual's family of origin, that individual can rise above automatic responses rooted in the biological instinctual system. It is by engaging this uniquely human intellectual capacity that individuals can counteract instinctual but maladaptive moves in the face of perceived or

even real threat. As such, psychoeducation on Bowen's interlocking concepts pushes the client to think in broader contexts. The challenge to understand these complex concepts and then apply them to an individual's own family system is at the core of the treatment. In a parallel process, the effectiveness of the Bowen therapist is determined by the extent to which he or she has been able to work within his or her own family of origin with these same concepts in a way to increase his or her capacity to manage self in session (Kerr & Bowen, 1988).

The literature has indicated that there is no treatment specifically developed for surviving siblings of homicide (Hogan & DeSantis, 1992; Rindt, 2001; Walsh & McGoldrick, 2004). Bowen therapy provided an excellent roadmap to guide the treatment of a sibling survivor of homicide. The model is broad enough to address the existential and ultimate concerns of a surviving family member of violent loss. For example, Bowen (1978) observed, "Direct thinking about death, or indirect thinking about staying alive and avoiding death, occupies more of man's time than any other subject" (p. 321). He identified death as chief among all taboo subjects and called upon therapists to use direct language about death to open up the relationship system. Bowen (1978) also emphasized the importance of coaching clients to study the depth and breadth of the interdependency in their own family systems, an interdependency that can result in cataclysmic emotional shock waves upon the death of important family member(s) (Bowen, 1978).

Thus, this treatment model empowered the subject of this case study in myriad ways. She developed a heightened awareness of the extent of interdependence in her family system between and within the generations. She developed an awareness of

maladaptive generational patterns that she could interrupt by working on her family of origin issues. She also gained an appreciation for multigenerational patterns that reflected resilience, as well as an appreciation of the individual strengths that allowed her to move from victim to proud survivor. She learned to move in triangles in a more neutral way, which allowed her to lower her level of anxiety. She learned to differentiate herself more completely from her brother, her mother, and her father. Cynthia considered carefully the ripple effects of her grandfather's death. All of this work within her family of origin aided her effort to resolve attachment and resolve complicated grief reactions. With greater resolution of attachment and grief, Cynthia moved from feeling numb to feeling motivated to use her strengths to move on with her life.

Bowen Family Systems also is useful to a client like Cynthia, who suffers from the loss of a brother, a father, and grandfather that, in most respects, she never really had, and from the effects of irresponsible, neglectful parenting. When a family is steeped in alcoholism, drug addiction, divorce, emotional cutoff, parental neglect, and family secrets, it can be assumed that the current generation suffers from multiple generations of transmission of severely maladaptive patterns. In fact, those families that present with such severe symptomology can be assumed to be in the end stage of a long multigenerational process (Kerr & Bowen, 1988). The interruption of longstanding generational patterns presented Cynthia with a profound opportunity to change the quality of life for herself, for her sons, and for future generations.

For example, Cynthia made considerable progress in modifying her impulse to over-function. Bowen Family Systems assumes that the higher degree of fusion that exists in a family, the higher will be the degree of symptoms (Bowen, 1978). Fused

relationships often maintain a symptom through a dynamic of over-functioning and under-functioning (Bowen, 1978). This pattern was apparent either in relation to alcoholism or drug addiction on both maternal and paternal sides of Cynthia's family through at least three generations. The treatment's focus on multigenerational patterns of transmission fostered a heightened awareness of Cynthia's own automatic habit of over-functioning, and she was able to decrease this behavior toward her partner significantly during the course of therapy.

It follows that understanding the nature and severity of the forces of fusion in family systems was an important part of this treatment. For example, Cynthia viewed her major life purpose as being a role model for Josh, an obvious symptom of their fusion. When her brother died, Cynthia felt adrift at sea, as if she had lost a sense of meaning and purpose to her own life. In decreasing the fusion between Cynthia and Josh by working on increasing differentiation of self, the client was able to move on with her life.

Cynthia became interested in articulating life goals and had taken baby steps toward realizing some of these goals. Her creativity blossomed in later treatment. Her spiritual nature, which had long been deadened after her multiple losses, began to flower again. Her interest in developing a support system of her own increased.

An example of her improved self-care in relation to developing supports for herself as a sibling survivor was her participation at an annual event sponsored by a group called Survivors of Violent Loss. She was not ready to participate in this organization's activities for over a year of therapy. However, the past holiday season found Cynthia attending an annual ritual to honor lost loved ones by hanging an ornament on a tree at a

Survivors of Violent Loss holiday function. She found the event to be extremely meaningful. Cynthia brought an ornament that she described as

> a beautiful, sparkley silver star that is heavy and solid. The blue stone in the center symbolizes Sparkle's (Josh's nickname) blue eyes and the red ribbon hanger symbolizes his red hair. I brought another ornament that is a seashell to celebrate his roots in our community. I covered it with glitter to symbolize his sparkle.

Cynthia went home from that event feeling lighter and motivated to establish an ornament ritual in her own family to honor Josh at the holidays. This ritual complemented the annual July barbeque event that she had established during the first year of therapy to honor the anniversary of his death.

At the time of this writing, the client continued to be challenged by the work of differentiating her own voice from her mother's voice directly to her mother's face. The client believed that she was gaining the courage to define a self to her mother, but that it would take her more time to actually express her pain to her mother more directly than she had been able to do to date. A major stride for the client in defining a self was to mourn the chaotic nature of her childhood without feeling guilty that she had such sad feelings, despite her mother's admonition that she should be more grateful.

Family secrets are often part of the clinical picture in undifferentiated families (Kerr & Bowen, 1988; Walsh & McGoldrick, 2004). Cynthia identified her paternal grandmother as "keeper of the family secrets." Early in treatment, Cynthia was intimidated by her grandmother, whom she viewed as "mean and cold." The bravery Cynthia demonstrated upon moving toward her grandmother late in the course of therapy underlined her successful efforts in increasing her functional level of differentiation of self. By approaching her grandmother with a curiosity and with respect, Cynthia was

taking a leadership role in bridging cutoff that ran generations deep. She was also making contact with her father's side of the family, a move that helped her resolve attachment with her father and occupy a more neutral place in her primary triangle between her parents.

Resiliency work insured that treatment would also focus on those multigenerational patterns of transmission that were positive. For example, in Cynthia's family of origin, there was clearly a pattern of charity with the accompanying moral family value of helping those who are less fortunate. Although Winnie's habit of taking in every derelict who asked for a place of shelter created a chaotic environment for her children, Josh and Cynthia also learned that kindness to strangers occupied a central and moral place in their world. The family home was considered a place of refuge, and this reputation sealed the children's commitment to community that permeated Cynthia's dialogue throughout treatment. Even as Josh was murdered, he placed himself in harm's way in the service of protecting his beloved community from invasion by another gang. An aspect of Cynthia's blossoming return to creativity also contained within it this same philanthropic and morally committed position. She recently created a tee-shirt line emblazoned with the word "Mama," which celebrated the responsibility of motherhood. Her aim was at once entrepreneurial and philanthropic, as expressed in the following excerpt from the creative mission statement that she wrote:

> Mama, you are the light of the world! It is my duty and honor to empower you by recognizing your mission on Earth as a Mama. All moms need to know that their job is the most important job in the world! You can't put a price on having a mom or being one. It is my duty and honor to empower you by recognizing your mission on Earth as a Mama. These "Mama" shirts are to be worn as badges that unite our independent devotion as we serve our families with privilege and purpose.

Cynthia's learned habit of giving back was expressed in her intention to give a portion of her anticipated profits to women's shelters. The risk of child focus and over-functioning in response to adult relationship tension continued to be underlined throughout treatment. In fact, even the creation of this tee shirt line provided yet another opportunity to remind Cynthia of the danger of her propensity to do so in the face of anxiety.

Resiliency work also helped Cynthia to appreciate her individual and family system's innate strengths, hone them, and work on developing other strengths that would shift her perception that she was damaged to a perception that she was a proud survivor. Adults who were children in dysfunctional situations hold onto a hope that if they find their flaws, they can fix themselves and fix the family (A. Lawson, personal communication, March, 2006). Therefore, it is useful to focus on finding their strengths in the face of the struggles they experienced on a daily basis.

Bowen's (1978) call to open up the relationship system by bridging cutoff and coaching clients to use direct language when dealing with death enhanced a family resiliency of open communication and flexibility of emotional expression. Cynthia's innate strength of relationships came to be valued as an avenue toward a future goal in the helping professions, as well as in her personal life.

Cynthia's commitment to responsible parenting is a direct reaction to her experience of being in a home that was characterized by irresponsible parenting. There was a desperate quality to her search for a partner with whom to have children. When her ex-husband exhibited a drug-addicted, swinging lifestyle, she immediately began plans to divorce him. She did not want anything more in life than to have children and to raise them in an environment that was a healthy and wholesome contrast to her childhood

environment. Cynthia viewed her ex-husband as a man who could not provide her with the partnership necessary to create such a wholesome environment.

When Cynthia's old high school sweetheart, Steve, promised her babies, she stated, "He handed me my dream on a silver platter." They reunited and quickly had two sons. Similarly, there was a desperate quality in her effort to replace him for another partner when the intensity in the parental/co-habitating relationship became intolerable for the original partners. Within the intensity created by the tensions of adding two babies to their nuclear system, once again Cynthia found herself with a man who demonstrated the same impulsive behavior so familiar to her from being her father's daughter. Steve's impulsivity created Cynthia's over-functioning, and Cynthia's over-functioning created Steve's impulsivity when the emotional environment became too intense for them.

Cynthia's challenge involved recognizing the reactivity, cutoff, and dysfunction that resulted from her tendency to fuse with partners and the risk of child focus that increases in relation to the need to fill the breach between the partners. Consistent work on managing closeness-distance forces for oneself and respecting another person's closeness-distance needs did not alleviate the reactive choices that Cynthia made in her romantic relationships.

Cynthia's mate choices from her first husband to Steve and to her latest partner also reflected Bowen's (1978) assumption that people with similar levels of differentiation mate. Cynthia's ambivalence about not wanting to rise too far above her origins, and her identification with her mother's functional position in the family also influenced and continues to influence her mate choices. It is possible that Cynthia may be repeating her mother's pattern with men in order to get her mother's approval. Also, Cynthia's position

as “daddy’s girl” contributed to her attraction to men who, in some ways, reminded her of her father. Her attraction to men like her father may have also reflected an attempt to fill the hole in her soul from not having one.

As a result of treating such a challenging case, the author became more humble about the ferocity of multigenerational forces and more modest in her treatment goals as therapy progressed. As this project came to a close, Cynthia had achieved a heightened awareness of the risks of child focus and the prophylactic need for her to balance her life with support systems and an array of outside interests. She began to work more hours per week, placed her children in a carefully selected, superior child care facility, became interested in developing her female friendships, and attended a function at a local support group of survivors of violent loss. She also began writing a children’s book, invented a new kind of pet leash, and became very excited to enroll in college in the approaching fall semester. She had positioned herself in a more neutral way in her primary triangle. Nevertheless, she still had trouble maintaining intimacy with a partner. This reflected the undifferentiation of her family of origin. Cynthia was able to raise her functional level of differentiation through therapy. Her basic level of differentiation had been set by the time she left home.

Case notes from a late therapy session with Cynthia reflected her excitement at getting her life back, a marker of her increased functional level of differentiation. She stated:

> I am so inspired. I am getting back my spirit and creative juices are flowing. If you had told me that I would get this much of my self back from the therapy, I would not have believed it. I have this total sense of myself again.

Research has shown that there is little evidence that one model of MFT therapy is more effective than another model (Shadish, 1992). It is the relationship between the therapist and client that is the most important factor in affecting change (Shadish, 1992). Cynthia's reflections on her therapeutic journey during the same treatment session are congruent with this research finding. When asked what had been most useful to her in her therapy, she stated:

> What made the difference is my connection to you. I mean learning about Bowen theory, especially triangles and my habit of over-functioning to bind my anxiety was really useful, too. I mean I reconnected with what I was frustrated with and never got over by looking at it all through new eyes. I know how mad I was at so many things and how I have just kept it inside. Just how much it hurt that no one was there to sign me up for Brownies or softball. And it was such a release to get mad at my mom and to get mad at Josh. Then it felt good to just get over it and realize that my independence and strength is definitely a result of all that. I don't have to hang on to being a victim. I mean what didn't kill me really *did* make me stronger. It feels so good to be in the game again, and it all started with my work here in therapy. I think that before therapy I have had trouble allowing myself to have a better life than my mom. I would feel guilty for shining and upstaging her. I remember how my heart would sink if I was shining with Josh in the background struggling just to pass his classes. Here I have learned that if I just control my urge to over-function for people, I won't have to shortchange my own goals—like returning to school. I won't have to watch my kids learn that they are not competent, because their mom always had to rescue them. I won't rob them of the joy of learning that they can pick themselves up instead of thinking that I will always pick up the pieces.

Cynthia felt a connection to the therapist, because the therapist had the ability to be a self in session. To be a neutral and calm presence as a therapist reflects the level of emotional maturity of the therapist, which in turn, reflects his or her ability to avoid fusing and getting caught in the client's emotional process while at the same time being able to remain emotionally connected to the client (Kerr & Bowen, 1988). Additionally, having a way to think about relational functioning and a body of knowledge that contributed to relational understanding served to calm the therapist within the emotional

environment of the therapy room in much the same manner that working with these ideas within her own family calmed Cynthia (C. Jacobs, personal communication, March, 2006). It is unlikely that a therapist can take a client further than he or she has gone. That is why Bowen theory looks at the self of the therapist as the major intervention in therapy (Papero, 1990). A toolbox of techniques is necessary when a therapist must rely upon over-functioning to calm oneself and upon "fixing it" to feel calm. This toolbox approach is the epitome of what it does NOT mean to be a Bowen therapist. The therapist who anxiously looks to fix a client disempowers the client and sabotages his effort to increase his or her sense of personal responsibility for achieving satisfaction in life and in relationships (Kerr & Bowen, 1988). A Bowen-trained therapist looks to keep his or her focus on self in order to create change (Bowen, 1978).

The Self of the Therapist

Choosing Cynthia as the subject of my case study for my doctoral dissertation caused me to look at how it was that I was so attracted to studying her case in depth. Cynthia's eagerness to undertake the journey, her commitment to working with me, and her engaging personality all contributed to the reasons that I chose her for a subject. I am aware that I also became hooked into the drama of the murder and the intensity of her family system because there were many parallels with my own family history. I prided myself on coming through intense family challenges as a person of greater rather than lesser substance and learned to appreciate my resiliencies and unique position within my own family of origin during the course of my training in Bowen Family Systems and during the course of my own personal therapy.

Cynthia's struggle contained enough fluctuation and emotional turmoil to keep me humble. As soon as it appeared that Cynthia had mastered managing herself in difficult relationships, she would often go into a regression. Such challenges provided me with a rich training experience. I learned that assessment is a fluid, dynamic process, and that dividing assessment and treatment into separate phases is an artificial distinction (Papero, 1990). I came to appreciate how much my investment in the outcome of this case took me off the neutral position that I attempted to maintain (B. Paul, personal communication, January, 2006). I could not be as objective with Cynthia as I could be with clients who were not the subject of my dissertation. Cynthia's case presented many challenges, and there has been a benefit to the struggle that I would not have had with clients who came from less intense family backgrounds.

Early in the course of therapy, it became important to me to situate myself by examining my own personal journey and considering how it informs my therapy. I took to heart Betty Carter's (1985) reminder to therapists that they cannot *not* react out of their historical background, gender, age, class, sibling position, ethnic background, personal history, theoretical orientation, experience, and wisdom, or the lack of it. In situating myself, this final chapter of my dissertation represents my own humbling effort to define biases and assumptions that I carry with me after almost 60 decades of life. This attempt to refine my self-definition in terms of assumptions I bring with me into my clinical practice is part of the work of differentiating the self of the therapist.

Like all of us, my path continues to wind and meander through expected and unexpected events that make up the tapestry of who I am and who I am becoming as a human being and as a psychotherapist. As such, differentiation of the self of the therapist

is a lifelong journey or a work in progress (Bowen, 1978). Each new personal and professional experience adds a small piece to a picture that will continue to change and to enlarge over time. It is essential for a therapist to define his or her personal epistemology and to appreciate that it will continue to shift as a result of the challenges presented by new experiences.

As an oldest child and only daughter, I risk over-functioning for my clients and/or being overly protective of them in the treatment room (Toman, 1976). It has been with great effort that I have reduced my propensity to rescue people in my personal and professional life. Studying my own family of origin has highlighted the dangers of how over-functioning can stunt the growth and development of individuals (Kerr & Bowen, 1988).

Many of these insights came about as a result of my 4 years of training in Bowen Family Systems. My training brings with it a commitment to the idea that I help people most profoundly by not helping them! When in doubt about what to do or say, do or say nothing! When I feel the urge to become more active, I monitor my own anxiety level to determine whether the urge is based on good thinking or reactivity. I do not believe that I should come up with interventions to "fix" the problem for my client. My aim is to model a consistent way of thinking and a congruent way of being that reflects transparency and the courage to self-disclose if such disclosure will empower the client to see similar patterns in his or her own life. When I am calm enough, I am able to articulately communicate complex concepts, use reversals, be playful, and still remain respectful of the slow process of emotional change. I offer my way of thinking only as a possibility, as it is essential to model respect for difference. My training in recognizing

patterns in relational functioning makes it incumbent upon me to offer up new possibilities in a clearly communicated manner. I must not assume an expert position on a client's life, so my posture is tentative and respectful, always remembering that my way of knowing is only one way of knowing.

I have been shaped profoundly by my own lengthy journey in psychoanalysis. Just as psychoanalysts must undergo their own analysis in order to become psychoanalysts, so must Bowen therapists work diligently within their own families of origin to become effective in working from the Bowen model. The experiential component of the training of the therapist is valued most highly from both modalities. My choice of studying Bowen Family Systems and using Cynthia as my subject is directly related to my belief that I know what I know from my experience rather than from my study of empirical data. Psychoanalytic therapy and Bowen therapy share the assumption that insight improves the quality of life and that insight is a route to change. Cynthia's journey in therapy was informed by deepening insights, just as my journey in therapy had been.

As a result of my life experiences and training, I believe that change will not occur unless existing conditions offer less comfort than change and unless existing conditions are not so overwhelming as to paralyze the individual from having the courage to move forward. Therefore, there were times that I was comfortable confronting Cynthia's use of defenses that I believed held her back. Sometimes I aimed purposefully to take her outside her zone of comfort. However, the overarching goal of lowering reactivity within the Bowen model always informed my judgment as to timing.

I have been influenced by the humanistic existential value of offering clients unconditional positive regard when I meet them (Rogers, 1951). I believe this humanistic

position is respectful, genuine, optimistic, non-possessive, and fosters the therapeutic alliance (Rogers, 1951). That Cynthia is still continuing in therapy with the therapist highlights the strength of the bond. From a Bowen (1978) perspective, her decision to go to twice a month sessions instead of 4 times a month shows that she has been able to increase her responsibility for self and not become dependent upon the therapist.

While psychoanalytic therapy works within the transference, Bowen therapists work to minimize the transference. The Bowen therapist coaches the client to resolve attachment issues with his or her own mother rather than with and through the therapist (Kerr & Bowen, 1988). I embraced this position with Cynthia. I believe that the therapist can offer a hand as a tour guide as a client tentatively approaches traveling along the less conscious and rockier terrain of his or her family system. My effort is to help the client become more aware of previously unconscious or preconscious processes by frequently asking him or her to say whatever comes to mind about material emerging in session.

My practice is informed by my natural curiosity. I ask a lot of questions. Combining a Socratic approach with psychoeducation helped Cynthia to embrace her own active role of researcher into her own beginnings. This approach complemented her own efforts to increase her level of differentiation and to decrease her anxiety (Papero, 1990). It is important to learn and to answer questions aimed at self-definition if an individual is to find out who he or she is and from whence he or she came.

Having grown up in a small town, most of my friends were Christian while I was Jewish. Belongingness became a central theme in my life from childhood. It has been important to me to feel a sense of connectedness all my life. This need to "belong"

reflects the challenge that I have in holding onto myself in relationship. Often, my decisions have shifted in response to relationship pressure during my life. In my own work within Bowen Family Systems, it was a constant challenge to allow my core values to guide my decisions instead of reactively caving in to others out of my need to belong and be liked. Even during my coursework, I would struggle to be a self instead of trying to please each professor who had a different theoretical orientation. Indeed, within the course of my Bowen training, I had a visceral recognition of myself as an accommodator. My skill in identifying reactivity is primarily borne of my own work at controlling my own.

Training within the Bowen model has increased my appreciation of people's inability to make good decisions when they are extremely anxious and/or stressed by situational stressors (Kerr & Bowen, 1988). I carry the assumption that what distinguishes humans from other species is their ability to think (Bowen, 1978; Papero, 1990). The neocortex that developed in humans provided the capacity to reflect. If a client is going through a crisis or developmental challenge, I encourage the client to delay making important decisions or big changes until he or she feels calmer. I view a person who has the capacity to distinguish between his or her thinking and feeling systems and the capacity to know where he or she stops and someone else begins as more highly differentiated than the person who cannot distinguish these areas (Bowen, 1978). Thus, the more differentiated person is better able to hold onto himself or herself in important relationships. Paradoxically, I believe that this ability allows an individual to sustain intimacy in an enduring way (Kerr & Bowen, 1988).

I believe that each sibling occupies a unique position in the primary triangle with his or her parents (Bowen, 1978). The sibling is less caught in the parents' emotional process and is freer to grow and develop (Kerr & Bowen, 1988). Bowen theory has taught me that child focus often reflects a marriage that has become problematic. Emotional, physical, or social symptoms usually reflect trouble at the top: the marital system (Kerr & Bowen, 1988).

My practice is informed by the notion that humans share more similarities than differences with regard to their emotional processes. I assume that all people develop within the context of ongoing family relationships and fail to flourish in the absence of human connectedness.

I value my age as a professional asset. Because I have experienced many individual and family life cycle challenges, I am more attuned to and can offer unconditional positive regard to people at various stages of their life cycles. Additionally, my experience in psychoanalysis and graduate training in Bowen Family Systems has provided me with a bifocal lens through which to view relational functioning. These divergent personal and professional experiences have left me with an awareness of the importance of having an epistemology that has a conscious awareness of itself. As Watzlawick (1964) explained, "Whoever is conscious of being the architect of his own reality would be equally aware of the ever-present possibility of constructing it differently" (p. 327). It is in this spirit that I have an abiding bias that emotional maturity is related to the ability to tolerate ambivalence and ambiguity. Thus, my philosophy in life and in the treatment room is informed by both a kind of thinking and, similarly, an appreciation for the isomorphic nature of personal and professional growth.

My cultural background in Judaism brings with it a respect for grief as a process. Long before modern psychology adopted such a position, sages from ancient Talmudic times honored the importance of remaining connected to the deceased. In Jewish tradition, an individual moves from total absorption in grief to complete re-engagement in everyday life (W. Dosick, personal communication, March, 2006). However, the dead are always remembered on the anniversary of death (*Yahrzeit*). They are remembered on certain holidays as well (*Yizkor*). My cultural attitudes have shaped my attitude that remaining connected to those who are gone offers healthy opportunities to remember and mourn. Bowen theory emphasizes that cutoff creates symptoms (Bowen, 1978). Congruent with his theory, it is probable that even in death, an individual can resolve attachment to loved ones. My culture and my training reinforce my clinical belief that Cynthia could heal by developing a continuing bond with loved ones whom she had lost.

As a former educator, I learned that the best training contains elements of the experiential and didactic. Such a view predisposes me to embrace Bowen Family Systems theory. In becoming an expert in the art of conversation, I must highlight the known and the unknown. I must listen for what is said and what is not said. My questions should open up possibility and raise new questions. I bring a value that the whole idea is not to have a final answer, but to keep thinking. I believe in the power of positive reinforcement. Thus, I look to expose and even magnify what I observe to be my clients' strengths and resiliencies. More than anything else, my assumptions are informed by the notion that although

> each of us is embedded in systems, we are also separate....Neither a psychology of separateness nor one of embeddedness alone is fully adequate to explain human behavior or to serve as a guide for clinical practice. Working with the whole

> system means not only considering all members of the family, but also taking into account all of the personal dimensions of their experience. (Nichols, 1987, p. 48)

The author developed a deepening appreciation for the courage it took for Cynthia to enter treatment. It became clear that the author's own continuing efforts to work at her own differentiation process was crucial to the successes and failures in this case. The task was to separate intellect from emotion and base behaviors concerning the case on intellect and trust this choice. It was tempting to give in to anxiety and abandon at times when the client's problems paralleled unresolved issues in the author's family of origin.

The writing of the dissertation forced me to become clearer and more focused about theory as it applied to the subject of the case study. Such an effort stretched me and perfected my application of theory within my entire practice. The struggle to remain neutral about the subject of my doctoral dissertation and not become tied to outcome was never ending. Taken together, all the challenges that Cynthia provided to me in my journey toward becoming a doctor of psychology served to polish and hone my own clinical strengths and resiliencies.

Supervision

The supervision received by the author while treating this case was provided by an AAMFT-approved supervisor with a Ph. D. in psychology. This female supervisor also held the position of director of clinical training at an agency that specialized in offering interns exclusive training in Bowen Family Systems Theory. Group and individual weekly supervision called upon interns, including the author, to work and apply theory to

their own family-of-origin issues and/or to cases being treated. The author felt fortunate to have had rigorous training in this modality from an expert in the field.

The writing of the dissertation began after approximately 3 years of training at this agency. Supervision of the case took the form of the supervisor's viewing videotaped and/or audiotaped sessions of the treatment and challenging the author to clarify her thinking about various aspects of the case. The emphasis was upon the author's management of self during session. To improve self-management, the author was called upon to find sources of reactivity that were related to unresolved issues in her own family of origin. The author's reactivity was reflected in her over-functioning and/or acting to rescue the client instead of thinking alongside the client. Another sign of reactivity in the therapist is getting caught in a client's triangles as reflected by her taking a side.

The supervisor offered support and encouragement to the author throughout the dissertation process. She also challenged the author by pointing out how difficult it was to maintain a neutral and objective posture toward a client in whom the therapist had invested so much energy (and resultant anxiety) in terms of outcome over the course of the dissertation process. Time and again, the author was challenged by the supervisor's observation that the client had become too "special," and that the therapist's anxiety may have decreased her ability to remain objective, thus affecting the therapy in one way or another. The supervisor allowed that the client had received very good treatment. Nevertheless, she taught the author that Cynthia's position as subject of a doctoral dissertation did the client a disservice in the sense that the treatment became somewhat compromised by the author's need to excel with a particular case.

Because the supervisor had trained the author for several years, she was very familiar with the author's family of origin issues. It was helpful when the supervisor pointed out sources of reactivity within the author that paralleled some of the emotional processes in Cynthia's multigenerational family. Additionally, the supervisor focused upon helping the therapist stay on track in terms of addressing process over content.

This supervisor modeled appropriate self-management by asking the therapist process questions, pointing out instances of the therapist's reactivity, and defining her own bottom lines in the process of providing supervision of this case. With the guidance of her supervisor, the author became increasingly aware of her own need to reduce symbiotic attachment with her mother through the course of treating this case. Such a realization helped the author appreciate the challenge for Cynthia to accomplish the same task with her mother.

The supervisor's non-anxious, low-key approach modeled the benefit of maintaining an environment that reduces reactivity. This approach also was helpful in aiding the therapist's own effort to lower her emotional reactivity and anxiety levels. This parallel process assisted the author in lowering anxiety in sessions with Cynthia.

After the author was well into the writing of the dissertation, the supervisor encouraged the author to define her own voice more completely and to avoid trying to borrow self from the supervisor. This style of supervision is congruent with Bowen theory's emphasis upon increasing self-responsibility in the client.

Weekly individual and group supervision involved psychoeducation and clinical application. Additionally, the Southern California director of Bowen Family Systems Training offered monthly trainings to interns at the agency, which included lecture,

discussion, and training videos. Finally, the author participated in monthly teleconferences offered by Michael Kerr and in biannual weekend-long trainings in theory. Such training offered the author a breadth and depth of understanding that highlighted that differentiation of self is a lifelong process.

Limitations of Treatment Model

While it appeared that the use of a resiliency-based Bowen Family Systems model proved helpful to Cynthia, there is a paucity of research on sibling survivors of homicide. Similarly, more empirical research on the efficacy of Bowen Family Systems is needed. The nature of the theory is not conducive to empirical studies. Also, with an N of 1, it is difficult to generalize Cynthia's outcome to the entire population of sibling survivors of homicide.

From a Bowen perspective, successful treatment depends on the ability of the therapist to remain objective and neutral toward the client. If a case study is being written while the treatment is continuing to develop, the objectivity of the researcher may be compromised. Such decreased objectivity may compromise the efficacy of the treatment.

Future Research

When writing a case study from the perspective of Bowen Family Systems, it may be beneficial to limit subjects to those people who have completed a course of therapy. In this way, the researcher may remain more objective and less invested in outcome. It is certain that more research needs to be done on sibling survivors of homicide and

treatment modalities that serve them. More case studies utilizing Bowen Family Systems with this population would be a useful addition to the literature in the field. Finally, research studying the effects of applying resiliency theory to this population would be an important investigation.

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APPENDIX

VIDEO TAPING AND AUDIO TAPING PERMISSION FORM

I, _____, consent to the videotaping and audio-taping of my counseling sessions. I understand that this information may be used only for Barbara Cunningham's case study project, which in part fulfills the requirements for the doctoral degree in psychology at Alliant International University. This agreement will begin on this day and will continue until I leave treatment, or until I request that this agreement cease.

Signed: _____ Date: _____
(client)

Therapist: _____ Date:_____

CONSENT TO PARTICIPATE IN CASE STUDY PROJECT

I, _____, agree to participate in Barbara Cunningham's case study project, which in part fulfills her requirements for the doctoral degree at Alliant International University. I understand that the information obtained will be kept confidential. I understand that this project may or may not be used for Barbara Cunningham's project. I understand also that I may withdraw my participation from the project at any point in treatment with her, and it will not have an effect on the course of treatment.

Signed: _____ Date: _____

Witness: _____ Date: _____