Marriage Counseling, Individual Counseling and Psychotherapy: A Theory of Therapy and Change

Underlying Philosophy and Theoretical Assumptions

My guiding principle as a clinician is Bowen family systems theory (BFST). I believe that family dysfunction is rooted in the extended family system. Unresolved conflicts from past generations and from childhood continue to be acted out in relationships in the nuclear family. It is assumed that external systems often determine intrapsychic feeling states, and that it is important to understand both the ". . .historical process in the family and the larger social context in order to transform family relationships in the present" (McGoldrick & Carter, 2001, p. 282). Furthermore, it is assumed that ". . . if one person changes her or his emotional functioning in the family, the system will eventually change. In this framework, family relationships are forever, and it never makes sense to write off a family member once and for all" (McGoldrick & Carter, 2001, p. 282).

My thinking has also been influenced by psychodynamic concepts. BFST and psychodynamic modalities share the assumption that the past is important. I believe that a close examination of past emotional processes in self (psychodynamic) and in one's family over at least three generations (BFST) is a route toward making conscious what was previously unconscious.

Finally, humanistic existential thinking influences the way I think about change. Like BFST and psychodynamic models, humanistic existential therapists privilege the experience of the relationship as a route toward change (Buber, 1970). While BFST and psychodynamic models are deterministic with an emphasis upon the past and upon insight, the humanistic existential therapist emphasizes the fluidity of life and the human potential for growth (Rogers, 1961; Yalom, 1980). Though personal choices may be limited by external circumstances, the existential therapist rejects the idea that people are victims of circumstance. Since there is a focus upon ". . . development of potential. . . awareness. . . peak experiences. . . oceanic oneness. . . self-realization. . . [and the] I-thou encounter" (Yalom, 1980, p. 19), humanistic existential ideas are saturated with hope. No matter how intense the family history, it is possible that an individual can make positive meaning out of any situation, and it is up to him/her to discover this meaning (Frankl, 1963). To create a therapeutic environment that fosters such growth, it is incumbent upon the therapist to develop the ability to have accurate empathy, congruence, and offer unconditional positive regard to clients (Rogers, 1975).

In embracing these divergent ways of thinking, I am aware that underpinning my theory of therapy and change is a "both/and kind" of thinking. I resonate with Watzlawick's (1964) idea that "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). I believe that an important marker of emotional maturity is the ability to hold complexity and tolerate the ambiguity that is part of the human condition. In this spirit, I pick up common theoretical threads that allow me to practice therapy from multiple perspectives in a congruent way. These divergent ways of thinking come together around emphases on theory over technique, insight over strategy,

experience over empiricism, process over content, and strength over pathology.

Additionally, I look to developmental theory as a guide to understanding the family and the individual in the context of the individual and family life cycle (Carter & McGoldrick, 1980). I often educate clients about the tasks of each developmental stage and normalize the crises marking their current stage in the individual and family life cycles. My theory of therapy and change is 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 the members of the family, but also taking into account all of the personal dimensions of their experience" (Nichols, 1987).

The scope of this article does not allow for a detailed treatment of each of the above theoretical orientations. Therefore, I will focus upon Bowen family systems, as it is the cornerstone upon which I base my work. However, other influences will be integrated into the discussion only as they illuminate and enrich my thinking.

Murray Bowen (1978) believed that it was possible to move towards a science of human behavior. His positivist view clearly reflected his assumption that a real world exists that is independent of an observer's subjective perceptions of it (Papero, 1990). More conservatively, I embrace a postpositivist perspective, in that reality ". . .can never be fully apprehended, only approximated" (Guba, 1990, p. 22). I believe that it is impossible for the observer not to affect the observed and vice-versa, but certain patterns can be identified regardless of these effects. Thus, although I am guided by Bowen theory, I am not a purist and have modified my application of the theory in some respects.

Bowen family systems is a natural systems theory that is based on evolution and biology. It is aimed at enlarging one's view of family functioning by exploring emotional processes over at least three generations. Bowen (1978) introduced eight interlocking concepts that must be viewed in relation to one another to be understood properly. These concepts include: differentiation of self; triangles; nuclear family emotional processes; family projection process; multigenerational transmission process; sibling position; emotional cutoff; and societal emotional process.

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. Thus, clinical work is conceptualized from the top down. Work on the self of the therapist begets improvement in clients, just as work on the leader of a family begets improved functioning in its members. By changing one's role in a system, one can improve one's situation.

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.

Core to BFST is the concept of differentiation of self, and working to increase differentiation in self is a lifelong process (Papero, 1990). Differentiation of self is inversely related to chronic levels of anxiety. 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). Friedman (1991) emphasizes 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. In fact, what exists in extreme conditions such as schizophrenia exists, to a degree, in all families (Kerr & Bowen, 1988).

From Bowen's (1978) perspective, people have much less emotional autonomy than previously assumed. While Freud (1924) 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 (Kerr & Bowen, 1988). I believe that both intrapsychic and interpsychic limitations upon autonomy must be respected when conceptualizing a case.

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 need for connection. The cliche "Can't live with them and can't 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.

It is important to emphasize that BFST does not deny emotions. It is quite the opposite. BFST is unique in that emotional, feeling and intellectual systems are differentiated from one another. "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" (Friedman, 1991, p. 136). In a broader sense, the emotional system can be conceptualized as automatic functioning or as a kind of instinctual reaction. The emotional system is more than the brain. It also includes the mind, the body and our relationships.

The feeling system involves the subjective experience that helps us be aware of what is going on in our body and in our environment. For example, our 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) explain that "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 us that is unique. It is the system that allows us to reason and be objective. Our intellectual system allows us 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 us the awareness that our reasoning can be clouded by subjectivity. To the extent that one's intellectual system can consider facts in spite of a feeling state is the extent to which one is able to process his/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. BFST attempts to use family relationships to help the individual to understand his/her intellectual, feeling, and emotional systems.

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, one can only comprehend functioning in the context of the functioning of the other people close to him/her. Kerr and Bowen (1988) explain that "The degree of polarized extremes that these reciprocal traits reach is influenced by the degree to which family members define the differences between them as a problem and anxiously focus on 'correcting' those differences" (p. 8).

I believe that people are doing the best they can with the tools that they have at any given time. I also view the principles of psychic determinism (Freud, 1924; Brenner, 1973) and evolution as complementary. One thing follows naturally from another. To attend to the evolving process between people while at the same time analyzing the evolving process within people is the heart and soul of my theory of change.

Assessment

Initial assessment must evaluate for the presence of any safety issues. For example, if significant depression is part of the presenting picture, I routinely assess for suicidal ideation, and, if present, evaluate the lethality of the threat. Symptoms may require a medical evaluation to rule out serious physical problems. Elder abuse, child abuse, neglect, and domestic violence must be addressed if relevant in initial assessment protocols.

From a life cycle perspective, I want 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 (McGoldrick & Carter, 2001).

From the perspective of BFST, outcome is viewed very differently from other theories. A small change in one person may significantly change his/her life course, and such a small change cannot be implemented without therapy that may last several years. Also, a small change in one person may not be reflected in the family system for three or more generations. Kerr and Bowen (1988) state that "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 clarify that ". . . 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 explain, "There may be an inherited predispositon (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. 240-41). 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 explain that "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 that the potential for psychosis is absent. . . . It just means he manages his anxiety, even when under extreme stress, in a different way" (p. 240).

The Bowen therapist is concerned with assessing intensity in relationship. Papero (1990) describes an intense interaction as ". . . 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 emotional system with the intellectual system being overriden" (p. 41). Such automatic behavior is viewed as reactivity.

Since Bowen family systems is based in natural systems rather than cybernetic systems, the focus in not on homeostasis so much as it is focused on reciprocity. 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. Similarly, if an overfunctioning spouse decreases his/her functioning, the underfunctioning spouse should improve.

Kerr and Bowen (1988) state, "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/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).

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Kerr and Bowen (1988) explain, "Assessment of the basic level of differentiation of a multigenerational family is one component of the assessment of basic level of differentiation of an individual. A second component is the impression about the individual's awareness of the self in relationship. Change can occur when people apply their will to their *own* self-differentiation rather than trying to will others to change. In this way, one can change one's position in his/her family system.

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). I agree, and coach clients to resolve transference directly with family members, especially within their primary triangles.

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. Through revisiting one's position, especially in his/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. It is in this context that the client can change from a focus on others to a focus on self-in-relation.

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. Change occurs outside of therapy, as the Bowen coach sends clients back to work with their families of origin.

To affect change in the system, I work with the person most motivated to change, who often is the overfunctioner. 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. Each sibling may have a little bit more or a little bit less differentiation than may his/her parents. Children that 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/

her family of origin may be more or less fortunate, leading to small but varying differentiation in lines of the family. 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/her family system. If only one variable is changed, it can prevent the storm that might otherwise have occurred.

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 that ". . . 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).

Case Formulation and Treatment Goals

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) emphasizes that "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 diagram evolves to reflect newly collected family facts. 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 me, which will highlight contrasts in how we view the nature of the problem.

Psychoeducation is a small part of most sessions, introducing the client to the natural systems concepts that are applicable to the material they bring to session. Broadening one's 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.

During the middle stages of therapy, I continue to work on reducing emotional reactivity. Continuing psychoeducation on the key constructs in BFST is accompanied by application of these concepts to the client's family of origin and nuclear families. As a coach, I act as a process consultant for the family and teach members how they can differentiate themselves from important others. I make an ongoing effort to remain emotionally neutral. With a couple, for example, I become the third part of a triangle, directing each partner to differentiate a self from his/her spouse. I take my 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 them from getting stuck in competitive debates. I may tell illustrative stories of fictional clients' success with a similar problem, use paradox, metaphor, or read a relevant adult fable (Friedman, 1990). Homework assignments that involve reading and/or asking questions generated either in session or out of session are given.

Since a healthy separation from one's family of origin contributes to healthy adult relationships, I coach each family member to detriangulate from his or her family of origin. 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.

During later phases of treatment, the client is transitioned from therapy to other environments. He/she is educated that differentiation is a lifelong process. It is re-emphasized that the ability to think systemically is related to one's 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. Systemic conceptualizations of one'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. Longevity is favored over frequency. It is not uncommon for a client to return for coaching even years later, if he/she gets stuck on an old or emergent issue. Just as the therapist reinforces the self of the client by asking at the beginning of each session how he/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/she is fully capable of managing life.

My treatment goals are also conceptualized from a psychodynamic perspective. The mnemonic HABIT is useful: Create a holding environment; attend to attachment issues; bridge defenses; investigate intergenerational issues; and tend to transference and countertransference issues. In the beginning stage of treatment, creating a safe holding environment is essential.

During the middle stages of treatment, I work with the client to bring into awareness conflicts that have been previously unconscious. I stimulate self-examination instead of externalization. Occasionally, I may point out an emergent parallel process, in that a client's style of relating to me is emblematic of what may occur in the client's outside relationships. I try to lessen the expectation that the other person will change first. I move the clients toward redefining their polarized positions, and they become increasingly aware of their own part in maladaptive, old patterns. Clients become increasingly aware of the projective identification process that occurs in their families. An effort is made to identify and reduce abandonment fears. If dependency issues are apparent, I may not confront them immediately. Timing is determined according to my judgement regarding the current ego strength of the client. Progress is reflected in an increased ability to tolerate information that exists about self, family of origin, and nuclear family. Constructive self-soothing mechanisms are substituted for destructive habits, increasing the clients' ability to tolerate stress. Clients may begin to integrate parts of self that have been repressed or conflicted. Increased insight may interrupt relational, negative patterns. Combining work with family of origin and work with self may eventually result in a strengthened ego. A sense of congruency, mastery and trust in self will begin to grow. Overall, I am interested in moving families and individuals toward improved management of themselves in relationships, which will subsequently lead to a better quality of life in work and in play.

In the long-term, I am not interested in an abatement of symptoms, unless symptoms are superficial or require crisis management. BFST takes a functionalist position that symptoms serve an adaptive function.

In my model of treatment, I want the client to work through transference issues within his own family instead of with me. Clients will be able to own their experience. An important goal is that the client will develop his/her own sense of self worth rather than looking to others for validation.

Role of the Therapist (Typical Intervention Techniques and Process Used in Sessions)

Bowen family systems theory is unique in its emphasis upon the self-development of the therapist. Thus, I continually work on an increasingly healthy separation from my own family of origin in a way while still remaining connected. Friedman (1991) points 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 explains that "In Bowen theory, *the differentiation of the therapist is the technique*" (p. 138). One 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 one's family of origin while applying the complex ideas of the theory. Work with one's family of origin and work with a supervisor is a central part of the therapist's development. Similarly, psychoanalysts must first complete their own psychoanalysis with a supervising analyst, before they are deemed competent to analyze clients.

It is important to maintain a non-anxious presence. To be objective and to promote differentiation in others is directly related to the being of the therapist, not to his/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. I push myself to work continually at separating my thoughts from feelings and knowing where I stop and my client begins.

I am warm, respectful, engaging, and matter of fact in asking questions. I maintain a collaborative atmosphere in all stages of treatment. The process of gathering family facts is, in itself, collaborative and inherently conducive to reducing anxiety. Additionally, the types of questions asked move the client toward a deepening appreciation for pattern and process. In a sense, I assume the role of researcher and am always curious. One question leads to another, and the calmer I am, the more I can call on my best thinking to expand the line of questioning into broadening perspectives. Eventually, clients begin to see replicating patterns from past to present and connections between events in their nuclear families and family of origin legacies.

I encourage family members to speak through me rather than to each other. By remaining a non-anxious presence in a triangle, I can induce a change in the relationship of the other two that would not occur if the same things were said in the absence of the therapist.

In my work with couples, I work to identify and reflect back repetitive, dysfunctional cycles of interaction early in treatment. For example, I want to identify patterns such as distancer/ pursuer, overfunction/underfunction, or withdrawer/blamer. Initial progress is facilitated if the couple becomes aware of their pattern early in treatment and works toward interrupting it.

There are times when I depart from The Bowen method of having a couple talk through me. For example, in the early phases of marital therapy, I believe that it is important to assess a couple's ability to talk to one another about sensitive material. To assess their ability to connect with one another, I may ask them to turn to one another and repeat important things to the other that they have just said to me. I watch their verbal and nonverbal styles of communication carefully. As treatment continues, I use the same method to heighten important material. I encourage communication in which one assumes responsibility for oneself, whether it is about expressing wishes for space or connection.

I am a coach, in that I teach differentiation moves, or ways that the client can increase his/her neutrality, especially in hot triangles. I also act as an educator in teaching the family about family systems dynamics. Often, I diagram or illustrate BFST concepts on a white board to increase clients' ability to think about their processes in a systemic way. Homework may include relevant readings and letter writing assignments, which may or may not be mailed. Clients may be asked to journal and/or generate questions to ask their extended family members. Photograph albums and videos brought to session 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/her cognitive process.

Kerr and Bowen (1988) encourage therapists to use humor and playfulness where appropriate, but warn 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/her own family and is often asked questions that lead him/her to take responsibility for his/her part in a family problem. A helpful guideline is that within the session, I work on making myself "small." Such an effort means that I have succeeded in being a non-anxious presence who does not overfunction for the client.

How My Theoretical Model Adapts to Different Units of Treatment

In most therapy models, the symptomatic person is the primary focus of treatment. I do not determine the unit of treatment from this perspective. Bowen (1978) blurs the distinctions among child problems, marriage problems, and individual health problems. He regards the central problem as ". . . a fusion of egos or undifferentiated family ego mass, and in which the psychotherapy is directed to the family ego mass, or to those family members most involved in the undifferentiated emotional oneness of the family" (p. 97).

I believe that Family systems therapy does not require the presence of all family members. Difficult life cycle or other challenges may indicate the need for supportive therapy for a child or adolescent. However, it is usually the parents with whom I work when the IP is a child. It is important to understand why ". . . Bowen-trained therapists tend not to see children but to work with the parents *instead*, [because] . . . there is no such thing as acting-out children with mature parents, and when the parents can learn to be better differentiated (and in that process to be more self-regulative), the transmission of immaturity to the next generation often ceases" (Friedman, 1991, p. 160). Child focus as a projection of marital conflict onto the child

is a common triangular pattern. As the symptom bearer, the child plays his assigned role. I assume that unresolved issues from the family of origin get played out in the marriage, and the family projection process places the child in an unfortunate position. Thus, the therapy in marital counseling, as in individual counseling, is directed at resolving attachment in the primary triangle of each partner with his/her mother and father in his/her family of origin in order to improve the partners' ability to have a relationship with each other. By increasing differentiation in the caregiver(s), it is likely that the child IP will improve.

I assume a universalist position, believing that all families are more alike than different (Bowen, 1978). Friedman (1991) points out Bowen's unique position in regard to diversity issues: "From the perspective of an emotional system, cultural and environmental factors are far less important than is the timing of significant changes; the kind of people they are (their personalities) and their backgrounds are less important than the positions they occupy in the triangles of their contemporary systems and the paths of multigenerational transmission" (p. 145). Thus, while individual differences are acknowledged, Friedman explains that Bowen theory goes beyond culture, gender, race, or socioeconomic background with the core concepts of differentiation of self and chronic anxiety, which are inversely related to one another. In fact, notions of individuality and togetherness are explained in a way that minimizes cultural context.

For example, Kerr and Bowen (1988) note that "Americans are sometimes referred to as a culture that values 'individuality' and the Japanese as a culture that emphasizes 'togetherness.' This should not be equated with the meaning of these words in family systems theory. . . . Both 'rugged individualism' and obligatory conformity are strongly influenced by the togetherness force. The 'rugged individualist' operates as much in reaction to others as the compliant person. His determination to be independent stems more from his reaction to other people than from a thoughtfully determined direction for self. He has trouble being an individual without permanently disrupting his relationships with others. The compliant person has difficulty maintaining his relationships with others without giving up his individuality. Rugged individualism and compliance, therefore, are two sides of the same coin" (p. 64).

BFST widens the focus from the individual to the nuclear family as the unit of treatment. As Friedman (1991) explains, ". . . what is important is not the location, or even the form, of the symptom. . . but getting to the systemic forces, both those within the nuclear family and those that are being transmitted from previous generations" (p. 137). Symptoms emerge from problems in one of three areas: in the marriage (expressed in terms of conflict, distance, or divorce); in the health of one of the spouses (either physical or psychological); or in one of the children (Friedman, 1991). Friedman (1991) clarifies that "For a Bowenian-trained therapist, the question of specialties ('Do you see couples? Individuals? Families with alcoholism, substance abuse, violence?') has no meaning. The specialty is always the same…[a] focus on systemic emotional factors rather than specific problems or their location" (p. 138).

Thus, in adapting to various types of presenting problems, BFST conceptualizes all of them as an ". . . interplay between what is occurring within the individual and the functioning position of that individual in his/her most emotionally significant relationship system" (Kerr & Bowen, 1988, p. 56). Chronic symptoms are viewed as a result of poorly differentiated relationships. Furthermore, the severity of symptoms is viewed as paralleling the intensity of

the emotional process (Kerr & Bowen, 1988).

BFST assumes that influential people in a family play a central part in the way members function in relation to one another (Bowen, 1978). Reciprocal positions may work just fine for the individuals involved if the stress is not too great. However, if the stress on a family escalates, such functioning positions become pushed to the extremes, creating serious symptoms in one or more members (Kerr & Bowen, 1988). For example, the symptom of alcoholism may become a third leg of a marital triangle when family anxiety is high. Whatever the presenting problem, Bowen theory posits that ". . . it is far easier to help the overfunctioning person to tone down the overfunctioning than it is to help the dysfunctional one to increase functioning. In any situation in which there is an either/or choice on where to put the focus in therapy sessions, it with the overfunctioning family member" (Bowen, 1978, p. 268). No matter what the presenting problem, the immediate goal is to cool down the reactivity in the system so as to engage the thoughtful behavior of the client(s). After this is accomplished, the work on differentiation can begin.

The Self of the Therapist Influences on My Model of Change

Learning how to create opportunity of the pain inherent in loss has been of interest to me since middle adulthood. My personal experience has encompassed profound losses in my family of origin and nuclear family. Death of a parent, polio, cancer, divorce, and addiction are among many family problems that have colored my view that human functioning exists on a continuum. In my case, I have been able to use adversity in a way to make meaning in my life in increasingly positive ways. In many respects, these same challenges have continued to plague those that I love.

For me, one of the factors that made a difference in my life was a longstanding commitment to psychoanalysis. In looking back, I can see that a certain innate resilience brought me to therapy. I believe in therapy. It empowered me to continue on an arduous path of self-discovery and self-examination. Certainly, this means that I bring a bias for the value of long-term, insight-oriented therapy to my treatment, which is compatible with BFST.

Additionally, continuing work on my own family-of-origin issues has been required of me in my clinical training. Having an intrapsychic experience on the couch and an interpersonal experience of work within my family of origin has afforded me a unique perspective, and this bifocal lens consistently informs my practice.

I also bring to my treatment a curiosity about the nature of resilience. Is it inherent in the human spirit? Can I find a way to ignite it? BFST is a strength-based model that does not dichotomize functioning, but places it on a continuum. BFST eschews the DSM diagnostic categories that pathologize natural emotional processes. My own life experience confirms this reality.

I resonate with the humanistic existential belief in the innate striving toward growth of the human being. How is it that some people become paralyzed by life's challenges while others can recreate and strengthen themselves in the face of adversity? In stimulating the will to meaning (Frankl, 1963), perhaps I can provide a beacon of light to clients who have lost their way.

Culturally, my Jewish heritage has developed within me a tragic appreciation for the multigenerational transmission of the effects of trauma. The Holocaust will affect families of survivors for generations to come, and people like Frankl (1963) inspire me. A study of my own family during three years of rigorous, clinical training confirms for me the ferocity of emotional process in maintaining repetitive patterns through generations. I have seen for myself the positive changes within the system that can occur, even in the face of trauma, with earnest and continuing work in one's family of origin.

As an oldest and only daughter, I have to take care in my practice not to overfunction or feel overly responsible to "fix" the problem. I struggle with this personality trait and have made significant progress over the past three years.

As a former educator, the psychoeducational aspect of BFST appeals to my professional skill set. It is like second nature for me to coach people to view their relational worlds through new lenses. Finally, a focus on theory over technique appeals to my abiding interest in intellectual pursuits.

My age is an asset to me in this profession. A rich life experience provides me with a unique perspective with which to view the family. Since the self of the therapist is the primary treatment intervention in BFST, it is fortunate for my clients to have the perspective of a therapist that has lived and loved on this planet for over half a century!

Evaluation of Empirical Support for the Efficacy of Theory

Miller, Anderson, and Keala (2004) offer the most recent findings addressing the validity of Bowen family systems theory in their literature review. The researchers state that "Despite the prominent role that Bowen theory has had in the evolution of MFT, as well as its influence on current practice, there is no empirical research supporting the effectiveness of the theory in clinical practice" (p. 454). Recent reviews of clinical outcome literature have indeed come up short in studies testing the effectiveness of Bowen theory (Johnson & Lebow (2000). Since Bowen (1978) believed that assessing differentiation through self-report measures is unreliable, he held that differentiation could only be assessed through observation by trained therapists. Because the theory is multi-layered and complex, and since clinical phenomena must be observed in real time and across time, designing studies that measure clinical outcome is challenging. Nevertheless, outcome research evaluating the efficacy in clinical practice of BFST is long overdue and sorely needed.

In contrast to outcome research, there have been a growing number of basic research studies. Miller et al. (2004) state that "Basic research offers another strategy to test the validity of Bowen theory. Rather than testing the effectiveness of a theory in clinical practice, basic research tests the validity of the propositions of the theory. If research supports the validity of the concepts and propositions of the theory, then scholars and clinicians can have more confidence in the soundness of the theory" (p. 454). The authors found that "In the last 15 years, a substantial number of studies have tested the theoretical validity of Bowen family systems theory" (p. 453). Basic research makes use of various measurement instruments to test the validity of theoretical concepts in Bowen family systems theory. Miller et al. (2004) state that the most valuable contributions to basic research emerged in the last decade, after the

development of two psychometrically sound instruments: Haber's Level of Differentiation of Self Scale (LDSS; Haber, 1993) and Skowron's Differentiation of Self Inventory (DSI; Skowron & Friedlander, 1998). The development of these instruments has made the basic research work of explicitly testing Bowen's (1978) theoretical concepts possible.

Miller et al. (2004) found that there was strong ". . . empirical support for the relationship between differentiation and chronic anxiety, marital satisfaction, and psychological distress" (p. 453). Conversely, they cite Skowron's (2000) and Kosek's (1998) findings which disprove the hypothesis that couples with similar differentiation marry.

The idea that higher levels of chronic anxiety point toward lower levels of differentiation is supported in the literature (Miller, et al., 2004). Also, higher levels of differentiation and lower levels of anxiety were found to be significantly associated with marital satisfaction and psychological adjustment (Miller, et al., 2004).

Although there is prolific research literature showing a general association between sibling position and personality characteristics, the researchers cite little evidence in support of Bowen's specific theory of sibling position (Miller, et al., 2004). Miller et al. (2004) also state that while ". . . there is empirical evidence that conflictual couples tend to triangulate children into their relationship, no research has been conducted that links chronic anxiety with the triangulation process, as theorized by Bowen" (p. 463). Furthermore, "Bowen's proposition that anxiety plays a mediating role in the influence of triangulation on children's symptomology is not supported by the research" (Miller, et al., 2004, p. 463).

While there is much support that family processes are transmitted from generation to generation, the authors state that Bowen's explanation for such transmission has received scant empirical attention (Miller, et al., 2004). Klever (2004), however, found that multigenerational relationship patterns of reciprocal functioning between the spouses and child focus were associated with the same patterns in the nuclear family. His quantitative analysis included a correlation analysis of the first five years of a 20-year, longitudinal study. In addition, ". . . all three areas of symptomology—physical, emotional, and social—in the multigenerational family were associated with the same areas of symptomology in the nuclear family" (p. 337). The authors suggest that future studies need to establish whether increasing differentiation of self in a clinical setting will predictably improve marital quality and increase psychological well being.

More questions still need to be addressed. For example, Miller et al. (2004) state that it needs to be determined whether children of poorly differentiated adults are more impaired than others. Testing whether low differentiation leads to less flexibility and adaptability in the family system is another area of research that must be explored. Additionally, the impact of differentiation on physical health has had scant empirical attention, with only one study (Weiner, 1989) addressing that relationship (Miller, et al., 2004).

Finally, in order to support Bowen's assumption that the theory is universal, research needs to address criticism of the theory for "overvaluing stereotypically male characteristics" (Knudson-Martin, 1994, p. 35) and for overlooking the processes by which women self-define (Ault-Riche, 1986). Lerner (1986) says that "Bowen and his followers view feminism as an emotionally reactive position that can lead clients down the non-productive path of linear thinking (i.e., blaming men) or the relinquishing of self-responsibility" (p. 39). With regard to differentiation, Miller et al. (2004) state that "The limited

number of studies that have been conducted have found few gender differences. . . [and that]. . . little research has examined the cross-cultural applicability of Bowen theory" (p. 463). The only evidence that the universality of the theory was supported was with a Philippine sample (Tuason & Friedlander, 2000). As such, Miller et al. (2004) call for gender, social class, and racial variables to be examined through use of multicultural samples.

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