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Trauma and Bowen Family Systems Theory: Working with Adults Who were Abused as Children

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Working with survivors of trauma is mostly challenging, exhausting, long-term and often 'messy', when interventions that 'should' work, don't, or the unexpected arises. Nevertheless, explanations that speak to recovery from trauma more and more rely on neurobiological concepts to account for any positive change. Combining the family systems approach of Murray Bowen and recent research on the brain and trauma, post trauma symptoms are viewed as part of the 'family emotional process' even when traumatic events have emanated from outside the family system itself. Variations in responses to trauma, including dissociation and self-harm are discussed in relation to chronic anxiety and 'differentiation of self'.

Keywords: child abuse trauma, anxiety, dissociation, Bowen family systems theory, differentiation, neuroscience
For clinicians aswell as researchers, there is an enormous challenge in bringing together an understanding of neurobiology, trauma theory and therapy in order to assess and intervene effectively with clients who struggle with the pervasive effects of trauma. Bowen family systems theory joins these discursive threads in a useful way, promoting an individual's opportunities for emotional growth and viability. The word 'viability' is used here to point to the individual's increased capacity to maintain optimum equilibrium in stressful situations, to sustain meaningful relationships, and to recover and develop more fully one's potential.

Bowen Family Systems Theory
Based on his clinical observations of families, the hypotheses he made about these observations, and knowledge from the biological and evolutionary sciences as developed at the time of his writing, psychiatrist and researcher Murray Bowen formulated a theory of natural systems (Bowen, 1978; Kerr & Bowen, 1988). This theory, known as Bowen family systems theory (BFST) explains how potent relational forces ensure survival and facilitate less anxious physiological states crucial to wellness.

In introducing BFST, I first define some key terms and core ideas, particularly the forces of individuality (or separateness) and togetherness (or fusion); unresolved attachment processes; differentiation of self; triangles and triangling; and chronic anxiety.

1. The forces of individuality (or separateness) and togetherness (or fusion)
Two counter-balancing agents, 'individuality' and 'togetherness', play out between members of a family, which is motivated by the need for approval, acceptance and closeness on the one hand and the push to be autonomous and self-defining on the other (Bowen, 1978, pp. 277–279; Kerr & Bowen, 1988, chapter 3). These forces for togetherness and separateness operate between people in person-to-person transactions that are inclusive of, but not limited to, the mother and child dyad, within what Bowen termed, the 'nuclear family emotional system' (Bowen, pp. 376–377; Kerr & Bowen, chapter 7).

In mammals, the togetherness force produces a symbiosis or 'fusion' that ensures survival of the infant (Kerr & Bowen, p. 238). As the infant matures physically, any symbiosis should reduce over time in both the parent and the child. Bowen also theorised that in times of crisis, the togetherness force produces a visible fusion in which people forget their individual differences and 'pull-together' for a higher good. A person's individuality needs can be appropriately sacrificed and replaced by a joining with the needs of the group or community and this functionally promotes survival.

2. Unresolved emotional attachment

According to Bowen, the degree of 'unresolved emotional attachment' to one's parents drives the ability of a person to adapt to and manage thoughtfully the tension of these two competing forces as an adult (Bowen, pp. 331–332). From this perspective, attachment in relationships is understood as the degree to which individuals are able to separate themselves fromemotional dependency on significant others. Over time, if the child remains overly sensitised to the needs of others, especially the needs of her parents at the expense of herself, this other-directed focus dominates the person's attention and overall functioning. This continuing dependency on others for approval and an emotional over-sensitivity to others' feeling states also reflects the degree to which the person's parents have themselves moved out of the fusion of the 'multigenerational emotional processes' embedded in their own families of origin (Bowen, pp. 384–385; Kerr&Bowen, chapter 8). The greater the degree of unresolved attachment, also understood as the 'fusion . . . between emotional and intellectual functioning' (Bowen, p. 362), the more the person operates by accommodating, distancing, or using other behavioural adaptations that challenge self-directed autonomy in relationships. The person is less able to manage real or perceived changes and stressors in relationships and the environment without a sustained increase in anxiety that reduces their functioning and negatively impacts on their physical and psychological wellbeing.

3. Differentiation of self

Understanding what constitutes various levels of emotional maturity led Bowen to develop the concept of 'differentiation of self' (Bowen, pp. 448–449, Kerr & Bowen, pp. 89–111). Taking into account that the functioning of even highly differentiated people is reduced when overwhelmed by multiple acute stresses, Bowen nevertheless proposed that more emotionally mature people function effectively at one end of a continuum; and people with severe symptomatology, such as schizophrenia function, poorly at the other. Thus, the ability to adapt to stressors is subject to a number of factors, the most salient of which is the level of chronic and/or acute anxiety (see below).

A person's emotional system, according to Bowen, includes survival mechanisms that humans share with other species, such as instinct, reproduction and the involuntary operations of the autonomic nervous system, that is, the activity of the limbic or fight/flight system (Bowen, p. 70; Kerr & Bowen, pp. 35 & 92, referring to the work of Maclean, 1978, p. 339). Bowen theorised that the degree to which a person is able to remain thoughtful and manage their emotional reactivity is indicative of the person's level of emotional maturity. A person with a welldefined or more 'solid' or 'separate' self, has a higher level of differentiation and is guided into action by their values and principles, even when their stress or anxiety is high.

4. Triangles and triangling

According to Bowen, 'the molecule of any emotional system' is the triangle (Bowen, p. 198; Kerr & Bowen, chapter 6). 'Triangling' is a process whereby two people in a relationship manage their anxiety by drawing in or focusing on a third person (Kerr & Bowen, p. 135). At a critical point in the family life cycle, one child more than another may become over-sensitive to the expectations of parents, the parents may triangle the child by focusing on him or her, at the expense of resolving relationship difficulties in the parental dyad. Anxious or depressed symptoms may have already emerged in a parent if they have been unable to manage the anxiety of facing issues with their partner in an emotionally mature way.

This is not to say that there are no attempts at managing conflict in functional ways; however even in the face of reasonableness', the other partner may counter with change-back' strategies such as attacking, defending or withdrawing. These strategies then may reduce the capacity of the first person to remain thoughtful, more responsible to and for herself and less reactive to their partner (Papero, 2011). As this sequence continues over time, symptoms may also emerge in the child in whom the unresolved attachment processes between the parents are played out.

5. Chronic anxiety

Bowen argued that in relationships people experience 'chronic anxiety' in relation to each person's different needs for togetherness and separateness (Bowen&Kerr, chapter 5). Anxiety may be triggered by conflict, disapproval or rejection and individuals develop ways to avoid conflict at the expense of their own differentiation. Research into neurobiology has demonstrated that the experience of anxiety is physiological as well as emotional

and that relational cues significantly trigger and determine the activity of our nervous system. Neurobiologist Steven Porges (2011) speaks to the hard-wiring of our sociality in the ways that our brains function to respond to each other. Certain transactions between individuals may down-regulate the action of the sympathetic nervous system which is triggered by stress.

A person may, for example, agree to study medicine, not because they want to, but because the anxiety of dealing with their parents' disappointment may be too difficult to manage. The young person's limbic system and physiological stress reactions may be temporarily reduced by accommodating his or her parents' expectations, although in the longer term, anxiety about the lack of autonomous decision making may emerge through symptoms. In this way, one person may be symptomatic, but the symptoms themselves have not 'started' in that person. Rather, the nuclear family's undifferentiation has become 'bound' in the symptoms and impaired functioning of one or more vulnerable family members. In other words, the symptomatic person has absorbed the chronic anxiety that belongs to other members of the system, and this anxiety has manifested in symptoms.
In families with higher levels of differentiation, parents may express disappointment whilst still respecting their young adult's move to more self-directed decision making about their future. In a family that demonstrates higher levels of emotional maturity, the young person is more likely to have the capacity to manage their parents' disappointment and find a way to 'self-soothe' or down-regulate their level of anxiety (Wright, 2009). This is achieved without either accommodating to the parents' through attempting to please them or by cutting off contact with them, either physically or emotionally. The ability to self-soothe in the face of physiological arousal requires conscious awareness and more often than not, well-thought out and determined action, given a family member's 'exquisite sensitivity to another's emotionality' (Hanes Meyer, 1987, p. 44). In people, sensitivity to how others respond and react organises behavioural adaptations, feeling states, neuro-endocrine stress responses and mediates health and well-being.

Bowen argued that in the effort to maintain harmony over individual autonomy, people adapt to the individuality-togetherness forces in relationships by being acutely sensitive and accommodating to the other's expectations. Emotional and physical distancing is also evident either intermittently or in the long term. Many families have sustained emotional 'cut-off' from each other, where members of the family have failed to engage in meaningful and emotionally intimate person-to-person exchanges for significant periods of time (Kerr & Bowen, pp. 273–274). Other families engage in longer-term physical cut-off, when family members have not had contact with each other for years due to their reactivity to each other.

Less obvious are those adaptations that include reciprocal functioning: one person may over-function for another by being over-responsible for the other's feelings or performing tasks the other should perform whilst at the same time, under-functioning themselves. The over-functioner consistently sacrifices their own needs to ensure another's well-being, whilst the other person, takes less and less responsibility. More obvious is the emergence of symptoms in a partner or child, who expresses or 'carries' anxiety for others. Parent's anxiety about their child's symptoms may temporarily reduce their anxiety about their own relationship.

Bowen Family Systems Therapy
The aim of a Bowen approach to family therapy is to reduce the client's sensitivity to the expectations, attention, distress and approval of others (Kerr, 2008). It usually involves family research to identify the way previous generations of the family have managed the togetherness-separateness forces. Thus the client can begin to contextualise the behaviour of parents or caretakers within the landscape of patterned adaptive responses to conflict and/or the avoidance of conflict. Adaptations that are uncovered in three or more generations of the family system provide evidence of the emergence or prevalence of less than viable functioning over the long-term.

Bowen used the term 'coaching' to distinguish his approach from psychotherapeutic approaches. Coaching is focused on reducing client over-sensitivity to others by increasing their capacity for more emotional mature responsiveness to others. The therapist or coach acknowledges the difficulties the person is experiencing, taking into account the capacity of the client to move into self-reflective responses when they are distressed and highly anxious, given that 'growing oneself up' can be arduous and painful (Brown, 2012). Coaching is carefully paced via interventions that assist clients to increase their self-awareness and reduce anxiety and to enhance their ability to act in accordance with their principles and values.

In this model, focusing on the client's sensitivities to others can be emotionally intense not only for the client, but also for the therapist (Brown, 1999). Bowen argued that therapists are also subject to togetherness and separateness forces that influence their ability to respond thoughtfully to clients. A therapist who in their own

family, works hard to avoid conflict and make others feel better may also over-function with clients. For example, a therapist may sacrifice a well-timed and appropriate challenge that would promote a move towards positive change in order to ensure that the client leaves a session validated and appearing 'lighter and happier'.

Child Abuse, Trauma and Family Emotional Processes

From the Bowen theory perspective child abuse is conceptualised as a facet of family functioning, in which there is 'insufficient emotional separation' between family members and the ability to act from principles and values rather than emotional reactivity (Bowen, p. 209) Bowen, like most theorists of his time, did not account theoretically for gender or power as mediators of behaviour and relationships. One common critique of Bowen theory is that a focus on the whole family system may effectively remove responsibility for the violence that ultimately lies with the perpetrator. Bowen theory nevertheless provides a conceptual understanding as to how an individual's functioning plays a part, even if it is not an equal part, in abuse and other forms of violence. Further, it assists with unpacking the important elements that may allow the abuse to remain unchallenged and the maintenance of symptoms in the trauma sufferer well after the abuse has stopped. When individuals experience overwhelming events outside of their family such as abuse in the workplace, their family's emotional processes may also influence the chronicity of their symptoms.

One family member may react to a child (or partner) with violence and the other parent reacts with emotional distance or accommodation, rather than undertaking appropriate action to intervene and stop the violence caused by the other parent. Whilst in no way transferring responsibility for the violence to this parent, it does give credence to the idea that abuse is embedded within the family's emotional processes. The non-abusing parent sacrifices his or her principles about what constitutes appropriate and protective care-taking responses in order to maintain relational harmony. It goes without saying that the abusive parent also fails to abide by such principles.

Dissociation and self-harm

Individuals who have experienced abuse often adapt by either distancing from the abuser or fusing with the abuser. Theymay also dissociate or engage in self-harm. Such trauma symptoms are at the extreme end of the continuum of Bowen's concept of 'cutoff', where a person manages overwhelming anxiety via the autonomic 'shut-down' or freeze responses as described by Porges (2011). The child unconsciously manages being 'overtaken' by the perpetrator and the enormous anxiety that is generated, by disconnecting from her own body. Dissociative responses become habitual when a person is exposed to their family's persistent and severe emotional fusion. Further, these dissociative responses are maintained by the climate of the family emotional process — family members who fail to intervene or minimise the abuse perpetrated by another family member, play a part in maintaining the child's symptoms. Selfharming behaviours calm the amygdala, the primitive, flight and fight centre and impact on the body's release of endorphins providing analgesia from pain, 'making us calm, safe and less vigilant' (Cozolino, 2002, pp. 264–265). Thus self-harming behaviours and dissociative states function to reduce anxiety in the same way that person-to-person exchanges 'both symbiotic and reciprocal' (Porges, 2011, p. 295) fire neural receptors that promote less anxious physiological states.

Donna – A Case Study

Thirty-eight-year-old Donna came to therapy with a history of self-harming and suicidal behaviour. Both her stepfather and her stepbrother, Steve, sexually abused her from the age of five until she was twenty-five years old. Donna was diagnosed with both schizophrenia and dissociative identity disorder. Unable to work, Donna has had multiple hospitalisations for suicide attempts and came with a long history of 'failed' therapies. I viewed Donna's symptoms as reflective of her family's multi-generational emotional processes, characterised by lower levels of differentiation and minimisation of abuse.

Much of my work with Donna involved managing my own anxiety in the face of the chronic nature of her symptoms, dissociative episodes that would occur in our sessions and my tendency (resulting from my own level of undifferentiation and a sensitivity to her distress) to be overly responsible for her. Furthermore, I had to set limits in therapy, that is, hold an 'I position' as to what I was willing and not willing to do. For example, early in therapy, after what had seemed to be an innocuous trigger, Donna dropped to the floor, began screaming, and crawled under my desk.When she seemed 'unreachable' and was not responding to my questions, I called an ambulance and she was admitted to Accident and Emergency. On her return to counselling, I told Donna calmly but firmly that I would not be able to work with her if that occurred again, that no useful therapy could occur on the floor, under a desk and with her crying and screaming especially as I had trouble thinking clearly in the face of such a high level of distress. I also said that I knew this would be hard, as I understood, as far as it was possible for anyone else to ever understand, that she had suffered greatly throughout her life and had a lot to be distressed about. I asked what triggered her to such a degree that she let herself fall to the ground and become

so distressed. How had this helped her in the past? Had it assisted any work she had previously undertaken in therapy?

Donna responded that she 'might as well behave like the insane person she is', if that was what she was expected to be. I replied that I wanted to assist her to think about how she might manage herself differently; so that treatment of her by others, particularly members of her family and other health professionals, would not 'tip her over the edge'. I also wanted her to be capable of obtaining paid work, both goals she had articulated for herself. I added that this would involve a lot of hard work on her part. I explained that my own values and principles about therapy involved Donna managing her emotional states better so she could think more clearly to resolve problems rather than invite others to see her as mad.

In this way, the therapy with Donna moved towards opportunities in which Donna could experience herself as a person who could think beyond her emotional reactions and take responsibility for her actions and decisions. Hence I assisted Donna to unpack the person-to-person exchanges that caused her distress and work out ways to manage that distress through self-soothing efforts. This involved Donna observing what she did or didn't do when upset and thinking about what she would like to be able to do or say in relation to the other people present, particularly family members.

One telling exchange presented itself, which spoke to her family's emotional process. In great distress, whilst adding as an aside 'Don't worry, I'm not going under your desk, Linda', Donna told me about a conversation that took place when she was with her sister who had just undressed her nine-month-old baby girl prior to a bath. Steve, her stepbrother, walked into the room, peered over the change table at the little girl, and said that she was 'developing nicely'. When I asked Donna how she responded, she told me she didn't say anything except to say she had to go home. Once home she cut herself badly and that the next thing she knew, it was morning, but she didn't remember sleeping. While I had gathered from a previous disclosure that her stepbrother would comment on her own developing torso from the time she was a pre-adolescent, subsequent therapy focused nevertheless on what Donna would like to be able to say and do if this happened again, rather than remain silent, distance and then hurt herself.

Coaching

After assisting Donna to manage her distress and reactivity through a very brief but effective tapping technique and breathing exercises, she was able to decide the 'right' thing to do if her stepbrother made a comment like this again. I encouraged Donna to reflect on the usefulness or not of 'telling her stepbrother off' if she had the courage to do so. We then explored possible values that might guide her actions, identifying her principles and ethics. What emerged was that Donna wanted to honour her own experiences in this exchange and to say something like, 'Steven, when you say that, I feel really uncomfortable.' With coaching, Donna was able to say just that when a similar event occurred. In response to her mother's comment that her stepbrother didn't say anything wrong, Donna was able to say that she 'still found it made her feel very uncomfortable and that it reminded her of things her stepbrother had said to her in the past which made her distressed'. The minimisation of Steven's comments by her mother contributed to Donna's symptoms.

The focus of this therapy was to help Donna learn to calm her anxiety in order to become differentiated in her relationships within her family. Throughout three years of a Bowen therapy approach, Donna was only hospitalised once in the very early stages as recounted above. Since the moment of speaking for herself and her own experience in a direct person-to-person exchange with her stepbrother and mother, Donna has held down a paid position, her self-harming behaviour and dissociative episodes have reduced dramatically, and she has consistently commented that she 'does not feel so bad about herself'.

The focus of therapy was not to challenge her cognitions about 'feeling bad' but on what she can do now, guided by her best thinking when difficulties arise in her interactions with members of her family. In this way, Donna's negative cognitions about herself were implicitly challenged. When one grows in self-efficacy, in the ability to be a separate and more solid self, whilst staying connected with one's family, negative cognitions lose their potency. Therapy focused on coaching Donna to think about her reactivity in her significant relationships as opposed to her transference relationship with me as her therapist. When Donna expressed distress about what I might have said, or about my absence, I asked her to *think* about this distress, who else in her family expresses similar distress and to ask her to think about what research she might like to do to find out more about the manifestation of this type of anxiety in her family system. That is, coaching within the BFST frame does not directly focus on working through transference issues in relation to the therapist.

Reflections

There is much more to this story of managing my own anxiety about Donna in my attempts to become more differentiated. BFST insists that the therapist or coach work on managing, for example, their own contribution to the under-functioning of their clients. In my own family, I work consistently towards reaching for an 'I position', speaking formyself without expecting a change from others. As Roberta Gilbert points out, 'there is no substitute for an ongoing effort to become more of a self in one's extended family . . . . without which, [therapists] don't have an idea about how to apply the concepts to real life' (Gilbert, 2005, p. 2). Nor do therapists otherwise learn that the concepts do work.

Whilst working concurrently on their own differentiation efforts, the therapist's work with the survivor needs to focus on assisting her to assume responsibility for her own life, happiness and comfort. This means that the focus of therapy is not on the client's experiences and feelings of betrayal, abandonment, hurt and pain. What is more useful is exploring the person-to-person behaviour that emanates from such feeling states:
'What do you do in relation to others when you feel shame? How do you communicate this to others, or not? Do you reach out to others or distance? How does this serve you, meet your goals for health and well-being? What do you imagine you would be able to do if you were less reactive to others' expectations?'

In this way, a Bowen approach moves to reduce less functional behaviour, manage the anxiety of being in conflict with significant others and assists the survivor to communicate her needs and wants in more mature ways. Further, a family systems view of symptoms takes into account the survivor's own reciprocal functioning in accepting invitations to function for others at the expense of herself. It also encourages work targeted at coming to grips with her own part in maintaining patterns of reactivity and anxiety binding behaviours. In so doing, this opens up many possibilities for viability and self-directed functioning.

Conclusion

Bowen family systems theory directs the trauma survivor towards reflectively examining her over-sensitivity towards significant others. Coaching is purposefully directed to assisting her to reduce her reactivity in those relationships and usually involves the utilisation of arousal reduction techniques before entering into work that encourages non-blaming person-to-person exchanges. Freedom to think for oneself, and awareness building around how some behavioural adaptations hold more possibilities are core to this approach.

Work within a Bowen family systems frame recognises that any extended focus on feeling responses reduces the ability of the survivor to think rationally, to have access to her higher cortical functions, and consequently set a course of action, guided by her own principles and values. Thus the focus is not on the reparative relationship of therapist and client, given this can replicate the original fusion from which the survivor is trying to escape. A focus on being responsive and sensitive to the client's needs by acting as a 'healer' and reparative parental figure can work to bind the anxiety even further, *reducing functioning* and discouraging self-defining, self-responsible action and self-soothing behaviours.

This is a significant challenge for therapists who have 'grown-up' through a valorising of the 'healing agency' of a traditional attachment theory frame, in which therapists themselves are inculcated into acting through a discourse that consistently blames mothers for their 'non-attunement' and ignores the embeddedness of relationality and functioning within the wider system of the family.

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The paper was originally published in Australian and New Zealand Journal of Family Therapy Vol.33 No.3 pp. 232-241.
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