Family Process Influences on the Resilient Responses of Youth

Monika Ingeborg Baege

University of Vermont

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FAMILY PROCESS INFLUENCES
ON THE RESILIENT RESPONSES OF YOUTH

A Dissertation Presented

by

Monika Baege

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The Faculty of the Graduate College

of

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Abstract

Family Process Influences on the Resilient Responses of Youth

The concept of resiliency, or how young people thrive in the face of adversity, brings a positive focus to youth development research, and has emerged as an important topic in the youth development field. Adversity, or risk factors, may be internally or externally generated, and may be acute or chronic. Researchers often point to the balance between risk factors and protective factors as the determining influences on a child’s resiliency. If protective factors in the layers of a child’s world (such as self, family, school, and community) outweigh the risk factors, then a child will be resilient. However, questions remain about why siblings who share the same family, school, and community, often respond differently to the same adversity. Though a child’s temperament is often considered the answer, researchers also point to the fact that underlying relationship processes surrounding adversity play a role in how young people respond and how children in the same family may have different responses.

This research examines how family processes play a role in the resilient and non-resilient responses of youth. The author proposes definitions of a resilient response and a non-resilient response that change the paradigm of resiliency from a fixed trait to a set of responses that vary in different relationships. The study uses Bowen Family Systems Theory to frame the discussion about family emotional processes that evolve to manage anxiety created by adverse conditions. Data are drawn from five case studies of families who participated in Bowen’s original family research study. The five families were among others who lived at the National Institute of Mental Health between the years of 1954-1959. The multi-year observations of these families provide a rich source of information on the interaction between family members that influence the resilient responses of their children.

Using a cross case analysis with a grounded theory methodology reveals the link between adverse conditions and the central phenomenon of anxiety. In the context of the family system, various action and interaction strategies (family emotional processes) evolve to handle anxiety, which then result in the consequences of resilient or non-resilient responses. A resilient response model illuminates pathways toward greater and lesser adversity, and Bowen’s concept of differentiating a self (here called a differentiating move) is offered as an intentional way that individual family members can influence resilient responses.
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My family of origin, without whom this endeavor could never have been possible.
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The main long-term psychopathological risks associated with parental death derive from the family consequences rather than from the event of parental loss in and of itself. In each of these cases, we have moved somewhere nearer the risk mechanisms, but there is a long way to go before we fully understand the processes (Rutter, 1984, p.365).

While important attention is now being paid to the "village" in which children grow up, not enough is widely understood about the importance and workings of the family system in which they develop. But that family group with all of its members together will no doubt prove to be an overwhelmingly more important factor in how they turn out as adults (Gilbert, 1999, p.70).

The focus of many families, educators, and policy makers in the early 21st century was "youth at risk." Millions of dollars are spent each year on programs and policies that help children, youth, and families thrive. Millions more are spent on secondary prevention programs designed to keep America's kids off the streets, out of trouble, and engaged in prosocial and productive activities or service to society. The focus on developing assets and preventive measures has been a positive step in the attention on children and the families around them. However, I detect an anxious element to the focus on today's youth. The social dynamics of many Americans and their frenzied efforts to mobilize resources and concern at the needs of children may obscure a need to pay closer attention to the family systems and interactions. It is my belief that these family processes have a
INTRODUCTION

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profound influence on youth and they need to be fully appreciated and understood for resilience to become a primary response for every child.

I sense a need for greater attention to the emotional details within families that have become part of a troubling status quo. It is my opinion that hopelessness, giving up on people and relationships, assuming that children cannot think for themselves and make sound decisions, all arise out of a heightened level of anxiety that is prevalent in 21st century American society. Certainty and quick fix solutions are alternate manifestations of this trend. I believe a systems perspective as I outline it in the pages to follow provides an important compass for orienting to a calmer, more considered approach to preparing our young generation for the challenges that lie ahead of them. A systems view can provide hope in a new way of seeing a difficult situation, and a way to effect change that is not only possible, but in the control of each person who takes on the endeavor.

This dissertation takes an in depth look at how the family system and its underlying processes influence youth resiliency. It addresses gaps in the literature identified by resiliency researchers about the mechanisms that surround a risk factor. For example, a divorce itself does not necessarily create risk. Risk seems to develop over time in relation to relationship processes that may precede and follow the divorce, such as conflict (Musick & Bumpass, 1999; Rutter, 1994). This dissertation explores how a risk factor becomes a problem for some children and not for others, especially those who grow up in the same family, neighborhood, school, and community. Through case study and grounded theory methodology, a resilient response model emerges. I delve into the archives of a family research project conducted in the 1950’s by Murray Bowen that
looked at the family as an emotional system, examined how family members influenced each other, and focused on the relationship process behind the content of interactions. I explore that archival dataset to offer some new perspectives on resiliency. I also use Bowen Family Systems Theory, which grew out of Bowen’s research project, to illuminate some of the family processes that influence resiliency. Bowen Theory is the lens. Resiliency is the focus.

The topic of resiliency has evolved in the youth development field for over 25 years (Garmezy, 1994; Garmezy & Tellegen, 1984; Rutter, 1994; Siantz, 1997; Wang, Haertel, & Walberg, 1997; Werner & Smith, 1984, 2001). Resiliency looks at how children thrive, especially those who have been exposed to a great deal of adversity. Much of the research done on resiliency outlines sets of protective factors that individual families may or may not be able to bring about for their children, or risk factors which they may not be able to escape. Researchers often point to the balance between risk factors and protective factors as the determining influences on a child’s resiliency. If protective factors in the layers of a child’s world (such as self, family, school, and community) outweigh the risk factors, then a child will be resilient. This perspective is often used on a social policy scale, as communities look at improving the balance of developmental assets in the environment.

Often when researchers discuss resiliency, they point to the temperament of the child or the presence of one significant caregiver in the child’s life as critical. Differences between sibling responses to a risk factor such as divorce may be attributed to the temperament of the child who has more difficulty. The coping problem is seen as originating within the child. While these are significant contributing factors, an important
perspective is missing from the dialogue: a family systems perspective.

When the problem is seen as individual temperament, there is little one can do to fix the situation unless one can convince the child engaging in problematic behaviors to change his or her personality or way of coping, which will likely meet with resistance. When the problem is conceptualized as residing in the family system, no one feels blamed or singled out. Each person in the family has the opportunity to change his or her part in the system, and hence, in the reciprocal nature of family systems (Bowen, 1978; Gilbert, 1992, 1999; Kerr & Bowen, 1988; Papero, 1990), to influence the dynamics that lead to more flexible behavior among all members of the system.

This dissertation adds to the dialogue about why a risk factor can be a problem for some children and not for others, even children in the same family. As Rutter (1994) states, “Many family-wide experiences impinge differently on different children in the same family” (p.366). He adds,

Marked individual differences in children’s response to parental divorce have been noted in all investigations but it is only relatively recently that there have been systematic studies examining why this is so even with children within the same family....Siblings within the same family differ in their perceptions of family conflict (Rutter 1994, pp. 357-358).

What are the underlying processes that make a stressor like divorce a problem for one sibling and not the other? Siblings who share the same family, school, and community, often respond differently to the same adversity. It is not uncommon to hear about a family where one child makes the school honor roll regularly while the other sibling skips school and experiments with drugs. The fact that the siblings grew up in the same family, the same school district, and the same community leads me to believe that more subtle processes are at work. What in the family system contributes to the difference?
My journey to answer this question led me to the archives of an unusual research study conducted at the National Institute of Mental Health (NIMH) from 1954-1959. Murray Bowen, MD, directed this project that studied emotional processes in families on a round the clock basis over several years. Entire families lived at the Clinic for periods of up to three years. Though each family in the NIMH study had a child who was diagnosed with schizophrenia, the emphasis of the project was on researching and treating the family dynamics hypothesized to underlie the symptoms. The multi-year observations of these families provide a rich source of information on the interaction between family members that influence the resilient responses of their children.

As one of the prime early originators of the family systems paradigm, Bowen attributes the early development of his family systems theory to the NIMH study. Bowen Family Systems Theory, which developed between the 1950’s and 1970’s, postulates that the same processes that operate in families where one of the siblings has been identified as exhibiting a severe mental illness, operate in all families to varying degrees (Bowen, 1978; Kerr & Bowen, 1988; Papero, 1990). He continued to refine and add to his theory over many years of work with families with severe to mild problems.

I gathered data on five families who participated in Bowen’s NIMH family research project. In the process of my cross case analysis, a model unfolded that was inspired by grounded theory methodology. I call this the resilient response model. The model links adversity to the resilient responses of youth through a central phenomenon of anxiety, mitigated or exacerbated by the family’s context and interactive processes. This dissertation study draws on Bowen Family Systems Theory to explicate the role of anxiety, family context and familial processes in the resilient responses of youth.
An ultimate purpose of this project is to give hope to those who are discouraged by the vicious cycles in their families that threaten their own resiliency or that of their children. I have seen people in despair when despite their heroic efforts to monitor and help their children, they have little effect or make matters worse. This is ironic because resiliency researchers often name the presence of one significant caregiver in the child’s life as critical. However, having a significant caregiver may not guarantee positive outcomes for a child. Some caregivers find that the more they “care” about the child, the more the child acts out (Bowen, 1978; Gilbert, 1999; Donley, 2003).

This was the case with a mother who started a study circle of parents who were experiencing delinquency problems with their teenagers. She invested a great deal of effort into arranging meetings, and invited police to speak to the group on how best to monitor their kids. Every night she was on the phone with the other parents and all day long she was worrying about how to help her child. During interactions with her son, she urged him to improve his behavior, and when he did not comply, she became openly angry with him. Meanwhile, his behavior continued to get worse. It was only when she began to alter her part in the family system that he began to behave more responsibly (personal communication, 2004). While protective factors such as a significant caregiver obviously are important contributors to youth resilience, the nuances of that caregiving deserve close attention. I have been extremely moved upon witnessing the transformation toward resiliency that results when people take their focus off saving the children and work on changing their own part in the family system.

Part of my goal in outlining the resilient response model is to illuminate action and interaction strategies that lead toward greater and lesser adversity, and to examine
resilient and non-resilient responses as outcomes of these strategies. I offer an alternative to the cyclical processes that can keep a family stuck on a vicious downward spiral. One of the core themes of the family research data was the occasional ability of a parent to change their part in the family system, an action that inevitably altered the resilient responses of their children. I have termed this a differentiating move, drawing on Bowen's concept of differentiating a self. The differentiating move is an intentional way that individual family members can influence resilient responses of youth, by shifting their focus.

With this dissertation project, I want to contribute to the notion that families have a great impact on children, but to do it in such a way that none of those reading this will feel overly responsible for their part in such an impact. If I succeed, it is hopefully because I have conveyed the family systems lens effectively. At best, this research details the family context through which anxiety travels and the processes that evolve to handle anxiety both within and between family members. In the course of the explication of the findings through a resilient response model, I hope to present concepts from Bowen Family Systems Theory in an original way that articulates their beneficial aspects. While youth resiliency has almost become a household word, so far the conceptual framework for resiliency includes criteria for protective factors, but not the knowledge of processes that make the criteria effective. The application of a systems paradigm to the concept of resiliency offers new perspectives and new possibilities for impacting the resilient behaviors of youth.
In my effort to help the reader orient to a systems perspective, I have created the following guided comparison between a family systems lens as I understand it, and an individual framework.

A Metaphorical look at Individually Focused vs. Systems Paradigms

Imagine you have two pairs of eye glasses. One helps you see things from an individually focused paradigm, and the other lets you see things from a family systems paradigm. Imagine putting on the first pair of glasses. You see a young person holding a bunch of strings. You see the individual engaged in self-destructive endeavors and you see others trying to convince him or her to change. The others are each pulling on one of the strings the young person is holding. They are urging the youth to take various actions to help him or herself. You watch the individual remain entrenched in his or her behavior and thought world. You go and advise the others on how to get the young person to change. You get mad at them when they don’t follow your directions. You go and try to convince the young person yourself with no success. In a sense, everyone, including you, is pulling on one of the strings the youth holds in his or her hands. The young person either pulls back as in a tug of war, or drops the string so you are left “holding the bag.”

In this scene, responsibility is passed around among the players. First, everyone abdicates the power of change to the young person and they each try to make him or her use power responsibly. In the meantime, each player loses sight of his or her own responsibilities and power. Some people stop their own activities until the young person changes.

Imagine now that you take off these glasses and put on the other set of glasses. You see a group of people, each influencing the other. The young person is part of this
group. They are each holding onto a web of continuous string that symbolizes the system
of interactions that connects them all. Tugs and pulls are felt throughout the system. You
join the system to feel how it works and you step back to reflect on what you
experienced. After several rounds of this, you get a sense for how you contribute to the
system. You change the way you tug on the string and everyone experiences the shift.
Everyone connected to the web changes, including the young person. This is the systems
paradigm of change. As a member of a system, you can effect change by altering your
part in the system of interactions. The effort is focused on self in relation to the system
rather than getting the other person to change.
CHAPTER ONE: LITERATURE REVIEW

What Can Bowen Family Systems Theory Offer the Study of Youth Resiliency?

Young people grow up with varying degrees of adversity in their lives. These challenges range from moderate daily hassles to acute stressors like illness, injury, disasters, or loss through death or divorce. Chronic stressors include poverty, violence, racism, sexism, mental illness (Compas, 1995), family discord, and parental alcoholism (Werner & Smith, 2001). On top of these, young people may experience the effects of unemployment, terrorism, social isolation, stigmatization, migration, child abuse, and disabilities (Garmezy & Tellegen, 1984). Adversity is a life long experience. Human beings vary from each other in their ability to cope with stress and one person may cope differently with various difficult situations (Pianta & Walsh, 1998). Some people resort to behaviors that exacerbate problems or create new dilemmas (Compas, 1995). For example, a person may relieve stress by drinking alcohol and using drugs irresponsibly, which may jeopardize the ability to drive, attend school, or hold a job.

Others who want to overcome their problems may not have access to the resources or information that will help them. Certain people perceive a lack of control over their situation, which presents another barrier to handling challenges well (Siantz, 1997; Wang, Haertel & Walberg, 1997; Werner, 1984; Werner & Smith, 2001). For example, Siantz (1997) notes that perceptions of an external locus of control are culturally and poverty based. Oppression is another form of adversity. Some philosophies of liberation place blame on oppressors without realizing that the oppressors can also be victims in other contexts (Weiler, 1991). Instead of calming down stirred up
systems, blaming contributes to processes that escalate problems (Bowen, 1978; Gilbert, 1999; Kerr & Bowen, 1988).

The irony is that resiliency, the ability to bounce back from hardship, may develop best in the context of adversity, precisely where people are most vulnerable. Most resiliency research points out the risk and protective factors that are present for resilient individuals (Garmezy, 1994; Garmezy & Tellegen, 1984; Rutter, 1994; Siantz, 1997; Wang, Haertel, & Walberg, 1997; Werner & Smith, 1984, 2001). However, these studies do not provide a comprehensive framework for how to navigate through difficulties. Bowen Family Systems Theory (Bowen Theory), a theory about human interactions, offers a way of understanding key relationship processes during periods of adversity. This understanding promotes flexibility for responding to challenges positively. Bowen Theory also guides helpers to avoid intensifying the processes that make misfortune unbearable or destructive (Baker & Gippenreiter, 1996; Bowen, 1978; Coco & Courtney, 1998; DeShong, 2001; Gilbert, 1999; Kerr & Bowen, 1988).

This literature review begins with definitions of key terms. I refer to classic texts to explicate Bowen Theory and its development. Major criticisms of the family systems theories are outlined, with emphasis on Bowen Theory. Then, I explore the concept of resiliency in the youth development field and the concept of adaptiveness among Bowen family theorists. The literature review ends with a discussion of what Bowen Family Systems Theory can offer to an understanding of youth resiliency.
Definitions of Key Terms

Defining the family is not an easy task. Families take many shapes and forms and constantly evolve (Berardo, 1988; Gilbert, 1999; Weinstein, 2002). The term includes extended, blended and foster families, as well as families with single, same sex, heterosexual, and co-habiting but unmarried parents (Weinstein, 2002). Whereas families exist in many configurations today, people in the United States generally create nuclear families by rituals like marrying or forming a union, and bearing or adopting children. People are born into or adopted by their families of origin (Bowen, 1978; Gilbert, 1992, 1999; Kerr & Bowen, 1988).

In most of the literature, authors define resiliency as the ability to adapt positively within the context of significant adversity or misfortune (Hendricks, 1998; Wang, Haertel, & Walberg, 1997; Werner, 1984; Werner & Smith, 2001). Bowen theorists use a related term, adaptiveness, to discuss “flexibility in responding to environmental challenges” (Noone, 1995, p.121). This view of adaptiveness has implications for current thinking about resiliency.

Community youth development is a field that gained recognition in the 1990s as policy-makers acknowledged that youth grow up in communities, not only in programs. In other words, young people need to be involved in meaningful projects that connect them with their communities and meet pressing needs. At the same time, leaders of the field shifted from a focus on fixing youth deficits to an emphasis on promoting youth assets (Pittman, 2000; Wheatley, 2001). Along with Hughes (2001), Pittman (2000) and Wheatley (2001) are now advocating that community youth development should involve youth working side by side with adults in creating positive change in their communities.
Educators in youth development organizations teach and foster the development of life skills, like resiliency, that help young people grow into successful and contributing members of their communities. American youth organizations, such as 4-H and Scouts, rank second only to public schools in the number of youth served annually. They share a long history of focus on positive youth development and prevention of problems that predates the recent emphasis on assets instead of deficits in the community youth development field (Quinn, 1995).

*Systems theories* have developed in several disciplines over the past 100 years (Bertalanffy, 1968; Bowen, 1988; Scott, 1998; Shenhav, 1995). Some see their origins in ancient thought (Kerr & Bowen, 1988). Each theory is distinct and needs to be studied in its own context. Systems theories share the general notion that change in one part of the system will affect change in the rest of the system (Bertalanffy, 1968; Bowen, 1978; Scott, 1998). This notion leads people to consider systems thinking a panacea that can cure all kinds of human problems (Callahan, 1962; Searight & Merkel, 1991; Shenhav, 1995). For example, systems are seen as predictable, and therefore, carefully planned actions can create desired results.

Systems theories developed since the 1950s describe processes that cannot be explained by cause and effect reasoning (Bertalanffy, 1969; Bowen, 1978). They represent a major paradigm shift to non-linear thinking. Rational, natural, and open systems theories are well defined in the organizational theory literature (Scott, 1998; Shenhav, 1995). Specific definitions are not critical to this review other than to briefly show the range of systems theory.
Rational systems are based on mechanical models of engineering efficiency, whereas natural systems grew out of psychological and sociological ideas of human motivation. Bowen Family Systems Theory is also called a natural systems theory, but in this use of the term, it differs from the organizational model. Bowen used the term natural systems to indicate that his theory was based on observations of living systems in nature and on what humans have in common with other life forms (Bowen, 1978; Gilbert, 1992; Kerr & Bowen, 1988). Bowen Family Systems Theory stems from Bowen’s research with human families. He outlined eight interlocking concepts that describe how emotional process works in human relationship systems.

Bertalanffy (1968) pioneered general systems theory. This paved the way for open systems theory to acknowledge environments surrounding entities, and to apply systems ideas across disciplines, like biology and psychology. One could conceptualize natural system models as either open or closed systems, depending on whether the encompassing political, social, or cultural environments were taken into account (Scott, 1998).

Bowen made it clear that his theory was not derived from Bertalanffy’s ideas, but developed independently (Bowen, 1978). This parallel development captures the essence of the family systems theory movement, which sprang up in various regions and fields simultaneously in the 1950s (Bowen, 1978; Holman & Burr, 1980, Weinstein, 2002). Within the family systems field, theories varied in their underlying models as well. Some were based on mechanistic models, whereas others, like Bowen Theory, were not. The next section reviews the development of Bowen Theory and its major concepts.
Murray Bowen developed his family systems theory over two decades beginning in the mid 1950s (Bowen, 1978). He began his formal training as a psychiatrist in 1946, at the Menninger Clinic in Kansas, which was known for its Freudian psychoanalytic approach. Bowen attributed his motivation to move toward theory and science as fostered by that environment (Kerr & Bowen, 1988). His growing interest in moving beyond a theory that was focused on individual pathology, led him to seek out a setting where he could test out his new ideas.

In 1954, he moved to the National Institute of Mental Health (NIMH) in Maryland, where he conducted research with families who each had a member diagnosed with schizophrenia (Gilbert, 1992; Kerr & Bowen, 1988). During this five year project, families lived in the research ward for durations of one to three years. Bowen (1978) based his working hypothesis for the research on the theoretical assumption that the psychosis in the patient was a symptom of a larger family problem. He departed from the usual theoretical position which considers the psychosis a disease located only in the patient. According to Bowen, NIMH’s director grew uneasy with the continuation of the research because of its focus on theory rather than schizophrenia alone. Bowen wrote that conflict arose “when it was discovered that the relationship patterns in the live-in families were also present in less disturbed families, and even in normal families” (Kerr & Bowen, 1988, p. 367).

At that time, the Chair of the Department of Psychiatry at Georgetown University became convinced of the importance of Bowen’s discoveries about families in general, and invited him to join the department (Kerr & Bowen, 1988, p.373). Bowen accepted the
offer and taught there from 1959 until his death in 1990. He also directed the Georgetown University Family Center (Gilbert, 1992). During these years, Bowen treated families with a wide range of symptoms using therapeutic approaches based on his emerging theory (Kerr & Bowen, 1988). He also began a professional training component which has expanded and continues today.

Bowen considered his NIMH research the first nodal point in the development of his theory of family systems. As he became familiar with relationship patterns in families with schizophrenia, he could see less intense versions of the same patterns in people with milder forms of emotional illness, as well as in normal people. Bowen based his theory on this comparison of the intense patterns in schizophrenia with the less intense patterns in others (Bowen, 1978, p. xiv).

At Georgetown, Bowen focused on the development of the theory, and on less severe emotional problems. He began multi-generational research on families, including his own. By 1965, he had developed the first six interlocking concepts of his theory. He regarded his own work on differentiating himself within his family of origin as “the most important turning point in [his] entire professional life” (Bowen, 1978, p. xvi). This led to his method of training professionals to differentiate themselves within their own families of origin, a method which he found had excellent results for trainees in their professional and personal lives. (Differentiation of self is defined in the section on the eight interlocking concepts.)

In 1972, the Environmental Protection Agency invited Bowen to present a paper on “predictable human response to crisis situations” (Bowen, 1978, xiv). His paper provided the impetus for a new addition to his interlocking concepts, one that extended
the theory to society at large. This concept, societal emotional process, along with sibling position, based on Toman’s (1976) work, completed the theory as it is today.

Bowen wrote that he supported “the view that the human is as scientific as the other forms of life on the planet” and that it will one day “be possible to construct a total human theory from scientific facts alone” (Kerr & Bowen, 1988, p. 360). Bowen considered other systems theories, based on mathematical and computer models, which were gaining popularity in the 1950s, as unfitting for “the idea of the human as an evolutionary being” (Kerr & Bowen, 1988, p.360). He developed his theory to be consistent with the principles of evolution and saw the human brain as having slowly evolved over time.

Bowen made a distinction between “what the brain is” and “what the brain thinks” (Kerr & Bowen, 1988, p. 360). This distinction reflected his quest to focus on objective facts. This objectivity made it possible to distinguish between relationship processes and the verbal content of interactions. A simple example of this involves a man who thinks and says that he never makes mistakes. That he thinks and says this is a fact. The verbal content of what he said, that he never make mistakes, is not necessarily a fact. That he says this whenever he gets in a heated argument with his sister is an observable relationship process. The following quote from Bowen’s NIMH research study illustrates this point.

That there is a wide discrepancy between what [the human] does and what he says he does....this was another guiding principle that permitted observers to gain some distance and begin to see some order to the multiplicity of messages and actions that are part of the hour to hour observations (Bowen, 1978, p.419).
Basic Terms, Social Constructs, and Background Processes of Bowen Theory

Four background processes weave through the eight concepts of Bowen Family Systems Theory: chronic anxiety, basic life forces, emotional process, and the family as an emotional unit.

Chronic Anxiety

Anxiety is an organism’s response to a real or imagined threat. Bowen presumed that all living things experience anxiety in some form. He used the term interchangeably with emotional reactivity. Both terms indicate an increase in physical manifestations, such as heart rate and blood pressure changes, gaze aversion, fight or flight responses, and heightened alertness or fear sensations. Though a certain level of anxiety may mobilize necessary responses for human survival, some reactions to threat may not be adaptive (Kerr & Bowen, 1988).

Chronic anxiety differs from acute anxiety. Acute anxiety is usually a response to a real threat and is of short duration. Chronic anxiety is ordinarily a response to an imagined threat and has a more enduring quality. “While specific events or issues are often the principal generators of acute anxiety, the principal generators of chronic anxiety are people’s reactions to a disturbance in the balance of a relationship system” (Kerr & Bowen, 1988, p. 113). Chronic anxiety often exceeds a person’s or family’s ability to cope with it. Various life events may disturb the balance in a family system, but once it is disturbed, family members may react more to the disturbance in the relationship system than to the events themselves. For example, when a child who served as an emotional buffer between parents leaves home, the parents’ emotional reactivity to each other may generate more anxiety than the absence of the child (Kerr & Bowen, 1988).
Life Forces of Individuality and Togetherness

Bowen defined two life forces at work in human relationship systems, *togetherness* and *individuality*. The togetherness force entails the pressure and desire to be like others, to agree on beliefs, principles, values, and feelings. Also known as the degree of emotional attachment, “the togetherness force assumes responsibility for the happiness, comfort, and well-being of others” (Bowen, 1978, p. 218). The individuality force, also termed the differentiating force, involves the impetus to define a separate self from others. Bowen viewed the differentiating force as responsible for self without making demands on others or blaming others. A person defining self to an emotional system takes action based on well thought out principles and “assumes responsibility for one’s own happiness and comfort and well-being” (Bowen, 1978, p.218).

Emotional, Feeling, and Intellectual Systems

While Darwin theorized a physical link between the human and other life forms, Bowen theorized an emotional link between the two. “The human, by virtue of possessing an emotional system akin to what exists in all life, has major portions of his behavior governed by processes that predate the development of his complex cerebral cortex” (Kerr & Bowen, 1988, p.28). The *emotional system* in the context of Bowen theory includes instinctual drives, reproduction, and responses controlled by the autonomic nervous system. “The emotional system is composed of genes, mitochondria, cell membranes, intercellular connections, extracellular fluids, organs, tissues, physiological systems, and all the emotional reactions supported by these components” (Kerr & Bowen, 1988, p.263).
Bowen distinguished between *emotions* and *feelings*. This made it possible to apply the term *emotional* to all living things. Feelings can be felt while emotions operate outside of awareness. Feelings like joy, despair, anger, or guilt, may be a surface awareness of emotions (Kerr & Bowen, 1988). The *intellectual system* separates humans from other animals. Bowen made a distinction between thinking that is overly influenced by the feeling and emotional system, and thinking that is independent of it. A person who distorts reality fuses thinking with feeling and emotional states. For example, my emotional state when arguing with my sister influences my tendency to think and say that I never make mistakes, which is a distortion of reality. On the other hand, objective thinking is more independent of the emotional and feeling systems (Kerr & Bowen, 1988). For instance, I may develop awareness that I am feeling upset and resist my urge to distort the facts.

*The Family as an Emotional Unit*

Bowen’s view of the family as an emotional unit represents a significant paradigm shift. This view of the family differs from the legal definition of a family as a group of individuals who are related by marriage or civil union, or who live in the same household (Black’s Law Dictionary, 1979). The concept of the family as an emotional unit implies a deep, multi-generational connection between family members that significantly influences the behaviors of its members outside of their conscious awareness. It conceptualizes the family as one organism with symptoms and diseases of its own. Various authors have covered this construct in depth (Bowen, 1978; Carolin, 1980; Gilbert, 1992; Kerr & Bowen, 1988; Weinstein, 2002). Pathology in an individual member of the family is seen as a symptom of imbalance in the family emotional system.
Symptoms can fall into three categories: physical, emotional, and social dysfunction (Kerr & Bowen, 1988). For example, developing cancer, getting depressed, or committing a crime, would each be symptoms of emotional process in the family. This way of thinking about symptoms reduces the stigma associated with certain human problems and increases objectivity for creatively addressing them.

Bowen’s theory departed significantly from Freud’s psychoanalytic theory. Freud, in aligning his theory with the traditional medical model, located pathology within the individual. Bowen saw unfortunate consequences of Freud’s model. For example, he thought it reinforced pathology and tended to blame others for problems. Bowen noted that Freud used concepts from Greek mythology and literature, such as the Oedipus complex, as analogies for mental processes. Bowen described these concepts as non-scientific and unable to be validated by science. His initial theory development at the Menninger Clinic sought “to help Freudian theory move toward the status of an accepted science” (Kerr & Bowen, 1988, p. 351). Bowen built his theory from his study of the human family as a living, natural system. Bowen strived for consistency between the theory’s concepts and knowledge from the rest of the life sciences. He wrote, “This systems theory has made a continuing effort to view [the human] as an evolving integral part of life on earth” (Bowen, 1978, pp. 417-418).

What are the Eight Interlocking Concepts of Bowen Family Systems Theory?

The eight interlocking concepts of Bowen Theory include: differentiation of self, triangles, nuclear family emotional process, family projection process, cutoff, multigenerational transmission process, sibling position, and societal emotional process.
Differentiation of Self

Depicted with a theoretical scale, differentiation of self describes how people cope with life's demands and pursue their goals on a continuum from most adaptive to least. Variations in this adaptiveness depend on several connected factors, including the amount of solid self, the part of self that is not negotiable in relationships. For example, a person with well thought out principles enhances solid self, and will not be swayed by faddish opinions. A person with less solid self, will feel more pressure to think, feel, and act like the other. This fusion between two people generates more chronic anxiety as one becomes more sensitive to what the other thinks, feels, and does. Acute anxiety also plays a role. A fairly well differentiated person can develop symptoms under acute anxiety, but will probably return to adaptive functioning soon after. A less differentiated person may live in a stress free environment and therefore function quite well for long periods of time. (Bowen, 1978; Gilbert, 1992, 1999; Kerr & Bowen, 1988).

Level of differentiation refers to the degree to which a person can think and act for self while in contact with emotionally charged issues. It also refers to the degree to which a person can discern between thoughts and feelings. At higher levels of differentiation, people maintain separate, solid selves under considerable stress and anxiety. They manage their own reactivity and choose thoughtful actions. At lower levels of differentiation, people depend on others to function, and they develop significant symptoms under stress. They act, often destructively, based on anxious reactions to the environment. Their intellectual reasoning fuses with emotionality. Even highly intelligent people can be poorly differentiated. (Bowen, 1978; Gilbert, 1992, 1999; Kerr & Bowen, 1988).
One cannot actually measure level of differentiation because it requires observation of multiple areas of functioning over a life course. However, the scale gives a way of conceptualizing variability in coping among people (Bowen, 1978; Gilbert, 1992, 1999; Kerr & Bowen, 1988). For example, the concept explains why children of the same parents can function quite differently. One may be a high achiever, while another develops physical, mental, or social problems.

*Sibling Position*

*Sibling position*, a concept which Bowen adopted from Toman's (1976) research, affects variation in differentiation as well. Oldest, youngest, and middle children tend toward certain characteristics based on their roles in the family, the particular mix of sibling positions in it, and the sibling positions of parents and other relatives (Bowen, 1978; Gilbert, 1992, 1999; Kerr & Bowen, 1988).

*Multigenerational Transmission Process*

Differentiation of Self is transmitted through the *multigenerational transmission process* (Bowen, 1978; Gilbert, 1992, 1999; Kerr & Bowen, 1988; Noone, 1995). This concept describes patterns of emotional process through multiple generations. It offers a way of thinking about family patterns that goes beyond a dichotomy of genes versus environment. One of the ways family patterns are transmitted across generations is through relationship triangles.

*Triangles*

*Triangles* are the basic molecule of human relationship systems. A two-person dyad becomes unstable once anxiety increases. Then, one or both members of the dyad usually pulls in a third person to relieve some of the pressure. In a three-person system,
anxiety has more places to go, and the relationship where it originated experiences some relief. When the three-person system can no longer contain the anxiety, it involves more people and forms a series of interlocking triangles. Bowen researchers consider triangles a natural function of living systems. Triangles can have either negative or positive outcomes depending on how their members manage anxiety and reactivity. Bowen postulated that if one member of the triangle remains calm and in emotional contact with the other two, the system automatically calms down. On the other hand, with enough stress and reactivity, members lock into a triangular position, and develop symptoms (Bowen, 1978; Gilbert, 1992, 1999; Kerr & Bowen, 1988).

**Family Projection Process**

The fixed triangle is evident in the *family projection process*, where parents in a nuclear family focus anxiety on a child and the child develops problems. Parents then usually attempt to get the child to change or they ask an expert to “fix” the child. Experienced Bowen family systems consultants report that when parents can instead manage their own anxiety and resolve their own relationship issues, the functioning of the child automatically improves (Bowen, 1978; Gilbert, 1992, 1999; Kerr & Bowen, 1988).

**Nuclear Family Emotional Process**

Other ways that the nuclear family manages differentiation and anxiety is with conflict, distance, over and underfunctioning reciprocity, or dysfunction in a spouse. People engaged in conflict fight, argue, blame and criticize each other. Partners who distance tend to be emotionally unavailable and to avoid potentially uncomfortable, though important, topics. Reciprocity in relationships occurs when one person takes on responsibilities for the twosome. The two people slide into overadequate and
underadequate roles. This can become so extreme that one partner becomes incapacitated either with an illness of a general lack of direction. These make up the concept of nuclear family emotional process (Gilbert, 1992).

*Cutoff*

An extreme distancing posture constitutes the concept of *cutoff*, where family members discontinue emotional contact with each other. This has significant implications for the functioning of future generations, as the emotional family unit is severed in such a way that anxiety has fewer places to be absorbed in the extended family system. Consequently, chronic anxiety increases. People look for other relationships to substitute for the cut off relationship. These new relationships intensify and people become vulnerable to symptoms (Bowen, 1978; Gilbert, 1992, 1999; Kerr & Bowen, 1988).

*Societal Emotional Process*

The last concept Bowen developed is societal emotional process. It refers to the tendency of people within a society to be more anxious and unstable at certain times than others. Environmental stressors like overpopulation, scarcity of natural resources, epidemics, economic forces, and lack of skills for living in a diverse world are all potential stressors that contribute to a regression in society (Bowen, 1978; Gilbert, 1999).

Some may think Bowen Theory appears too deterministic, but it actually promotes personal agency and improving one’s life, the life of one’s children, and the life of one’s family. The process of differentiating a self involves a conscious effort at strengthening or raising the amount of solid self by defining beliefs and principles, managing anxiety and reactivity, and relating differently to the family system. People engaged in these efforts reap positive benefits for their own functioning, and they
What do the Critics Have to Say About Systems Thinking and Bowen Theory?

The majority of critics acknowledge strengths of Bowen Family Systems Theory while evaluating it against postmodern themes, such as gender (Bograd, 1986; Brown, 1999; Coco & Courtney, 1998; Cool, 1988; Innes, 1996; Knudsen-Martin, 1994, 2002; Lerner, 1985, 1988) and culture (Coco & Courtney, 1998; Holman & Burr, 1980; Murphy, 1999; Searight & Merkel, 1991). Others raise clinical and ethical concerns (Bograd, 1986; Brown, 1999; Cool, 1988; Innes, 1996; Lerner, 1985, 1988; Searight & Merkel, 1991), plus theoretical and research weaknesses (L’Abate & Colondrier, 1987; Larson & Wilson, 1998; Searight & Merkel, 1991). A minority criticize family systems thinking generally, citing originators other than Bowen (Holman & Burr, 1980; L’Abate & Colondier, 1987; Ryan & Barham, 1984; Searight & Merkel, 1991). Some authors debate with the critics to stimulate thought-provoking dialogue (Horne & Hicks, 2002a, 2002b). According to Horne & Hicks (2002a), Bowen and his cohort of faculty never engaged in a formal and thorough defense of his ideas, so they are almost absent from the debate presented here except when quoted. Also, in the following criticisms of systems thinking applied to schizophrenia, one of Bowen’s faculty members does respond to the critique. The following sections elaborate on each major area of criticism.

Feminist Perspectives

Writers focusing on feminist issues commonly criticize Bowen’s focus on the biological evolutionary component of families because it fails to situate families within a political, economic or social context. They argue that the theory ignores the social reality
of the hierarchical relationship between husband and wife (Bograd, 1986; Brown, 1999; Cool, 1988; Lerner, 1985, 1988; Weinstein, 2002). Lerner (1988) cites the lack of attention by Bowen and his colleagues to the influence of the patriarchal social context on the family. She adds that patriarchally defined work and family roles inhibit differentiation in women and contribute to family dysfunction. Feminists contend that Bowen theorists focus too much attention on the mother’s contribution to symptom development in the child (Brown, 1999).

Critics point to problems with the blameless stance of family systems theory, believing it victimizes the woman (Bograd, 1986; Lerner, 1985). Lerner (1988) asserts that differentiation of self by subordinate group members is thwarted “when anger and frustration is disqualified by arguing that no one is to blame” (p. 56). Bograd (1986) advocates expanded notions of the functional equivalence of parts in a family system, and an awareness of the female’s power disadvantage. She adds that family theorists promote a traditional family paradigm that has not kept pace with changing definitions of the family. The traditional ideal is biased against women and removed from current statistics on women in the workforce and as heads of households.

Feminist writers interpret Bowen’s definitions of the emotional, feeling, and intellectual sides of the human, as a male-female dichotomy. For example, Cool (1988) quotes Hare-Mustin’s 1978 critique of Bowen’s concept of differentiation of self scale: “Bowen ignores the fact that women’s socialization encourages them to be emotional and intuitive rather than rational” (p. 26). Others consider the scale a stereotypic caricature of feminine and masculine attributes with women placed low on the scale (Bograd, 1986; Lerner, 1988). Leupnitz (in Brown, 1999) criticizes Bowen theorists for not questioning
societal norms that "school females into undifferentiation" (p.101). Research studies indicate that female processes of psychological development and patterns of social interaction are distinctive, and raise questions about the universality of differentiation of self. Critics propose modifications to make the concept less prejudicial against women (Innes 1996, Knudsen-Martin, 1994).

At the same time, some see efforts at differentiating a self as a common goal between feminism and Bowen Theory. According to Lerner (1985, 1988), Bowen theory is the least conducive to mother-blaming of all individual and family perspectives. She adds that Bowen Theory best suits her feminist values and beliefs. Despite some feminist assumptions that Bowen theorists do not value expression of emotions, therapists applying the theory with families highlight the importance of emotions in the work (Brown, 1999). Gender sensitivity, along with racial, ethnic, and class awareness, has been incorporated by several proponents of the theory.

Controversy surrounds the concept of emotion in Bowen Theory. Feminist interpretations assume that Bowen's definition of "emotional" pertains to women only. This seems to stem from a misinterpretation of his definition of emotional. The concept of "emotion" in Bowen theory "includes responses that range from the most automatic instinctual ones to those that contain a mix of automatic and learned elements" (Bowen & Kerr, 1988, pp.27 - 28). This includes how a man or woman reacts to threat. Both males and females would respond instinctually to threat, by experiencing a fight or flight impulse. For instance, an argument between a man and a woman illustrates a moderate fight response, and a distancing posture by a man towards a woman indicates a subtle flight response.
Clinical and Ethical Concerns

Along with feminist concerns about the ethical, historical, contextual, and political treatment of women as discussed in the previous section, clinical and ethical concerns arise from the application of family systems theory (Bograd, 1986; Brown, 1999; Cool, 1988; Lerner, 1985, 1988; Searight & Merkel, 1991). Searight and Merkel (1991) critically examine family systems theory in general, in what they call “a hopeful and optimistic call for future refinement” (p.29). They cite various leaders in the family systems theory movement, excluding Murray Bowen. Due to this omission and the examples they cited, it was unclear whether they were familiar with Bowen Theory. However, Searight and Merkel raise some interesting points about what it means to apply a new family paradigm within society’s legal and ethical systems.

For example, family systems concepts clash with the American legal system, which protects the rights of individuals and holds them accountable for their actions (Searight & Merkel, 1991). The notion of the family as a unit that influences its member’s behavior does not carry weight in the tenets of American criminal law. The authors express strong concern that family members who abuse their kin may not be held liable for their behavior when it is explained as a function of the system. Instead, they see a tendency for the victims to be blamed, because of what they consider a twisted logic. According to the authors, this “bizarre and tortured reasoning” (Searight & Merkel, 1991, p.27) is derived from conceptualizing the recipients of abuse as automatic participants in a system that leads to maltreatment.

Searight and Merkel (1991) also criticize family theorists for neglecting America’s fundamental individualistic ethic. In their view, the notion of the family as an
organism places undue emphasis on relationship goals at the expense of individual goals. This shows up in clinical practice as an ethical dilemma. How should a consultant handle individual family member requests when they are not congruent with the consultant’s perceptions of what is best for the family? (Brown, 1999; Searight & Merkel, 1991).

**Theoretical and Research Weaknesses**

One of the most interesting debates over Bowen Theory centers on its emphasis on science. Critics see Bowen’s disciplined effort to situate his theory in a natural science model as too limiting (Carolin, 1980; Innes, 1996) and not neutral (Knudsen-Martin, 2002). Titelman (in Carolin, 1980) argues that Bowen’s “primary training in biology, chemistry, and medicine left him imbedded in theoretical models from the natural sciences without being aware of their severe limitations” (p. 123). Others believe Bowen’s adherence to the logical empiricist tradition and his disdain for philosophy kept him from questioning his own assumptions. Whereas Bowen sought to develop his theory from facts of human functioning, “facts do not speak for themselves. A presuppositionless body of knowledge does not exist” (Innes, 1996, p.492).

Postmodernists contend that all scientific concepts, theories, and data are socially constructed. They propose incorporating information from socio-cultural research into the theory to broaden its scope and universality (Innes, 1996; Knudsen-Martin, 2002).

Responding to the criticism that science is not neutral, Horne and Hicks (2002b) argue that Bowen was moving his theory toward the neutrality of nature, not science. “Science...is subject to all the biases and limitations that mark most human endeavors. Nature, however, is a process ruled by universal laws to which humans are subject along with the rest of the natural world” (p. 119). Regarding the universality of the theory, they
add, “If using a sociopolitical lens is a valid method of critiquing natural systems concepts, wouldn’t it be equally valid to use natural systems concepts to critique that same sociopolitical lens?” (Horne & Hicks, 2002b, p. 119). What would it look like to use natural systems concepts to critique a sociopolitical lens? One answer is that if relationship triangles can influence human behavior, then they may play a role in how and when human beings apply a sociopolitical lens. Another answer includes the concept of differentiation of self. For example, people interpret and react to information, such as theoretical definitions, within the context of their level of differentiation of self, or degree of fusion between their emotion and intellect.

Some researchers criticize the limitations of case study data and brief illustrative anecdotes often used as guidelines for practical application of the theory (Larson & Wilson, 1998; Ryan & Barham, 1984; Searight & Merkel, 1991). Little research exists on Bowen Theory in the literature even though it “is recognized as one the most carefully elaborated of the family systems theories” (Larson & Wilson, 1998, p.40). Ryan & Barham (1984) responded to the paucity of empirical data by examining past studies that lend some evidence to family systems claims. L’Abate & Colondrier (1987) believe family systems theory is too divergent from the field of psychology and too abstract, nonspecific, and lacking in substance to be testable. Their summary belies a lack of knowledge of Bowen Theory, which is also not referenced in their article. Hence, it is questionable if many of their claims are applicable to Bowen Theory.

Cross Cultural Considerations

Murphy (1999) offers a socio-cultural perspective in his doctoral dissertation, by questioning the applicability of Bowen’s concept of differentiation to Asian families.
According to Murphy, what may be seen as less differentiated in Bowen Theory, are behaviors that preserve highly valued group harmony in Asian culture. Asians may experience less anxiety than Caucasians from the same pressure to conform, because of different cultural factors. Being less differentiated may not carry the same consequences for emotional, cognitive, and behavioral functioning of Asians as it might for Westerners. However, Murphy's study results support Bowen Theory as a viable assessment tool with individuals, couples and families of Asian descent.

Similarly, Coco & Courtney (1998) found positive results with the application of Bowen Family Systems Theory as an intervention in a Mexican-American family with a daughter who was running away from home. These studies add to the cross-cultural research that Holman & Burr (1980) recommended in their review of the growth of family theories. They hoped research would add validity and universality to family theory. Such research may also raise questions about Searight & Merkel's (1991) claim that there is a uniformity myth operating in family systems theory that negates the impact of ethnicity.

Controversy over Systems Thinking Applied to Disease

Specific criticism of family systems concepts applied to schizophrenia shed light on the controversy over a family systems model of disease. In this case, one of Bowen's faculty members did respond to the comments. When Dr. Michael Kerr, Bowen's protégée, had an article on chronic anxiety and differentiating a self published in the Atlantic Monthly (Kerr, 1988), one letter to the editor pointed out that "what looked like inappropriate overinvolvement by parents in the fifties was simply the heroic and desperate attempt of parents to help children with this devastating and mysterious illness"
Another wrote, "It is equally plausible that the anxiety and stress of coping with a person severely disabled by a disease like schizophrenia increases maladaptive feelings and behavior. This view implies a synthesis of dynamic and biological explanations for mental illness— that coping with disease causes problems in living" (Davidson, 1989, p.9).

The viewpoints expressed in these letters to the editor are interesting when considering that Kerr's article was not as much about schizophrenia as it was about family emotional process. These letters show how easily people take offense to ideas about the role a family plays in the symptoms of its children. They show how difficult it is for people to grasp the notion of family processes that evolve innocently. They demonstrate how difficult it is to overcome the tendency to blame someone, or to assume one is being blamed, for a negative outcome. However, Bowen Family Systems Theory attempts to explain complex processes that evolve in nature and are not anyone's fault.

Unfortunately, reactivity to family systems ideas makes it difficult to hear their nuances and appreciate their usefulness. Furthermore, popular literature that portrays schizophrenia as a disease that falls out of nowhere adds to the misconceptions. On the contrary, the findings of this dissertation study indicate that in most of the families who participated in the NIMH study, the schizophrenia in the child was not an isolated case and often was linked to a number of preceding symptoms and intrafamilial processes.

Another contributor to the letters reacting to Kerr's article was a medical doctor, who indicated that he was from NIMH at the time of the article in 1988. His use of the term, 'caused' indicates that he did not grasp the concept of systems thinking. He called the article anachronistic and wrote,
Kerr describes schizophrenia as caused by family relationships, especially "the emotional intensity of the relationship" with the patient's mother. In 1958 this was a valid and reasonably widespread theory. In 1988, however, it has been completely superseded by studies showing conclusively that schizophrenia is a brain disease. There are now literally hundreds of studies showing that the brains of individuals with schizophrenia are different both structurally and functionally. Thus schizophrenia is in exactly the same category as multiple sclerosis, Parkinson's disease, and Alzheimer's disease—chronic brain diseases whose specific causes are unknown but strongly suspected of being biological insults, with perhaps a genetic predisposition (Torrey, 1989, p.9).

Kerr responds to the various letters by commenting on the "clash between an individual and a systems model" (Kerr, 1989, p.9):

An individual model assumes that if we can discover all the things that are wrong with a patient, we will know the cause of his condition. A systems model assumes that defining what is wrong with the patient...is not the same as explaining what creates and perpetuates it. We do not even know, for example, what causes tuberculosis, though we know that the tubercle bacillus is an essential ingredient. Many people live in harmony with this bacillus. We are still quite ignorant about many of the forces that govern the conditions we treat. Family systems theory defines relationship variables that are assumed to be important in the creation and perpetuation of all clinical dysfunctions, but assigning cause to one variable or even a group of them is antithetical to systems thinking (Kerr, 1989, p.9).

The fact that these ideas are still argued about, as recently as 1989, is fascinating in light of thinking going on as early as 1945, when Richardson discussed the need to take the entire family into consideration in the disease process. Richardson's book, Patients Have Families, was mentioned in Bowen's archival papers. Richardson wrote, "to say that patients have families is like saying that the diseased organ is a part of the individual. Both facts seem too obvious to discuss, yet for a long time neither received due recognition from the medical profession" (Richardson, 1945, p.vii). He continues:

It was something of a feat on the part of so many members of the profession that they managed so long to insulate themselves from the personal or environmental problems of their patients. The insulation was partly maintained by the form of the medical history...based on the concept of organic disease...for example, the death of a relative may appear on one page and the date of onset of the patient's
symptoms two pages below, so that there is not reason to suspect that both events occurred in the same week. Under any one heading, data are selected which favor the organic concept of disease. It is customary, for instance, to state the age of the parent at death, and not the patient’s age at the time, although often the latter is much the more important for the understanding of the illness (Richardson, 1945, p. xii - xiii).

Bowen Theory has been both revered and misunderstood. The ideas are complex and usually require a personal experiential approach with coaching from those experienced in the application of the theory in their own lives (Gilbert, 1999, 2003).

Quick reads of the theory without an investment of personal application and study over time fall short. Criticisms of the theory often seem to react to some aspect of the theory or its delivery without understanding the core meaning of the concepts. Researchers often focus on testing the validity of the concepts and assumptions (Charles, 2001; Miller, Anderson, & Keala, 2004). While the critiques and the research on validity serve some useful purposes, they also divert attention away from the hopefulness that the ideals behind the theory are able to impart. Use of Bowen Family Systems Theory has resulted in greater resilience for a number of people and relationships (personal communications, 1996 - 2005). Even if these were placebo effects, they were powerful ones.

**What is the Current Thinking in the Youth Development Field on Resiliency?**

Most researchers interested in resiliency designed their studies to measure risk factors and protective factors in a child’s life (Garmezy, 1994; Garmezy & Tellegen, 1984; Musick & Bumpass, 1999; Perkins & Butterfield, 1999; Quinn, 1995; Siantz, 1997; Wang, Haertel, & Walberg, 1997; Werner & Smith, 1984, 2001). Risk factors cover a range of areas, for instance, marital discord and low social status. Protective factors also range widely, from stable families to constitutional predispositions (Garmezy & Tellegen,
Bronfenbrenner developed the ecological perspective that studied the relationship between the developing young person and the various contexts in which he or she engaged. These contexts encompassed the child, family, neighborhood, school, community, culture, and society (Bronfenbrenner, 1979; Kazak, 1989; Quinn, 1995).

Werner & Smith (2001) have carried out a landmark longitudinal study on resilience. Over a 40 year period, they tracked the development of 698 subjects who were born on the Hawaiian island of Kauai in 1955. Thirty percent of the cohort encountered multiple biological and psychosocial risk factors and stressful life events. One third of these youth coped successfully, which led to the identification of key protective factors. One sixth of the cohort developed serious problems. Of those, most who developed serious coping problems in adolescence, recovered by midlife. The criteria for successful coping in adulthood centered around work satisfaction, school achievement, good health, and positive relationships within their nuclear families and their families of origin.

Coping refers to all responses of the individual to stress. Compas (1995) identified two categories of coping responses. Problem-focused coping attempts to act on a stressor and emotion-focused coping attempts to manage one’s emotions associated with a stressor. According to Compas, coping efforts can either resolve or worsen stress. Whether a person can distinguish between a situation that is controllable and one that is not is an important variable in successful coping. Resilient children appraise the controllable nature of a stressor accurately and choose the congruent coping category. When a situation is out of a person’s control, emotion-focused coping is more appropriate.
Compas (1995) as well as other researchers are now looking beyond causal factors and seeking underlying mechanisms and processes involved in the relationship between environmental and individual variables (Compas, 1995; Garmezy, 1994; Garmezy & Tellegen, 1984; Rutter, 1994). They acknowledge that a stressor like divorce itself does not necessarily create risk. Instead, risk develops over time in relation to processes that may precede and follow the divorce, like conflict (Musick & Bumpass, 1999; Rutter, 1994). Researchers increasingly recognize that acute events may not happen randomly. Some suggest that there is an interplay between acute and chronic life experiences, and that people shape and select their environments to some extent (Rutter, 1994; Werner, 1984; Werner & Smith, 2001).

Writers in the youth development field also think holistically about the processes that lead to resilience (Compas, 1995; Perkins & Butterfield, 1999; Pianta & Walsh, 1998; Quinn, 1995). In other words, coping is only part of the gestalt. Children also need to pursue personally meaningful goals in order to develop positively (Compas, 1995; Perkins & Butterfield, 1999). Natural processes that develop holistic competencies over time are seen as better than teaching that tries to impart isolated skills in brief sessions (Pianta & Walsh, 1998). However, according to Quinn (1995), US funding of youth programs and research tend to support efforts focused on youth deficiencies, rather than overall positive youth development.

Other researchers are considering general family systems concepts in their thinking about resiliency (Kazak, 1989; Ryan & Barham 1984). These authors discuss homeostasis, where maladaptive behaviors in a child may function to stabilize the family. In other words, a problem a child develops in school might be serving a function within
the family system. Ryan & Barham (1984) discuss the notion of circular causality in systems thinking. The child and parents may be unknowingly cooperating in ways that perpetuate problem behaviors. Kazak (1989) considers family systems theory to be a more integrative and complex view of adjustment and pathology.

Pianta and Walsh (1998) take a developmental systems view. They point out that the resilience that appears to reside in a child is actually distributed in the relationship between the child and various systems and contexts. Along with this view is the idea that children can succeed in one area and fail in another. Their competence levels vary over time. In addition, the socially constructed nature of how success is defined makes a difference in who is considered resilient.

*How do Bowen Theorists Conceptualize Offspring Adaptiveness?*

Those well-versed in Bowen Family Systems Theory suggest that adaptiveness is rooted in a multi-generational transmission process (Baker & Gippenreiter, 1996; Coco & Courtney, 1998; DeShong, 2001; Gilbert, 1999; Larson & Wilson, 1998; Noone, 1995, 2001). Larson & Wilson think that Bowen Theory’s carefully elaborated insight into emotional mechanisms enhances understanding of processes within families and across generations that affect young adult developmental tasks. Coco & Courtney used the lens of Bowen Theory to conceptualize runaway behavior in a teen as a symptom of interlocking and multi-generational relationships in the larger family system. Their theory-based intervention was successful in alleviating the symptom.

DeShong (2001) used the lens to take an objective non-blaming view of a suicide by a young family member in the midst of its emotional aftermath. Gilbert (1999) outlines the intricate interactions in the family system that she believes will prove to be
overwhelmingly more important than other factors in how children turn out as adults. Baker & Gippenreiter (1996) found that the effects of emotional cutoff in a grandparent generation had an enduring influence on the adaptiveness of the grandchildren. They found that members of those families who took steps to bridge the cutoff were better able to function through and beyond the acute adversity that they faced.

Noone (1995, 2001) has been particularly interested in phenotypic variations in adaptiveness which are not accounted for by genetic transmission nor other environmental effects on a developing offspring. For example, an offspring who is most dependently attached to a parent may be the least adaptive of the siblings. Parental over-involvement with one child may improve their functioning but undermine the child’s. Other siblings may function better because of this dynamic. Noone believes that the family as a relationship unit governs and shapes the neuroendocrine, immune, and other physiological systems of individuals throughout their life course. He cites evolutionary theory in biology and gives examples from animal studies that add a meta-perspective on human adaptiveness as a function of family emotional process.

**What Might Bowen Theory Have to Offer the Study of Youth Resiliency?**

Bowen developed a comprehensive and unified theory (Horne & Hicks, 2002a) that fills in some gaps identified by researchers of resiliency. For example, researchers question the variation in resiliency among young people (Compas, 1995; Garmezy, 1994; Garmezy & Tellegen, 1984; Rutter, 1994). Bowen’s concept of a differentiation of self scale offers a theoretical base for further inquiry and investigation. Researchers wonder what makes conflict before and after divorce a more potent risk factor for children than the divorce itself (Musick & Bumpass, 1999; Rutter, 1994). Bowen Theory’s concepts of
triangles and the nuclear family emotional process lend insight into the underlying mechanisms involved.

Resiliency researchers define chronic stress as environmental variables like poverty, neighborhood violence, racism, sexism, or parental psychopathology (Compas, 1995). Bowen's concept of chronic anxiety would add a different dimension to chronic stress. It also offers an understanding of emotional process underlying human adaptiveness and maladaptiveness in the face of chronic environmental challenges (Kerr & Bowen, 1988). Compas (1995) wrote that as threat appraisals and emotional arousal increase, more effort goes into emotional regulation. In other words, emotional coping is governed more by emotional arousal than by control beliefs. This correlates with Bowen's concept of the increased fusion between thinking and emotions when anxiety goes up.

Bowen's concepts of the family projection process and sibling position present new ways of thinking about why some children develop more problems under adverse circumstances than others. The concept of the multigenerational transmission process broadens the perspective of how adaptiveness evolves in a family over generations (Baker & Gippenreiter, 1996; Bowen, 1978; Gilbert, 1999; Kerr & Bowen, 1988; Noone, 1995, 2001). It may also help with the design of family research across generations, a challenge that Hirschman (1997) discussed. The concept of the multigenerational transmission process also impacts the definition of resilience, since what may look less adaptive in some offspring may be the best they can achieve, considering the forces of the multigenerational family system.
Societal emotional process offers the field of resiliency an interlocking theoretical concept which addresses the interplay between the larger societal system and the family. The effort to differentiate a self introduces a novel way for people to enhance their adaptiveness and to understand the relationship forces impacting their efforts (Bowen, 1978; Gilbert, 1999; Kerr & Bowen, 1988). In conclusion, Bowen Family Systems Theory deserves serious consideration as a framework for understanding how families adapt to change, and how motivated individuals can work toward resilience in the face of adversity.
CHAPTER TWO: METHODS
Overview of the Methodology

I studied the voluminous data from Bowen’s research that was conducted at the National Institute of Mental Health (NIMH) between 1954-1959. My study integrated a conceptual analysis and a historical analysis (McMillan & Schumacher, 2001). Historical analysis involves the study of documents that describe past events. I studied and analyzed the NIMH archives with a conceptual analysis of resiliency as my framework of inquiry. I focused on five families from the NIMH project with the intent of achieving a deep understanding of the familial processes that underlie resiliency.

I collected a wide range of data described in the next section on sampling. I synthesized this disparate data into case studies (Merriam, 1992, Patton, 2002) that present a full picture of each case. I also created family diagrams for each family that are displayed in the text. In some cases, several diagrams show the evolution of a family over time. For one case where extensive family history was available, I created a timeline of nodal family events to augment the narrative.

I have analyzed how the families evolved over time and how ongoing events and interactions coincided with resilient and non-resilient behaviors in their offspring. To facilitate this analysis, I developed a working definition of a resilient response and a non-resilient response. During the analysis process, I used grounded theory methodology (Strauss & Corbin, 1990; Glaser & Strauss, 1967) to create a model that synthesized the family systems lens with the concept of resiliency.
Sample Description and Rationale

I used *purposeful sampling* in my selection of data (Patton, 2002). “The logic and power of purposeful sampling derive from the emphasis on in-depth understanding. This leads to selecting information-rich cases for in-depth study. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research” (Patton, 2002, p. 46). I collected and analyzed data on five families involved in Bowen’s original research at the NIMH clinic. During 1954-1959, these families lived on the ward for up to three years.

The archival data included notes and records written by nurses, physicians, social workers, and psychiatrists working on the project. Examples of the data included: hourly and daily observations of individual and family behaviors; notes describing clinical meetings; sociograms depicting interactions between staff and patients; charts describing interactions between family members, between family members and staff, and between patients and staff; family histories; incident reports; medical notes tracing physical symptoms; records of attempts to track the interplay between physical and emotional symptoms; research project summaries; and drafts of papers prepared for conferences, which discussed early findings from the family research project. The following description gives further insight into the data set and how it came to be.

* Bowen's NIMH Archival Data Set

As mentioned in the introduction and literature review, Murray Bowen, M.D. was the originator and director of what he called an “unusual” family research project at the National Institute of Mental Health (NIMH) that took place from 1954-1959. Other members of the medical staff were Robert H. Dysinger, M.D. and Warren M. Brodey,
M.D. As one of the first formal psychiatric studies in the new Clinical Center, it started at a time when the Institution had a very idealistic research philosophy. NIMH encouraged new and imaginative research and had the resources to make it possible. "This attitude and unusual setting provided the incentive for the staff to go all out in theoretical thinking, and for the Institution to go all out in supporting the effort. This project probably would never have been possible under other circumstances" (Bowen Archives, 1954-1959). Incidentally, citations of Bowen's NIMH archives will comply with recommendations by the National Library of Medicine. They will be nonspecific.

Many of the families joined the project with the hope of finding help for their schizophrenic child. They had already tried other treatment approaches that had not worked. The families who participated in the project lived on the ward for up to three years. It was obviously a sacrifice for many in the pursuit of wellness for their children and relief for their families. They had to make arrangements to give up their homes, their jobs, cooperate with the Center, and be willing to be observed 24 hours a day. In addition, family members had to risk occasional violent exchanges with their symptomatic children, or with the symptomatic members of other families.

The project involved an extensive effort to study human families in depth, while using an experimental approach to treat schizophrenia.

There was a full time research staff of three psychiatrists, one social worker and two research assistants; a ward staff of 12 nurses, attendants, and observers; and a part time staff of 12 to 15 consultants and observers who represented psychiatry, psychoanalysis, psychology, sociology, anthropology and other disciplines. The total four year investment represented an estimated 80 man years of staff time and a total cost of almost one million dollars (Bowen Archives, 1954-1959).
The family study produced voluminous research data.

Every psychotherapy hour was tape recorded. In addition, there were three simultaneous written records of each hour. One observer made a summary of the content of the hours, another made a set of process psychotherapy notes, and a third observer made a process sociogram. The nursing staff made detailed observations on each family member, and on each family unit for the 24-hour period of each day. Research assistants have abstracted much of the voluminous data into daily, weekly and monthly summaries (Bowen Archives, 1954-1959).

As the research progressed, more emphasis was placed on the family unit and their actions as well as their verbalizations.

From the time of the beginnings of the group, the data collecting has moved closer to a focus on the family unit in action, as has the whole project. At present recordings are kept daily of the family-staff group conference. It is felt that this action observation is important..., since there is a great gap between what the families do and how they see verbally what they are doing. Thus, one set of notes is kept emphasizing the verbal content of this meeting, another set of the process of interacting and relating. Sociograms of the meeting are made. 24-hour nurses notes are maintained highlighting the intrafamily action, noting the efforts to engage the staff in this action, and when possible, interfamly discussion groups that often follow the meetings (Bowen Archives, 1954-1959).

The researchers would then meet to come to consensus on key observations of individuals, families and staff and their relationships. These observations would be carefully charted on a daily basis and were felt to be “important in understanding changes in relationships within the family, and the operation of the family unit. (Bowen Archives, 1954-1959).

The project started as a “study of symbiosis as seen in schizophrenia and a specific treatment effort focused on the symbiosis rather than on the schizophrenia” (Bowen, 1978, p.4). At first, mother-daughter pairs were chosen who had an active and extreme symbiotic relationship. “Intensity of symbiotic attachment was considered more important than the intensity or configuration of schizophrenic symptoms” (Bowen, 1978,
Mothers were matched with a supportive social worker for daily therapy. Daughters met with what Bowen referred to as a medical psychotherapist. It was not long before the researchers concluded that the symbiosis was part of a “larger, active, shifting unit,” meaning the family (Bowen, 1978, p.4). Families were then chosen for the study to include father, mother, and siblings.

From the start of the project, the therapeutic setting was designed to simulate as far as possible a normal environment that would encourage the family members to relate to each other with minimal interference. For example,

The usual administrative ward rules were minimized because of the way in which mother and child invoked the rules with one another rather than to work upon their problems in relating to one another; i.e., [mother] cannot say “no” to her daughter; the daughter requests to drive her car; mother cannot refuse but does not wish this and she would prefer to borrow a hospital regulation to answer her daughter. In a similar manner, the mother and child used their relationships with staff to escape the problems implicit in their intense relationship (Bowen Archives, 1954-1959).

Partly because family members would inadvertently involve staff in their emotional issues, daily family-staff meetings were instituted. These eventually replaced the one-on-one therapeutic relationships between mother and social worker and between patient and medical psychologist. All patients and staff on the project were encouraged to discuss any problems in the group meetings. Each member had an equal vote. “As the group continued, there was a marked increase in mature functioning of patients and less of the family conflict was absorbed by the staff” (Archives).

Staff made an effort to be supportive without taking sides. They found this difficult to do because they would have to resist the impulse to give direction or get involved in family conflicts. The treatment approach was essentially to coach families but
not make decisions for them. Bowen wrote, “Our program requires the parents to assume primary responsibility for the patient’s care. The nurses are available to help them with their problems with the patient” (Archives). When the project started, the goal was to find the most intense clinical examples of mother-daughter symbiosis, or fusion, in which the mother still functioned in the responsible role as mother. The research and treatment program was designed to make it possible for them to act out the symbiosis and the conflicts so that they could be worked on and improved (Archives).

Sometimes it has been difficult for me to get past the fact that each of the families in the NIMH research project included a member diagnosed with schizophrenia. Sometimes I thought to myself, what can a family suffering with mental illness in one or more of its members tell me about resiliency? Looking back now, I realize I would have missed a rich source of data on family process if I had dismissed families with schizophrenic members. I would have limited my investigation and definition of resiliency if I did not have an open mind to the role of family process in the course of disease.

Data Collection Methods

According to McMillan and Schumacher (2001), “documents are the most important data source in conceptual analysis and historical studies” (p.42). To explore Bowen’s archives from his NIMH research, I made several visits to Washington, DC, spending three weeks in the library where the archives are housed. The archives are currently housed at the Bowen Center for the Study of the Family in Georgetown and will eventually be moved to the National Library of Medicine.
As a researcher, the Bowen Center granted me permission to view and take notes on the documents. I adhered to the policy sent to me by the Bowen Center as outlined by the National Institutes of Health and the National Library of Medicine. The policy was implemented to align with the Privacy Rule [45 CRR 160; 140] of the Health Insurance Portability and Accountability Act of 1996 (HIPPA). This policy allows photocopying, however, when I arrived at the Bowen Center to do my research, I was not allowed to photocopy any documents, which made the data collection process much slower and more tedious. At first, I took notes in pencil (as pen was not allowed), then I made arrangements to have my computer shipped to the Center and typed notes into my computer, and to save time, I tape-recorded the notes and transcribed them later.

I originally had hoped to be able to photocopy the daily observation notes so that I could look at family process over time. Since it was physically impossible to record that much data manually, I recorded particular months and entered them directly into a chart I created where I could compare each family member’s behaviors on a daily basis. Later, I also recharted some of these observations on a scale of five levels of resilient responses: non-resilient response, less resilient response, undeterminable, more resilient response, and resilient response. This way of looking at the raw data made it evident that people vary their responses throughout a day and also revealed the links between the responses and family processes.

Data Analysis Procedures and Presentation of Findings

I coded the archival data using open, axial, and selective coding (Strauss & Corbin, 1990). Open coding is “the process of breaking down, examining, comparing, conceptualizing, and categorizing data” (Strauss & Corbin, 1990, p. 61). At first, because
there was so much data in different forms (charts, papers, interviews, notes), I coded the data into major categories such as family process (with eleven subcategories), and case studies (with six subcategories). Other categories included resiliency, the NIMH research project, and self as researcher.

Then I synthesized the data into narratives about each family, starting with whatever multigenerational history was available, nodal family events leading up to their participation in the Family Research Project, their progress during the project, and whatever was known about their progress after they left the clinic. During this time I also created family diagrams for each family as I discovered mention of the various extended family members in the data. Family diagrams were not yet used during the time of the original study.

I also experimented with several ways to code the observational data that I had charted or that I copied from charts. After several experiments, consistent categories began to emerge that led to the themes that comprise the findings. When I finished composing the family case narratives, I then reviewed them to devise codes. The themes generated from the cases resembled many of the codes that were emerging from the various charted observations.

This moved me toward axial coding, which reconnects data in new ways (Strauss & Corbin, 1990). Using axial coding, I began to see relationships between the themes that were emerging through the coding process. Themes such as reactions, focus of attention, the inability to say no, and fluctuation of functioning began to come together into a coherent framework. The next step in the coding process, selective coding, allowed me to build relationships between data categories around a core phenomenon, verifying
relationships and filling in information (Strauss & Corbin, 1990). As I worked with selective coding, further refinements of some of the categories, such as resilient responses, emerged.

Using Grounded Theory Methodology

Throughout the iterative procedure of coding and analysis, I carried grounded theory methodology in mind. Grounded theory procedures were helpful as I analyzed the data and formulated ideas about how the family system relates to resiliency. Central to the methodology is the analysis of process, defined as “the linking of action/interactional sequences” (Strauss & Corbin, 1990, p. 143). As I emerged from the intricate coding process, I had an inspired moment when I saw how the grounded theory methodology could help me explain and link together what I was seeing in the data about how family processes influence resilient responses.

The elements of grounded theory methodology are discovered with axial coding and further refined during the selective coding phase (Strauss & Corbin, 1990). The elements include a phenomenon, defined as a central idea, event or happening to be managed and handled. Grounded theory involves two kinds of conditions (Strauss & Corbin, 1990). Causal conditions are events, happenings, or incidents that seem to precede the phenomenon. Intervening conditions are broad and general such as economic status, culture, time, history, and individual biography. They have a bearing on the action/interaction strategies taken to handle the phenomenon. Both types of conditions are included in Figure 1 as “conditions.”
The context is "the location of events or incidents pertaining to a phenomenon" and also the place or conditions within which action/interaction strategies are taken to handle the phenomenon (Strauss & Corbin, 1990, p.101). Action/Interaction Strategies are natural processes that evolve to manage or respond to the phenomenon (Strauss & Corbin, 1990). Action/Interaction strategies evolve in a context. Action/Interaction strategies have consequences -- the outcomes, events, happenings, responsive actions and interactions that can become part of the context or intervening conditions (Strauss & Corbin, 1990).
I used analytic induction (Becker, 1998) as I studied the NIMH data. Analytic induction facilitates inquiry into processes such as the influence of family process on the resilient responses of youth (Becker, 1998). I used concepts from Bowen Family Systems Theory as a framework for the data analysis, including differentiation of self, nuclear family emotional process, family projection process, multigenerational transmission process, cutoff, and sibling position. I also referred to precursors of these concepts that were forming during the NIMH research.

My synthesis of grounded theory and case study methodology with the family systems lens resulted in a new model of resilient responses that explains how resilient responses grow out of the family system context and its processes. I have used this model to organize the presentation of the findings. At the same time, the findings illustrate each component of the model using the case studies as examples. In the discussion section, I will show how the entire model works, using the stories of two families.

**Using Case Study Methodology**

I used case study methodology to analyze and present the data (Merriam, 1992). The case study is a unique way to weave together data from a variety of sources to illuminate a concept such as resiliency. First, by concentrating on a single case, I uncover the family processes that seem to influence resiliency. “By concentrating on a single phenomenon or entity (the case) the researcher aims to uncover the interaction of significant factors characteristic of the phenomenon” (Merriam, 1992, p.29). Then, by using cross case analysis, I find similarities and differences between families in both the manifestation of resiliency as well as the family processes that influence it. The resilient
response model, which grew out of the grounded theory methodology, serves as a framework for presenting the cases, illustrated by examples from the cross case analysis.

Case studies often show how a unit of analysis evolves over time (Merriam, 1992). I have used the nuclear, and where possible, multigenerational, family unit as the case. I have analyzed its development during the time living on the research ward, and the time before and after as documented in family histories and other correspondence.

The case studies of the five families who participated in Bowen’s research project have been pieced together from a variety of data sources within the Bowen Archives, 1954-1959. Due to the highly confidential and sensitive nature of the documents, specific citations cannot be given. To comply with the recommendation of the National Library of Medicine, one non-specific citation will be used for all data from the archived papers of Dr. Murray Bowen. Since these are the only archives used in the research for this dissertation, the citation, “Bowen Archives, 1954-1959,” will be shortened in most cases to “Archives.” In addition, all names, dates, ages, and geographical locations in the stories and quotes are non-specific or fictitious to protect the anonymity of the family members.

*The Challenge of Data Analysis Using a Family Systems Lens*

The challenge of researching and analyzing data through a systems lens is that it requires multi-dimensional thinking. This is difficult for minds trained in linear thinking. For me, it is like the difference between playing C scales on a piano, where one note follows the other in one line, versus playing C scales on a guitar, where notes follow a jagged pattern involving four strings. I have to be aware of the location of notes on four different strings instead of just one set of keys. In other words, when applying systems
thinking to families, I have to be thinking about actions of various family members simultaneously. The goal is to discern how each person mutually influences the other rather than to find individual motivation. It is a way of looking at how processes in the system simultaneously act on and are acted upon by the players in the system.

In my research it has been time-consuming and complex to chart the actions of a daughter toward her mother and then to graph the actions of the mother toward her daughter. In addition, it has been challenging to keep them both in mind simultaneously. The human brain can barely take it all in or focus in two directions at once. Also, it seems important to not only look at the interaction between mother and daughter, but also to see how those interactions co-exist with simultaneous interactions with others in their worlds. For one mother, this includes her interactions with her family, her neighbors, her social worker, and the Center. For her daughter, this includes her interactions with the nurses, the aids, the doctors, and the other kitchen staff. It is difficult to hold all of this in mind at once and to sustain this broad view for long. Perhaps it is best to take a slice in time, almost like a cat scan, in order to present a glimpse into this wide angle lens of emotional process. Essentially, this is what the cross-case analysis hopes to accomplish.

**Working Definition of a Resilient Response and a Non-Resilient Response**

Before moving on to the findings, it is important to define what I mean by a resilient response. The concept of a resilient response takes a slightly different approach than the definitions of resiliency presented in the literature review, summarized here as 1) normal development despite high risk circumstances or an environment for problematic development; 2) the ability to adapt positively within the context of significant adversity or misfortune, including the ability to bounce back from a hardship;
and 3) flexibility in responding to environmental challenges. The term resiliency tends to imply a fixed state. For example, one might say a brother is resilient but his sister is not. This reflects an individually-focused paradigm that fixes the trait of resiliency within a person. The idea of a resilient response takes a systems view by looking at how resiliency changes under different relationship circumstances. Both the response and the ability to respond are flexible and operate reciprocally in relationships.

So, essentially, a resilient response is a thought, action, behavior, feeling, instinct, or a mixture of these that is adaptive, flexible, and may involve choice. It can include some or all of the following criteria. In the category of adaptive, a resilient response promotes survival and quality of life. It protects the organism from harm. It remains alert to changes in the internal and external environment. Also, it promotes independent functioning while in contact with significant others. The meaning of independent functioning here involves being responsible for oneself within a relationship system. It involves less fusion between people so that thinking is clearer and functioning is neither overadequate nor underadequate. Overall, a resilient response helps resolve problems and lessens the creation of new problems.

In the category of flexible, a resilient response leads to options for response to threat other than a fight or flight response. It allows anxiety to return to a lower level after the stimulus or threat subsides. A resilient response interrupts automatic, habitual patterned thoughts and entertains new thoughts that lessen stereotypes and fixed ideas. A resilient response recognizes when expectations become rigid and counterproductive. It allows self and other to move out of rigid positions. Overall, a resilient response allows for fluctuation and fluidity.
Regarding choice, a resilient response recognizes automatic emotional reactions and feeling states. It is able to help self and others. A resilient response overrides less adaptive impulses and uses personal power in healthy ways. At the opposite end of the spectrum, a non-resilient response may not involve choice. It is unaware of automatic emotional reactions and feeling states. It involves a sense of helplessness and powerlessness (and sometimes hopelessness). It acts on maladaptive impulses and uses personal power in unhealthy ways.

A non-resilient response is a thought, action, behavior, feeling, instinct, or a mixture of these that is non-adaptive, non-flexible, and may not involve choice. It can include some or all of the following criteria. In the category of non-adaptive, a non-resilient response is destructive to self and others. It also allows harm to self and others. This is different than the first criteria in that it allows destruction to occur, rather than producing the destruction. A non-resilient response is unaware of changes in the internal or external environment. It diminishes quality of life. Functioning with others overlaps beyond normal developmental requirements. In other words, a person depends on another for things he can do for himself. Problems get recycled, displaced or intensified, and often more problems are created.

In the category of non-flexible, a resilient response acts on an automatic fight or flight response to threat when that action is contraindicated. The anxiety level stays elevated after the stimulus or threat has subsided. A non-flexible response maintains automatic, habitual, patterned thoughts and behaviors. It holds onto stereotypes and fixed ideas. A non-resilient response carries expectations that are rigid and counterproductive. It holds self and others in rigid positions.
A friend and colleague who reviewed the above criteria commented that "adapting" for women can be non-adaptive. In other words, she meant that adapting to men can diminish a woman’s quality of life. To me, that definition of the word adaptive does not meet the criteria that I describe in the adaptive qualities of a resilient response. Instead, it meets the criteria for a non-adaptive response because it diminishes the quality of life for the woman. Also, if she feels she has no choice in the matter, it is also non-resilient. Perhaps adapting in this way, however, promotes survival if there is a threat to survival by not cooperating with men.

These are the gray areas of trying to define a resilient response and separate it from a non-resilient one. At times, responses might be a mixture of both. Figure 2 presents them as two ends of a continuum. The element of creativity seems important here. When a woman finds creative ways to manage or transcend an adverse condition, she often devises options and new ways of thinking about her situation. The problem with creativity as an element of a resilient response, though, is that people can use creativity in both resilient and non-resilient ways. One can be creative about robbing a bank, but it may not be a resilient approach to making a living and will likely invoke other problems.

![Figure 2: Continuum of Resilient Responses](image-url)
CHAPTER THREE: FINDINGS

The Families as Viewed Through the Resilient Response Model

In this chapter, I share the model of family process and resiliency that emerged during my analysis of the data. I call this the Resilient Response Model. Each component of the model is illuminated with examples from the family case studies. Figure 3 shows the Resilient Response Model and its components with the parallel elements from grounded theory methodology in parentheses. I have depicted this model as a figure eight diagram with two additional pathways representing types of resilient responses that lead back into the figure eight. The following paragraphs give an overview of the model.

![Resilient Response Model Diagram]

Figure 3: Resilient Response Model
The figure eight begins with *adversity*, inspired by the conditions mentioned in grounded theory methodology. Adversity would include challenges that raise anxiety and activate a person's coping mechanisms. It can include daily hassles that arise, acute stressors such as injury, disaster, or loss, and chronic stressors such as poverty, racism, and sexism. As I discuss other elements of the resilient response model, I will show how an action/interaction strategy and a resulting non-resilient response can also become a new adversity.

Following the figure eight model from adversity, the next component is *anxiety*, which is the central phenomenon to be managed. Anxiety is the automatic human response to threat and thus is increased by adversity. Everyone experiences anxiety and finds various ways to handle it, whether automatically or consciously.

From anxiety, the model then points toward the *family system*. The family system represents the context through which anxiety travels and in which it is hosted. The evolution of the family system over the generations and its current status is a filter through which anxiety passes. Imagine a pinball machine where anxiety is the ball. It follows a specific route through the family system, avoids certain people, activates others, and sometimes gets stuck along the way.

From the family system, the next point on the figure eight is *family emotional process*. Within a family system context, family members naturally act to manage anxiety, often reflexively trying to relieve the discomfort that it raises. These actions and interactions on the part of the family are the family emotional processes. They are the strategies that evolve to handle anxiety that arises within and between individuals in a
family group. These strategies may be purposeful or reflexive. They also may include purposes unrelated to the phenomenon but have consequences for it.

Now the resilient response model takes three possible pathways. The path that completes the figure eight and leads back toward adversity is the path of a non-resilient response. As a consequence of the family emotional processes that have evolved to manage anxiety raised by adversity, one or more family members may find themselves gravitating toward a non-resilient response. An opposite consequence of the family emotional processes may be that one or more family members make a resilient response.

Resilient responses can take two pathways on this figure eight diagram. One leads back to the family context, where it reinforces the patterns in which anxiety flows in a family. The other type of resilient response, which I call a differentiating move, re-enters the figure eight model at the point of anxiety. As an intentional way for family members to change their part in the family system, it raises anxiety but does not create new adversity for the family. Over time it alters the family context and emotional processes, and helps the family cycle out of a non-resilient response mode.

Now that the components of the model have been outlined, one might ask if they occur sequentially? As my discussion in the coming paragraphs will show, a family emotional process can also become an adversity and alter the family system context. While a sequential order helps the mind to think through the parts of the model, I believe these components can occur simultaneously or reciprocally. They can mutually influence each other.
Family Adversities: Divorce, Death and the Resilient Response Model

Let us consider how divorce would fit into this model. Is a divorce a way to manage anxiety through family emotional processes, or is it an adversity? Is it a resilient response or a non-resilient response? A divorce can be both a resilient and a non-resilient response because it can increase and decrease flexibility, adaptability and choice. It can increase anxiety in some family members and not in others. A partner may be relieved to be free of the bondage of the marriage while a child may be devastated by the separation of the parental union.

As the family acts and interacts to manage the anxiety created by the divorce, each person will respond with some level of resiliency. If a child who is devastated by the divorce develops a psychosis this response creates a new adversity for the family to handle. A divorce can change a family system context or maintain it. If a family has a multigenerational history of divorce, the new divorce may simply maintain the status quo of the system. If divorce is new for a family, or the nature of the divorce is new, then it may alter the family system context. As a way to manage anxiety, divorce deserves scrutiny.

Death as a form of loss also alters a family system. Even though family emotional processes that involved the deceased person can live on in the remaining members, the context of the system is still altered by the loss of one of its members. A major adversity that claims the lives of many family members also alters the family configuration and puts into play a number of emotional processes to compensate and handle the resulting shock and trauma, which fall under the phenomenon of anxiety. Death is an adversity and can in some cases also be looked at as a family emotional process in itself. Some deaths
can be seen as ways that people manage anxiety. These can represent both resilient and non-resilient responses. For example, a conscious choice to end life due to a debilitating disease may be a resilient response because it involves choice and protects the organism from further pain and harm. However, a suicide or some accidental deaths may occur out of a non-resilient response emerging out of family processes that make it difficult for individuals to respond flexibly to adversity or anxiety.

Assumptions about Variability Between Individuals

A few questions arose as I developed this model. How can it account for variation in perception of adversity experienced by an individual? How can it account for variation in the range of anxiety experienced by an individual? How can it account for variation in the individual’s ability to choose a resilient response? Perhaps these are assumptions that need to be made. In other words, an underlying assumption of the model would include the fact that people vary in their perception of adversity, the amount of anxiety they experience, and their ability to choose a resilient response. However, another assumption would be that family processes play a role in that variation.

Introduction to the Research Families at NIMH

In the following sections, I will begin referring to the case studies. To give the reader an orientation to the families, I will briefly introduce them at this point. Further details about each family will be given throughout this chapter and the next to highlight the various aspects of the resilient response model.
This brief overview includes the nuclear families only. The $N$ Family is an intact marriage between James and Katherine, also referred to as Mr N and Mrs N. They have two sons: Jeff, who is about 19 years old, and Sam, who is 12. Jeff is the child diagnosed with schizophrenia. Katherine's attention is almost constantly on Jeff. Jeff and his parents live at the Clinical Center. Sam lives with an aunt nearby, but visits often and stays overnight (Archives).

The $O$ Family is also an intact marriage, of 25 years, between John and Shelby, who will also be referred to as Mr O and Mrs O. They have two daughters: Jane, who is 22 and Leslie, who is 15. Jane is the child diagnosed with schizophrenia, however, her
father has struggled with depression and was at one time given a diagnosis of schizophrenia himself. Shelby and Jane are almost inseparable. Leslie is mature beyond her years and takes quite a bit of responsibility for herself and others. Jane and her parents live at the Clinical Center and Leslie alternates between visiting and living at the Center (Archives).

The R Family is a single parent family. Mary Jo, or Mrs R, is the mother. She has five children: Carol, who is 18, Frank, who is 16, Paula, who is 15, Philip, also known as PJ, who is 14, and Andy, who is 10. Paula is the child diagnosed with schizophrenia and she lives at the Clinical Center. Philip is failing in school and has been getting into trouble with the law. Partly because of the two younger boys, Mary Jo has arranged to live at home and visit the Center daily to participate in the project (Archives).

The S Family has been divorced for five years. The parents are Robert and Liza, also referred to as Mr S and Mrs S. They divorced after 17 years of marriage. They have one daughter, Nancy, who is 17. Liza and Nancy live at the Clinical Center. While Nancy was initially diagnosed with schizophrenia, the clinic staff came to believe that it was actually Liza who had symptoms of schizophrenia. Liza and Nancy are inseparable (Archives).

The L Family is also divorced. Edward and Jeanine, or Mr and Mrs L, are the divorced parents. They have two daughters: Sandra who is 35, and Linda who is 32. The divorce precipitated Linda’s first psychotic episode, when she was 14 years old. She lives at the Clinical Center. Her mother, Jeanine, lives nearby and participates actively in the research project (Archives).
Now that the reader has been introduced to the families, each component of the resilient response model will be explained. Each component will be illustrated by examples from the family case studies, and then linked to resilient responses.

**Figure 5: Adversity**

The Components of the Resilient Response Model Illustrated by the Families

**Adversity: Conditions that Increase Anxiety**

This section will take an in depth look at how adversity plays out in the NIMH families. Examples from the O Family, the S Family, and the R Family will illustrate various types and durations of adversity. I will discuss how these challenges eventually had an impact on resiliency.
A Continuum of Adversity

Case studies of the NIMH families illustrate a range of environmental challenges that I categorize as external, internal, family related, and as an interplay between these sources. External adversity originates outside of a person in the environment while internal adversity arises within the self. Family related adversities originate within the family. Each source of adversity tends to interact with the other, resulting in an interplay between adversities. These adversities are located on a continuum from acute to chronic. Acute adversities last temporarily while chronic challenges go on for a long period of time, sometimes indefinitely.

Short Term Adversity in the O Family.

For example, John O experienced an acute internal challenge when he twisted his ankle on an outing (Archives). It needed attention immediately, but healed quickly and then was over. Shelby O experienced an acute internal, external, and family related challenge when she needed to have an operation for a tumor, found to be benign (Archives). The tumor presented an internal challenge and the operation presented an external challenge for her body. Her inability to function as the family leader during this time also presented a family challenge to the rest of the family, who had to orient themselves differently during her recuperation. However, the entire episode was an acute challenge because it was temporary.

Long Term Adversity as a Trigger for Imbalance in the O Family.

Longer term personal illnesses present a chronic internal challenge to the individual experiencing the illness, and a family related challenge to the family members who live with the individual. For example, John O had a series of physical ailments that
led to a deep depression, in which state he eventually landed in the hospital off and on over a period of 18 years (Archives). This raised anxiety in his family, and Shelby reacted by distancing from John and taking Jane to live with her at her parents’ home. Later, Shelby also took over responsibility for the family business in John’s absence and fell into a role of over functioning and meeting her attachment needs in her relationship with her daughter Jane. Shelby had already been prone to a high level of chronic anxiety that manifested itself in panic states, rashes, and fainting spells (Archives). Her emotional reliance on Jane made it difficult for Jane to respond resiliently on a regular basis. On the other hand, Leslie, the younger daughter by seven years, demonstrated resilient responses more often. Leslie and Jane’s resilient and non-resilient response patterns grew out of a family imbalance, which had evolved over time as each member did what it knew how to do to manage a high level of anxiety on a regular basis.

*From Acute to Chronic: Adversity and the Erosion of Resiliency in the S Family.*

An acute external challenge for the S family involved persecution three generations back in history. One branch of the family immigrated to the United States and established themselves successfully in a short amount of time. The other branch of the family split up. Some stayed behind and were killed. Others dispersed to different places and eventually lost touch with each other (Archives). What started as an acute external challenge became a chronic family challenge when the dispersed members of the family no longer communicated with each other and grieved the loss of those that died. Eventually, this cutoff between generations of the family had a deleterious effect on the resilient responses of the younger generations of the family. Anxiety was high and members compensated with intense conflict, extreme distance and cutoff, loss of
independent functioning, and increased fusion among those dwindling family members who remained.

It was in this context of sparse emotional resources within the S Family that a family move within the United States in the second generation and the fall of the stock market within the third generation, became risk factors. They became new adversities that exacerbated the S family's problems, not directly, but through the heightened anxiety and the increasingly rigid family processes that evolved to compensate for it. More family members became ill and died early, adding death and illness to the load of adversity that was now emerging within the family on a regular basis. Anxiety spiraled and the fusion between the few remaining members did as well. Over the course of four generations, this line of the family had fallen into such a state of imbalance that the mother, Liza S, was described as follows:

She had regressed to a level that caused the sociologist to classify her as coming from a low, low social class and which all staff people have tended to use in thinking about her. Her sloppiness, vulgarity and cursing would seem real and any mention of the culture from which she came was made to seem like megalomania (Archives).

In the S family example, the acute external challenges eventually led to a variety of chronic challenges that were generated within the family and within its members. It is already becoming apparent that challenges can spill over from an acute external or internal challenge to one that involves an interplay between internal, external, and family related sources. As these build on each other, chronic challenges seem to evolve out of the processes that families use to manage the heightened anxiety that results. As anxiety increases in manifold ways between fewer family members who become more fused over the generations, then resilient responses become less of an option without a balancing
agent. It was only after regular coaching from Bowen, that the daughter, Nancy S, was able to begin to make differentiating moves that helped her move toward a pattern of greater flexibility, adaptability, and choice in her life.

_Adversity and the Intensification of Anxiety in the R Family._

In the R family, several challenges were also at play. Mary Jo had to cope with irregular public assistance checks, at which times she would express her anger by saying that “unless she got some help she was going to tell her boys ‘to get their meals wherever they could and I don’t blame them if they steal’” (Archives). Obviously, her anxiety was raised at these times and she handled her discouragement by thinking vindictive thoughts. This was probably one of her only outlets since she had little family other than her children from which to seek support. She did lean on her children for support and that was often too much for them to handle. Mary Jo had been deserted by her husband when her youngest boy was born and he was completely cutoff from the family (Archives). Cutoff and desertion by a family member represented two family related challenges.

Mary Jo had other challenges added to these. In addition to the chronic adversity of ongoing poverty, she also worried about the non-resilient responses of her children. For example, she was concerned about Philip’s juvenile delinquency and not fitting in socially as well as Paula’s mental illness and her teen pregnancy (Archives). She was not able to see as clearly the increased fusion and anxiety that were also operating behind the scenes of these non-resilient responses by her children. Occasionally she managed her anxiety with extreme distancing from her daughter, Paula, which resulted in a striking increase in her non-resilient behaviors. Extreme distancing, or cutoff, from family can
raise chronic anxiety and exacerbate non-resilient responses. However, with work at bridging cutoff and differentiating a self, anxiety can decrease.

**The Impact of Adversity on Resilient Responses**

In this discussion of adversity, some examples were given of external and internal adversities, both acute and chronic, as well as those that arise within the family. While a few adversities remained benign and short term, many of them triggered anxiety that needed to be managed by the families. In the course of trying to handle the increased anxiety, families often evolved toward greater fusion and less flexibility. Over time, this snowballed into a series of difficulties that taxed the resources of the families and left some of the members nearly helpless to alter this trajectory. Certain children who were receptors for this increased anxiety exhibited more non-resilient responses that added to the adversity that raised anxiety for the family. The interplay between challenges emerging from these various sources begins to illumine the complexity of underlying mechanisms surrounding risk factors.
Figure 6: Anxiety

Anxiety: The Central Phenomenon to be Managed

This section takes a look at anxiety and how it manifests itself in the families. When families encounter adversity, especially the chronic type that leaves them vulnerable to an interplay of challenges as discussed in the previous section, anxiety increases. Increased anxiety mobilizes the families to intensify the processes they use to manage it. Without a counteracting balancing move, this is where families can go astray and where some of their members can get caught in a vicious cycle of non-resilient responses.
Anxiety as a Reaction to Real and Imagined Threat

Anxiety is the arousal that occurs in reaction to perceived threat. Arousal can include autonomic reflexes such as an accelerated heartbeat, sweating palms, dry mouth, or shaking. When Shelby O got anxious, she would begin to shake. She could also develop a nervous tic. At best, anxiety can increase alertness to the environment and provide energy to accomplish whatever needs to be done for protection from threat.

When his brother Jeff threatened his father, Sam N held his brother down to protect his father even though Sam was much smaller and younger than Jeff. However, anxiety can also manifest in repetitive or compulsive behaviors, difficulty thinking clearly, narrowed vision, irritability, and difficulty sleeping. Jeff himself exhibited compulsive behaviors and difficulty sleeping. On the day that he threatened his father, he had been unable to sleep until nearly 7:00 that morning (Archives).

When...aroused, the emotional system of the anxious individual tends to override the cognitive system and behavior becomes increasingly automatic. Subjective decisions based on internal feeling or affect predominate. People tend to act to relieve discomfort, even though their decisions and behavior may lead to long-range difficulties and even greater discomfort (Papero, 1990, p.42).

In the example above, Jeff impulsively acted aggressively toward his father, an automatic fight response that is indicative of heightened anxiety in reaction to threat.

After the incident, Jeff’s parents were upset and anxious, more convinced that his illness was a random phenomenon and that the treatment at NIMH was not working. They distanced themselves from him and felt helpless to change him. Jeff was also upset and paced the unit for a long time afterward (Archives). Unfortunately, Jeff’s actions probably contributed to future decisions his parents would make about his care and treatment. He may have been transferred to a facility not as open and hospitable as the
Jeff’s fight response seems to be in response to an imaginary threat. The record states that Jeff had started the fight. This is relevant to Bowen’s definition of chronic anxiety, as introduced in the literature review. Bowen distinguishes between two kinds of anxiety. According to Bowen’s definition, acute anxiety is a response to a real threat, such as a death, or an earthquake. Chronic anxiety is a response to an imagined threat, such as a fear of impending disaster. “Acute anxiety is fed by fear of what is; chronic anxiety is fed by fear of what might be” (Kerr & Bowen, 1988, p.113). The lighter spirit of chronic anxiety might be summed up in Mark Twain’s statement, “I’ve had a lot of trouble in my life, most of which never happened.” The darker side of chronic anxiety is its insidious erosion of coping capacities and as we can see with the example above, the deleterious effects on the ability of young people to choose resilient responses.

Anxiety in itself is not good or bad. It is necessary for mobilizing a person to meet challenges. However, while too much anxiety can overload a person’s coping capacity, too little can place a person in danger when a real threat exists. Anxiety (also termed reactivity) “is manifested along a continuum that ranges from hyperactivity (the extreme is behavioral frenzy) to hypoactivity (the extreme is behavioral paralysis)” (Kerr & Bowen, 1988, p.112). Applied to the data I collected on the families, this continuum provides a landscape in which to understand the range of observed behaviors, symptoms, and expressed thoughts that could be classified as anxiety.
Manifestations of Anxiety

In the families, sometimes anxiety showed itself in facial expressions, postures, movements or somatic symptoms. For instance, a staff member would record that Jane had a tense expression on her face. Other manifestations included mood and psychological state. Daily observations would note if John woke up in a seemingly good mood. With stress, there was often a narrowing of vision. Thinking became less flexible and clear. For instance, John and Shelby would find themselves in a stand off about who was going to handle getting Jane upstairs. Both would get more and more rigid in their postures toward the other, even though it obviously was not helping the situation. Ruminating and obsessing were similar manifestations of anxiety. Occasionally people were more conscious about their anxiety and simply said they were anxious.

Often, anxiety became detectable by the various strategies people used to manage and react to it. A way of managing anxiety was to displace or recycle it in triangles, such as when family members talked about other members of their family and when they talked about their own child’s illness. John O and Katherine N were often found sitting at the breakfast table long after the meal conversing about their family members and their children’s mental illness (Archives). This was often a way to let off steam or to find better ways of coping. The idea of managing anxiety through relationship triangles introduces the interaction strategies that will be discussed in further detail in the section on family emotional processes.

As we saw in previous examples, the exchange and expression of anxiety between two or more people included open conflicts as well as other verbal and nonverbal reactions. Distance and flight represented common ways to lower anxiety by getting
away from the other party perceived as the threat. When anxiety was up, some family members talked about mental illness in order to understand it or cope with it. However, some of the talk may or may not have lead to better ways of handling anxiety.

**Anxiety as a Magnetic Force for Closeness and Distance**

When people become anxious they often seek comfort. "As anxiety increases, people experience a greater need for emotional contact and closeness" (Kerr & Bowen, 1988, p.121). Sam N demonstrated acute anxiety when he became "very frightened after seeing Jane O being held by her father and led to her room." Sam told a staff person, "daytime is all right around here, but not nights" (Archives). He followed that with an automatic flight response expressed in his request to go to his aunt’s home nearby. He showed the impulse to seek comfort in togetherness by huddling near his mother and then spending a long time playing games in his brother’s room. He also demonstrated the need for distance from the threatening party when later, he “consented to remain on the unit as long as the room door is locked” and decided to sleep in his mother’s room for the night. Whenever Jane was in the TV room, he watched TV from a distance in the hallway or an adjacent room.

Sam’s anxiety was primarily acute, because it responded to a particular incident. Within two days he was actively involved in all ward activities and giggled when he saw Jane wearing his mother's robe (Archives). If there was a chronic element to his anxiety, it was because he was not directly being threatened. However, it is understandable that a child would become aroused when witnessing unusual behavior.

Unfortunately, a few days after the first incident Jane attacked Sam’s mother and he became quite frightened, saying, “Let’s get away from here, Mother,” a definite flight
response. He sought closeness by staying near his mother for the rest of the evening. The next day he interacted mostly with his mother and played ping-pong with her. Two days later, he still watched Jane “with some fright apparent” (Archives). Anxiety can permeate a family group. Later that day the entire family “left en masse when Jane threw a coke bottle on the floor.” They “sort of milled around the lounge until she was safe in her room” (Archives). This is a good example of the family operating as an emotional unit, where anxiety is felt by all simultaneously and the group reacts as a whole.

When anxiety is higher, people may react to pressure for closeness from significant others with “a greater need for distance and emotional insulation” (Kerr & Bowen, 1988, p.121). One evening, Katherine and James N were sitting at the supper table with John and Jane O when Jeff N entered the dining room. He did not sit down with the group despite urgings by his mother and John O to take a place at the table. Instead he ignored them and made continuous trips in and out of the dining room gulping down food. His father remained quiet throughout the meal except to joke with Jane O. Here both Jeff and his father were distancing and insulating themselves from the need for closeness expressed by both Mrs N and Mr O.

This is an example of how children in the same family can react differently to anxiety. One seeks comfort in closeness and the other tends to distance and insulate himself. Each experiences anxiety but shows it in a different way. However, this is not due to temperament alone. Later, in the sections on family system and family process, the influence of the family on individual ways of managing anxiety will become more apparent. That system of interactions then plays a significant role in the tendency of a child to respond resiliently.
Anxiety and Its Impact on Flexible Thinking

The previous example where Katherine and John encouraged Jeff to sit at the table also hints at the following tendency: “When some people get anxious, they are more intent on getting others to do things their way. The more anxious they get, the surer they become that they know what is right or best” (Kerr & Bowen, 1988, p.122). The following scene illustrates this process:

At lunch...Mrs N initiated a long description of Jeff’s anorexia...[directed] mostly to Mrs O. Mrs N pictured Jeff as “hollowed cheeked”, not having eaten for a long time, and very tense. She expressed herself anxiously, and ended that phase of her monologue by asserting she thought she would ask Dr D to prescribe something for him. Mr N ate with only random comments (Archives).

Also, “the more people respond based on anxiety, the less tolerant they are of one another and the more they are irritated by differences” (Kerr & Bowen, 1988, p.121).

Mary Jo R became more critical of her children during a month in which she worried about not receiving her public assistance check in a timely manner. She complained more about them, expressing quite a bit of anger. She also showed signs of being overwhelmed and hopeless about her situation, a state which fluctuated from month to month as her adversities fluctuated. She used the term “never” which is often a tell-tale sign that anxiety is up and thinking has become more muddled. She lamented, it is “easier to have an eight hour a day job than to rear children; one never sees any values accomplished in rearing children, but one can in doing a job” (Archives).

Without having worked, her statement is a fantasy about things being easier in the work world. This is a typical statement that I might find myself saying when I get anxious, only in my case I would be saying that it would be easier to raise children than
to have a job. The content is different, but its source, anxiety, is the common phenomenon that we are both experiencing.

A similar manifestation of anxiety exhibits as "feelings of being overloaded, overwhelmed, and isolated, feelings that are accompanied by the wish for someone to lean on, to be taken care of, to have responsibility lifted" (Kerr & Bowen, 1988, p.121-122). For example, in this same month,

Mrs R talked about her feelings of utter hopelessness. She stated "maybe someday I will be out of all of this." She continued "I don't care whether I sink or swim; the children don't care about me either; I wish someone would shoot me." She later brought out that she was terribly worried and couldn't even sleep at night. (Archives).

This and the other examples above demonstrate how anxiety affects the thinking process.

Under the pressure of anxiety, both Mary Jo R and Katherine N tended toward skewed thinking. One tended to become convinced that she knew what was best for others, and the other became helpless and overwhelmed. Both examples represent thinking when it becomes infected with anxiety. The skewed thinking also reflects a less resilient response on the part of the two mothers.

The Impact of Shifts in the Relationship System on Anxiety

It is interesting to watch anxiety levels shift when the family context changes at the Clinical Center. This is important to notice since it demonstrates the impact of the relationship environment on individual resilient responses. After James N left to return to work, Jeff and his mother were the primary family members remaining on the unit. Sam would come visit when his father did. According to Kerr & Bowen (1988),

While specific events or issues are usually the principal generators of acute anxiety, the principal generators of chronic anxiety are people's reactions to a disturbance in the balance of a relationship system. Real or anticipated events
such as retirement or a child’s leaving home may initially disturb or threaten the balance of a family system, but once the balance is disturbed chronic anxiety is propagated more by people’s reactions to the disturbance than by reactions to the event itself. (Kerr & Bowen, 1988, p.113-114).

This may offer some understanding of the increased level of chronic anxiety in Jeff’s behavior and his mother’s increased anxious disappointment with his progress after his father left the program. Interestingly, she continued to not participate actively in the family – staff meetings, possibly due to her desire to keep family issues private. It is striking, though, that Jeff’s compulsive behavior was much more acute during the last three weeks on the project. While his behavior could reflect underlying anxiety about knowing that a change to a new environment was coming, it may also have been a reflection of a disturbance in family balance. He slept during the day, paced the hall and flushed the toilet repeatedly during the night, and rarely joined in activities (Archives). Jeff’s behavior when exhibiting this much anxiety could be seen as less-resilient. In this scenario, there seems to be a direct correlation between anxiety level and resilient response. The more anxiety Jeff had to manage, the less resilient his behavior appeared.

During the first few weeks on the project, Jeff’s behavior was less anxious and more resilient. Though he paced in the beginning and smoked cigarettes, he joined in activities, games, and sports with his father, mother, brother, staff, or other families, upon first invitation. Sometimes he would initiate games such as ping-pong with the staff. On the second day, he was described as “in good contact, responsive and decisive.” He would still eat with the family at meals though he often left early. Jeff was often talkative, engaging staff and others in conversation. He would offer his brother, Sam, a sandwich. One afternoon, he enthusiastically shared his self-designed schedule of activities with a
staff person (Archives). The variability in Jeff's behavior shows fluctuation in resiliency. Through these examples, it becomes apparent that changes in anxiety level that occur in relation to contact with significant others, accompany this fluctuation.

A noticeable and recurring dynamic in the N family was the mother's concern about Jeff not eating and her tenacious efforts to get him to eat. During their first month on the project, her husband would intervene in this behavior. For example, Mrs N was anxious to have Jeff eat breakfast but accepted her husband's decision to let Jeff eat when he was ready. She did, however, take food to the kitchen in case Jeff wanted breakfast later. At lunch she was concerned that Jeff left the table early and suggested to Mr. N that they follow him, but then agreed with her husband that they should let Jeff set his own pace (Archives).

Mr N (and possibly Sam) may have provided a buffer that kept Mrs N calmer and less focused on Jeff. He may also have had a calming influence on Jeff, but perhaps indirectly. Since he would balk at his wife's requests to do things for Jeff, he may have provided a slight mitigating factor to her tendency to focus intently on Jeff. However, it would be a very small mitigating factor, since he often gave in to her urgings.

I found some evidence for Mr N's influence on his wife's anxiety in my analysis of anxiety managing behaviors during the last month of their participation on the project. During that time, Mrs N and Jeff were living at the Clinic and Mr N and Sam would come visit on weekends. I notice a pattern in Mrs. N's management of anxious behavior. A day or two after her husband would arrive for a visit, she would not be engaged in anxiety management activities at all. I interpret this to mean that her anxiety level dropped. This happened five times during her husband's visits and an additional time
when Jeff ate all of his dinner. These findings indicate to me that the father's presence had a calming effect on Mrs N or that his behaviors possibly regulated Mrs. N's anxiety management. Jeff's anxiety management behaviors were not visible the day before his father arrived for a visit, which happened three times. This may indicate that the anticipation of his father's arrival also had a regulating effect on Jeff's anxiety level.

These examples show that the presence of additional family members can have a mitigating effect on anxiety between, in this case, a mother and son. This is important to think about when considering the impact of anxiety on resilient responses. The more isolated people become and the more anxious, it is likely that non-resilient responses will result. This isolation becomes apparent in the following discussion of Jeff N's tendency to bind anxiety.

**Binding Anxiety in the N Family**

Binding anxiety involves recycling or displacing anxiety that remains elevated, rather than finding ways to resolve, lower, or manage anxiety constructively. I place compulsive and addictive behaviors in this category. This can include addictions to relationships, drugs, alcohol, work, sex, or gambling. It can include preoccupations and obsessions. People can divert their attention away from anxiety with elaborate plans and activities that consume their time. Some of these can be valuable endeavors. Relationships can bind anxiety. They take attention off internal manifestations of anxiety and give participants in the relationship another person onto which they can project or transfer anxiety.

The notion of binding anxiety becomes intriguing when considering Jeff as a receptor for anxiety in his family system. He tended to distance and insulate himself
when anxious and his parents tended to focus anxiously on him. There was only so far that he could distance himself physically within the confines of the Clinical Center because of safety issues. Since he had a tendency to occasionally react to threat, real or imagined, with aggressive behavior, he was not as free to leave as were his parents and his brother Sam. For someone who tended to distance when anxious, being confined to the proximity of others would make anxiety and discomfort more intense. Even Jeff’s tendency to distance is curious. When did it begin? What was he reacting to initially when he developed this preference? I would venture to guess that there were emotional pressures in the family environment long before he arrived at the Clinical Center.

At the Center, Jeff was constantly in the proximity of caring family members who were anxiously focused on his well being, paradoxically to his detriment. Consequently, Jeff had a tremendous amount of anxiety to manage. It just so happened that Jeff engaged in many anxiety binding behaviors. He paced the halls. He flicked through the viewfinder without really looking at it. One observer noted, “Jeff spent...five hours going between his mother’s room and the TV room, compulsively flicking the dials on the TV sets in each room” (Archives). Another time he “remained in the lounge flicking the light switches” (Archives). Another observer noted that Jeff “secluded himself in the TV room compulsively flicking the switch of his hand projector” (Archives). When considering the impact of anxiety on behavior, it is hard to consider Jeff’s compulsiveness as a random event. It is hard to disconnect his behavior from the ways in which anxiety was managed in his family, even though his family had good intentions. I know I would become more anxious if my family were continuously watching and worrying about me.
Jeff flushed the toilet repeatedly until told to stop. Sometimes after the person who asked him to stop left, he started again. When they went so far as to lock his own bathroom so that he could not flush, he found another toilet down the hall (Archives). The compulsion to flush became paramount. When other families began complaining about the noise he created during the night due to the constant flushing, his father fixed the toilet so that it would not make noise (Archives). This is a beautiful example of how other family members aid in the anxiety management strategy of anxiety binding.

Mrs N’s determined efforts to get Jeff to eat could almost be considered an obsession. She resorted to offering him second helpings, saving food for him, preparing a tray for him, serving him in his room, leaving money for staff to take him to the snack bar, and sometimes leaving food for him but asking staff not to tell him it was from her (Archives). In a sense, this could be considered an anxiety binding mechanism on her part, bound in an ongoing obsessive concern about his eating behavior. Perhaps this dynamic between the two of them bound anxiety for the entire family unit.

Often Mrs N urged Jeff to eat before he seemed to make a decision about eating. Perhaps she urged him due to anxiety triggered by observing his eating behavior on the previous day. Every day was not a new day in this process. Her observations of him over time would mix with her fears that he would starve himself to death. This is a great example of a chronically anxious state. While there may have been some threat that he would starve himself, it was not a clear-cut reality. Could she have been responding more to her own anxiety rather than his behavior when she urged him to eat? Did her fear of impending worsening of his condition make it difficult for him to choose self-preserving behavior?
Using a cause and effect framework, it is hard to know the starting point in the situation between Jeff and Mrs N. Did her anxiety perpetuate his behavior or did his behavior perpetuate her anxiety? Reciprocal functioning offers a systems view of this mutually perpetuating behavior. Neither one is singled out as the instigator when the cycle is viewed as a reciprocal process. The assumption that it is mutually generated then leaves it up to either one to take the initiative to change their part in the cycle in order to lower anxiety. However, Mrs N may not be receptive to the idea that her anxiety precedes Jeff's behavior, and Jeff may locked into an automatic rebellion against his mother’s efforts. In this case, it would be up to others to alter their part in the system that feeds this cyclical dynamic.

The following brief scenario illustrates the nature of the unresolved anxiety between Jeff and his mother: Jeff asked his mother for money. She bargained with him to drink milk first. Later, he was observed throwing money on the floor of her room (Archives). This example highlights the tension between the two that was never alleviated in a constructive way. Money was asked for and then thrown on the floor rather than used for a specific purpose. Bargains were made out of fear that the other could not choose a resilient response without intervention and prompting. Jeff was not perceived as able to function independently and resiliently, nor did he behave productively. Anxiety was perpetually recycled in the relationship and a pattern of non-resilient responses was the norm under these circumstances.

This section explored anxiety as the central phenomenon on the resilient response model and its link to non-resilient responses. Chronic and acute anxiety were further defined and illustrated. Various case examples showed how anxiety manifested itself in
individual behaviors and in relationship patterns, and how it decreased flexible thinking. Vignettes about Sam N illustrated the automatic tendencies to seek comfort in closeness. Examples of his brother Jeff showed how family members also sought distance in reaction to increased pressure for closeness. The perpetual unresolved binding of anxiety was explored through the story of the N Family. The example of James N’s visits to the Center illustrated the impact of shifts in the relationship system on the degree of anxiety that needed to be managed.
Family System: The Place Where Anxiety is Managed

This section will highlight the contextual elements in a family system that have a bearing on the particular ways anxiety is managed in a family, and on how those processes then influence the resilient responses of youth. First, I will give an overview of these contextual elements. Next, I will discuss the concept of fusion in some detail, because of its centrality to an understanding of many of the contextual factors. Then, I will discuss the context of three families in depth, telling their stories while analyzing what the narratives can tell us about family context and its impact on youth resiliency.
Overview of the Family System as Context

As shown in Figure 6, the third component on the resilient response model is the family system. I am defining the family system as the context in which the family emotional processes occur, and the filter through which anxiety flows. The family system as a context, while ever changing, shapes the flow and transfer of anxiety between individuals in the system. Existing relationship triangles and cutoff define the pathways through which anxiety travels through the system. Sibling position of children and parents also provide a course for the flow of anxiety between parents, between siblings, and between parents and siblings. Examples include the coincidence of birth dates with nodal family events and adversities, and how the sibling positions of the parents shape their relationship with each other and with their children.

The number of members living, and the number of members in viable emotional contact with each other, provide a pathway of receptors by which anxiety permeates the system. The degrees of fusion, or undifferentiation, between members of the system, provide a context for how anxiety will be hosted in the system. The particular branch of the family, and its place in the multigenerational family line, contribute a location of fusion and its transmission to subsequent generations.

To understand how anxiety permeates a family system requires a basic understanding of the concept of emotional fusion. I will begin this section with an explanation of fusion. My purpose is to help the reader conceptualize how anxiety is hosted in a family system and how it is transferred from one person to another. I will discuss fusion as a central element of family context and its role in the processes that lead to resilient and non-resilient responses of youth. Though fusion evolves, its evolution is
gradual enough to be a relatively stable aspect of the family system. Hence it belongs with contextual elements, rather than in the family process section. Figure 8 depicts the fusion between members in the five families. The parents, depicted at the top level in each family group, vary in the degree that they are overlapped, or fused, with each other. The children overlap to varying degrees with both parents and with each other. The children who are shown as more overlapped are the ones more fused in their relationship with the parents.

Figure 8: Degrees of Fusion Between Family Members
Fusion: How Anxiety is Hosted in a Family System

Fusion is another term for differentiation of self. It encompasses both the overlap between people and the overlap between intellect and emotions within a person. Both seem to go hand in hand. In other words, greater fusion between people is accompanied by greater fusion between emotions and intellect. For example, when I say something I do not mean in the heat of an argument (to someone I am fused with), my emotions are also fusing with my intellect. The fight or flight response is a good example of an instinctual emotional reaction that may use the intellectual system in its service. A demonstration of this would be making a cutting remark to my brother-in-law (fight), or avoiding an important topic that might be upsetting to my mother (flight).

However, fusion can take many forms of identification with a significant other. In a file of research ideas, Bowen had outlined the "psychic interchanges in ego merger," which I find very useful to understanding fusion. There were three categories of psychic interchanges: dependence and independence, love and friendship, and anger and disturbance (Archives). Figure 9 outlines these psychic interchanges in ego merger between people. The three lists provide some examples of common ways people merge with each other on an emotional level.
### Dependence and Independence

<table>
<thead>
<tr>
<th>Responsible for</th>
<th>Clinging to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leaning on</td>
<td>Forcing self upon</td>
</tr>
<tr>
<td>Ambivalent toward</td>
<td></td>
</tr>
<tr>
<td>Switching roles</td>
<td></td>
</tr>
<tr>
<td>Concerns about opinion of</td>
<td></td>
</tr>
<tr>
<td>Indecision about</td>
<td></td>
</tr>
<tr>
<td>Feeling influenced by</td>
<td></td>
</tr>
</tbody>
</table>

### Love and Friendship

<table>
<thead>
<tr>
<th>Proud of</th>
<th>Lose self in</th>
</tr>
</thead>
<tbody>
<tr>
<td>Puttng self in place of</td>
<td></td>
</tr>
<tr>
<td>Feeling same as</td>
<td></td>
</tr>
<tr>
<td>Embarrassed about</td>
<td></td>
</tr>
<tr>
<td>Giving in to</td>
<td></td>
</tr>
<tr>
<td>Distressed about reactions of</td>
<td></td>
</tr>
<tr>
<td>Pleased with</td>
<td></td>
</tr>
<tr>
<td>Concerned about relationships with</td>
<td></td>
</tr>
<tr>
<td>Awareness of needs of other</td>
<td></td>
</tr>
<tr>
<td>Supportive toward</td>
<td></td>
</tr>
<tr>
<td>Desire to please other</td>
<td></td>
</tr>
</tbody>
</table>

### Anger and Disturbance

<table>
<thead>
<tr>
<th>Disappointed with</th>
<th>Sarcastic toward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical of</td>
<td></td>
</tr>
<tr>
<td>Denies existence of</td>
<td>(erroneous references)</td>
</tr>
<tr>
<td>Changes existence of</td>
<td></td>
</tr>
<tr>
<td>Ridiculing</td>
<td></td>
</tr>
<tr>
<td>Ignoring</td>
<td></td>
</tr>
<tr>
<td>Rejecting</td>
<td></td>
</tr>
</tbody>
</table>

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**Figure 9: Psychic Interchanges in Ego Merger (Bowen Archives, 1954-1959)**

The ego merger concept expanded to include the entire family with another term that Bowen used: the *undifferentiated family ego mass* (Bowen, 1978). This concept broadened the notion of fusion to include an entire family. The term eventually developed into the concept of the family as an emotional unit and viewed the family as one emotional organism. However, for the following discussion, I will focus primarily on fusion between two people.

To further explain fusion, I will cover three main points. First, *as two people become more fused, their relationship is paramount*. Each person in the fused relationship depends on the other to meet his or her emotional needs. When this...
dependence on the other is extreme, it impinges on a person’s own goal directed activity and ability to function.

As discussed earlier in the section on anxiety, people seek ways to alleviate the discomfort of increased anxiety, often with some combination of moving toward significant others and moving away. As anxiety increases, getting comfortable takes precedence over other endeavors. When people seek comfort in their most important relationships, they give up a certain amount of self, the natural instinct to be different, to maintain the togetherness. This creates a natural tension between the desire to be different and the desire to be enveloped and protected by the other. That natural tension becomes a source of anxiety triggered by the relationship environment.

That brings me to the second point of understanding the correlation between fusion between people and fusion between intellect and emotion. Since togetherness is a survival instinct, \textit{any threat to fusion becomes a source of anxiety}. Sensitivity to the other is heightened in order to avoid this threat. A person becomes increasingly attuned to emotional signals, such as facial expressions, that may indicate threat to the union. These readings on the other may or may not be accurate. Avoiding fear of rejection, it becomes difficult to take a stand that is different from the other person. The instinctual fear of rejection can cloud thinking and preclude the development of personal opinions. When the relationship is paramount, it is instinctually more comfortable to remain in a state of agreement without questioning or thinking critically.

Imagined threats to the fusion lead to concerns about losing the other through outside influences. As imagination rules, unrealistic thinking becomes the norm and non-resilient responses are the likely result. People become less flexible as they restrict their
movement or the movement of others to avoid upsetting the togetherness. This works until the restricted movement becomes too uncomfortable. Eventually the lack of flexibility, due to the maintenance of the emotional union, becomes a form of emotional crowding. In other words, it impinges on a person’s ability to pursue personal interests and to function for self.

Now for the third element of how fusion between people and fusion between intellect and emotion go hand in hand. Fusion itself becomes a source of threat by impinging on flexibility and the toleration for differences. A reaction to anxiety discussed earlier includes the tendency to think one knows what is best for another. One person’s problem or complaint becomes the other person’s problem to solve. In this situation, it is common for a person to take over the thinking and functioning of the other, while the other reciprocally decreases his or her ability to function or think for self. Thinking not only becomes less clear, but people also borrow thinking from others. A reaction to this takeover is ambivalence about the other person.

Fusion can exist in varying degrees of intensity between people. Mild forms of fusion can range from caring about others, enjoying their company, and a sense of belonging. All of these are important for emotional well-being. However, fusion becomes more restrictive as people find themselves not wanting to ‘rock the boat’ or not broaching difficult topics that are important to discuss with significant others. They might agree to something they do not want to do and regret it later. More extreme fusion might find people moving across the country from each other because they cannot stand to be in the same room. This reflects the lack of tolerance that often accompanies fusion. In one
sense, extreme fusion, which can lead to ugly outcomes, is nothing more than attachment needs gone awry.

In the resilient response model, I am making the case that fusion increases during stressful times. Families react to stress and do their best to adjust. Given the natural forces toward togetherness as a source of protection and to meet emotional needs, it is no wonder that greater fusion evolves in a family over time. For instance, if a child is born at a time of stress in the family, there might be a greater vulnerability to more fusion between a parent and that child. Let us say that a mother’s own mother dies at the time her child is born. She may be slightly more invested in the newborn child and somehow look to the child to reciprocate, especially if her husband and other extended family members are not emotionally available.

With the accompanying infringement on clear thinking and flexible functioning that fusion brings with it, resilient responses are less apt to emerge of their own accord. As several of the upcoming examples show, extreme fusion can lead to non-resilient responses. The rest of this section on fusion will further elaborate on the points made in this introduction and give examples from the family case studies.

As two people become more fused, their relationship is paramount.

Fusion was the core focus of Bowen’s family research project at NIMH when it started in 1954, however at that time, the term symbiosis was used instead of fusion. It grew out of work he had done previously with mother-daughter pairs where the daughters had schizophrenia. After one consultation earlier in 1954, before the project began, he wrote,
There was acted out in the office for almost the entire hour the amazing intensity of the relationship between a mother and her schizophrenic daughter....Seeing these two people together was a new experience. I have never seen a previous case of the dependent intensity of both the mother and the daughter that is present in these two people....Because the entire consultation time was taken up in this relationship between the mother and daughter, I could get very little historical information. I did not particularly want it and certainly think this opportunity to see the mother and daughter together was worth a great deal more than volumes of carefully recorded objective historical data (Weinstein, 2002, p.205).

This quote sheds light on several key aspects of intense fusion. First is the dependent nature of it. Both mother and daughter depend intensely on the other to meet their emotional needs. The fact that little historical information could be gathered from the pair because they were so involved with each other shows that the relationship consumed so much of their focus that they had little ability to answer questions. This speaks to a second aspect of fusion: the overlap between emotional and intellectual functioning. Greater emotional intensity disables the ability to engage in anything else.

The concept of fusion was important 50 years ago and it continues to be significant today. I witness fusion in my own family and between others I know. There was a time in my life when I could not go through a day without being able to get my partner out of my mind. I was extremely angry at him and I wished he would change to meet my needs. However, my focus was completely on him without a sense of how I played a role in the relationship. Furthermore, I perceived that he held the power over my happiness, a very helpless place for me to be.

Another term for fusion is differentiation of self. Bowen's discussion of differentiation of self involves the degree to which a person depends on relationships to function. To explain this as a universal continuum on which all people find themselves, he proposed a hypothetical scale of differentiation. "The scale eliminates the need for the
concept 'normal.' It has nothing to do with emotional health or illness or pathology….The scale has no direct correlation with intelligence or socioeconomic levels” (Bowen, 1978, p.472). A compliment can raise the functioning level of self and criticism can lower it. The functioning level of self is the part that is negotiable in relationships. The basic level of self is non-negotiable. The more fused people are, the more negotiable self is subject to fluctuation in functioning.

A prime illustration of fluctuation in functioning is in the story of Liza S who experienced mood swings that were triggered by her relationships and her sense of acceptance. At one point she indicated that she has experienced these swings for a long time. For example, when she felt criticized by the other families or staff at the Clinical Center, especially at a group meeting, she fell into a deep despair. This included being unable to sleep and a lack of attention to grooming herself. She would focus on how awful her past 20 years had been and her fear that things would always remain awful. She would discuss taking her own life but say that her religion prevents it. When she got this upset, her delusions of grandeur became more pronounced. When she had more of a fight in her, she would demand to leave and say that she would not take any more criticism. She would talk about wanting to go where she was not known. She would talk about how when staff criticized her, it would have a deleterious effect on Nancy (Archives).

At other times, when Liza felt accepted, she was well-groomed and could be “a delightful conversationalist,” discussing philosophy, beauties of nature, and creativity. She could become more insightful about her own issues. For example, she would talk about how her own emotional upsets got in the way of her constructive endeavors. She
would recall that her father told her as a child that it was difficult for her to read when she was upset. She would reflect on her own immaturity and her tendency to cover her sadness with inappropriate childish and clowning behavior. Liza would quote old sayings about hope and despair. There was one point after a period of despair and criticism, that the staff had become more sympathetic toward her. The next day she was extremely calm and attributed it to buttermilk she was drinking. When a staff member commented that maybe it was the fact that things were calmer with the other staff, she somewhat agreed (Archives).

This example of Liza shows severe fluctuation in functioning triggered by a relationship environment. When others were anxious and critical of her, she took a turn for the worse. When they were calmer, she functioned better. She may only have ‘felt’ criticized by the others, which indicates that she carried an amount of chronic anxiety in the form of reaction to an imagined threat. This reaction, however, goes hand in hand with increased sensitivity to others and to anxiety in the environment. A large part of her self, and consequently her well being, was negotiable in her relationship environment.

Bowen further described differentiation of self at different points on the hypothetical scale.

In relationships with others, high scale people are free to engage in goal directed activity, or to lose ‘self’ in the intimacy of a close relationship, in contrast to low scale people who either have to avoid relationships lest they slip automatically into an uncomfortable fusion, or have no choice but continued pursuit of a close relationship for gratification of emotional ‘needs.’ (Bowen, 1978, p.475).

In the N family, Mrs. N is a talented and healthy woman with no complaints other than her concerns about her son, Jeff. She indicated that her happiness depends on Jeff’s health. “If my son were better, I would be better.” While she had her own profession, she
found it difficult to work productively since Jeff’s illness due to her anxiety about him. As discussed earlier, Jeff’s functioning also fluctuated (Archives).

The correlation between fusion and fluctuation in functioning becomes relevant when thinking about resilient responses. It explains why people can exhibit more resilient responses in certain relationship circumstances. However, it also suggests that the more people work on differentiating a self from the relationship fusion, the less functioning will fluctuate, and the more often a resilient response will result. In addition, the effort may reduce the sense of threat that comes with greater degrees of fusion.

*Any threat to fusion becomes a source of anxiety.*

Fusion can restrict the movement of individuals as independent selves. If I am worried about not saying anything that might upset my significant other, my siblings, or my parents, my freedom to be a whole self is diminished. My sensitivity to others is so heightened that I am in a constant state of self-regulation in reaction to them. One mild way this sensitivity played out in the research families involved the inability to bring up a sensitive topic with the significant other. This was sometimes as benign as announcing a brief separation from the other to go on an outing. For example, one morning, Mrs. O left for another city without telling Jane. The following scene, from another morning, illustrates why it may have been easier to leave without telling her.

When Mrs O came to the lounge to bid Jane goodbye before leaving on pass with Leslie, Jane delayed her, asking her to sit down and get some coffee. Mother complied, despite Leslie’s annoyance at the delay. Mother initiated a conversation with Jane, addressing her as ‘sweety’ and telling her to get Mr O to consent to go out and the whole family would go out when Mrs O and Leslie returned from pass. Seemingly, she consoled Jane for not being permitted to go along too. Jane seemed complacent about the separation. She told her mother, “I’ll be alright, I am going out to play golf at 2:00 (Archives).
It is interesting that Mrs O spontaneously postponed her outing and did it despite Leslie's annoyance. It was less important in that moment to please her younger daughter than it was to join with Jane. As a matter of fact, it may have been hard for Mrs O to keep both daughters in mind at that moment. The emotional impetus to join with Jane may have clouded her awareness of the needs of both daughters as well as her own. Again, this is an example of the interplay between intense fusion in certain relationships and how it impacts the ability to think clearly. Mrs O's relationship with Jane was probably at least slightly more fused than her relationship with Leslie.

When there is fusion, there is sometimes great concern about the "influence-ability" of significant others. In other words, a mother can be quite concerned that others will influence her daughter in negative ways. She senses that the negotiable part of her daughter's self, that can overlap or fuse with the mother, is vulnerable to fusing with others as well. An example from the S Family illustrates this point:

Down through these past several months, the mother has been terrified of the tendency of her daughter to grow away from her. This she has handled by paranoid tirades against the malignant forces in the environment that undermine her and causes the daughter to be influenced adversely. Most prominent in this for the past several months has been the paranoid ideas against patient Paula R for being a very low form of life that very malignantly influences her daughter adversely. The daughter, for all her loudness and bragging and acting big, is a terrified child who is absolutely terrified of the thought of even trying to go to downtown Bethesda alone. She makes all kinds of threats to her mother about going away for vacation or going up to Baltimore to visit and leaving the mother here, but she is practically incapable of carrying through on any of these things. The mother takes these threats more or less on face value and, being terrified of the thought of loss of the daughter, begins attacking the malignant forces in the environment that threaten to take the daughter away (Archives).

From this illustration, it becomes apparent that imagined threats to the fusion between self and the significant other can cause tremendous anxiety. So, in a sense, increased
fusion makes one vulnerable to anxiety about imagined threat. The imagined threat and the consequent chronic anxiety then become adversities that are internally generated.

When the family system context does not support a more realistic view of threat, then the family emotional processes try to reduce the imagined threat, often by restricting free movement of individuals even more. Mrs. S’s nuclear family context added to the rigidity and the unrealistic thinking. Liza’s ex-husband did not approve of her involving Nancy in the NIMH study. For example, “Mr S objected to Mrs S bringing Nancy here. She feels if he didn’t like it, he should provide a home and care for Nancy but he will not do so. He and his sister condemned Mrs S for coming here” (Archives).

In addition, Liza’s relationship with her siblings was equally rigid. Liza indicated that her siblings “have had nothing to do with me since that time,” referring to her decision to marry Robert. Perhaps her siblings saw the marriage as a threat to the family fusion. It is interesting that Liza’s brother felt the need to approve her romantic partners, and he rarely, if ever, did. Immediately after her father died, her brother began to call her ‘crazy’ when they fought. After she married Robert, her brother labeled her “crazy” even more often. Hence, she had “been in a state of almost total hostile ex-communication from her sister and brother since the marriage.” While her husband, Robert, communicated with his siblings, he had no relationship with her family (Archives).

Without a viable attachment to her own family of origin or her ex-husband, Liza’s relationship with her daughter became very important, and any threat to that attachment became a source of anxiety. For example, Mrs S was afraid of anything coming between her and Nancy. She tried to negotiate to have her room near her daughter’s, so that she could set a good example for her. She did not like to have anything too personal
discussed during group meetings for fear that it would make Nancy hostile toward her.

When personal issues were discussed, she threatened to leave the group if it continued (Archives).

Mrs S was also afraid of Nancy becoming physically hostile toward her and that she would not be able to stop her. When questioned about why she would take that from her daughter, she added that she could never spank her daughter and that she tended to cater to Nancy in some ways (Archives). The fusion and the sensitivity to the loss of the other person in that fusion make it more difficult to negotiate problems realistically. Mrs S did not think she could protect herself from her daughter because of her attachment to her.

When fusion is high, it becomes difficult for a person to take a stand with the other. Because one is so sensitive to the other person, saying anything negative about the other threatens the feeling of togetherness that has become so important. This can include admitting that one is not in favor of granting a request to the other, or that one needs time alone without the other person. The following example from the L Family illustrates this point:

The patient asked mother for her wrist watch. Mother asked about ward rules concerning watches. The patient kept asking. Mother avoided talking to the patient about it. She told a nurse the patient might flush a watch down the toilet. The next day the patient attempted to take the diamond watch off the mother’s wrist. The following day the mother was not wearing the watch. The patient took her mother’s handbag, found the watch there, took it and went toward the bathroom. Mother’s looks seemed to plead for help. In a few minutes the patient flushed the toilet. Later the patient returned and after a few minutes of tense silence opened her hand and gave back the watch (Archives).

In this interaction, Mrs L became anxious and rather than talk to her daughter, she involved staff. Triangles start with this discomfort between two people, when a
difference of opinion or viewpoint threatens the feeling of togetherness in the fusion. In describing this dynamic, Bowen wrote about the R family:

One of the most striking things was the incapacity for either mother or patient to be responsible for negative attitudes or actions about each other and it was only after a long effort that we began to get some breakthrough on this point. For instance, it was impossible for this mother to tell her daughter that the uncomfortable relationship had anything to do with her missed visits. The mother always says "I love you and I wanted to come but I could not because of money, or stopped up sink, or your brother was sick" or some other factor outside of her. The mother was adept at using some hospital rule or some direction from the staff as being the cause for her failures with the patient (Archives).

For example, one day Paula wanted to go home but her mother said no, giving the excuse that Dr. Bowen would not let her go home. Later that day Paula stuck a bobby pin in her arm (Archives). The fusion, the anxiety, and the way of managing anxiety by not taking personal responsibility for decisions, seemed to evoke a non-resilient response in her daughter.

\[ \text{Fusion itself becomes a source of threat by impingement on flexibility and the tolerance for differences.} \]

A higher level of fusion can raise chronic anxiety in a relationship system. Fusion becomes a source of anxiety itself because of the innate reaction to an impingement on self by another person. Inevitably, this happens when there are conflicting needs. To alleviate the discomfort, one person may try to accommodate the other person's conflicting need. Or, they may suppress or ignore the other person's need. This does not have to be a conscious process. Fusion also includes difficulty thinking clearly or realistically. This stems partly from anxiety elevated by fusion, and partly from the overlap between emotional and intellectual reasoning whether or not anxiety is raised.
People vary in their levels of chronic anxiety and relationship fusion. Without too much outside stress, a person can function well with a greater degree of fusion (Bowen, 1978).

When considering resilient responses, these ideas indicate that when anxiety is elevated in a system that contains a higher degree of emotional fusion, it may be more difficult to think clearly enough to act resiliently. Those family members who are able to circumvent the family anxiety may function more resiliently despite tending toward a similar degree of fusion in relationships. For example, in the N Family, when there was an incident that raised anxiety higher, Sam was usually free to leave and visit his aunt while Jeff was bound to the environment in which he was the focus of his parents’ anxiety. Along with the emotional fusion between Jeff and his parents, the increased anxiety would have made it difficult for him to think clearly. As an outcome, he tended to engage in non-resilient responses that in turn elicited more concern from his family. Thus, Jeff became a primary receptor for family anxiety.

Emotional Crowding is another term that can describe fusion. I link it to the concept of fusion between two people, especially when one person begins to make decisions for the other or takes over functions that the other is fully capable of doing. In this case, two can be a crowd, when there is little or no room left for the other person to think for him or herself. For example, in the S Family, Liza constantly ordered medications for her daughter, Nancy. One of the medical doctors on the project noted, “The mother has more complaints regarding Nancy than does Nancy. When Nancy is questioned alone, she has very few complaints.” In other words, Liza would raise concerns about Nancy’s health when Nancy did not share these concerns. He commented that Nancy took many non-specific medications at the urging of her mother “and it
became very difficult to know who really wanted the medications, the mother or Nancy” (Archives).

Another incident illustrates this further. A letter came to the Center addressed to Dr. Bowen from a young man asking him to make Nancy stop contacting him. Apparently he had asked her to stop writing him at his home address and she started writing to his work address. He emphasized, “the job I now hold depends upon the future of my life and I cannot and will not have it ruined by someone that is mentally sick and doesn’t know any better.” When Dr. Bowen shared this with Nancy and her mother, Nancy simply said “she was through with the Blank!” Her mother, however, “went in long paranoid detail about the ungrateful terrible fellow who wronged us....When questioned about why she responded she said, ‘Nancy and I are one flesh and blood’” (Archives).

Paula R’s relationship with her mother demonstrates the ambivalence that accompanies extreme fusion. For example, she would call for her mother in her sleep, but when her mother arrived she pretended to be asleep. She barged into her mother’s appointment with the social worker demanding to be taken home immediately, but was relieved when her mother refused her demand. Paula would act very distant from her mother when she visited, but then when a peer engaged her mother in conversation, Paula vied with this peer for her mother’s attention. She could be angry with her mother, avoid and reject her, or she could be excited about fun outings with her mother, such as going shopping. She ignored her mother, at times ridiculed and embarrassed her, but then wanted her mother to sign her out of the hospital, obviously depending on her for reality needs (Archives).
Her attachment to her mother seemed strong but then her mother’s presence seemed to be too much to handle. The old adage, “can’t live with ‘em and can’t live without ‘em” comes to mind. This phrase is often used by one intimate partner to describe the other, but it fits equally well here in such a fused mother-daughter relationship. On her sixth day at the center, Paula told a nurse that having her mother coming five days a week was “five days too many” (Archives). On the fourth day, she expressed that she did not want her mother to come to see her, but that she could not tell that to her mother because it would hurt her feelings. The same afternoon, she hit her mother with a ball at the gym after warning her and then apologized (Archives). Here again is the aggressive act toward the mother that appears to be a reaction to the intense fusion that restricts developmentally appropriate independent functioning and consequently heightens anxiety.

After four weeks at the Clinical Center, Paula was upset about telling her mother to leave. She said that she wanted her mother to stay but that her mother added to tension. She said, “It goes from too much love to hate.” This strikes me as another interesting description of fusion in a relationship. The togetherness force between two people can become too uncomfortable, as humorously illustrated in the following folktale:

One very cold night a group of porcupines were huddled together for warmth. However, their spines made proximity uncomfortable, so they moved apart again and got cold. After shuffling repeatedly in and out, they eventually found a distance at which they could still be comfortably warm without getting pricked. This distance they henceforth called decency and good manners. (Wilson, 1975, p.257).

When emotional distance gets too tight, people also get uncomfortable, as evident in the following examples, which tie fusion back to resiliency.
It seems that the more fusion restricts the movement of offspring emotionally, the more the young people tend to resort to non-resilient modes of interaction. One time, Nancy reacted to her mother asking her to wash her hands before dinner by throwing a glass at her mother’s head. Mrs. S. was so offended she could hardly bear it and went elsewhere to be alone. After that incident, she inquired anxiously about whether the Clinic could keep Nancy if she herself decided to leave.

Jeff, who was the identified patient in the N family also exhibited similar behavior in the following incident. “On leaving the unit, Jeff began to drag his coat. Mrs N told Jeff twice to put the coat on. Jeff threw the coat over his mother’s head and said, ‘you put it on.’” Moments later, “Mrs N asked Jeff whether he wanted to sit in the back or front of the car. Jeff then picked up a bottle in the car and threw it at Mrs N.” This evolved into more of an incident which I will share later, but interestingly, when Jeff’s father demanded to know why he behaved that way, “Jeff looked frightened and answered ‘Henry’ told me to do it, he wants to live his own life.” His father, who was quite angry, answered, “Henry, Charlie, Charlie, if you do that again you won’t be around to live your own life.” Jeff then answered, “if he’s not around then I can’t live” (Archives). I can only speculate that ‘Henry’ was the independent part of Jeff who had become quite hemmed in by the family fusion.

**How Anxiety Transfers Between “Emotionally Fused” Family Members**

Early in the family study, Bowen was very interested in the intense symbiotic attachment between the mother-daughter pairs. He wrote about the transfer of anxiety that was observed in these highly fused relationships. “This is one of those peculiar things about these mother-patient symbiotic attachments when the symptoms and the
tension seem to flow back and forth from one to the other” (Archives). He also found that “anxiety can be seen arising in one family member and actually manifest itself in physical symptoms or emotional problems or behavior problems in the other member of the symbiosis” (Archives). In an early paper, Bowen discussed observations of the transfer of anxiety from the mother to the symptomatic child.

Mother would become anxious and then her thinking would focus on the sickness in the patient. The timing of this seemed related to the mother’s own functioning rather than to the reality of the patient’s functioning. Mother’s verbalization would include repeated emphasis on the patient’s sickness. Very soon the mother’s anxiety would be less and the patient’s psychotic symptoms would be increased (Bowen, 1978, p. 6).

However, fusion is not limited to mothers and daughters. Mr N was able to articulate his own fusion with Jeff, when he stated in a family staff meeting, “even the thought of Jeff creates anxiety in me” (Archives). Occasionally anxiety would be transferred from daughter to mother. This happened between Linda L and her mother. Each time Linda made a positive step her mother would develop somatic symptoms (Archives). This will be discussed in greater detail later.

*Fusion and its Connection to Resilient Responses.*

One way to think about fusion is the part of self that is negotiable in relationships. An example of this would be when a person changes opinions or views based on whom he is with, in order to preserve harmony. Gilbert (1992) considered the amount of solid or basic self (the part that is not negotiable in relationships) to be important for coping with life’s demands. The less solid self a person has, the more difficulty a person will have adapting to the challenges life presents. Bowen wrote, “the greater the fusion, the more [one] is vulnerable to physical illness, emotional illness, and social illness, and the less
is able to consciously control one's own life” (Bowen, 1978, p.305). This speaks to the link between fusion and resiliency.

In summary, examples from each of the five families illustrate how fusion results in great dependence on relationships to meet emotional needs. It becomes apparent that thinking and functioning overlap leaving people somewhat crowded by each other, to the point of non-resilient responses. The fear of losing the other generates chronic anxiety. The degree of fusion is variable and can be like a magnetic force that attracts and repels people as they seek to relieve the discomfort of heightened anxiety and increased fusion. As will become more apparent in the ensuing discussion on other contextual elements of the family system, fusion increases during stressful times in families.

*Elements of Context in Three Family Narratives*

The next part of this discussion of the family system context will use parts of three family case narratives to illustrate the various elements of context. In simple terms, each story will answer the following questions: How many family members are alive and in viable emotional contact? Where are the noticeable triangles and cutoff? In other words, who talks to whom? Who do they talk about? Who avoids whom? Who ends up absorbing the family anxiety? How does the sibling position of the parents effect how they interact with their spouses and children? What are the consequent pressures on the oldest, youngest, and middle children? What nodal events happened around birth? Which relationships have become most important?

The following three narratives primarily focus on the parents and their relationships with their families of origin. The stories illustrate the impact of those relationships on the particular ways parents interact within their nuclear family. The
stories set the stage for later discussion of family emotional process and resilient responses that grow out of a specific family context. That discussion can be found in subsequent sections addressing those parts of the resilient response model.

What follows is an analysis of the family system context of three of the NIMH families: the O Family, the N Family, and the R Family. To review, the O Family is an intact marriage with two daughters, seven years apart. The N Family is also an intact marriage with two sons, also seven years apart. The R Family is a single mother with five children ranging in age from 18 to 10 years old.

![O Family Diagram](image_url)

Figure 10: O Family Diagram
The O Family.

The O Family story points out a number of contextual elements of the family system. Family triangles are notable in the narrative along with sibling position. The influence of a nodal family event on fusion between generations of the family sets the stage for increased chronic anxiety, ambivalence, and fluctuation of functioning. The impact of fusion on reciprocal functioning is discussed along with its impact on the absorbing of anxiety.

John O was born just after the turn of the 20th century. He was the son of a long farmer and his wife, who both lived to be a ripe old age. Stuck in the middle of five healthy and well-adjusted siblings, he was his mother’s favorite child, the one closest to her (Archives). The closeness between John and his mother may offer some clues into the nature of the triangle between John, his mother, and his father. For example, it may be an indicator of distance between the mother and father, so that the mother looked to John for closeness. It might be an indicator of more fusion in his relationship with his mother than perhaps his other siblings had with her. Bowen commented that John tended to take a passive role with his mother as well as with his wife. In addition, as his mother’s favorite child, John may not be as close to his siblings, who may compete with him for their mother’s attention.

Not enough is known about his siblings nor the amount of years between the siblings to know whether he had a special role as a youngest or an oldest, or some combination of the two in a middle position. According to Toman (1976)
he and his spouse may be categorized. If the other spouse also has a multiple or middle sibling position, things get still more complex (Toman, 1976, p.233).

However, John’s functional position in relation to his siblings may have been different than the characteristics of his actual birth order position. From the little we know about his place in the family, it raises curiosity about what forces put him in the position of mother’s favorite child. What nodal family events or adversities were happening in the family when John was born? How was the relationship between his mother and father changing at that time? Had a nodal family event increased tension and hence sensitivity and distance between the spouses so that the mother leaned on John more? Or did he simply remind his mother of one of her other relatives?

As a toddler, John suffered a serious injury during an explosion in a store. He was not expected to live but he recovered (Archives). Perhaps this event played a role in his closeness with his mother. This is an example of how a nodal family event could make this relationship more important to the mother. She almost lost John to the accident. His survival may have felt like a gift.

John was a serious child, more interested in work than play. Plagued with frequent minor illnesses, he tended to be a bit shy (Archives). The fact that John was plagued with nagging illnesses indicates a level of chronic vulnerability to symptoms. From a systems perspective, this may be a function of a greater level of chronic anxiety and fusion. Nevertheless, in his own quiet way, he graduated from high school and went right to work in management, for which he had a knack (Archives).

Shelby, John’s wife, was born a middle child with an older and a younger sister, each two years apart (Archives). This age difference would make her more competitive
with her sisters. Being a younger sister would make her a rival for parental attention. When her younger sister was born, she would have experienced the flip side of this as well (Toman, 1976). This contextual possibility may explain one of her concerns later during her stay at NIMH. She wanted to explore whether her feelings of rejection, in her relationships with her sisters and her parents, were real or of her own construction (Archives).

One of her significant teenage memories involved a struggle that she had with her weight, which was too high for her comfort. At age 16, she starved herself for several months to lose 40 pounds, but this act took a toll on her nerves. She found herself shaky and having difficulty concentrating, enough to cause her family doctor to advise that she take a year off of school. At this advice, she made a personal decision to pull herself together lest she slide farther toward what she called a “nervous breakdown.” She finished high school on schedule with the rest of her classmates (Archives). This brief illustration of Shelby’s teenage years provides some evidence that she carried a certain level of chronic anxiety that needed to be managed. Obviously she had enough inner resources to handle these episodes so that she could function in school.
When Shelby was 21 and John 27, they secretly got married. It is hard to tell what the secretiveness hoped to accomplish, but they often lived apart for weeks or even months due to work in separate locations (Archives). The secretiveness hints at the possibility of family triangles that prevented open communication. It seems that both were reticent to share the fact of their intent to marry with their parents. Was this a function of heightened sensitivity to their parents’ possible reaction due to fusion in these relationships? During that early time in the marriage, John entertained doubts about his ability to be a family man and wondered if he would have been better off single (Archives). The nature of John’s close relationship with his mother comes to light in his....
ambivalence about being married. His closeness with his mother may have interfered with his ability to be fully engaged in his relationship with his wife.

Throughout the same period, Shelby developed a rash, which reappeared whenever she experienced significant stress. She found herself feeling tired and nervous, making it difficult to think clearly. Eventually she protracted another more severe case of nervous symptoms, including episodes of fainting. However, she once again decided to pull herself together and draw on an inner reservoir of strength (Archives). Shelby’s history indicates further evidence of a certain level of chronic anxiety that would have existed in her family system and was expressed in her somatic symptoms. Her difficulty thinking clearly hints at fusion as well.

To an outsider, the marriage may have seemed distant. To Shelby and John, it was the closest relationship they had ever had, despite their constant quarrels (Archives). Here is another clue to the nature of their family relationships. Perhaps they were not able to be as open with others as they would have liked. They may have experienced what Bowen described as unresolved emotional attachment to parents where people use emotional distance from parents by isolating self emotionally while living in physical proximity to the parents. These are psychological mechanisms that operate within the person. When emotional stress is low, such people can relate to each other more spontaneously and freely. When anxiety is higher, they become more reserved and more isolated from each other (Bowen, 1978, p.535).

After the first six months of the marriage, the couple split up, each returning to their own parents, hundreds of miles apart. A week later, Shelby initiated their reunion, and so began a long marriage of fits and starts (Archives). Again, this illustrates their ambivalent attachments to each other and to their families of origin. The struggle was no easier when it came to having their first child. Shelby wanted the child, but John did not.
He did not feel ready for the responsibilities of taking care of a family and wanted to delay having children. After some time, he reconciled himself to having the child, and so it was that after three years of marriage their first daughter was born. They named her Jane (Archives).

Shelby devoted herself to her home and her new-born child. One might say that Shelby and Jane fully invested themselves in each other (Archives). Here is an indication that Shelby replicated whatever fusion existed in her relationship with parents in her relationship with Jane. If she had feelings of rejection in her own family of origin, she now had a role where she was needed. If she felt any sense of rejection due to John’s
mixed feelings about being married, she now had a relationship with an infant who needed her. She also had a focus for her anxiety.

Over the next four years John excelled in his work. He would go into troubled businesses and help them get back on their feet. His reputation sent him far and wide to help those in need of his expertise, which meant that the family moved several times from state to state. John got involved in civic affairs and was well-liked (Archives). This is a great illustration of how people can function adequately outside the family but have difficulties in their personal lives. Bowen wrote, "It is striking to see a father, who can function well as a leader in his business, become paralyzed by indecision within the family. Either parent can function 'adequately' outside the family but, within the family, one becomes 'inadequate' (Archives).

At the end of the fourth year, John suffered a series of physical illnesses. He was asked to help another business and became depressed. He was advised to take a vacation but did not. At some point during that time John was so despondent that he became unable to work. In reaction, Shelby took their daughter, Jane, and stayed with her parents. John returned to his own family home. As the months progressed, his depression spiraled to a psychotic level and he was hospitalized for several weeks (Archives).
There were fluctuations in John's depression leading up to the hospitalization. At one point he seemed to be improving. Three months later he felt badly again, upset about his relationship with Shelby. Four weeks after that he became very preoccupied with his work. He fell into a depression that intensified to the point where he could not work. He was admitted to the hospital, where he stayed for several weeks. He left after that to stay at a friend's house, but within a week had become preoccupied, "spending much time standing in front of the mirror combing his hair" (Archives).

Six days later John was re-admitted to the hospital where he became very depressed and sometimes seclusive. Interestingly, this hospital staff diagnosed him with...
schizophrenia (Archives). His functioning also fluctuated during his 13 months stay there. After five months he received a shock treatment and became less depressed. Three months later he found himself more agitated again. After several months, his depression subsided. When his improved mood had lasted five months, he was discharged (Archives).

Throughout the time that John was ill and hospitalized, Shelby maintained a distance from him. At the same time, she increased her attention to Jane (Archives). Here is an example of distance from the spouse as a natural response to anxiety. While this falls under the category of family emotional process, it also speaks to the nature of how the spouses manage anxiety. Distance plays a role in how the child is involved in the parental relationships. In this triangle, the parents were distant and the child became the focus of attention, and most likely, heightened anxiety. However, Shelby’s intense relationship with Jane that often excluded her husband, started at Jane’s birth. So the triangle was already in place before John became ill. It may even have played a role in his illness. When members of a triangle are not able to be flexible and open with the other members of the triangle, people tend to become less flexible. If people cannot move out of their positions in a triangle consciously, they become more helpless. If John was excluded in the triangle, this is an indication of a less flexible triangle. Jane was four years old when her father first collapsed and six years old by the time he came out of the hospital (Archives).

Upon John’s discharge, the family moved to another state and John started a business with a partner. He resumed his civic activities. However, the couple argued continuously. After three more years, their second daughter, Leslie, was born. At this
juncture, both parents were in agreement about the pregnancy, even though they continued to experience their usual conflicts. They were calm when they maintained their distance from each other, but extremely argumentative when they got close (Archives). Here we get another glimpse into how the couple managed their anxiety within their relationship with distance and conflict.

**Figure 14: O Family at Time of Leslie's Birth**

Jane was seven years old when Leslie was born (Archives). This age difference makes them like two quasi-only children (Toman, 1976). In other words, they are too far apart to be much of a threat to each other. John's business thrived. Two years later, Shelby's father died and in reaction she found herself blacked out in the street one day.
(Archives). Again, here is an indication of the anxiety level Shelby endures and how it is often expressed somatically.

Seven years later, Shelby insisted that John buy his partner’s half of the business and she began to involve herself in the business. She would often step in as manager when he left on business trips. Over time, he took a back seat to his wife and seemed to become less of a driver in his community leadership activities as well (Archives). This gradual change provides a clear example of the shift in functioning that occurs between marriage partners. One slides into the under functioning position while the other takes an over functioning role. At the times when John moved into the completely inadequate position and became dysfunctional in his bouts of depression, it is unclear whether Shelby took on more responsibility other than distancing from him and focusing on Jane.

As Shelby became more involved with the business, Jane did not take well to her mother’s absences, becoming quite upset and childish when separated from her. When her mother was nearby she functioned better (Archives). It is curious why Shelby pushed to get involved in the business at that particular time. Was it a way to get some respite from her fusion with Jane? Was she becoming aware that Jane depended on her too much?
When Jane initially became ill in her freshman year of college, her father, John, dropped out of his community activities completely. His moods fluctuated frequently and for longer durations. He fell into episodes of depression. By the time Jane had spent three years in various hospitals, John had become more depressed, tense, and ineffective. He was against Shelby's decision to take Jane to another hospital. As a matter of fact, he and Shelby often quarreled about Jane. Around that time he worked through a busy holiday season while his wife went to visit Jane at the hospital. His outlook was very poor and he saw his future as hopeless (Archives).
John became increasingly depressed during this time and went to visit his parents. During the visit, he slashed his wrist, neck, abdomen, and calf. He was hospitalized briefly and his wounds were treated. A week after being released back to his family, he overdosed on pills. This time he was hospitalized for three weeks and received electroshock treatments. Upon release, he attempted to go back to work but was disoriented and despondent. Six weeks later he was readmitted to the hospital (Archives). It is obvious that John’s response was non-resilient at this time. He became destructive to himself and thereby created more problems. His anxiety stayed elevated and he seemed unable to shake his mood. He certainly seemed powerless. It is intriguing that it was during his visits to his family of origin that he engaged in self-injurious behavior. As a way to manage anxiety, self injury also seems to emerge out of a relationship process. It could be conceptualized as a non-resilient outcome of family emotional processes.

The data did not contain enough about John’s visit home to know what the family processes were, but as far as family of origin context is concerned, it is obvious that it exacerbated his non-resilient behavior. It may reflect a tendency to be in close proximity to important others without being in viable emotional contact with them. It also hints at a context in which John did not deflect anxiety or pass it on to others, but instead absorbed it. A hypothesis would be that the pathway of anxiety in that system found its way to John and he absorbed it to the point of self-destructive incapacity. It is possible that to be a favorite child, John had to give up a certain amount of self in order to comply with mother’s wishes and fulfill her needs. This may have let his father, siblings, and others in his mother’s family of origin off the hook from doing the same. If John’s sense of self
was already severely depleted by the time he got home for the visit, the context in which he originally learned to give up a certain amount of self may have put him over the edge. However, the fact that he did not succeed, speaks to a certain level of resilience in the family context.

Over the next four months, arrangements were made for the family to join the NIMH family research project. Shelby met with Dr. Bowen who explained the philosophy of the project. Bowen shared the belief of the researchers and staff on the project that the family problems could resolve themselves more quickly if other family members could tolerate living at the Clinic. He reviewed potential difficulties involved
with her living there due to having two family members with adjustment problems. He proposed arrangements that would allow Shelby to get away from the Clinic if it became too stressful for her. Bowen noted that she showed an attitude of great hopefulness and enthusiasm about joining the project (Archives).

John’s depression lifted as he looked forward to the prospect of joining the study. There was an unforeseen delay of about six weeks that affected his outlook detrimentally. He once again became suicidal and was given electroshock treatments because the hospital staff did not think he would be safe, even in a closed ward. Again, here is an example of the fluidity of the resilient response. Eventually the time came to transfer Mr. O to the NIMH clinic. The medical director at the hospital where John O. had been staying before admission to NIMH diagnosed John’s condition as manic-depressive with many features of schizophrenia. He believed that John’s outlook could improve if he could see a solution to his unhappy family situation (Archives). This speaks to me of this director’s understanding of the need for hope to spark a resilient response.

The director described Shelby as an “awfully complex person, who appears fiercely possessive, distraught and ambivalent, to the extent that projection and guilt are constantly although seldom concurrently present (Archives)” He added that she is “an intelligent person, who is doing her best and who is capable of arousing some sympathy and warmth in other people, even at her most exasperating worst” (Archives).

This story of the O Family has illustrated the way John and Shelby came together with a considerable amount of chronic anxiety and tendency for fusion that they brought from their own families of origin. A nodal event in John’s family where he almost died at a very young age may have intensified fusion in his relationship with his mother. This

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fusion, in turn, may contribute to his tendency for ambivalence in his relationship with his wife, and his fluctuation in functioning. The ambivalence may have played a role in Shelby's tendency to distance when things became difficult between them, exacerbated by the additional anxiety created when John became ill. The state of their relationship with each other, which was particularly ambivalent at the time of Jane's birth, created a context for heightened fusion between Shelby and Jane. In contrast, by the time Leslie was born, the parents agreed on having her and the family was calmer.

The triangle between John and his parents and the triangle between Jane and her parents seem to shadow each other. Anxiety flows in the direction of the child in each triangle, whether that child is John in his family of origin, or Jane in hers. The sibling position of each parent seems to play a role in decreased openness of communication between the parents and their siblings. This consequently limits the pathways for anxiety in this family system. Next, the contextual elements will be examined in the N family narrative.
The N Family.

The following story of the N Family illustrates the interplay between nodal family events and adversity and its impact on contact between family members. It shows how nodal family events coincide with birth order and how increased anxiety and fusion result. The story indicates how fusion and chronic anxiety grow out of adversity in the parental families and how these dynamics play a role in the formation of an inflexible triangle between the parents and the oldest son in this family. Other triangles provide clues as to how anxiety travels in limited ways through this family and how cutoff
exacerbates the limitations. The story also shows how sibling position shapes the ways parents relate to each other, to their sisters and brothers, and to their children.

Figure 18: James N’s Family at Time of his Father’s Death

James N. was born before World War I and his father died of an acute disease when James was a toddler. He was the third in a line of four children. First was an older sister, five years his senior, then a brother, three years older, and finally a younger brother, one year younger. After his father’s untimely death, the family became quite poor. The children were divided to live in different places. James lived with his mother until he was five years old, and then two aunts took care of him until he was seven. At that time he went to a boarding school of sorts where he lived until he was 18.
Apparently, James referred to the school as a place with tons of money but a lack of love. According to Dr. Bowen, James grew up as an orphan and "while his early life was very difficult, he has incorporated into his life a way that says he wants you to recognize how awful it was so he can say, 'it was nothing'" (Archives).

James' father died within months after James' younger brother was born (Archives). While the history is not clear about where the youngest brother went after the father died, he would have been an infant and James merely a toddler. The timing of the death and the fact that James was only a toddler at the time may have played a role in his staying with his mother. Apparently his siblings, at least the older ones, were sent elsewhere (Archives). This is an example of how birth order combines with family adversity to influence the particular relationship a parent will have with a child. In this case, it is likely that James' mother was quite shocked at the sudden death of her husband. Due to her increased anxiety, she may have developed a different type of relationship with her children at that time. For the children who were just born into the family at that point, they would probably not know the same type of relationship with their mother that perhaps their older siblings would have known.

As already mentioned, the family became quite poor after the death of the father, which would have been an added stress on the family. Difficult decisions had to be made, such as dividing the children to live in different places (Archives). It is possible that this may have been a very vulnerable time emotionally for the mother and that James as a toddler would have been more sensitive to his mother's vulnerable state. This would most likely not have been a conscious sensibility, but a reciprocal way of interacting with his
mother. In other words, the fusion between them may have slightly increased during this time.

For some reason, James was sent to live with two maiden aunts after he turned five years old (Archives). The reason is not explained in the archival data. However, it raises curiosity about the family circumstances at that time that necessitated the shift in living arrangement. From age seven to eighteen, he attended a boarding school that had “tons of money, but a lack of love” (Archives). This statement by James raises several questions related to potential relationship fusion and the type of emotional contact between family members. What was the nature of James’ continued contact with his mother after that time and when he attended boarding school? Where did he get his comparative notion of the love that was missing in the boarding school situation? Was he talking about the closeness he was accustomed to in his relationship with his mother and aunts?

As a middle sibling, James may have acted more like an older brother of brothers than a younger brother of brothers or sisters, since he was closest in age to his youngest brother. “Of several sibling roles that a person may hold in his sibling configuration, the one that will be stronger than the rest is the one he holds vis-à-vis the sibling closest in age to himself” (Toman, 1976, p.189). This would be especially true if he lived with his younger brother at his mother’s and aunt’s homes and not with his older siblings.

Furthermore, the more effective sibling role is “the one he assumed earlier in life and retained without interruption” (Toman, 1976, p.189).

As an older brother of brothers, all things being equal, James would have been seen by his own nuclear family as too strict, controlling, or not involved enough. He
would have identified with his oldest son the best, but would have had the best interactive contact with his youngest son. These tendencies seem consistent with the observations. According to James’s wife, Katherine, their son, Jeff, never had temper tantrums because his “father stopped him.” James seemed to identify with Jeff when he expressed his feelings that Jeff would eat when he got hungry and did not need the interventions that Katherine provided for him. James was very responsive to their younger son, Sam (Archives).

James did not drink, smoke, or take any drugs. He had the same occupation for 20 years. He served in the army for two years starting when his oldest son Jeff was seven years old. He was unhappy there in the beginning but felt better once he adjusted to army life. He turned down an offer to become an officer. From the outside, he appeared to have a quiet and thoughtful manner. On the inside, he reported experiencing a great deal of tension and said he had a “hard” temper. When interviewed for the family research project, he indicated an interest in learning how to handle his conflicts with his wife about how to manage their son’s behavior and illness. He added that he had difficulties with certain situations and frustrations. He acknowledged his own unhappy feelings, his tendency to get emotional quickly, and difficulty concentrating. These sensations had been relatively constant and he reported that he also held back when involving himself in family issues, experiencing guilt feelings. He perceived less general conflict between he and his wife during their son’s illness because of the need to be strong (Archives).

From this description, I get the impression that James is an anxious person who hides it well most of the time. However, the anxiety interferes with his ability to concentrate and leads to his emotionality. Some of his statements hint at the primary
triangle in his nuclear family being that between himself, his wife, and their oldest son, Jeff. The conflict he describes between he and Katherine regarding how to handle Jeff is a classic example of a triangle. Conflict and distance between the spouses contributes to intense focus on the child. The fact that James perceives less conflict with Katherine since Jeff’s illness alludes to the anxiety binding mechanism of the family projection process.

James’ wife, Katherine, was also the third in a line of four children. Her father was a successful businessman. She had a brother who was six years older, a sister who was two years older, and another brother, four years younger, who refused to go to high school. The younger brother developed a psychosis that resulted in his hospitalization with a diagnosis of schizophrenia about two years later. He was talented at golf but their father disapproved of him playing the game. She believed his disappointment over losing a golf tournament contributed to his illness. Katherine expressed considerable unhappiness that his hospital experience had not helped him (Archives).

Katherine was closest in age to her older sister of two years. She may have held the position of a younger sister of sisters, with some tendencies of an older sister of brothers. Since her older brother was six years older, he may have had less of an influence on her position. All things being equal, “her best partner would be an oldest brother of sisters,” although “it is more likely that she will attract an oldest brother of brothers, but the two would not find it very easy to live together as husband and wife. However, if they ‘conspire’...to cooperate in a special venture, they can get along with each other better” (Toman, 1976, p.176). This quote from Toman’s research on sibling position is interesting in light of the conflicts James spoke of between them. It is also
interesting in light of the fact that they got along better with a joint project, which in this case could be seen as their efforts to get Jeff well.

Figure 19: N Family Around Time of Jeff’s Birth

Katherine’s pregnancy with Jeff was normal although she found out her brother was diagnosed with schizophrenia during that time. This is another example of the timing of nodal family events with the birth of a child. It could well be that Katherine had greater worries and concerns about her unborn child during this time when her brother had a psychotic episode. This aspect of family context may have intensified Katherine’s normal concerns as a mother with a new child, especially the first child. According to
James, Katherine was overly clean. For instance, she would change Jeff’s diapers the moment they were soiled. Perhaps this was an outgrowth of her concern, or perhaps it was simply a difference of style between James and Katherine.

When Jeff was seven years old, his father joined the service. Jeff lived at home with his mother and newborn brother (Archives). Toman’s (1976) research on sibling position indicates, “the youngest sister of sisters finds it difficult to put up with children unless she has a governess, a maid, her own mother, or one of her sisters to assist her. If that is not possible, she needs her husband’s support more than other wives do” (Toman, 1976, p.176). This may explain the difficulties Katherine experienced when her husband

Figure 20: N Family During Father’s Absence

[Diagram of a family tree showing the relationships between James, Katherine, Jeff, and Sam.]

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went off to serve in the army for two years, in addition to the normal anxieties that would be associated with the adversity of war. With newborn Sam, she also had two children to think about. However, it is likely that her anxious focus continued to go toward Jeff, since that precedent had already been set since her pregnancy with him.

Regarding viable emotional contact with family members, little mention is made in the data I recorded. Katherine was in contact with her older sister, and Sam lived with this aunt during the course of the family’s stay at NIMH. Even when he lived at the Clinical Center, he would often go visit his aunt, with and without his mother. On an outing with the entire family and a staff member within the first two weeks of their stay at NIMH, Jeff became very anxious at this aunt’s house in anticipation of his uncle returning home. He refused to stay there which cut the visit short. This exchange provides clues into the relationship triangles in the family. Sam related comfortably with his parents and his aunt. Katherine and her sister seemed close. Jeff, on the other hand, distanced and secluded himself from the family. This was possibly an outgrowth of the triangle in which his parents anxiously focused on him. When there was anxiety in the family, it would travel in a pathway toward Jeff. It did not have too many other places to go except back to his parents. His parents, in turn, managed the anxiety by focusing on him, resulting in a vicious cycle. A speculation based on the concept of the triangle would be that Jeff absorbed this anxiety and managed it with a variety of compulsive and psychotic behaviors.

Family secrets provide another indication of inflexible family triangles. Katherine did not always participate fully in family-staff meetings at the NIMH project and urged her family to keep its secrets. Secrets limit the pathways by which anxiety travels in a
system. In a particular triangle of three people, two people may conceal information from a third. Each person is connected to other triangles. Those who know the private information either spread it through other triangles or they keep it to themselves. The concomitant anxiety that feeds the need to keep the secret travels along with it but even those who are not privy to the secret sense the anxiety without knowing its source. Furthermore, if certain subjects are taboo then it becomes more difficult to relieve anxiety by talking about family issues.

Jeff and Sam were far enough apart in age to be like two only children. Katherine, in her dual role as a youngest sister of sisters and an older sister of brothers, would have had a tendency to treat the men in her life like little boys (Toman, 1976). Reciprocally, if James did not have much contact with his family of origin, although his mother was alive, and if this contact was distant or cutoff, then he would most likely have been dependent on his nuclear family for more of his emotional needs and outlets. He would have been less comfortable disagreeing with his wife.

This story of the N Family has illustrated how basic elements of sibling position mixed with cutoff stemming from increased fusion and anxiety all converge to create a context for particular kinds of interactions between family members. Triangles were activated by secrets and by the need to find an outlet for anxiety, and then became conduits for anxiety within the family system. In this case, most of the anxiety flowed back and forth between Jeff and his parents in an unending cycle. The mixture of nodal family events and adversity with birth dates was also notable, and its concomitant influence on anxiety and fusion.
The story of Mary Jo R reveals a number of contextual elements of the family system. First is the coincidence of date of birth with nodal family events. The second element is sibling position and its role in interactions with spouse and children. Third is cutoff. Fourth is the number of people living and in viable emotional contact. The last element is fusion and its transmission to future generations. Mary Jo was born just after World War I. She lost her mother when she was an infant, and her father deserted her then as well (Archives). This way of coming into the world illustrates how Mary Jo’s date of birth coincided with nodal family events. Her mother died and her father cutoff from her. There were no doubt adversities that caused anxiety and reduced the number of family members with which Mary Jo was in viable emotional contact.

Figure 21: R Family Diagram

The R Family.

The story of Mary Jo R reveals a number of contextual elements of the family system. First is the coincidence of date of birth with nodal family events. The second element is sibling position and its role in interactions with spouse and children. Third is cutoff. Fourth is the number of people living and in viable emotional contact. The last element is fusion and its transmission to future generations. Mary Jo was born just after World War I. She lost her mother when she was an infant, and her father deserted her then as well (Archives). This way of coming into the world illustrates how Mary Jo’s date of birth coincided with nodal family events. Her mother died and her father cutoff from her. There were no doubt adversities that caused anxiety and reduced the number of family members with which Mary Jo was in viable emotional contact.

Luckily, Mary Jo’s grandmother, who was approximately 60 years old, married a younger man. There is no mention of other family members, so it is possible that Mary Jo was an only child (Archives). At this early life stage, the people living in Mary Jo’s immediate family were few. She had no siblings. It is likely that when stress increased, there were not many places for support contributed to her marrying young in the selection of a life partner (Rabinovitch, 1976). Little history until Mary Jo’s indication that her husband was no good. Other individuals more anxiously, more heavily and less critically than other people do (Tonnies, 1976, p.48). I believe young people also lack experience about the world and the stresses that may face them.

The loss of significant family members makes people enter into new ties with other individuals more anxiously, more heavily and less critically than other people do (Tonnies, 1976, p.48). I believe young people also lack experience about the world and the stresses that may face them.
of birth coincided with nodal family events. Her mother died and her father cutoff from her. These were no doubt adversities that raised anxiety and reduced the number of key family members with which Mary Jo was in viable emotional contact.

Luckily, Mary Jo’s grandmother, who was approximately 55 years old, raised her. There is no mention of other siblings so it may be possible that Mary Jo was an only child (Archives). At this early life stage, the people living in Mary Jo’s immediate family were few. She had viable emotional contact with her grandmother. It is likely that when stress increased, there were not many places for anxiety to go. Maybe this contributed to her marrying young in order to get some distance from her grandmother.

Little history of Mary Jo’s marriage exists other than Mary Jo’s indication that her husband was ‘no good’ to her (Archives). Here is a clue that her decision to marry may have been a reaction to anxiety and fusion, without full reality considerations. In addition, the loss of significant family members makes people enter “into new ties with other individuals more anxiously, more hastily and less critically than other people do” (Toman, 1976, p.45). I believe young people also lack experience about the world and about the stressors that may face them.

In her early 20’s, Mary Jo gave birth to her first daughter, Carol. Two years later, she had a son, Frank. Her third child, Paula, arrived a year later. Two years after that she had another son, Philip, and her youngest son, Andy, came into the world four years later. By her early 30’s, she had five children. Her husband deserted her around that time, so Andy never knew his father. Apparently, there were several stories about his disappearance. He did not let anyone know where he was going. Mary Jo considered him irresponsible and blamed the irresponsibility on his epilepsy (Archives). Toman suggests
that people who have experienced significant losses tend to choose partners that will be
more apt to leave them more easily (Toman, 1976). However, the mechanisms by which
she chose such a partner may also be explained by a look at her other relationships.

The desertion of her husband would have been Mary Jo's second experience with
cutoff. Her father deserted her and now her husband did the same to her and their
children. This would leave the father and the husband to be little more than objects of her
anger and anguish, with little viable way to resolve these relationship issues. Perhaps as
an outgrowth of these experiences she later encouraged her oldest daughter, Carol, to
work out her marital problems with her husband instead of separating from him. She
indicated some understanding of her son-in-law's side of the story, and hoped that Carol
would not behave too impulsively (Archives). However, without active work on bridging
cutoff, these words may not be as effective as the precedent set by the family context.

The story of Mary Jo also illustrates the impact of sibling position on the way she
interacted with her children and on her expectations of other family members. As an only
child, Mary Jo "would rather still be a child herself" than take care of children, unless she
receives help from her own mother or a motherly person (Toman, 1976, p. 186). This
may explain her joy when Paula visited, paid attention to her mother's needs, and helped
take care of the boys (Archives). At times Mary Jo could become quite depressed about
her feelings of inadequacy as a single parent and her fears that her children would desert
her.

Sibling position also intersects with family adversity to shape the way Mary Jo
interacted with her children and the pressures she may have instinctually placed on them.
"One child, preferably a girl, will often be enough" for an only child like Mary Jo. An
only child with several children will tend to expect her husband and his family to help and encourage her. Mary Jo certainly did not have this support and that must have been extremely difficult. The idea that one child, and preferably a girl, would be enough for her is interesting, considering who Mary Jo looked to for support. If we look at the timing of nodal family events and adversities, her husband left when Andy was born. If she tended to look to female children for support, this would explain why she focused more on Paula than on the two younger males, although it does seem that she leaned on Philip when Paula was less available. She saw Carol as competition for Paula and felt she could be closer to Paula when Carol was not around. However, she expected Carol to help with the other children and was extremely disappointed when Carol did not follow through (Archives).

Another aspect of Mary Jo’s position as an only child is also worth noting.

“Sometimes a...wish to prove something to her parents may be the chief reason for a greater number of children. In that case, the prognosis for the children’s development may not be very good” (Toman, 1976, p.187). This is interesting to consider, given PJ’s delinquency and Paula’s diagnosis of schizophrenia. Could Mary Jo have been trying to prove something to her father who deserted her?

Without much viable emotional contact with extended family members, and without many members living in her immediate family of origin, there were not many pathways for anxiety to travel or get resolved in this family system. Most of the anxiety was focused on the children in varying degrees. The main recipients were Paula and Philip, and it impaired their ability to function. A high degree of fusion was evident in these relationships, most likely increased due to challenging life events in Mary Jo’s
family of origin and her nuclear family. This fusion was then transmitted to the next generation making it difficult for some of the children to function independently.

In this story of the R Family, I have illustrated how nodal family events and adversities that occurred at Mary Jo’s birth diminished the pathways and receptors for anxiety in this multigenerational family, leaving Mary Jo and her children with more anxiety to handle. It also became apparent that Mary Jo’s sibling position shaped the natural expectations she had for assistance with parenting. Due to the family adversity and cutoff, Mary Jo did not have this support, which placed more pressure on her children. Mixed with these elements, the location of increased anxiety and increased fusion in this family played a role in the automatic non-resilient responses of some of the children and the resilient responses of others. These will be discussed in detail in the section on resilient responses.
While the discussion of the family system focused on the context in which anxiety flows through the family, the next section focuses on the various action and interaction strategies that evolve in families to manage that anxiety. The context of the family system sets the stage for the way in which family processes are enacted to manage family anxiety. These strategies arise as families adapt to changing conditions and react to each other during and after those transitions. Two concepts from Bowen Family Systems Theory help frame the analysis. The first is nuclear family emotional process. This describes how family members, usually the spouses, manage anxiety and fusion with...
conflict, distance, and underfunctioning and overfunctioning reciprocity. Another way they manage anxiety is by focusing on a child, which is a concept of its own called the family projection process. This concept, also termed child focus, is the second concept from Bowen Theory that will frame the discussion of family process. At the time of the NIMH study, pre-cursors of these concepts were being discovered. Early terms included the emotional divorce, overadequate-inadequate reciprocity, intra-family relationships, and the interdependent triad. I will discuss some of the strategies under the heading of the emotional divorce, because it was a predominant term in the archival data.

It will become obvious from the examples that each element of nuclear family process seemed to reinforce the child projection process. The data suggest that the family projection process was the most prevalent way of managing anxiety in these families. This becomes important when considering the impact of this management strategy on the resilient and non-resilient responses of the youth. The pattern tends to increase non-resilient responses of the child most involved in the projection process, and leave the less involved children freer to respond resiliently. However, as we will see in the O Family example, this changed when the other child became the object of the projection. Each of the anxiety management strategies will be highlighted with examples from the five families.

The walk went quite comfortably until Mrs O and Jane started to return to the unit. They passed through the lobby, at which time Jane proceeded to take a seat on a couch in the lobby, and Mrs O somewhat reluctantly joined her. Soon Jane had stretched herself out on the couch and Mrs O began asking her to sit up, with Jane refusing. This exchange was repeated several times over a period of some minutes with indications, from the story, that Mrs O’s tension was increasing as time went on. She eventually went to the telephone and called the unit for some help in bringing Jane back to the ward. The unit responded by sending two staff downstairs. This was a few minutes before 3 pm (Archives).
The O Family provides an example of ongoing conflict and distance as a way to manage anxiety between the partners. John and Shelby O had a marriage of constant conflict with separations and reunions right from the start. In their case, child focus had intertwined with this management strategy. The following incident in the O Family illustrates how fusion and the resulting inability to set limits, in addition to marital conflict and child focus, contribute to escalating anxiety and acting out behavior.

The situation began with Mrs O taking her daughter, Jane, for a walk in the early afternoon of that day, having checked in the nursing station to inquire whether the nursing staff felt that Jane was particularly tense or not. The reply was in the direction of, “It’s up to you” (Archives).

It is interesting to note that Mrs O relied on staff for sensory feedback to “read” her daughter’s tension level.

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It is intriguing that Mrs O "reluctantly" joined her daughter, which seems to imply that she acquiesced when she really preferred to say no. Mrs O began focusing on her daughter and correcting her behavior, getting locked into an interaction in which she could have chosen not to engage. Jane participated in the exchange by rebelling against her mother's demands, possibly as a reaction to the fusion. The result was increasing tension and Mrs O's apparent decision that she was helpless to effect change in her daughter's behavior. Hence she turned to staff for outside help. The rest of the scenario illustrates the conflict between John and Shelby and how Jane became the object of this conflict.

At about the same time of the call to the unit, Mr O, aware that his wife and daughter were out of the building and that the unit meeting time was approaching, left the unit to see what was going on and to see if he could be of some help. He arrived just a couple of minutes in advance of the attendants and asked Mrs O to go on up to the unit and he'd take care of getting Jane upstairs. This Mrs O felt was an unreasonable request and she did not do this. Mr O then proceeded to ask Jane to come on upstairs and did so several times while Mrs O hovered a little distance away but still on the scene. The tension grew between Mrs O and Jane.

While Mr and Mrs O were arguing about who was going to handle the situation, the attendants appeared, with Mr O indicating to them that he could handle the situation and Mrs O encouraging them to step in. The attendants, particularly Steve, did not like the position of being in the middle of a parental squabble and returned to the unit.

Apparently, the tension grew between Mr and Mrs O, with Mr O dragging Jane screaming across the lobby floor. She finally got to her feet and they were able to reach the unit by the elevator, Jane screaming and crying as she entered the unit shortly after the meeting had opened, being held by Mr O. Mrs O was walking along with this, fussing at Mr O.

On arrival at the unit and in the meeting, Jane was seated by Mr O, who was still holding her, on a footstool. After he asked her if she wanted to go to the meeting and she had indicated to him that she did, she asked him to let her go. He did not do so immediately, but in a few moments let go, asking her if she wanted some coffee. He proceeded to ask people in the group if they would get Jane some coffee. No one volunteered. He asked Mrs O if she would and she refused, so Mr O went and got it himself and brought it to Jane who drank it forthwith.
This incident illustrates how the conflict between the parents and their focus on Jane went hand in hand with her non-resilient response during the situation. The events of the preceding day provide some background for this incident. At a group meeting the previous day, an interchange between John and Shelby illuminated their struggles for the researcher. Both agreed that there was considerable emotional distance between them.

John likened this to a ‘cold war’ and said he felt it involved the staff as well. He indicated that Shelby maintained the distance and he appealed to her to stop. Shelby responded aggressively, but her message reflected a change in her position. Whereas before she felt responsible for her husband’s care, now she was asking for his understanding and consideration. She was not going to take full responsibility for solving their relationship problems. She was asking for his help and if she did not get it, she said she had little hope for the marriage (Archives).

Unfortunately, though they were both communicating from new positions, they had difficulty hearing each other or acknowledging the shifts the other was making. One researcher interpreted John as saying, “I am in better health, more capable, more competent than I have ever been before in the marriage. It is your problem to recognize this and do something to make the marriage function!” (Archives). The researcher summarized Shelby’s response to John as, “I don’t see how you are so much better. You still do very inconsiderate things. When you still do such inconsiderate things how can you expect me to trust you to look forward to a marital future with you?” (Archives)

Shelby did not seem to acknowledge John’s improved strengths, however, for the first time, she expressed her own needs and asked him to consider them. Unfortunately, John
only heard her comments as badgering and felt insulted. For the record, their daughter Jane was absent throughout the entire meeting where this interchange occurred (Archives). This example demonstrates how difficult it can be for a couple to shake off rigid beliefs about the other that hold each in a fixed position. However, they were making progress.

![Figure 24: Symbol for the Emotional Divorce](image)

**The Emotional Divorce**

The symbol in Figure 24 depicts the emotional divorce. This is also the symbol for extreme distance and cutoff. Bowen wrote about the "emotional divorce" and its impact on the special attention to the overinvolved child.

Clinically, the parents were separated by the emotional divorce but either parent could have a close emotional relationship with the child, if the other parent permitted. Descriptively, the child appears to have served the function of an emotional shunt between the parents, with the parents sharing the child, much as divorced parents share their children (Archives).

Dr. Bowen described the parental disagreement in the N family over Jeff's care as "deep and intense," despite the appearance of agreement on the surface. He added that this disagreement included their decision to join the family research project at NIMH. Katherine wanted to join while James did not. Eventually, James conceded "with an undertone of wanting to prove it would not work." He agreed to try the project for one year (Archives).
When it came to daily decisions about how to help their son, Mrs N asserted her approach which was to constantly pressure Jeff to do things such as eat and dress. In her viewpoint, his sickness prevented him from knowing what to do and he needed outside help. His father, on the other hand, believed that Jeff would eat when he was hungry (Archives). When asked about his family, Jeff answered with a great deal of feeling, “the family does not seem to work together. You can get three together but not the fourth” (Archives). An observation during their early participation in the project also highlights this marital distance. Mr. N “refused to dance with his wife when she asked him and tended to ignore her most of the evening, devoting most of his time to Jeff” (Archives).

The S family provides another illustration of this concept of an emotional divorce. Liza described her ex-husband Robert as “hard-headed,” adding that “he always takes the opposite view, if you say it’s a nice day he says it’s an awful one” (Archives). Liza would comment on “how much his wealthy sister does for him and then neither of them will do anything for Nancy” (Archives). Their daughter, Nancy, had a close emotional relationship with both her father and her mother, even though her parents were divorced both legally and emotionally.

During the year after leaving NIMH, Nancy lived with her mother in various apartments. She would escape to her father’s when she had quarrels with her mother and sometimes her father would visit Nancy when he was lonely or had problems (Archives). When Nancy moved out on her own some time later, it was only three months before her father moved into her apartment. Their relationship was less intense than that with the mother, but essentially, “she was the resourceful, mother figure to her father, who was in the position of a helpless little boy…. She cooked for him and maintained the apartment.
and he was the complaining, irresponsible one” (Archives). Bowen felt that “psychologically, the situation would work out the best if it could continue until Nancy got mad at her father and kicked him out” which occurred two or three months later (Archives).

A colorful example of the emotional divorce from Nancy’s father’s angle is illustrated by a letter that he wrote to Bowen about a year after Liza and Nancy left the project. Robert S wrote to Dr. Bowen in reaction to a comment Nancy made to him about renewing his marriage to Liza. Apparently, Robert understood Dr. Bowen to be suggesting to Nancy that he remarry Liza:

My Dear Dr. Bowen:

I am taking this liberty to write you on a very important matter. It is in re: Mrs Liza S, a former patient at your famous institution. My daughter, Nancy S, recently paid you a visit. While in conference on Monday...I understood from Nancy that you thought or suggested after Nancy decides to go for herself to be independent, that Mrs S would want to renew her former marriage partnership with her husband. I think it is very foolish to even think about starting all over again.

Dr Bowen – this correspondent recalls several cases of this, and they have been very unsuccessful. One case alone where there is a young married daughter, plus grandchildren – score – a complete failure. The other case – Dr. Bowen – I recall that after some years of divorce the couple (minus children) remarried... – the cousin came to this writer, crying to me – I told him one day – aren’t you a man, you claim to be – where is your manly traits, intelligence, etc. I told him that you always were considered a real man. – In my book I told him "he was a little lamb – and followed her to school.”

At the time of my divorce case, the judge asked both her lawyer – and mine – if a reconciliation could be in the offing – we were both approached – result -- no business. I asked the judge – one question. Had he ever been kicked by a mule, horse, or even a human being? He wouldn’t answer, Dr Bowen. I’ll bring this long epistle to a close. Waiting for a reply as soon as possible. Thanking you in advance in this matter. I remain yours sincerely, Robert S. (Archives).
Bowen’s response to Robert, in its classic style, illustrates Bowen’s view of the symbiotic attachment (fusion) between mother and daughter and the role of the husband in that attachment. This vignette also emphasizes Bowen’s goal to allow families to utilize their own strengths to solve problems. In the letter, he articulated that the family is responsible for its decisions and he removed himself from the over-responsible position in which Robert placed him:

When your daughter Nancy was here three weeks ago, she spoke of her wish to have her own life separate from her mother, and of the difficulty she had in trying to work it out. Of course, one of Nancy’s concerns is what will happen to her mother if and when she moves out. We did talk about a number of things including the possibility that Mrs S might want to resume a marriage relationship with you. Right now I do not remember whether Nancy mentioned it first or whether I did. I believe Nancy spoke of it first.

My position in this is one of being interested in learning how people go about solving such problems. I would not want to put myself into the position of being a “King Solomon” who can figure out the answers to such complex problems. How in the world could anyone other than Mrs S, and you, ever decide how it should go? Nancy is in the position of being a companion and a kind of nurse-daughter for her mother. Nancy and I also discussed the possibilities of what might happen if she has to give up any hopes of ever having a life of her own. Many children decide that it is better to devote their lives to the welfare of parents rather than to marry and have their own families. Of course Nancy wants to have her own life but who is so wise that they can know what is best? If she finally ends up spending her own life to make her mother comfortable, she will not be the first daughter to do it that way.

As I have heard it, Mrs S would want Nancy to remain with her. Nancy would like to eventually have her own life, free of both her mother and you, if she is eventually able to do it. It sounds to me like you would like to help Nancy but you are opposed to anything that would again involve you with Mrs S. As I see it, the problem is between Mrs S, Nancy, and you to decide what is best. I certainly would be glad to hear how it works out (Archives).

In the L Family, it seems that Linda began showing signs of mental illness when her parents divorced. Jeanine and Edward had been married at least 13 years when they began having severe disagreements. At the time, their older daughter, Sandra, was a young teenager and Linda was only 10 years old. After four years, the couple divorced
and almost immediately, Edward married another woman. He and his new wife eventually had several children.

Linda took the divorce very hard. She was able to go to school where she did quite well (she graduated from junior high school with honors), but she was quite disturbed and once was found crying in the attic. The scene alarmed her family. Somehow they thought she would have jumped out of the attic window if she had not been restrained. Linda was at camp during the summer when the divorce was finalized. She was 14 years old. Her father came to visit her at camp with his new wife. Linda became upset and confused. She could not sleep. By the end of the summer she became overtly psychotic (Archives).

Obviously, the divorce itself was not the main problem, but a manifestation of a family emotional process that had been developing over several years. I would speculate that the crystallizing emotional divorce may have intensified the family’s anxiety about Linda’s behavior and she responded by becoming more anxious to the point of incapacitation. As the youngest daughter, she may have become more of a focus in the thoughts of family members. Consequently, she may have been a target for considerable anxiety generated by the changing dynamics. The family’s reaction to her crying in the attic belied some heightened fear that she would engage in self-destructive behavior. There is not enough information to know if the thought that Linda would jump out of the window originated in the family member watching or was actually a real threat. This vignette presents an example of how a family emotional process resulting in divorce became an adversity for one of its members (Linda) and how her non-resilient response
became a new adversity for the family to handle. As they increased their anxious focus on her, her ability to respond resiliently became more limited.

The R family provides another example of the emotional divorce. Mary Jo R married young. Her husband deserted her around the time that their fifth child, Andy, was born. Mary Jo thought it was possible that her husband was still in the area but “he dropped out of existence as far as this family was concerned about ten years ago” (Archives). She reared her children alone since the time that he left. This emotional divorce demonstrates extreme distancing to the point of cutoff, not only in the marriage, but also between the father and the children. Extreme distancing makes the existing close relationships more intense and fused because of the need for attachment. In this family, Mrs R did not have parents of her own and had limited contact with her grandmother and an aunt. She seemed to look to her family to meet her emotional needs and was consequently very sensitive to acceptance and rejection from them.

To summarize, the emotional divorce was a key process in the families that intensified the focus on one child in each family. In the N Family, Jeff was the object of his parent’s disagreements. In the S Family, both parents had a relationship with the daughter Nancy, but maintained their distance from each other. In the L Family, the actual divorce between the parents coincided with anxious attention on Linda and her non-resilient response. In the R Family, the emotional divorce between the parents was extreme to the point of cutoff. This had ramifications for Mary Jo’s expectations of her children. In each case, resilient responses decreased in the children who were the object of increased attention.
Overfunctioning and Underfunctioning Reciprocity

Reciprocity is a mutual process of managing anxiety and fusion between two people through the act of one person functioning for the other person and the other person decreasing their functioning ability. It seems more likely to arise in situations of stress and adversity, when anxiety and fusion are likely to be more intense. Reciprocity can evolve to the point where one person becomes dysfunctional or ill. It usually occurs between couples, but can involve children as well.

Bowen described the functioning position of the child involved in the family projection process as “stabilizer of the ‘overadequate-inadequate reciprocity’” between the parents (Archives). The situation in Mrs S’s family of origin highlights this reciprocity. Liza’s mother had developed diabetes that worsened when the youngest son died. According to Liza, her mother changed from her former robust and healthy self to a “sick, aching, complaining, and sharp-tongued” woman. Reciprocally, the father pampered his wife and became even more “kind, gentle, and attentive.” He could not say “no” to his wife or their children (Archives). Consequently, Liza moved into an overadequate role in the family as her mother became more inadequate and the father was unable to provide a mitigating element to this evolving situation. In some ways, Liza became the person functioning as mother in the family.
Family Projection Process

Of all the ways that families manage anxiety, the Family Projection Process may be one of the most prevalent in the families who participated in the NIMH project. In early writing about the concept, Bowen called it "the interdependent triad" and described it as

the emotional interlocking between the father, the mother, and the child who becomes schizophrenic. In the family with a psychotic son or daughter, these three people are involved in a special emotional 'oneness'.... From the time the mothers first knew they were pregnant, the parents had a different kind of relationship with this child, than with other children (Archives).

One illustration of this early inception of the projection involves the mother in the N family, Katherine. She found out that her brother was diagnosed with schizophrenia while she was pregnant with her first child, Jeff. It is possible that her anxiety about having a normal son was heightened during this time. Another example is Paula R, who not only looked like her mother, but was also considered the closest to her of all the children. According to Dr. Bowen, she was the most involved in the family problems and the most impaired member of the family (Archives).
In Liza S's family of origin, her sibling position left her most involved in the family projection process. Her parents started their family in the town where her father grew up. The first four of their six children were born there and the last two were born in another state where they moved after the paternal grandparents' factory was sold. Liza and her younger brother were the two born after the parents moved. Partly because there were seven years between her and her older brother, Liza felt that she and her younger brother were like a second family born to her parents (Archives).

Her oldest sister did not finish high school and married young. She had five children soon after so was out of the house raising her family while Liza was still at home and in school. Liza's older brother lived at home, also did not finish high school, but started working full time at a steady job soon after. The other two older sisters had died in infancy. Liza's younger brother, only about a year younger than she, was very close to her. Always prone to illnesses, he died of influenza at the age of 15. That left Liza, age 16, as the main child involved with her parents at home (Archives).

In this position, Liza became the primary caretaker for her mother when she became ill with diabetes. Since these were the years before insulin treatment, her mother had several amputations. Over the six years after the younger brother died, the mother regressed and in turn, Liza became "the completely adequate mothering one." One time, when Liza attended to her mother while she was in the hospital, a doctor commented that he would like to hire Liza as a nurse. The mother responded that she would never hear of her daughter carrying "bed pans for other people. She wanted her daughter home to nurse her" (Archives).
In an early discussion of the family projection process, Bowen describes three main steps.

The first begins with a feeling in the mother which merges into thinking about defects in the child. The second is the examining-labeling step in which she searches for and diagnoses a defect in the child that best fits her feeling state....The third step is the treating step in which she acts toward and treats the child as though her diagnosis is accurate (Bowen, 1978, p.128).

Late in their stay at the Clinic, Katherine would bargain with Jeff to eat when he asked her for money. “She told him if he didn’t eat – not to talk to her about money” (Archives). She would check his lunch or dinner tray and for a while tried rewarding him for eating by taking him on walks or taking him to the candy machine. She tried to diagnose his not eating and to find ways to get him to eat. She spent a lot of time talking to other parents about Jeff’s eating habits and said she was certain that Jeff never got his ideas about eating from his parents (Archives).

One afternoon, she made “semi-apologetic comments about several little items she set aside for Jeff despite her feeling that he wouldn’t eat them” (Archives). Later, she was heard asking Jeff sharply, “Why do you think I’m here?” In the ensuing “TALK” she remarked: “You’re sick mentally; your ideas are all screwed up. We are trying to get you straight. We didn’t help much that’s true, but we tried” (Archives). She went on to use the word “dopey” regarding Jeff’s behavior in comparison to another family’s daughter.

For the next hour, Mrs N stayed with Jeff, trying to get him to watch TV, to go to the snack bar, and to shower. She yelled at him to stop delaying, which was interfering with her own desire to watch a TV show at 9:30 pm (Archives). Bowen wrote,

The projection system can create its own defects....The projection is fed by the mother’s anxiety. When the cause for her anxiety is located outside of the mother, the anxiety subsides. For the child, accepting the projection as a reality is a small
price to pay for a calmer mother... Each time he accepts another projection, he adds to his increasing state of functional inadequacy" (Bowen, 1978, p.128).

There is no evidence in the record that Jeff responded to his mother’s comments verbally. However the next day he engaged in a variety of compulsive activities, such as taking one shower after another and flushing the toilet during most of the night (Archives).

One of the behaviors I charted that relates to the projection process was attention. This included times when a person focused attention on another or sought it from another. It included topics of conversation that occupied attention. From the data, Jeff rarely, if ever, seemed to focus visible attention on his parents, other than to amble into his parent’s room, or to react to their bids for attention. More of the time he would distance himself by withdrawing or becoming seclusive. Mrs. N almost always focused attention on Jeff, except for four days during her husband’s visits.

The following incident between the N family members illustrates the nuclear family emotional process and family projection process dynamics that managed an increase in anxiety: Mr N came to breakfast, listened to the O Family’s conversation and asked a few questions. Mrs N came to breakfast and sat quietly listening to the conversation. Jeff came to breakfast and squeezed into a seat between his brother, Sam, and his father even though there was not a place setting. He did not eat well and hurriedly left the table to get ready to play golf with his father. Sam ate hurriedly as well. He hugged his father once, then tagged along behind him when he left the table (Archives).

As Mr N and Sam were leaving the table, Mrs N told her husband to “take along a carton of milk in case Jeff gets weak.” Her husband seemed annoyed at this request and shook his head several times saying ‘no.’” When he refused, Mrs N called Sam aside and...
whispered the same thing in his ear. Sam responded, “Dad’s the boss mother, talk to him about that.” When Sam said, “Dad’s the boss,” she quite emphatically said, “He sure is.” When Mrs N asked Sam to take the milk and kept pressing the subject, Mr N finally consented to take the milk (Archives).

Mr N left at 9:20 am for the golf course with Jeff, Sam, and a male staff member. They returned late for lunch. Mr N whispered to Mrs N at lunch, apparently telling her about Jeff’s behavior on the golf course. Jeff was very quiet at lunch, saying little about the golf game even when specifically asked. He left the table after eating hurriedly. Sam also had little to say about the golf game. He was “dreamy” at the lunch table, needing to be asked two or three times to pass things before noticing he was being spoken to (Archives).

Several things strike me about this incident. First, golf is a hot topic in this family since Mrs N believes that her brother’s psychotic break stems from losing a golf tournament. Second, judging from everyone’s behavior, something obviously happened on the golf course that raised Mr N’s anxiety level. He managed his anxiety by whispering a conversation to Mrs N about Jeff. Jeff became the focus of attention in a conversation between his parents that he was not privy to. Jeff was not included in the whispering, he did not share his experiences at the golf course, and he became uncomfortable enough to leave the scene quickly. In addition, he ate poorly. Sam was so preoccupied that he had to be asked several times to pass things. In this anxiety management approach, issues did not get discussed openly. The situation did not get resolved. Anxiety did not lessen. Jeff distanced himself. Most likely the parents reinforced their belief that something was terribly wrong with Jeff. Sam did not engage
but began day-dreaming about something. I would have to guess his thoughts were on the golf course incident.

The family projection process usually defaults onto one child but can temporarily ‘spill over’ onto others.

Child Focus usually involves one child the most. When that child is not available, sometimes other children will be drawn into the process, but the projection seems to revert back onto the original child. This will be illustrated with examples from the R Family, the N Family, and the O Family. In rare instances, the focus will shift onto another child for a longer period of time. This was eventually the case in the O Family.

In the R Family, Paula was most involved in the child projection process. Philip was drawn into the dynamic when Paula was less available to the mother. This came to light during an interview between Philip and Dr. Bowen. Philip shared his sense that when Paula left their home his mother looked to him for understanding and support. He said,

Mothers have to get their understanding from women. They seem to understand each other better. My mother is trying to get this from me and it is killing me. I cannot stand it. There has to be some kind of a way for her to get her understanding without her making me feel that I am responsible for her unhappiness” (Archives).

When Dr. Bowen asked what he thought might happen if this did not work out, Philip seemed to think the only answer was for Paula to come back and resume this relationship with their mother. He could not see a way to change it by himself, nor did he see his mother able to get her needs met in another relationship outside of the immediate family (Archives). This example shows how the family projection process can, in Bowen’s
words, "spill over" to other siblings. It also highlights the pressures on the children in the R Family as a result of the contextual elements discussed in the previous section.

Bowen added, however, that while the family projection process may "involve normal siblings to a lesser extent, the primary phenomenon is confined to this central triad" (Archives). He added, "In the beginning we believed that normal siblings were intimately involved but, as the families progressed in psychotherapy, the normal siblings would separate themselves and leave the father, mother, and patient still locked in the emotional bind of the "interdependent triad."

This was apparent in the N family. In the following scene, when parental anxiety was focused on Sam, Jeff was calm. However, this anxiety eventually reverted back to Jeff, leaving Sam free of it. A conversation between Mrs N and her younger son Sam precipitated an aggressive incident between Jeff and his mother (in addition to the fact that Jeff had not been able to fall asleep the night before until he finally retired at 6:45 am). Apparently, "Mrs N tried to talk Sam into staying on at the hospital." He must have been against the idea, because she eventually said, "we'll talk about it later" (Archives). Earlier that day, Mr N had reminded Sam about the doctor coming to draw his blood the next morning. "Sam had voiced his disapproval, saying he'd rather be discharged and blaming his father for not telling him sooner. 'You're joking about it, its funny to you'... Mr N looked quite bothered by Sam's behavior" (Archives). During this interchange with Sam, Jeff appeared calm. Both parents seemed "bothered" about Sam's refusal to have a blood test the following morning and Sam spent the time "pouting" (Archives).
Following this interchange, the family got in their car to go on an outing. Then came the incident where Jeff threw a bottle at his mother’s head when she asked him where he wanted to sit. This escalated into the following event. When Jeff threw the bottle, Mrs N jumped out of the car to run. At this point, Jeff swung at his father. He grabbed Mr N, threw him to the ground, and began to choke him. Sam then jumped on Jeff and began to choke him in order to release his father. An NIH Guard assisted the N’s with getting Jeff under control while Sam ran to call the unit, saying that Jeff had started a fight in the car. When two staff members reached the front lobby Mr N and Jeff had already started back to the unit via the elevator (Archives).

It is interesting to think about this interchange in relation to the earlier interaction with Sam, where he had been the focus of negative attention from his parents. At that time he and his parents were upset and Jeff was calm. The anger was not resolved when the family got in the car to go out but the focus shifted to Jeff’s behavior as he became aggressive. If we think about the family as an emotional unit, then the anger could shift within the family organism to be acted out by Jeff, in his case compounded with other unresolved issues. He then became the focus of the parents’ attention and Sam was off the hook.

Following the incident, the parents arranged for Sam to visit relatives on pass and get away from the Clinic until late evening. Mr and Mrs N stayed in their room all evening while Jeff paced restlessly around the unit, still seeming quite upset and stopping only for a few minutes to flick through the viewfinder. At one point a staff person told Jeff his father was not hurt and asked Jeff how he felt. In response, Jeff said, “Oh, is my father still here, I’m glad he wasn’t hurt” and went into his parents’ room, asking for a
soda. His father responded “that he didn’t think it advisable,” because Jeff did not “know how to handle bottles’” (Archives). Later, the father “still appeared quite angry in discussion of Jeff, said ‘Jeff had aimed to kick in my privates’ and that he would have fought back but Jeff was too tricky and elusive” (Archives). Mrs N also appeared upset, saying, “violence makes me feel so hollow inside” (Archives). She tried to rationalize Jeff’s actions, citing her thoughts that it was because she was not saving food for him, that he might be apprehensive over leaving, and that Sam was present (Archives). Both parents “agreed that Jeff should feel guilty over the incident – that it would be good for him” (Archives).

Shortly after, Jeff made several visits to the dining room “to gulp down any soup that was left over” and his mother encouraged him to eat while she avoided any close physical contact with him. By the next morning, Sam’s blood test had become a non-issue. Mr N had notified the nursing staff that they could call Sam for blood work and Sam indicated that it would not be necessary for his father to accompany him. This scene illustrates the tenacity of the family projection process onto one child.

Leslie, in a way similar to Sam, was able to stay out of the projection process, at least most of the time. When there was a quarrel between her parents, she tended to take her father’s side without jeopardizing her relationship with her mother (Archives). However, while she could separate herself from the family issues, she also took on an unusual amount of responsibility for herself at a young age. Leslie may not always have been this way. She describes early memories of being fearful at her parents’ frequent and often severe arguments. Those fears became simple annoyances as she reached age eight or nine (Archives). This shift, from fears to annoyances, would have occurred when
Leslie’s sister Jane was 15 or 16 years old. Could this have coincided with the decline in Jane’s functioning to a more psychotically vulnerable state? When Leslie came to the Clinic to visit for the first time, she managed to visit friends nearby during her stay, and eventually returned to her home state to finish the school year. The family home had been rented out and she lived there with the renters (Archives). In a similar way, Sam lived with his aunt nearby and visited the Clinic. For the most part, he was able to stay out of the family projection process.

At one point, about six months into their participation in the project, Leslie stayed with her sister Jane at the clinic while her parents took a trip. On the day when the O’s returned, Leslie expressed her wish to leave as soon as possible to visit friends in her home state, including a boy friend. This led to a long discussion that kept the O’s up into the middle of the night. They were concerned by Leslie’s sudden desire to leave and they had some worries about her ability to be responsible with her boyfriend. The differences took several days to resolve and eventually Mr and Mrs O saw Leslie off on her trip home (Archives). Despite occasional focus on her from her parents, she still managed to be freer to leave and be independent from her family. This does prove to fluctuate later as the parents work on their relationship and begin shifting positions. At that time, Leslie also drew the anxious attention of her parents.

When the family projection process shifts onto another sibling.

About nine months into their stay at the clinic, Shelby brought Leslie back with her after a business trip to their home state. A researcher noted a remarkable change in Shelby’s demeanor from her discharge two weeks earlier. She was much more “cold, haughty, and distant” and her voice was “tense and strident” (Archives). The researcher
related her changed behavior to a process of moving into an increased closeness with her
daughter Leslie, and a greater distance from her husband. She seemed to be particularly
tense about Leslie and about finding an appropriate school situation for her. The
researcher also noted that Leslie acted much less independent than previously and more
like a “spoiled neurotic adolescent” (Archives). He related her fuss about a physical exam
to her mother’s high anxiety at that time (Archives).

The parents then made arrangements for Leslie to attend school nearby and live
with a friend of the family. After several months of this arrangement, Leslie indicated
that she was not getting along well with the family and was not happy at school. She was
upset about this. Leslie, who had been described as slim up to this point, had gained some
weight and sought assistance with a diet (Archives). Although her psychological state
was good, she allowed herself to be more of a moody adolescent, taking less
responsibility as she had in the past. She and her mother were at odds about where she
should attend school. She visited the Clinic off and on over the next weeks and months,
trying to establish herself at another school nearby (Archives).

At the time, a researcher interpreted the repeated discharges and readmissions as a
symptom of the family’s inability to take a definite stand together on the matter of
schooling (Archives). The family seemed to improve in this regard as the parents moved
closer together on decisions in this area. However, one researcher noted that Leslie tested
her parents solidity on these decisions with “adolescent temper tantrums” (Archives).

According to the researcher, her testing may have reciprocally brought the parents closer
together (Archives).
It was during one of these visits that Leslie received a blow on the head from her sister that may have shaken her confidence. Normally she was able to bring out the best in her sister. Shelby then took Leslie with her on a trip for family and business matters (Archives). This trip served several purposes. It gave Shelby and Leslie a chance to discuss the school issue. The decision to go on the trip also relieved considerable tension that Shelby had been experiencing for several weeks. The trip took longer than expected and arrangements were made to extend the pass. When they returned, it was decided that Leslie would take the year off from school, take some correspondence courses, and live at the Clinic for the time being (Archives). It is interesting that Leslie, who had no prior medical complaints, sought help for an ear infection during this time (Archives).

The family felt it would be helpful for Leslie to be more present as a member of the family study. They wanted her to attend school but could not work out a suitable plan. One of the researchers commented, “the inability to work out a plan seems more related to the family turmoil than the absence of resources” (Archives). The researcher was of the opinion that Leslie’s rapid movements in and out of the Clinical Center were related to the increased tension and upheaval in the family. Apparently, Shelby was very anxious about the fact that Leslie was still not in school. Most of her discussions with Leslie focused on this point.

When Leslie returned from the trip, she was quite tense and easily got into arguments, especially with her father. The researchers noted a strong and tense alliance between Leslie and her mother against the father. Apparently, since living at the Clinical Center over those months, Leslie had become increasingly allied with her mother and less tolerant of her father, manifested by tense verbal attacks and conflicts (Archives).
It is interesting that a year before, Dr. Bowen noted that the family problems involved the triangular relationship between the parents and Jane, leaving Leslie relatively free to be an active and mature person (Archives). As she moved into the Clinical Center and spent more time in direct proximity to the family, another researcher noted that she was working out a new position for herself in the family between too distant and too close. While this was part of normal adolescent development, he added that her struggle was more extreme given the imbalance in the family relationships (Archives).

Eventually, Shelby made the decision to take Leslie back home and stay with her for the school year. While visiting their home town with Leslie, Shelby communicated a decision to Dr. Bowen that she would spend the next year at home with Leslie. Their family physician had recommended that she lend strong support to Leslie at this crucial time in her adolescence. Shelby expressed to Dr. Bowen that for six years she had expected Leslie to put her needs behind Jane’s while they focused on getting Jane well. Now, she felt that she needed to meet Leslie’s need for security, love, and attention (Archives).

Shelby added that Leslie’s experience at NIMH had left her less stable and secure, such that she feared returning there (Archives). This development lends more credence to the concept of a resilient response that changes in different relationship circumstances. In her letter, Shelby expressed being quite torn between her feeling of obligation to Leslie, her concern for Jane’s care, her desire to be with her husband, and wanting to continue the family work at NIMH. She wrote, “this whole situation is a
tremendous load and I have been deliberate and prayerful in coming to this decision" (Archives).

Shelby’s decision raises several questions. Was it a sound decision or a distancing move? Why could the parents not work it out for Leslie to spend the year in school near the Clinic? Was it a lack of flexibility in the system? Were the shifts in family functioning too threatening to Leslie’s former high functioning position? Mrs O definitely seemed to agonize over the decision. There is not enough information in the records to know whether Shelby had discussed this decision with John or had made it alone with Leslie and with advice from the family’s hometown physician. However, the alliance between Leslie and her mother against the father during this time would indicate that he may not have been a big part of the decision-making process. Shelby’s decision seemed to be an outgrowth of her concern about Leslie. Was it a manifestation of family projection process focused on Leslie? The outcomes of this decision will come to light in the next few paragraphs and in the following section on resilient responses.

Several months after the O Family had left NIMH, John O wrote to Dr. Bowen:

Things have been going along on a ‘business as usual’ basis in the O Family since I last wrote. We’ve had some rough sailing and slow mileage but it’s my opinion the general direction is good. My physical condition is much improved. My psychological functioning fluctuates and is still quite a bit under par but it’s my feeling I’m heading in the direction of a more stable level.

We came through the holidays quite well and Jane’s general conduct, attitude and participation was such that gave us pleasure and satisfaction. She is handling herself with more ease and confidence in the home and outside contacts, while her initiative and creative activity remains more or less the same. It appears she still lives in an unreal and fanciful world. At times, however, she can be quite realistic.

I hardly know how to comment on the relationship with my wife. Maybe it could be called, ‘just middling,’ and minus the old conflicts and hostilities. We are able to discuss problems with some degree of satisfaction and success. It is quite evident she occupies the key position as she assumes the major
responsibilities of the business and home. I am less inclined to rise and fall with her anxieties but Leslie becomes involved quite often.

That brings me to the significant problem that exists at this time. Leslie has been unhappy, noncooperative and critical. She has not been in school since Christmas, having been on a leaving home tirade. So far I have remained more or less on the sideline and she is giving her mother a rough time. My wife insists that she needs help and connection has been made with the guidance clinic in ______. Leslie is going along with the idea so far. She and I were there yesterday for a briefing with the psychologist and social worker. My wife will go with her next week. I am feeling this connection could have some value and maybe an effort in which the four of us could participate. What do you think? We still have many hurdles to make (Archives).

John’s mention of his ‘sideline’ approach and the focus on finding treatment for Leslie show how difficult it is to manage oneself in the family projection process. Bowen’s response to the letter emphasized his perception that John was losing the perspective of the family as a unit. He wrote that Mr O “represents Leslie’s problem as confined entirely within Leslie and having no relationship to the rest of the family….I do not believe he is so involved that he cannot find some kind of position to see the overall situation” (Archives). Bowen continued with his thoughts that John’s reliance on Bowen for family advice could only lead to inaccurate assessments. He wrote, “How could I do a valid assessment of it? If I did a guess, it would be a wrong guess. If he accepted my guess as accurate, then what kind of an inaccuracy would that be?” (Archives). Bowen ends the letter with the following comment:

If the O family is so mixed up in emotional entanglements that no one can see forest for trees, then the problem is not one of, ‘What is the involvement,’ but rather one of, ‘which family member is going to assume the responsibility of finding an objective position that will enable them to see the forest instead of the trees’ (Archives).

Here, Bowen distinguished between the tendency to focus on the child and to try to figure out how best to help her, versus the personal attempt to become more objective about the
whole family system. This would be a step in learning how the system is working and changing one’s own part in it.

In the preceding paragraphs, two concepts from Bowen Family Systems Theory, nuclear family emotional process and the family projection process, have framed the discussion of family emotional process. These action and interaction strategies evolved naturally in the families to manage anxiety. The data suggest that focus on a child was the predominant anxiety management strategy used in all of the families and was reinforced by nuclear family emotional processes such as conflict and distance or the older term of the emotional divorce, and over and under functioning reciprocity. The family projection process had serious ramifications for the resilient responses of youth. These will be discussed in the next section.
In this section, we look at the outcomes of family emotional process. These are the resilient and non-resilient responses of youth in the NIMH families. A third type of resilient response is discussed called the differentiating move. This is an intentional way of responding resiliently by becoming aware of those automatic processes and changing one's part in them. This section is divided into three parts. First, the resilient responses of siblings who are not primary recipients of the projection process will be illustrated with examples from the four families with siblings. Then the fluctuating resilient and non-resilient responses of the youth who are the primary focus of the family projection.
process will be illustrated with examples from each of the five families. The third part of this section illustrates the differentiating moves initiated by youth, parents, and staff that had an impact on resilient responses. One example involving Mary Jo and Paula R shows the striking ramifications of a lack of a differentiating move.

Figure 28: Resilient Response

Resilient Responses of the Siblings

In each family with more than one child, there was at least one sibling who was outside of the family emotional fusion enough to carry on a relatively productive existence. Usually this seemed to be an almost automatic outcome, but in some cases there were considered choices being made to allow the child to remain free of the family
intensity. The children themselves seemed unconscious about their resilient responses, at least they seemed to assume that they were immune from the symptoms. They focused their energies on school, friendships, and other productive activities.

Leslie O, seven years younger than Jane, was somehow freer of the intensity that tended to characterize the relationships in the family and which often caused difficulties (Archives). She seemed to receive the affection and understanding she needed from both her mother and father (Archives). Others described her as active, mature, bright, and alert, as well as outgoing, outspoken, and unaffected. As a teenager, it did not bother her at all to speak out about her family’s difficulties (Archives). Leslie was also free of physical maladies. Dr. Bowen described Leslie as the most normal member of the family. She occupied a mature and adequate position in the family, giving the impression that she was older than her 15 years (Archives). However, as the examples shared earlier demonstrate, this was not a fixed state.

Paula R’s sister, Carol, was married with a child at 18. She and her husband lived in another state, although Carol divided her time between that home and her mother’s home. During Paula’s course of stay at the clinical center, Carol talked about separating from her husband, which upset her mother a great deal. Frank R, at age 16, lived at home and attended high school nearby. He held a job delivering newspapers and contributed his earnings to help support the family. He had ambitions to join the military. Frank seemed to have a more flexible relationship with his mother, one that could return to an even keel even after an upset. One weekend, he refused one of his mother’s requests, she yelled at him in front of his friends, and he ran away. However, Frank returned later and both were able to reconcile their differences and apologize for their part in the upset. Andy R, the
youngest at age 10, tended to be the baby and the ‘good little brother.’ He had some eating difficulties when he was young. His mother likened Andy to his oldest brother, Frank (Archives).

Bowen described Andy as the least involved in the family interchange of symptoms than any of his siblings. “Why it is so, we do not know. One of the suppositions is that he is the youngest, he is the most dependent, and he has not yet had to begin his struggle for maturation and autonomy” (Archives). Bowen described Andy as the best adjusted of his family members. While he had a few minor physical symptoms and illnesses over the years, these were attributed more to intra-family stresses than to any constitutional or pathological processes. He was undernourished, and had some minor eating problems, including food allergies. He enjoyed school and got along well with both teachers and peers, often helping the teachers. When he once had to attend summer school for reading, it was discontinued because he made such rapid progress (Archives).

Andy got along better and more smoothly with Paula than any of his other siblings did. He and his sister were described as having a close and comfortable relationship. She liked to do things for him and he seemed to like her motherly behavior toward him. On at least one of the family visits to the clinical center, he slept in his sister’s room. He enjoyed participating in the clinic’s social activities during the visit (Archives). Andy’s relationship to his sister was similar to the relationship that Leslie and Jane O shared most of the time. Jane tended to relate more maturely to her sister than to either of her parents or the staff. The siblings had a calm and comfortable relationship, which was evident during early visits Leslie made to the clinical center (Archives).
Sandra L was also freer to have her own life than her sister Linda. Sandra looked like her mother and was considered quite attractive. At the time of her parents’ divorce, Sandra was already 17 years old and almost out of the house. It was not long before Sandra married and established a family of her own, with several children. She lived at a distance from her mother (Archives).

Jeff N’s younger brother Sam was an active 12 year old boy, who was as comfortable pursuing independent games as he was asking families or staff in the project to play games and sports with him. Often, he asked staff to play games with him before breakfast. After quickly eating breakfast, he would engage in a ping pong game followed by a variety of other activities. Then he would go to the gym with his father. Sam would stare with a fascinated expression on his face at Liza and Nancy S yelling at each other in their usual fashion. Then he would be off to the gym again and back in time to join in a family orchestra. Whenever he was free he sought out a game or activity. At times he vied for his father’s attention, sometimes demanding a lot of it. When his father was away, he interacted mostly with his mother. Sometimes he was noted to have a shorter attention span than at other times. He was afraid of Jane O after witnessing her aggressiveness. He would avoid going near her and if she came to the dinner table, he would leave his seat “like a shot” (Archives).

When a child chooses, unconsciously or not, a resilient response to an adversity, the response reinforces the family context. The response, if unconscious, may be an outgrowth of automatic relationship processes that reinforce the predominating pathways of anxiety through the system. In other words, if children are relatively free of the flow of anxiety, they will probably continue to stay free with each new resilient response they
make. This reinforces or at least maintains the status quo in the family system context. These children remain able to think more clearly, make self-protective decisions, and have energy left over for other activities. By learning more about these siblings, such as Leslie O, Sam N, and Sandra L, we see what it looks like when family processes leave some of the children freer of anxiety. In the R Family, Carol, Frank, and Andy were all able to pursue personal and academic goals as well as social relationships with greater ease.
Non-Resilient Responses of the Receptors of the Family Projection Process

The children who were the focus of the family projection process tended toward more non-resilient responses, at least during the time leading up to their hospitalization and diagnosis with schizophrenia. In certain hospitals, their non-resilient responses increased dramatically which says something about the treatment environments and how they reinforced child focus. Sometimes during the NIMH research project, their functioning declined dramatically as an outgrowth of observed family processes such as extreme distancing. A striking example of this in the R family will be discussed later in this section.

Figure 29: Non-Resilient Response
extreme distancing. A striking example of this in the R Family will be discussed later in this section.

At NIMH, the youth who were identified as symptomatic also exhibited resilient responses, even though from an individual framework, one might assume that they were not resilient. However, from a systems framework, they were just as capable of a resilient response. Those responses were visible in varying degrees. It seemed that their functioning fluctuated significantly throughout even a day, from resilient to non-resilient and back again. Perhaps this was an outcome of the fusion that made a greater part of their selves negotiable in relationships. Hence their resilient and non-resilient responses were like a barometer for their sensitivity to significant relationships and to anxiety.

For example, one evening Jane O sat listening attentively to a conversation being held in Spanish at the dinner table. After dinner, she asked her father if he would speak Spanish with her. He was so thrilled at her request that he first went off to tell the nursing staff. He and Jane then conversed for a half hour in Spanish and followed that by going to the gym to play a game. These events followed an afternoon where her father was calm and very patient with her when she overloaded her lunch plate with food. On another day, she spent the afternoon with a “tense, set expression on her face” and spent the evening withdrawn (Archives). This followed a morning when her mother ignored her father and then her parents “had an altercation in the bedroom” (Archives). The contrast between these two resilient responses highlights how they fluctuated depending on anxiety level and relationship events in her family.

In general, Jane’s way of interacting with the family was quite different from her sister’s. Jane was extremely sensitive, almost to a fault. She was shy and inhibited, and
had difficulty making decisions (Archives). Nevertheless, despite some so-called “personality difficulties,” Jane did quite well in school and graduated as valedictorian of her high school class at age 17. She entered college in her home state the next Fall. Early the next Winter, she came down with a case of the measles which landed her in the college infirmary. She went into a panic state that developed into an acute psychotic break. Thus began a series of hospitalizations. The first two hospitals treated her with electro-convulsive shock treatments resulting in slight and temporary improvement. Her family took her out of the hospital against advice and attempted to keep her at home for four months (Archives). During this time her behavior was very psychotic.

In the late Fall, she entered a third hospital for 15 months. There she received insulin coma and electroshock treatments, with some psychotherapy. The insulin coma treatments “frightened her terribly” (Archives). Despite over 50 treatments, she continued to have tantrums and assault others at a mere routine request. When she did settle down, she became compliant in an infantile manner. She spent a lot of time in seclusion. She had a few brief periods of calm behavior but in general she required constraints and confinement for combativeness. Her behavior was described as paranoid and catatonic, with much silly laughter and babyishness. At one point earlier in the hospitalization, her mother started to visit three times a week, hoping it would help, but there was no improvement. Her father finally signed her out of this hospital against advice. He had gotten involved when Jane threatened to kill her mother (Archives).

When Mrs. O arranged to bring Jane from the sanitarium to NIMH, she had the help of a nurse from NIMH. The sanitarium staff furnished them with restraints, anticipating that Jane would be difficult to manage on the trip. However, the NIMH nurse
and Shelby felt secure without the restraints and the trip was uneventful. Apparently, Jane settled into the open ward setting at NIMH quite smoothly (Archives).

The medical director at the hospital where Jane’s father had been staying before admission to NIMH knew Jane, since she had been a patient in that hospital in the past. He described Jane as having been in an acute disturbed schizophrenic state for several years. He interpreted this to mean that she had continued struggling (Archives). The ongoing struggle he mentioned indicates a level of resilient response. In other words, she was not giving in and not giving up.

Jeff N was born a healthy weight and size, and was an active and lively baby. He seemed to grow normally, except he sucked his thumb until age five and wet his bed until age seven. According to his mother, Jeff “had a persecution problem all his life.” He was always obedient and never had temper tantrums because his “father stopped him” (Archives). His first school experience was nursery school as a three year old. He seemed to be afraid of the group and showed a tendency to want everything arranged in an orderly fashion, something his mother considered early signs of compulsiveness. Jeff was described as an active and excitable child. He did not like Kindergarten so his parents kept him out of school and entered him into First Grade at the age of six, despite his teacher’s misgivings about his age. However, he did well by the end of the year. When he was seven, his father joined the service and Jeff lived at home with his mother and newborn brother (Archives).

According to Bowen, Mrs N was ‘very insecure’ during her husband’s absence and Jeff exhibited ongoing anxiety and nervousness about his father as well. It seemed that from age seven on, Jeff was “always nervous.” According to his parents, Jeff “never
asked for affection and never got it.” His mother said, “we could never get close to him, he was always running.” He did not get along with other children very well which became especially difficult in junior high school. He did well in boy scouts but was somewhat obsessive about attaining merit badges.

A psychiatrist examined Jeff at age 13 but the results were negative. By age 15 he “masturbated regularly.” Apparently, his parents made literature on sex available to him at age 16 because “he was so mixed up about sex.” Around that time, he and a friend were seduced by a woman who approached them on the street, after which he felt very guilty (Archives). It is hard to know if his sexual habits were more of a problem for his parents or for him. I would be curious about the anxiety management function that masturbation may have played if his anxiety was regularly at a high level. Jane masturbated occasionally when in public spaces at the Clinic or on outings. I wonder about the need to manage anxiety as a factor in this behavior.

During adolescence, Jeff was diagnosed with obsessive-compulsive neurosis. After his junior year of high school he had his “first illness.” At age 17, his parents took him to a child guidance clinic. Seven months later he was admitted to a psychiatric hospital for one week. At that point his psychological exam gave an impression of a schizoid personality but no overt psychosis. From there he went to a children’s service center where he received treatment for eight months. He was able to finish high school during that time. After graduating, he went home and got a job but after two weeks he ran away to another state. After returning home, he eventually spent three weeks at a children’s service camp (Archives).
Several months later he was readmitted to the psychiatric hospital where he had been earlier, this time because he was disoriented with ideas of reference and body delusion. Also, he would physically assault his parents and become destructive. He received numerous insulin shock treatments and electro shock treatments, both of which were not helpful. In addition, he was given Thorazine. He left seven months later for a state hospital where he spent five months. During that time his parents visited regularly and took him to private psychotherapy several times a week. Individual psychotherapy met with little, if any, success because he was not very communicative (Archives).

After that, Jeff was outside of the hospital for three months before returning to the first hospital. From there he was finally transferred to NIMH for the family research study in which his whole family participated. The hospital he was transferred from indicated that Jeff had been admitted there originally because of “a severe struggle with his parents.” They also added that he was sexually preoccupied and had a handwashing compulsion. By age 17, he was diagnosed with schizophrenia. Dr. Bowen considered his psychosis a “catatonic inhibition with occasional bursts of very psychotic overactivity and rituals” (Archives).

Jeff had not been able to hold a job for more than a week or two, sometimes only a day. He smoked cigarettes. Jeff indicated that he hoped to get better. He added, “I seem to need to talk to doctors who give me medication. I was put into the last hospital because I hit a couple of people, and my parents thought I had crazy thoughts.” During his entry interview, he was quite accurately oriented to time and space. His speech became somewhat tangential and less focused when pushed. He did not appear to show any insight (Archives).
From daily observations over a twenty-day period after about two months on the project, Jeff could be seen exhibiting a range of behaviors that seem resilient. He would seek contact with other patients and their families as well as staff. For instance he would chat with Jane O or seek close contact with her. Sometimes they would dance together. He played games with staff. He would talk with Leslie. He embraced Linda L in the TV room. He would help his father with secretarial duties and listen intently to his parents’ discussion. He would play sports with his father and actively participate in picnic activities. Some days he was more alert and could be seen beaming when his father complimented him. One day he seemed confused, but after spending some time out on pass with his father, he returned alert and in a good mood. Another evening he ate dinner twice (Archives).

Paula R was 15 years old when she and her mother became involved with the NIMH family research project. Described as a very sensitive person, Paula was also a dynamic patient, at times acting as a leader with great energy and positive force. One time, she organized a one-person show where she sang songs, danced, and read poetry, most of which she created herself. Her family as well as other families and staff were invited. Bowen called it “a public ceremony of considerable emotional impact.” At her low periods, she could require long periods in seclusion (Archives).

Paula’s brother, PJ, had been held back in seventh grade for three years. He indicated that he hated school and planned to quit as soon as he could. He said he did not get along with teachers or authority figures. His mother concurred that he had no interest in school, and added that he did not seem to have interest in anything. At one point, when PJ failed all of his subjects and got suspended, the school insisted that PJ see the school
psychiatrist. During this interview, PJ reported that his mother did not cook for the boys and relied on them to do the cooking. He also told the psychiatrist that his mother did not care what time he came home and that she beat him and his brothers with a strap (Archives).

The psychiatrist recommended psychological testing to rule out schizophrenia and suggested a mental hygiene clinic. Mary Jo saw it as a great threat to the family to have two children in hospitals and therefore found it difficult to make plans for PJ’s treatment. She still had not taken action by the time Paula left NIMH, but by then PJ had been taken into a receiving home for carrying a knife (Archives).

PJ depended on his mother for financial support, although he worked part time at menial jobs in his neighborhood. He spent his free time swimming or hanging out with his gang of friends. PJ complained of headaches and had enuresis all his life with only occasional remissions. His mother said he was afraid to go to camp because of the fear of other boys discovering that he still wet the bed. She also said he did not attend church with her because he had nothing but tennis shoes to wear. However, his mother shared the fact that he was so excited about giving her a gift for mother’s day that he gave it to her early. He also made a card and let her know how much he loved her (Archives).

He smoked but did not indicate any history of alcohol or other drug use. PJ exhibited a lot of physical movement. He appeared anxious and tense with an attitude of ‘smart-aleckness.’ He acted like he knew everything there was to know and that anyone who disagreed with him was obviously wrong. His memory was normal and he had no other physical complaints (Archives).
PJ saw himself as getting along with friends and family members. His younger brother agreed that PJ was the idol of his friends, but said that he did not get along well with their mother. Andy himself was disgusted with his older brother. Andy explained that he himself often got into trouble for things that PJ did because PJ lied about them. Mary Jo saw PJ as a loner rather than the idol of his gang. While he made friends easily, he had a hard time holding onto them. He usually only had one or two friends at a time. Hence she was concerned about his social adaptability. She had noticed that over the past four years he had developed an attitude that everyone was against him. She described him as ‘a wise guy with a chip on his shoulder’ (Archives).

During his sister’s and mother’s course of treatment at NIMH, PJ had increasingly more problems. These may have been non-resilient responses as an outcome of the projection process that would ‘spill over’ onto him during Paula’s absence from the home. He would stay out late and sometimes not come home at all. He got into trouble for juvenile delinquency such as stealing bicycles. (Later, however, his mother gave him a bicycle that he used to go visit his sister at NIMH.) When asked about his stealing behaviors by Dr. Bowen, he showed no remorse and indicated that if he could do these things again, he would do them more anti-socially. Mary Jo began to fear bodily harm from him. Both Andy and his mother tended to blame PJ’s troubles on an accident where he hit his head at an early age.

In contrast to this portrait of PJ, Dr. Bowen got a very different impression in another interview where he was struck by Philip’s ability to easily switch to a very sincere, objective, and non-defensive way of presenting himself. As a matter of fact, Bowen commented on the “peculiar and very interesting paradox” that PJ had the ability
“to speak more objectively about the difficulties within the family and his own adjustment than any single member of the family” (Archives). PJ also indicated to Dr. Bowen an ambition to become a policeman. Unfortunately he believed that was impossible now that he had a police record. He did mention a desire to join the Marine Corps (Archives).

Linda L was born three years after her older sister Sandra. She looked more like her father and was considered less attractive. Linda had a normal childhood and adjusted well. Others considered her a thoughtful girl. She participated in brownies and girl scouts and had a very close friend throughout her grade school years (Archives). Her resilient responses fluctuated as well, from good school performance to a psychosis that coincided with her parents’ divorce (Archives).

At that time she entered a psychiatric hospital for two and a half years. She was considered a difficult patient to handle in the hospital. She would assault others and destroy clothes and bedding. She talked to herself, giggled inappropriately, smeared feces, and urinated uncontrollably. She underwent several courses of insulin shock and electroshock treatment. When she finally left there, she lived outside of the hospital for a year. Then she went back in for a half year receiving further electroshock treatments. After another half year outside she entered the hospital for a two-year stint. She started psychotherapy at this hospital and followed her psychotherapist to another state for continued treatment. During those years she finished high school. She lapsed a few times into acute upsets that required brief hospitalizations. Eventually she returned to her home state and lived with an aunt for two years in a fairly protected environment. She continued psychotherapy and worked part time (Archives).
On one occasion, she visited her family home for the first time in several years. She became quite upset in reaction to a visit from her sister and her sister’s children. She quickly returned to her aunt’s home but could not calm down. She entered another psychiatric hospital where she remained for more than a year. At the hospital, she stayed in a disturbed or semi-disturbed delusional state, often hallucinating and speaking incoherently. She often needed to be secluded because of her behavior. Apparently, she would constantly rebel against hospital rules (Archives).

Nancy S. was 12 when her parents divorced, although they were separated often after Nancy was born. After a year her mother went on welfare, after which she and her mother were constantly moving due to “intense paranoid fights” and “constant hostile arguments” with landlords (Archives). Nancy had a congenital abnormality for which she had already had two operations. She “kept regressing to a lower and lower level as her mother regressed” (Archives). When her mother’s functioning declined to an incapacitated level, Nancy “fell back to a more helpless position” than her mother’s. Although her mother, Liza, was seen by the researchers as “far more impaired than Nancy,” she still managed to fulfill her role as mother (Archives).

At the times when her mother became more psychotic or incapacitated, Nancy “would fall back into position of stupid, immature, irresponsible, and childish one” (Archives). When she did this, she expressed psychotic delusional thinking that seemed to mirror her mother’s thoughts. However, the researchers believed that her thinking was not truly that disorganized. She deferred to her mother and acted like a scatterbrained and irresponsible teenager. While she “seemed superficially disorganized,” she gave the impression that she was more solid on a deeper level (Archives). Nancy spoke in “a high
squeaky voice which became higher when she was anxious" (Archives). “She would alternately relate to the environment the same attitudes and thinking disorders as the mother, or, when the mother became most psychotic she would attack, criticize, physically abuse her mother for acting this way” (Archives).

When Nancy S became more infantile every time her mother tried to depend on her, she unconsciously created a new adversity that needed to be managed. When PJ R stole bicycles and got picked up by the police, his mother had more challenges to deal with, and her anxiety level rose. The more Jeff N did not eat well, the more eating became an adversity for his family, raising concern in his mother. When he was aggressive with his parents, his parents had to recuperate from their wounds. In addition, they became more anxious and more convinced that he had problems they feared were insurmountable. When Jane O had her first psychotic break, the family had a new adversity to manage on top of her father John’s illness.

If a child makes a non-resilient response to an adversity, which can be as equally unconscious as the resilient responses of the siblings, the response becomes a new adversity that raises the anxiety level in the family. When Linda L got upset at her parents’ divorce and ended the summer in a psychotic state, her illness created a new adversity that raised anxiety in the family. Whether this cycle is seen from a systems perspective versus an individually focused perspective makes a difference in treatment and intervention. From a systems perspective, one could say the anxiety raised by Linda’s illness was difficult for the family to manage. The family already managed their anxiety by focusing on Linda, so this created a vicious circle. As a result, she was sent to clinical settings for assistance, when instead, the family could have used help managing anxiety.
The individually focused view of the L Family situation would say that Linda’s illness was too much for the family to handle and experts were needed to treat her illness. Unless she received treatment that took into account the family process involved, it is doubtful that anxiety would have been resolved in a way that left her freer of it.

In summary, each of the children who received most of the family anxiety was prone to non-resilient responses. The responses of these youth fluctuated from resilient to non-resilient, in some cases like a barometer for the relationship processes and anxiety in the families. However, each person demonstrated resilient responses, reinforcing the systems view that resiliency is accessible to everyone and changes in different relationship environments. The differentiating move, which will be discussed in the next section, shows how a family member can influence the relationship environment and consequently make a difference in the automatic resilient or non-resilient responses of youth.

Figure 33: Differentiating Move.

The Differentiating Move

As a type of resilient response, the differentiating move may reduce anxiety initially, but does not add to adversity. It alters the family system by enhancing connections between family members. The differentiating move is an intentional response to the family emotional process that involves managing one’s own anxiety and changing one’s part in the typical interactions. Eventually, the move alters the predictable resilient responses of the youth and moves the family away from adversity and toward the resilient end of the model.
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Figure 30: Differentiating Move

The Differentiating Move
In one sense, a person is differentiating from the family fusion, by exercising the ability to be a self while still maintaining contact. Even though this move is calming over time because of the continued contact, it can be threatening at first as chronic anxiety works to raise fears of imagined loss of the union. However, while it may increase anxiety initially, it reduces chronic anxiety over the long run. In some of the NIMH family cases, youth initiated this differentiating move, especially when they became young adults. Often it was a parent who initiated the differentiating move. Sometimes staff took this step with families who tried to involve them in the family fusion.

The differentiating move is a purposeful way that any family member can change their part in the system to influence the resilient responses of youth. It is based on clarifying one's own beliefs and acting on those with full awareness of the consequences. A person who makes a differentiating move essentially says, “This is who I am, what I believe, what I stand for, and what I will do or will not do, in a given situation” (Bowen, 1978, p.365). The effort builds on the part of self that is not negotiable in relationships and requires risk taking in the face of threat:

The solid self is made up of clearly defined beliefs, opinions, convictions, and life principles. These are incorporated into self from one’s own life experiences, by a process of intellectual reasoning, and the careful consideration of the alternatives involved in the choice. In making the choice, one becomes responsible for self and the consequences. Each belief and life principle is consistent with all the others, and self will take action on the principles even in situations of high anxiety and duress” (Bowen, 1978, p.365).

The differentiating move is counterintuitive to the desire to agree with others or to give in to the wishes of others. It threatens the comfort of fusion and comfortable togetherness. The disturbance that the move creates in the system makes people
uncomfortable, especially those who have been relatively free of the anxiety flow in the past. Hence there is a predictable reaction in the family to the differentiating move.

When any family member makes a move toward differentiating a self, the family emotional system communicates a three-stage verbal and nonverbal message: (1) You are wrong. (2) Change back. (3) If you do not, these are the consequences. Generally, the messages contain a mixture of subtle sulks, hurt feelings, and angry exchanges, but some communicate all three stages in words. (Bowen, 1978, p.216). When the differentiating one can finally control self throughout the step without fighting back or withdrawing, the family usually reaches a final showdown session with maximal attack and feelings. If the differentiating one can maintain a calm stand through this, the family anxiety suddenly subsides into a new and different level of closeness, with open appreciation and a higher regard for the differentiating one as a person. (Bowen, 1978, p.218).

This process is observable in the L Family, when Linda’s efforts at a differentiating move meet with resistance from her mother.

Linda initiated the differentiating moves with her mother, Jeanine, who gradually found ways to adjust to Linda’s improved functioning. Her family diagram is pictured in Figure 31. The treatment program in the family research project minimized hospital rules. This was partially designed so that problems would remain between family members and not draw staff into them. The more rules there were, the more families could blame staff or rules for problems. When Linda arrived at NIMH, she was bewildered by the lack of structure and rules, asking hundreds of questions about procedures. Eventually she calmed down. When her mother arrived, Linda began to rebel against her. Her mother could not say yes or no to her daughter. Three days after her mother arrived, Linda had an acute but mild psychosis that lasted nearly a week. Episodes like the one with the wrist watch, shared earlier, were common during that time (Archives).
When her psychotic episode subsided, Linda began asking her mother to take her out for a ride. Her mother, Jeanine, looked to the hospital staff for rules. She told the staff that she could not answer her daughter directly because Linda was sick and would not comprehend. However, she eventually got up the nerve to take her daughter for a ride and Linda behaved beautifully. They went on numerous outings like this over the next two months. A curious side effect of the trips showed up in the mother. She would develop some kind of physical symptom within a few hours after each trip. Her symptoms included sudden laryngitis or hives. One day, after the mother could not visit the clinical center because of one of these illnesses, Linda arranged for a staff person to take her to
visit her mother. Within a few hours, the mother developed a case of severe gastroenteritis (Archives).

Linda eventually talked her mother into letting her spend the holidays at home. The visit went well but when Linda returned to NIMH, the mother developed hives.

When Jeanine flew to another state to visit relatives, her hives disappeared before she landed. She stayed with relatives for a couple of weeks. When she got back in the plane to go home, her hives returned. After several months, Jeanine stopped having somatic reactions relative to her contact with her daughter (Archives).

Linda began visiting with her mother regularly on weekends. Her mother arranged to have a third person with them at all times out of fear that Linda would act out.

However, Linda got herself a volunteer job, she developed a social life, and continued diligently with psychotherapy. Apparently, Linda was seen as quite “gracious” (Archives). As the visits progressed without a problem, Linda began asking her mother if they could spend the summer together at the family home in another state. Jeanine’s reaction was to say to the social worker, “it was so out of the question that I did not even reply to her.” Later she said to Linda, “I know the staff will not permit this, so why talk about it?” Several weeks later, Jeanine gave the staff what sounded like an ultimatum, “she has to be told that she cannot go. If you people will not tell her, then I will” (Archives).

Eventually, however, as Linda persisted and refused to bargain or compromise, Jeanine began to ask a lot of questions about how she should prevent and handle potential problems if she did take Linda home for the summer. As Linda negotiated for her goal of going home for the summer, she became calmer and more sure of herself. Her mother, on
the other hand, shifted into the position of being very anxious and uncertain. Dr. Bowen commented, "even though there had been a shift from weak to strong in the patient and strong to weak in the mother, the staff felt that if something happened at home, the patient would be the one to be hospitalized" (Archives).

Over the summer, Linda did very well. She developed a social life in the new area and visited friends in other states. Jeanine began to calm down and feel more secure. When they returned in the Fall, they moved into an apartment together and continued with the treatment program at NIMH, on an outpatient basis. Linda held a job, was active in church and community functions and divided her time between her mother and her friends. Bowen commented, "the next move will be to suggest that if the patient is to achieve maximum progress, the mother will probably have to find some other person with whom she can share her life in order to free the patient of the responsibility of looking after mother" (Archives).

The contrast between Linda's behavior before and after taking a differentiating step is remarkable. On one occasion before her arrival at NIMH, Linda visited her family home for the first time in several years. She became quite upset in reaction to a visit from her sister and her sister's children. This triggered an agitated state that she could not shake and she entered another psychiatric hospital where she remained for a little over a year before joining the family research project at NIMH. After three years in the NIMH study, Linda and her mother had made great progress and eventually she and her mother had a good holiday visit with Sandra and her family involving a long drive each way (Archives).
In the O Family, it was John who worked on differentiating himself and pulling himself up to a higher functioning position. The following situation followed after about five months on the project and comprised what Bowen called “a turning point” in the family emotional process. John told Dr. Bowen that he had written down some complaints about the Head Nurse and wanted to discuss them before taking any action. Some possible courses of action that he considered included telling the nurse directly or taking it up in the family – staff meeting in the presence of all the families and the nurse. He also thought about simply considering it “entirely his own problem as to why he became so angry at her authoritative attitude” (Archives). Dr. Bowen indicated that he tried hard not to influence John in any direction. Eventually, John arranged an interview with the Head Nurse so he could tell her directly. He also discussed the issue in the group therapy meeting. Bowen considered this an important step in John’s “emancipation from his mother” (Archives).

According to Dr. Bowen, John had always functioned passively and compliantly in his relationships with his mother, his wife and most others, outside of his business relationships. Following the stand John took with the Head Nurse, he maintained a stronger functioning position than he had before. He could maintain his will despite his wife’s aggressive opposition. Apparently, Shelby became very anxious in response, with bouts of crying, screaming, and yelling. “Her head shook when she tried to talk” (Archives). It was the predictable response that Bowen later wrote about, or what Anthony (1988) might term, a “crescendo of awfulness.”

In the creative process there is often a buildup of tension so that the situation we are enduring seems to get out of control. In the course of self-development we develop an inner power and independence which creates envy in others,
particularly in those whose egos (fears) are firmly in control. This envy causes
them to test us to see if we can be driven off-balance, or if we can be driven away
from serenity to become doubtful and fearful. This effort succeeds if they can
arouse our fears, spur us to anger, or otherwise cause us to become disturbed by
their inferior behavior....If we maintain our inner independence, firmness, and
integrity, the testing will continue through a ‘crescendo of awfulness’—an almost
unendurable tension—then end. At this point the aggressors become repulsed by
their behavior, and they make an important forward step in correcting themselves”
(Anthony, 1988, p.120).

As the crescendo subsided, Mrs O transformed from her former aggressive and
dominating demeanor, to a kinder, firmer, more objective one. Before, she would be
ready to fight anyone who disagreed with her, since she always considered herself to be
in the right. Now, she was peaceful and self assured (Archives). As the O’s continued to
work on their conflicts, Shelby’s tension subsided and there was a noticeable shift in their
relationship. John functioned with strength. One evening, John and Shelby requested a
pass to go to dinner together, leaving Jane at the clinic. Jane reacted to the shift in her
parent’s relationship with an “exhuberant and happy mood” (Archives).

The couple eventually went on a two-week trip that had the characteristics of a
honeymoon. They were described as similar to teenagers in love, walking arm in arm.
Neither experienced any symptoms during this period. Mr O’s diagnosis was changed to
“normal control.” According to Bowen, “both were so much in love with each other that
neither seemed to have the time or energy to get over-involved with the psychotic
daughter” (Archives).

Before this remarkable shift, Shelby would instigate an emotional argument with
Jane until Jane became physically aggressive. Shelby would then call on John to restrain
Jane. After the shift, Shelby was able to handle Jane herself. Bowen indicated that this
dramatic change in the O Family “became the basis for a change in our thinking about
family problems” (Archives). He wrote about the “growth toward maturity” when families were able to resolve the emotional divorce between them:

In the families that were able to resolve the emotional divorce, and to grow toward maturity in family psychotherapy, there were observations that have far reaching implications for mental health, for new theories concerning normal emotional development, and for new principles concerning the rearing of children. When it was possible for the parents to resolve the emotional divorce, and the parents could be more emotionally invested in each other than either was invested in the patient, then the patient began automatically to grow toward maturity. When the parents would lapse back to the emotional divorce, and either parent became more invested in the patient than with the other parent, the patient would automatically become more psychotic. The parents had all spent years in reading and seeking advice about the proper way to raise and handle the child. No matter what they tried, whether it be acceptance, firm kindness, giving love and attention, permissiveness, no demands, realistic punishment, or whatever, the results were equally unsuccessful. When the emotional divorce was resolved in family psychotherapy, it made little difference which approach they used in dealing with the patient. All approaches were equally successful. (Archives).

John returned from his ‘honeymoon’ trip with Shelby in very good spirits and became more involved in both therapeutic and recreational activities at the clinic. He even took up one of his favorite hobbies. His relationship with Shelby was closer and he experienced no unusual mood swings (Archives).

There were nevertheless a number of ups and downs in the family during this time, but the fluctuations were more rapid, and it took less time to move from one position to another. Though there was some regression to prior behaviors and interactions, increased flexibility to return to better functioning was seen as progress. John maintained a state of good physical health during this period, outside of a little incident when he nearly sprained his ankle at an outdoor event. Within a few weeks after the incident, he received news of his father’s unexpected death and attended the funeral (Archives).
As the O parents worked on their relationship and family processes began to shift, the context began to change. Anxiety no longer traveled along the same pathways. Mr O’s depression lifted. Mrs O became more aware of her own anxiety and her tendency to project it out onto others. Leslie became more of a rebellious teenager and felt threatened by her proximity to the family at the Clinical Center. She gained weight, she had more physical ailments, and could not get settled into a school situation. In the meantime, Jane became a little more realistic (Archives). This is depicted on Figure 32.

Figure 32: O Family After Differentiating Move

During the earlier semester that Leslie lived with a family friend and attended school nearby, her father went on a business trip for over two weeks. Upon his return,
researchers noted that Mr O made great progress on his insight into the family’s issues. Staff agreed that he was handling his role in the family constructively and interacting effectively. By the end of that year, he and Shelby were able to evaluate each other’s capabilities on a more realistic level than in the past. Bowen noted “We have been pleased that a family as disorganized as this one has been able to pull together so quickly and to manifest so much family strength instead of so much family pathology” (Archives). He also remarked on their ability to live on the clinic with the door open, quite an accomplishment considering their behaviors in hospitals where the father and daughter had stayed prior to NIMH (Archives).

Shelby also altered her position with the family during this time. She moved closer to her husband and was more tolerant in her relationship with not only him, but also with her two daughters. Somehow, she had gained the ability to see her own role in the family more realistically and to lessen her tendency to dominate or feel helpless. She treated both daughters as more mature than she had previously. When she did get into relationship difficulties, she was able to get out of it more rapidly and with greater self awareness and insight (Archives).

A researcher noted that the family tendency has been for each member to discharge any personal anxiety by externalizing it onto other family members. In other words, each would work to change another rather than taking some responsibility for self and acknowledging personal anxiety and inner conflicts with some objectivity. Shelby started showing gains in this area, by working at learning to handle her own anxiety. Her tendency had been to become very anxious about being anxious. Her work on this was noticeable when she focused discussion in the group session on her own feelings of
unhappiness and of 'not belonging.' Normally her focus during group sessions would be on what to do about the behavior of her daughter or her husband (Archives).

Shelby began to examine her feelings and whether they were based on real or imagined circumstances. She decided to explore her sense of rejection in her relationships with her own parents and sisters. She made a visit to her family of origin around this time (Archives). When she returned to the Clinical Center after an absence, she recounted that she had been reflecting on her own needs and how they might be met. Again, this was a departure from her tendency to focus only on the needs of others. While she was at the Center because she felt her family needed her, she also sensed that she could not go on as usual. She was experiencing much 'free floating anxiety' which was motivating constructive self-reflection (Archives).

During the following month, Shelby’s anxiety continued to increase to the point where she developed a noticeable head and neck tic. She recalled that she had this tic as a child when she was under considerable tension. She also developed increased muscular tension that affected her movement in general. Shelby and John had been arguing a great deal, with Leslie on her mother’s side. This course of increasing tension culminated in her abrupt departure from the center, taking Leslie and her luggage with her. She had not made formal arrangements for the discharge (Archives).

Over the next few months, Shelby continued to exhibit a high level of stress, which was highest during John’s absence for a business trip and peaked just before he returned. John had a profitable and uneventful trip. However, the stress did not manifest to the extreme that it had a few months earlier. She also seemed to be more flexible in her relationships with family members, which was evidenced by her relating more to the
reality of the person than to a role that she would cast them in. She also spoke of her own needs with more conviction and less guilt (Archives).

In the N Family, the father, James, began to make a differentiating move shortly before the end of the time that he would be participating on the project. His move involved the family's participation in the family-staff therapy meetings. Not only did the parents disagree about how to handle Jeff, they also disagreed about what to discuss in therapy meetings. According to Dr. Bowen, Katherine was opposed to sharing family secrets and “worked to pledge others to keep the secrets.” James, on the other hand, believed that bringing the family problems into the open could help. Since he tended to give in to his wife, it took some time before he asserted his will to bring sensitive issues into the therapy meetings. At first he just “kept reminding the family that months were passing and they still avoided the family problem.” Near the end of the year that the father had agreed to try the project, there was considerable anxiety in the family. He decided to take more responsibility and become more active in helping with seeking solutions. “He said the family had a problem and he was going to do something about it” (Archives).

In response to Mr. N's active stance, relationships shifted. He became more active with his son while his wife withdrew. Jeff's behavior became more flexible so that “he could now swing from regression to a fairly good level in a few days.” He was no longer stuck at his “chronic fixed level of adjustment.” For example, he attempted to get a job. His compliance disappeared and he became more aggressive towards both parents. However, “his psychosis was directed at things the parents had done and for the first time there was a connection between their actions and his psychosis and it was harder for them.
to refer to his action as the aimless sickness of schizophrenia” (Archives). The parents then tried to suppress their son's symptoms and he once again returned to a continuous regressed state. This could be viewed as a more catatonic position with his mother feeding him. There was some subsiding of symptoms four months later. In the meantime, the father got an extension of his leave from work in order to stay for these additional four months (Archives).

Eventually, leaving the project became an area of underlying conflict for the parents. James wanted to leave and place Jeff in a state hospital. Katherine wanted to stay at NIMH and she opposed the idea of placing Jeff in a state hospital. Eventually they settled on a private institution. However, while she appreciated her husband's new assertiveness in the matter, she continued to want to stay and her actions belied that stand even though on the surface she seemed to go along with her husband. Bowen said he purposely did not take sides on the issue because he felt it would be beneficial for the family to try to resolve the issue between themselves. However, he commented that when the father spoke about his leaving the project at the end of the year, his reasoning was that the project would be ending. Bowen shared his own preference for "having the father say they were going because he said so and not because circumstances forced him” (Archives).

The differentiating move may heighten anxiety initially, but the result is a change in the family system context toward greater flexibility. This seems to coincide with a greater ability for youth to choose resilient responses or to make them automatically. Adversity in the traditional sense is not increased. The only thing introduced into the system is a change in how a member participates in the system. While it requires adjustment, it does not cause adversity that recycles or intensifies anxiety through the old pathways.

The beauty of the differentiating move is that anyone in the system or anyone relating to the system can make the move. For example, the staff at the family research project had to practice their own differentiating moves with the R family. In response to
the mother’s tendency to use the hospital or staff rules as an excuse for not allowing her daughter to come home for a visit, the clinical center staff clarified with the mother that as long as the mother understood the risks and was willing to assume the responsibility for her daughter, the hospital would not prohibit it. Most of the daughter’s visits home were uneventful and therapeutic. A couple of visits ended in Paula being picked up by the police. After the first incident, the mother told the clinic staff that she would not allow Paula home until she improved, but she could not tell Paula directly. She only said, “I want you when the doctors say you can come.” After the second incident, the clinic staff said they would only take responsibility for Paula if the mother would take the responsibility for telling Paula that she did not want her home (Archives).

Again within a few days Paula was nagging her mother about a visit home. At this point Mary Jo said that she had enough and she simply would not take her home. This seemed to be the one most therapeutic day of the entire hospitalization. This was the first time the mother had taken a firm stand on her own. Paula sobbed deeply for an hour or so but she did not act out or get panicky or scared and soon after she seemed to feel better than in a long time. The mother seemed proud of herself for taking the stand but her daughter’s tears were difficult for her. It was the research staff’s opinion that this may have been the first time in Paula’s life that her mother had taken a firm stand for which she was personally responsible (Archives).

Two days later, Paula again asked about going home and this time her mother skirted the issue. Mary Jo indicated the doctor said Paula was not ready to come home, thus her mother would not take her. Paula immediately flew into a destructive rage at the people and furniture around her. Bowen commented that Mary Jo could not see “her
wavering stand as the triggering mechanism.” Instead, Mary Jo believed it was her failure to comply with Paula’s demand that caused the upset. Bowen continued that when the mother was able to say no to Paula and be responsible for the decision, their relationship was calm. When she made the environment responsible for her decisions, then Paula acted out against the environment (Archives).

One more incident related to this issue came up, but in this case the doctor decided to take a stand. Paula wanted to go home and Mary Jo said she would decide after consulting with the doctor. The doctor only agreed to consult if they were both present. When the mother said, “now, honey, the doctor and I think...,” the doctor indicated that he was “uncomfortable when mother set it up for the two of them to think alike. Could they not work it so she could be responsible for her own thoughts and let the doctor be responsible for his” (Archives). This is a fascinating example of separating oneself from being pulled into the fusion between two people in an intense relationship.

*The impact of extreme distancing and cutoff on resilient responses.*

The need for staff to initiate differentiating moves becomes clear with the following behavior on the part of Mary Jo, which is a striking example of the impact of extreme distancing (cutoff) on the resilient responses of Paula. It is important to remember that extreme distancing is an avoidance strategy for managing anxiety and fusion within the relationship. Although I have discussed cutoff mainly as an element of family system context in terms of existing cutoff, it is also an extreme end of a distancing strategy within family emotional process. As mentioned in the fusion discussion in the section on family system context, the symbiosis between Mary Jo and Paula was so great
that it was accompanied by a great deal of ambivalence about the other. For this pair, the ambivalence would repeatedly lead to rejection that was hard for either to tolerate.

In this situation, Mary Jo did not have a convincing reason for being absent, nor did she make an attempt to maintain contact in any other way. For the entire month starting on Day 166 of their involvement in the project, Mary Jo did not visit the Clinical Center, saying it was because of the transit strike and partly for lack of money since her public assistance check had been delayed. However, she was able to visit Frank in another state by catching a ride with friends and she asked her social worker not to tell Paula that she did this. Specifically, she asked the social worker to tell Paula that she loved her very much but that she had no control over whether she could come or not.

Throughout the month, Paula made suggestions to her mother of various ways she could get to the Clinical Center despite the transit strike, including catching a ride with one of her friends who worked nearby (Archives).

The consequences of a lack of self differentiation and a lack of contact is apparent in the decline in Paula’s functioning during that same month. It was a difficult month for Paula who exhibited behavior such as choking the nurse, attacking the aid, and being hostile and unpleasant. She classified the nurses by who she liked best and least and spent time teasing them. She alternated between rejecting and needing their attention, being demanding, and otherwise wild. She could also be silly and playful, friendly and sullen. On the 186th day, she was in a good mood after sticking another bobby pin into her arm. She was skeptical about her mother’s messages about not being able to come and later she became angry at her mother for not coming or writing. She expressed some insecurity about the attention she got at NIMH being required rather than genuine. Paula spent most
of the month in a seclusion area with full-time special nursing attention. She was on a restricted program (Archives).

If I can suspend cause and effect thinking about the phenomenon that Paula spent the entire month that her mother did not visit in seclusion and on her worst behavior, then the reciprocal nature of these relationship moves come to the forefront. Cause and effect thinking would say that the mother stayed away because the daughter was unmanageable, or that the daughter became unmanageable because the mother stayed away. Systems thinking would become intrigued with the reciprocal nature of the phenomenon. Neither caused the other – they happened simultaneously. Ideally, mother and daughter could learn to change how they participated in the automatic tendencies of the system.

Bowen described the difficulties in treatment when the mother stayed away. “To get the kind of a result we were looking for with this patient, demands more participation on the part of the family, and the family has controlled the clinical situation by staying away.” He continued, “for a time we permitted the patient to go home any time the mother would take the responsibility for it by telling us so or by actually coming to the hospital for the patient, but again the mother controlled this by refusing to come” (Archives). Describing the period when the mother stayed away for over a month, Bowen wrote, “the mother relinquished any responsibility for the treatment program and ‘turned the patient over to us’ to get her better.” He added, “during most of this time the patient was acutely upset and mostly confined to a seclusion area and on a schedule of wet sheet packs or continuous tub baths” (Archives).

It should be remembered that the mother agreed to come to the hospital several hours a day, five days a week, to participate in the treatment program, so she obviously
relinquished her responsibility. But regardless, the impact of her lack of contact on Paula is notable and speaks to the need for contact with significant others, especially the mother. As soon as Paula could use the phone, she called her mother four times with no success, including a friend of her mother's in case she might not answer. Differentiating moves and bridging cutoff.

Another important aspect of the differentiating move involves being a self while in contact with significant others (as opposed to having to run away or stay away to be a self). Several more differentiating moves led to more resilient responses in Paula. One was the result of a move on the part of the research staff. After the month that Mary Jo did not visit at all and Paula spent most of it in seclusion, the clinic staff made the decision to allow patients to use the telephone to stay in touch with family. Staying in touch is a necessary ingredient for differentiating a self within important relationships. In this case, Bowen wrote,

We decided to... permit this patient and all other patients to use ward telephones for local outside calls. This came much closer to our old principle of permitting patients and mothers to communicate with one another and certainly it took away from this mother the control she had over the patient's communications with her. Following this change... the patient began making many calls to the mother and bringing up issues with the mother that would otherwise have been left untouched (Archives).

Under the new policy, Paula was able to call her mother as often as she wished and she announced proudly to her mother's social worker that she would no longer need her to relay messages for her. Four days later she moved back into her old room and out of the seclusion area where she had spent the last month. After the change in telephone policy, Bowen wrote, “in looking back over this one wonders why we had missed this area so long,” adding that in this month Paula had been separated from her mother for a
long time and most of her tension was generated from thoughts about her mother (Archives).

As soon as Paula could use the phone she called her mother four times with no success and became sullen. She then resorted to calling a friend of her mother’s in case she might be there. The next day she spoke with her mother for 20 minutes. The following day she received a letter from her mother with some money. As a result of Paula’s telephone contact, her mother agreed to come for a weekend visit with the two younger boys on the 202nd and 203rd day. During the weekend, Paula “pulled her self up to an excellent operating level.” She acted as the “responsible mother-figure” while Mary Jo and the boys acted “helpless.” Bowen wrote, “it is rather amazing to see this patient as probably the most mature member of this family” (Bowen Center Archives, 1954-1959). All enjoyed the visit a great deal, however, Paula asked her mother for five dollars and Mary Jo promised her ten dollars a month which was unrealistic for her means (Archives).

Mary Jo had difficulty making realistic decisions about money when she was feeling close to Paula. For instance, Paula sent her mother a birthday card and prepared a birthday celebration for her mother at the Clinic. After the birthday celebration, Mary Jo made a decision to use twenty-five dollars of her public assistance to buy Paula clothing. The next day she was depressed that she would not be able to pay bills because of this decision (Archives). When the cutoff was bridged, the mother’s difficulties came to the forefront.

In summary, differentiating moves in the L Family, the O Family, the N Family, and the R Family, shifted the processes that managed anxiety. They altered the
relationship environment. Resilient responses became more accessible to the child who normally absorbed the family anxiety. Other family members found themselves facing more anxiety and the need to adjust.

In this section, three versions of a resilient response have been discussed. First, examples were given of resilient responses as an outgrowth of family emotional processes that allow a sibling to function freer of the family anxiety. Then the fluctuation between resilient and non-resilient responses with a tendency toward the latter was illustrated by the youth in each family who were recipients of the family projection process. Third, another type of resilient response, the differentiating move, was illuminated through case study examples. In some cases older youth who were susceptible to greater fluctuation in resilient responses initiated the move with promising results.

Both Nancy S and Linda L were able to separate from the family fusion to some extent and to live a more productive life. In other cases, parents initiated the move with positive results for their own resiliency as well as greater flexibility in their children. John and Shelby O’s efforts at managing their own anxiety and John’s effort to function for himself eventually brought their marriage closer and improved Jane’s functioning. In the meantime, Leslie’s functioning became more like a difficult teenager. It is hard to know if she had become an object of the family projection process when her mother decided to take her back home to live, or whether the fluctuation in her functioning was just a temporary setback as the family became more flexible.

James N initiated a differentiating move with some limited results but would have needed to persevere for a longer time than he did for lasting change. However, the results
he got with a short term effort were worth noting. Mary Jo also initiated a differentiating move with some striking results and in her case, the mere establishment of regular viable contact between her and Paula improved Paula’s resilient responses markedly.

This concludes the Findings section and the discussion of each component of the resilient response model. We have explored how a continuum of adversity raised anxiety in a family that then filtered through the family system context. Family members, within their family system contexts, engaged in various family emotional processes to manage that anxiety. As an outcome of these processes, youth who were freer of the family anxiety tended to gravitate toward resilient responses while those who were receptors for family anxiety through the family projection process tended to exhibit more non-resilient responses, and more fluctuation between resilient and non-resilient responses. The differentiating move, another type of resilient response, raised anxiety at first but did not add to the adversity. Family members who became more aware of the family system and who consciously altered their part in the processes eventually helped their families move out of a non-resilient response cycle to a more resilient one.
In this chapter, the entire model will be illustrated using two family case studies. Limitations of the study will be reviewed.

This chapter begins with an illustration of the entire resilient response model using two families. A family may cycle through this model from adversity to resilient response or non-resilient response over and over again. If the family processes become more intense and the family context in which anxiety travels becomes more restrictive, then it is likely that more non-resilient responses will result. The following narratives will
show the evolution of a family from adversity to resilient response, over several generations. The first case follows the S Family from persecution in the great grandparent generation through to the increasingly non-resilient functioning in the grandparent, parent, and daughter generations. This will be followed by the daughter’s use of a differentiating move to change her part in the family system, leading toward her ability to choose more resilient responses.

Figure 34: Multigenerational Diagram of The S Family

From Adversity to Resilient Response Over Five Generations in the S Family

The S Family story illustrates how the process depicted in the resilient response model unfolds in a family over several generations. Charted timelines located throughout
this story give the dates and details of the family’s history in the first two columns, and name the related components of the resilient response model in the third column. When it is a contextual or process component, the specific type is listed, such as sibling position or conflict. Most of the time, anxiety is not listed, but it is considered present. Several family diagrams throughout the narrative show the dynamics operating in the family at various points in time.

The S Family experienced a progression of adversities or challenges that created anxiety to be managed. Taking a multigenerational view, the first known external adversity was a real threat of persecution in Liza’s grandparent generation. The paternal grandparent family’s response to this was to emigrate to the United States as an intact family unit. The grandfather set up a successful business in the new location. In this case the response was resilient. To emigrate and escape persecution was adaptive because it promoted survival, protected the family from harm, and remained alert to changes in the external environment. In this case the response was a flight response that was indicated. It did involve some choice in terms of deciding to move and deciding where to move.

On the maternal grandparent side, some family members dispersed to other countries while others remained behind and were killed (Archives). In this family the response was not always resilient. In addition to the great loss of those who died, the remaining family members emigrated to widely scattered places. Liza considered the maternal grandparent’s family “wiped out” from her memory. This family dispersed, and Liza’s mother left the family, without maintaining contact with significant others (Archives).
<table>
<thead>
<tr>
<th>DATE</th>
<th>HISTORICAL FAMILY EVENT</th>
<th>RELATION TO RESILIENT RESPONSE MODEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1865</td>
<td>Nancy’s great grandparents on her mother’s paternal side married.</td>
<td>Nodal Family Event</td>
</tr>
<tr>
<td>1866</td>
<td>Nancy’s maternal grandfather born – oldest of 18 children. He was the only child to pursue an academic career, which his mother valued. His mother “loved the ground he walked on.” All were proud of him.</td>
<td>Nodal Family Event Sibling Position Resilient Response</td>
</tr>
<tr>
<td>1870</td>
<td>In reaction to threat of persecution, Nancy’s great grandparents on her mother’s paternal side emigrated to US as an intact unit with their children.</td>
<td>External Adversity Resilient Response</td>
</tr>
<tr>
<td>1871</td>
<td>Nancy’s maternal grandmother born – oldest daughter of 10 children, later to become a blended family of 18</td>
<td>Nodal Family Event Sibling Position</td>
</tr>
<tr>
<td>1870’s</td>
<td>Nancy’s great grandparents on her mother’s maternal side had mixed reactions to the threat of persecution. Some stayed behind and were killed. Family property seized by persecutors. Others split up and emigrated to widely separated places. Family was “wiped out” as a continuing unit.</td>
<td>External Adversity Anxiety Non-Resilient Response Family Adversity Cutoff</td>
</tr>
<tr>
<td>1881</td>
<td>Nancy’s great grandfather on her mother’s maternal side died when grandmother age 10. Grandmother became “second mother” to the younger children.</td>
<td>Family Adversity Sibling Position Reciprocity</td>
</tr>
<tr>
<td>1882</td>
<td>Nancy’s great grandmother on her mother’s maternal side remarried a man with eight children. All the children thought highly of her.</td>
<td>Resilient Response</td>
</tr>
</tbody>
</table>

Figure 35: S Family Timeline: First Generation

This loss of contact with the family of origin is worth noting. Baker & Gippenreiter (1996) studied families who had lost grandparents in Stalin’s purge. The grandchildren in families who made an effort to bridge cutoff with those lost functioned better than grandchildren in families who maintained the cutoff. In this case, bridging cutoff meant seeking out facts about the grandparents and keeping the memory of them alive.

Liza heard about her maternal ancestors only through her mother, who grieved the loss of her family for the rest of her life (Archives). In this sense, the way the emigration
happened for the maternal family, the deaths that resulted for those that did not emigrate, and the grief that lasted a lifetime, did not resolve problems, but created new ones. It would seem that for Liza’s mother, the anxiety created by the threat, the move, and the loss, stayed elevated after the threat and its aftermath subsided. This would be an indicator of chronic anxiety. I would speculate that Liza’s mother not only grieved, but felt helpless about the political events that impacted her family so drastically.

Liza’s father and mother were both the oldest children in their respective families of 18 children each. Her maternal grandfather died suddenly after ten of the children were born, and the grandmother remarried a man with eight children. Apparently the grandmother was highly revered by the children in both families (Archives). This could have meant that she used her power in healthy ways. Her choice to remarry to help herself and her family seemed adaptive and flexible as well. As the oldest daughter, Liza’s mother played a key role in the family farm and with raising the other children (Archives). In many ways this seems like normal development of an oldest child, all things being equal. Something about the description of her mother as “always adequate and always giving” belies a possible inflexibility in functional position. Did this possible inflexibility play any role in her decision to emigrate to America when she met Liza’s father on one of his trips overseas? Was it easier to leave in order to start a new way of relating to others?
<table>
<thead>
<tr>
<th>DATE</th>
<th>HISTORICAL FAMILY EVENT</th>
<th>RELATION TO RESILIENT RESPONSE MODEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Late 1880's</td>
<td>Nancy’s maternal grandfather married and brought wife back to US from overseas.</td>
<td>Nodal Family Event</td>
</tr>
<tr>
<td>1890’s</td>
<td>Nancy’s maternal grandparents lived near great grandparents. Grandfather worked in great grandfather’s factory. First four children born. Two of these were daughters who died in infancy. Grandmother grieved the loss of her infants and her family who were killed. She began to change from being robust, adequate, and healthy, to being sick, complaining, and sharp tongued.</td>
<td>Nodal Family Events, Family Adversities, Non-Resilient Response</td>
</tr>
<tr>
<td>Late 1890’s</td>
<td>Nancy’s maternal great grandfather on father’s side died. Family sold factory.</td>
<td>Family Adversity</td>
</tr>
<tr>
<td>1900</td>
<td>Nancy’s maternal grandparents moved to another US State. Oldest two children rebelled against schooling, perhaps in response to greater pressure from father, who valued and pursued academic life.</td>
<td>Cutoff, Sibling Position</td>
</tr>
<tr>
<td>1902</td>
<td>Nancy’s mother, Liza, born – first child born in new location</td>
<td>Coincidence of Birth Date with Nodal Family Event</td>
</tr>
<tr>
<td>1903</td>
<td>Nancy’s mother’s younger brother born</td>
<td>Nodal Family Event</td>
</tr>
<tr>
<td>1910</td>
<td>Nancy’s maternal great grandmother died</td>
<td>Nodal Family Event</td>
</tr>
</tbody>
</table>

Figure 36: S Family Timeline: Second Generation

Liza’s father, the oldest of his siblings, internalized his mother’s love for academic achievement at an early age. He was trained as a religious leader but worked in his father’s factory for ten years after his training ended. The researchers on the NIMH project speculated about possible fusion in his relationship with his mother, since he was the oldest son and appeared to have the closest relationship with her. He also made the greatest break with the family by moving to another state and through his choice of profession, which may have been a way that he managed that fusion. When he moved, he seemed to separate himself from the family. The researchers questioned whether Liza’s mother changed in relation to her husband at the time of the move (Archives). Perhaps his move away from the family, which hints at a cutoff, increased her depression. Her
depression could be seen as a non-resilient response to the cutoff and its impact on the
family, which exacerbated the cutoff in her own family of origin.

How would this have worked? If the husband was extremely distant from his own
family, he may have invested himself more into his work. The few family relationships
he kept in contact with may have become more important to him. As a consequence, he
may have become more sensitive to upsetting anyone in his nuclear family. This may
have contributed to his inability to say no to his wife. He may have also distanced himself
emotionally from her in order to keep from upsetting himself. His inability to say no hints
at the possibility of his own fixed ideas about others and how they would react. In a
sense, the inability to say no is a mild automatic flight response to an imagined threat.

Also, if he was less available, his wife may have turned to her children for greater
support. In this case, she turned to Liza as she herself became sicker and more depressed.
Also, if she was grieving continuously, without a way to manage her own feelings, her
need for consolation may have become too much for the couple to manage. Certainly her
increasing reliance on others indicated an overlap of functioning that was non-adaptive. If
she held herself (with thoughts and behavior) in an inadequate functioning position and
her daughter and husband in an overadequate functioning position, there were elements
of inflexibility in the relationship system. Her sense of helplessness and consequent lack
of choice certainly feels palpable today. This would have been a reciprocal process in
which all three participated.
DATE | HISTORICAL FAMILY EVENT | RELATION TO RESILIENT RESPONSE MODEL
---|---|---
1910 - 1918 | Liza’s oldest sister married and lived outside of the home. Rebelled against academic pressure from father. Grandmother had increasing physical symptoms, complained more, and was caustic and critical of those around her. Father became more gentle, kind, and attentive. He could not say no to his wife or children. Liza began to care for her mother and for the home. Her younger brother was sickly and tended to get every illness going around. | Context of Cutoff Reciprocity Non-Resilient Responses
1918 | Liza’s youngest brother died of influenza at age 15 | Family Adversity
1918 - 1924 | Liza’s oldest sister now had her own children. Liza’s older brother went to work outside the home. Liza was the only child to finish high school. Liza and her parents lived at home. Mother developed diabetes that intensified after youngest son’s death. Mother rapidly regressed and Liza assumed total responsibility for the home and her mother’s care. She was the ‘moral strength for all.’ Liza was most favored one in family during this time. | Reciprocity Sibling Position Non-Resilient Response Family Projection Process

Figure 37: Impact of Cutoff on Family Process and Non-Resilient Responses

By the time Liza’s parents settled in the new state, they were considered different people than they were when the older children were young. The two children born in the new state “were much more involved in parental obligations and attachments” and the youngest son may have been most involved (Archives). Bowen speculated that the youngest son’s early death may have been a reaction to that emotional responsibility. He wrote, “this death has more a tone of purposeful abdication, as is seen in suicide, rather than an act of fate” (Archives). Here the emotional process of moving away from family to a new state also became a challenge. In this sense, the birth dates of Liza and her brother coincided with a nodal family event, which was the move away from extended family toward a more insular existence. Existing relationships in the nuclear family
became more heavily relied on without the larger family network available. The increased pressure on the remaining children that accompanied these family processes may have resulted in a more extreme non-resilient response in the brother.

When Liza’s youngest brother died of influenza at the age of 15, her mother had a very difficult time from which she never recuperated. She had already developed diabetes, which worsened when the youngest son died. According to Liza, her mother changed from her former robust and healthy self to a “sick, aching, complaining, and sharp-tongued” woman (Archives). Here it seems that her mother, already worn down by losses in her family of origin and two infant deaths of her own, was extremely devastated by her youngest son’s death. The context of her family system included a loss of contact with many members of her family of origin as well as deaths of those family members. Having immigrated, she was more isolated from her own family of origin and more reliant on her immediate nuclear family in which to manage anxiety.

As Liza’s mother’s anxiety increased, her physical symptom of diabetes intensified. It would seem that her particular family system context mixed with the family processes that were allowing her to become more dependent on her daughter, contributed to the environment that allowed her symptoms to worsen. This emotional environment could have been a contributing factor in her disease process. In an article about emotional factors in physical illness, Kerr (1980) proposes a background process that is transmitted through generations of a family and that play a role in the onset and course of diseases such as diabetes.

If we look at the worsening of Liza’s mother’s diabetes as a non-resilient response, it added to the challenges that she needed to manage and eventually that her
family had to handle. It certainly added to the stress that was experienced by all. She became sharp-tongued which would appear to mean that she blamed others and projected her ill feelings outward. Her behavior became an added stress on the other family members who managed their own anxiety by catering to her needs. The father pampered his wife and became even more “kind, gentle, and attentive.” Liza became her mother’s caretaker and took over responsibility for the home (Archives). All of these actions and interactions were the ways that the family members functioned and tried to help each other. However, it is obvious that people were suffering.

<table>
<thead>
<tr>
<th>DATE</th>
<th>HISTORICAL FAMILY EVENT</th>
<th>RELATION TO RESILIENT RESPONSE MODEL</th>
</tr>
</thead>
</table>
| 1924 | Nancy’s maternal grandmother died — age 53  
      Liza and her older brother began to fight openly  
      Liza’s brother began to call Liza ‘crazy.’  
      Liza was uncomfortable at home and she got a job outside the home.  
      Nancy’s maternal grandfather died several months later of a sudden illness after never having been sick his entire life — age 59 | Family Adversity  
Anxiety Increased  
Conflict  
Projection Process  
Resilient Response  
Non-Resilient Response |
| 1924 | Liza and her older brother sold the house and settled the estate. They were in constant conflict.  
Liza’s brother called Liza ‘crazy’ more frequently.  
Liza lived with her sister temporarily and her brother moved out and got married.  
Liza dated but did not feel committed to any relationships. | Conflict  
Projection Process |
| Late 1920’s | Liza traveled to find her parents’ relatives. She worked and saved money. Liza invested money on advice from her brother. | Resilient Response |
| 1929—1931 | Liza lost all her money in the stock market crash.  
Liza was in two serious relationships, one of which almost led to marriage. She returned to her home state ‘completely broke’ and became panicky. | Adversity  
Anxiety Increased  
Non-Resilient Response |

Figure 38: Decline in Number of S Family Members Living

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When Liza was in her early 20's, her mother died and she felt a part of her died too (Archives). After devoting herself to her mother's care most of her teenage years, it is not surprising that her mother's death was a great loss. The sense that a part of her died too also speaks to the fusion in their relationship. At this point, she and her older brother began to fight openly. This could have been partially a function of decreasing tolerance for differences when anxiety is up. It was an interesting development in the relationship process within the family. Anxiety in the family was undoubtedly heightened after the death and it found expression in conflict between Liza and her brother. Why not Liza and her father? Why not her brother and her father? Somehow the mother's presence may have served as a buffer between Liza and her brother. Perhaps the father occupied a position on the outside of the family triangle? If he could not say no to his wife or children, he obviously avoided conflict.

Liza started working outside of the home. Several months later, her father died suddenly of an acute kidney disease (Archives). It is interesting that he died within months of his wife's death. How much of this was a result of the family emotional process? After her father's death, Liza felt "dead" too (Archives). Again, another adversity added to a succession of adversities in the family. Anxiety must have increased, with little time to recuperate from the last death, or to work out new relationships with existing family members. Despite constant conflict, Liza and her brother sold the house to settle the parent's estate. She moved in with her older sister but did not like it there. She worked several jobs and dated frequently but did not feel committed to the relationships, even though they often ended in marriage proposals. Her brother did not
approve of most of her relationships, which was an interesting dynamic in itself (Archives). What role did her brother play in the family triangle?

Eventually, Liza traveled to find her parents’ relatives. She lived in another state for a few years, working and saving a considerable sum of money. Bowen saw Liza’s travels after her parents died as her attempt to become more autonomous and mature (Archives). She invested the money she saved in the stock market on the advice of her brother. Unfortunately, she lost this money after the stock market crash in the late 1920’s. She almost married but left for her home state completely broke and panicky.

<table>
<thead>
<tr>
<th>DATE</th>
<th>HISTORICAL FAMILY EVENT</th>
<th>RELATION TO RESILIENT RESPONSE MODEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1898</td>
<td>Nancy’s father, Robert, born the second child of a wealthy family. He was closest to his mother.</td>
<td>Sibling Position</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fusion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Child Projection Process</td>
</tr>
<tr>
<td>1921</td>
<td>Nancy’s paternal grandmother died when her father, Robert, was 21 years old. The grandmother left money with a judge to ‘take care of little Robert. Never let him down.’</td>
<td>Family Adversity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Child Projection Process</td>
</tr>
<tr>
<td>1932</td>
<td>Liza decided to return to the state she had been living and working in</td>
<td>Resilient Response</td>
</tr>
<tr>
<td>1932</td>
<td>Before leaving, Liza met Robert and after two weeks she married him in the same month that her mother had died eight years earlier. Robert’s father had died just before the marriage. Liza considered this “the flightiest of all [her] flighty decisions.’ Liza’s brother called her crazy more frequently. Her siblings did not approve of the marriage and stopped communicating with her.</td>
<td>Nodal Family Events</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fusion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-Resilient Response</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Anxiety</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cutoff</td>
</tr>
<tr>
<td>1932-1934</td>
<td>After the wedding, Liza found out that Robert did not have a job. Liza went to work and provided for him. They began fighting immediately. He worked occasionally and held short term jobs.</td>
<td>Reciprocity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Conflict</td>
</tr>
</tbody>
</table>

Figure 39: S Family Timeline: Third Generation
In a more composed state, Liza decided to return to the other state where she had been working successfully. Just before leaving she met Robert, and after two short weeks, agreed to marry him. Unfortunately, she speaks of this as an impulsive decision and the marriage as her "downfall." She married him in the same month as her mother’s death eight years earlier (Archives). Her husband, Robert, came from a wealthy family with some royalty in their background, but he had not finished school and could not hold a job for long. He was the second of five children and was considered the one closest to his mother and the most immature. He was her favorite child while his father was said to have hated him. He had an older sister and three younger brothers. His mother died when he was 21 and left money to take care of him. He waited until his father died before he got married. He actually married Liza the same year (Archives).

Liza indicated that her siblings had essentially dissociated themselves from her since she married Robert (Archives). Here is an example of non-resilient responses on both Liza’s part and her siblings’ part. Liza was unaware of Robert’s status as a wage earner and her marriage to him created new problems in her life. She acted on potentially maladaptive impulses without awareness of the facts of the situation. She did not even give herself time to learn the facts. My guess is that their relationship was quickly intense, replicating the fusion each had with their mothers.

Her siblings, in a non-resilient response, held onto their fixed ideas about Robert, calling him a “no good bum” (Archives). They did not entertain any ideas that lessened their fixed ideas about him and they did not allow him to move out of the rigid position as the problem. They probably would not have been so disapproving of him if they were not also protective of their sister. Were they too afraid of her being influenced
negatively, as Liza would later come to fear about Nancy? This would have been an outgrowth of fusion. Immediately after their father died, Liza’s brother began to call her ‘crazy’ when they fought. After she married Robert, her brother labeled her “crazy” even more often (Archives).

Unfortunately, the family anxiety recycled and intensified itself in hostility. It appears that the relationship postures crystallized in a triangle with Liza (and Robert) on the outside of the triangle and her two siblings on the inside. Liza found herself “in a state of almost total hostile ex-communication from her sister and brother since the marriage” (Archives). It is important to note that while Robert also did not communicate with Liza’s siblings, he was in touch with his own siblings. Hence he had a slightly more open family network in which to manage anxiety. Liza, on the other hand, did not have other viable relationships within which to resolve it.

So, the father’s death, which could be considered a non-resilient response as well as an adversity for the other family members, created new anxiety. Without his presence, as well as the mother’s, the context of the family system was altered in terms of people in the parental generation who were living and in viable emotional contact with the next generation. Their absence, though, may not have altered the basic processes that undergirded some of the repeated incidents of early deaths in the family. Nevertheless, the remaining family members, Liza, her brother, and her sister, had to manage that anxiety. Without an extended family to go to for support, the tension seems to have become too much to handle. In addition, the increased fusion in this family contributed to the difficulties.
Eventually, the siblings dealt with the high anxiety and fusion by ending communication with each other. This non-resilient response added to Liza’s emotional isolation. This became a new adversity that would have intensified her anxiety yet further. Here we see how the S family cycled through the figure eight process over and over again in the direction of a non-resilient response that created new adversity. As her family emotional processes became more rigidly entrenched in non-communication, the family system became more cutoff and more rigid. Any relationship she did have became more intense an object of focus and fulfillment of attachment needs. It is no wonder that when she started dating after her father died, no relationship succeeded until she met Robert, and perhaps the reason that one succeeded was due to fusion. In an unsigned reflection about this family, Bowen characterized this transfer of fusion:

Liza married an infant that she smothered and supported until she had a child very much as she had cared for her own mother. It was as if she cast off this “husband baby” when she had her own baby and as if she then set out to raise Nancy until Nancy could take over and support her (Archives).

Figure 40 shows the family dynamics in the time of Liza and Robert living.

The jagged lines indicate conflict and the double lines indicate fusion. Both exist internally between Liza and Robert, and between Liza and her siblings. This gave rise to a pattern where both were the focus of the family attention process, indicated by the lines to and from their parents.

However, the intensity of the conflict would likely make the relationship difficult to maintain. Certainly Robert was in no position to take for all of Liza’s needs, and they managed their relationship with a great deal of distance from each other. When she found out that Robert did not have a job or money, she went to work and became the provider.
Figure 40 shows the family dynamics at the time of Liza and Robert’s wedding. The jagged lines indicate conflict and the double lines indicate fusion. Both were intense between Liza and Robert, and between Liza and her siblings. This grew out of a context where both were the focus of the family projection process, indicated by the lines to and from their parents.

However, the intensity of the fusion would likely make the relationship difficult to maintain. Certainly Robert was in no position to care for all of Liza’s needs, and they managed their relationship with a great deal of distance from each other. When she found out that Robert did not have a job or money, she went to work and became the provider.
He worked occasionally and when, after two years, she became pregnant with their first child, he held a job for a little longer in response to pressure from her. Unfortunately, the child who was a girl, died in infancy. After this event, Liza changed from her healthy, robust state and tended to become sick more often. Another girl was born dead two years later. Robert was not emotionally available during either of these tragedies. Liza dated a variety of illnesses to the birth of her second child. These included “arthritis, repeated gall bladder attacks, diabetes, dental problems, visual complaints, and an endless variety of lesser disabilities” (Archives).

Here again are examples of the underlying processes behind less resilient responses. Liza played the role of the overadequate provider while her husband underfunctioned. Pregnancy and birth are two of the more stressful life events that couples undergo. Hence anxiety must have been higher between Liza and Robert. She managed this with pressure on him to help more and he managed it by being less available and more distant. At times she pressured him to get a better job and bring in more wages but he was only able to sustain this request briefly (Archives).

She was operating out of a family context where her automatic emotional process would be to overfunction. He was operating out of a family context where his automatic emotional process would be to underfunction in the reciprocity. His mother left money for him to be taken care of for the rest of his life. He was already fixed in a rigid position by his mother who did not see him as capable of caring for himself. Each of their automatic tendencies to over and underfunction probably led to their reciprocal dissatisfaction and heightened anxiety about the success of the relationship. She could not
maintain that level of overadequate functioning physically as she developed more and more ailments.

<table>
<thead>
<tr>
<th>DATE</th>
<th>HISTORICAL FAMILY EVENT</th>
<th>RELATION TO RESILIENT RESPONSE MODEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1934</td>
<td>First child born, died in infancy.</td>
<td>Family Adversity</td>
</tr>
<tr>
<td>1936</td>
<td>Second child born dead of a heart malformity. Liza’s former robust health declined. Robert distanced during this time</td>
<td>Family Adversity Non-Resilient Response Distance</td>
</tr>
<tr>
<td>1937</td>
<td>Nancy, the third child, was born. Liza and Robert separated for first time.</td>
<td>Nodal Family Event. Conflict Distance</td>
</tr>
<tr>
<td>Late 1930’s</td>
<td>Liza was diagnosed with diabetes</td>
<td>Non-Resilient Response</td>
</tr>
<tr>
<td>Early 1940’s</td>
<td>Robert tried to convince state institution that Liza was crazy and should be hospitalized Liza tried to convince them that he was the crazy one. Robert forced Liza into a state institution and then signed her out a few days later against advice. Liza continued to provide for the three of them.</td>
<td>Triangle involves social institution Projection Process Fusion Reciprocity</td>
</tr>
<tr>
<td>1949</td>
<td>Liza initiated and obtained a divorce. She continued to support Nancy and herself for a year.</td>
<td>Distance Cutoff Reciprocity</td>
</tr>
<tr>
<td>1950</td>
<td>Liza decided to go on welfare so she could educate Nancy and be a homemaker. Her net after expenses while working was less than welfare.</td>
<td>Reciprocity with a social institution Non-Resilient Response in terms of independence</td>
</tr>
<tr>
<td>1950-1954</td>
<td>Liza was in constant hostile arguments with landlords, welfare agency, and other benefactors. She would get into intense paranoid fights in each new apartment until she was asked to leave. She regressed to a point where she exhibited vulgar behavior.</td>
<td>Conflict Non-Resilient Response Reciprocity</td>
</tr>
<tr>
<td>Early 1950’s</td>
<td>Nancy was diagnosed with schizophrenia</td>
<td>Family Projection Process Non-Resilient Response</td>
</tr>
<tr>
<td>1954</td>
<td>As Liza regressed, Nancy would become more helpless than her mother. She would mirror her mother’s disorganized thoughts. On her own, she was more lucid.</td>
<td>Family Projection Process</td>
</tr>
<tr>
<td>1954-1957</td>
<td>Liza and Nancy joined the NIMH family research project on the urging of the welfare agency. They participated for three years. The researchers at NIMH considered Liza to be the psychotic one of the two.</td>
<td>Resilient Response</td>
</tr>
</tbody>
</table>

Figure 41: S Family Timeline: Fourth Generation

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Essentially, their marriage was turbulent from the beginning, but it was not until five years into the marriage, when Nancy was born, that they separated for the first time. It would seem that the new relationship with Nancy made it possible for them to separate. Perhaps Nancy provided a new receptor for anxiety and a host for fusion. Periodic separations continued where Robert stayed away for days, weeks, or months, but always came back. Liza continued to be the provider. Robert often arrived in time to babysit for Nancy while Liza worked and then left immediately after (Archives).

![Diagram of nuclear family emotional process](image)

Figure 42: Nuclear Family Emotional Process at Time of Nancy’s Birth

Liza and Robert managed their relationship with each other through distance and each was available to focus on Nancy. This set the stage early for Nancy to be the focus
of the projection process and to gravitate toward non-resilient responses. Anxiety must have been high at times. Several times, Robert tried to have Liza committed to a mental institution for being “crazy” and she would try to convince the authorities that he was the crazy one. Once, he managed to have her admitted for a day and then signed her out against advice (Archives). This high level of anxiety probably continued until they finally chose divorce as a way to manage the anxiety. Most likely, the more she demanded of him, the more he distanced until she gave up on him. After 17 years of marriage, Liza initiated a divorce (Archives).

The divorce seemed to represent an emotional process of distance that had been a mode of operation between the couple since early in the relationship. Distance and intense closeness can be two sides of the same coin that is fusion. Both are ways of managing the anxiety that accompanies it. The divorce, since it was chosen, had an element of a resilient response to it, so it may have been a relief to Liza on some levels. However, it may have been a short term solution that did not really resolve anxiety, but instead came with new challenges. In this sense, it had elements of a non-resilient response. Now Liza’s family context was yet smaller as far as actual relatives with whom she communicated and on whom she could rely for support. Her tendencies to overfunction, to distance from her husband, and to focus on her daughter, represented her part in the predominant family emotional processes in play at that time.

It appears that she continued to work and support Nancy until a year later when the divorce was finalized. At that time, she went on welfare because she believed she would have more time at home to educate, sew, and provide for Nancy. Following this decision, “she was in constant hostile argument with welfare people and landlords.” Thus
began a pattern of being thrown out of apartments with the welfare agency taking the responsibility for finding her a new place to stay. Regarding Liza’s relationship to the welfare agency, “the pattern was one of complete helplessness with great anger and hostility directed to the agency for things the agency did not do.” She would “call influential people in the community to complain about the agency.” According to the researcher, “hospitalization [at NIMH] represented a kind of expulsion by the welfare agency” (Archives). The inability to keep an apartment hints at a non-resilient response that would be one outcome of the family emotional processes just discussed.

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Figure 43: S Family at Time of Entry into NIMH Study

The following observation shows that as treatment progressed, Nancy and her mother were less fused in their relationship and less fused in their thinking. Dr. Brodsky, Nancy and her mother were less fused in their relationship and less fused in their thinking. Dr. Brodsky, Nancy and her mother were less fused in their relationship and less fused in their thinking.
Five years after the divorce, Liza, and her daughter, Nancy, joined the NIMH research project. At this point, they were both exhibiting a pattern of non-resilient responses and their relationship was seen as tightly fused. Early in the treatment, Liza and her daughter operated on “an extremely primitive level” without consideration for anyone around them. They were described as wanting “everything they can see and all kinds of things they can think of and both of them are righteously indignant and mortally offended if their wishes are not immediately gratified” (Archives). Treatment was focused on helping the mother and daughter separate themselves from the fusion that existed in their relationship and the fusion that made it hard to think clearly or realistically about issues that arose. The coaching toward greater differentiation of self that they received was as follows:

Our general management around this problem has been to offer as much support as possible to both the mother and the daughter. We have tried not to encourage the daughter in her attempts to go away from the mother, but instead we have attempted to support each and to watch the evolution of the process. With all of this there has been a growing objectivity in both of them. The mother can be a great deal more calm and objective in her verbalizations and there has been a shift in the way she has handled anxiety (Archives).

In the beginning of treatment, the NIMH staff often had to differentiate themselves in their interactions with the S Family. For example, Liza related to the environment as a completely helpless and deprived person and expected others to give to her. Each time the hospital staff took a firm stand about the extent that they would give in to Liza’s unrealistic demands, she would first berate the hospital staff but then would handle issues with greater capacity and independence.

The following observation shows that as treatment progressed, Nancy and her mother were less fused in their relationship and less fused in their thinking. Dr. Brodey,
one of the psychiatrists on the project, noted that Nancy had increased her awareness of her ability to deal with external reality. This could be seen as a resilient response. As treatment continued, the mother placed less emphasis on a deformity her daughter had which the daughter was not eager to have operated on anyway. It also became less noticeable as time went on. Nancy also improved her ability to take a stand of her own and hold to it in a constant way. Prior to that her stands would take the form of joining with her mother’s stands or merely opposing them. These are indications that Nancy was also practicing differentiating moves toward greater resiliency.

During this time, Nancy began developing relationships with people that her mother did not already have a relationship with or have intense feelings about. One of the researchers noted, “It is true still that any relationships that Nancy makes, her mother soon intrudes into. This intrusion, of course, is partly by invitation of Nancy” (Archives). While this may well be partly due to fusion in their relationship, it is also a function of Nancy’s sibling position as an only child. When only children get involved in significant relationships, their mothers tend to be “part of the package” (Toman, 1976, p.186).

After they left the project, Nancy worked on differentiating a self from the fusion with her mother in particular. At first she separated a self geographically but not emotionally. After Nancy and her mother left the Center, they first lived in a hotel and then got an apartment together. They would still get into quarrels that drew complaints from landlords and neighbors. One of the landlords threatened to throw Nancy and her mother out unless they were separated. Nancy finally did separate from her mother a year after leaving the Clinical Center. She got an apartment on her own and would not give
her mother the new address. This was a challenge since she would still meet with her mother on a weekly basis and her mother would try to follow her home.

<table>
<thead>
<tr>
<th>DATE</th>
<th>HISTORICAL FAMILY EVENT</th>
<th>RELATION TO RESILIENT RESPONSE MODEL</th>
</tr>
</thead>
</table>
| 1958   | Liza and Nancy lived in a hotel temporarily and then got an apartment together. They quarreled which drew complaints from landlords. Nancy visited Robert when she was upset with her mother. Robert sought out Nancy’s attention when he had problems or felt alone. | Fusion  
Conflict  
Triangle |
| Later 1958 | Nancy moved into her own apartment. She met with her mother weekly but did not let her mother know where she lived. Nancy began a series of brief, intense, close, sexual relationships, which would end in fights and distance. | Pseudo separation.  
Replicated Fusion  
Conflict  
Distance |
| Late 1958 | Nancy met with Dr. Bowen two times for psychotherapy consultation. Nancy was able to tell her mother where she was living. Liza was able to meet with Nancy without pressuring her to live with her. Nancy stopped having intense sexual relationships. Nancy’s relationship with Robert became closer. Welfare agency reported that Liza was calmer and more objective than they had ever seen her. Liza would still get angry and make scenes, but not to point where neighbors would complain. Liza bought a variety of pets and turned her attention to them. | Resilient Response  
Differentiating Move  
Decrease in Anxiety  
Decrease in Fusion |

Figure 44: S Family After Leaving NIMH

Immediately after moving on her own, Nancy lost weight and started having “brief, intense sexual relationships.” These relationships duplicated the kind of fusion she had with her mother: “They would have a period of over closeness, intense sexual activity, fights, separation, and distance” (Archives). In an outpatient visit, Dr. Bowen pointed out to Nancy that he noticed this activity started as soon as she separated from her mother (Archives). Her behavior was an indication that Nancy had not emotionally
differentiated herself, but only geographically and physically separated herself. Bowen, in later writings, wrote about this kind of an attempt at separation: “At the other extreme are people so sensitized to the physical presence of the other that some degree of physical distance is necessary for emotional equilibrium” (Bowen, 1978, p.535). Examples of this are people who run away from home or those who only return occasionally.

A few months later, Nancy and her mother were able to visit without her mother pressuring her to come back and live with her. Nancy was able to tell her mother where she was living. Interestingly, her intense affairs with men stopped and she developed a closer relationship with her father. At this point, people who had known her mother, Liza, reported that she became “calmer, more restrained, and more objective” than she had been for close to twenty years. She still could make scenes, but not to the point where the neighbors complained. She acquired several pets when her daughter moved out and turned her attention to them (Archives). Here it is apparent that Nancy’s differentiating move, when made while maintaining a connection to her mother, calmed the system down and increased resilient responses.

It was during this time that Nancy’s father, Robert, moved in with Nancy for several months until she asked him to move out. A month or so after he moved out, Nancy was functioning at a good level, volunteering one day a week at a guidance center (Archives). What followed was a critical point in her own maturity and relationship with her mother.

Liza had been in the hospital for some minor surgery. When she went back to have sutures removed, she had one of her former emotional outbursts in the clinic. The doctors got excited about it and put her in a detention room. At this she became more
excited and paranoid, in a sense escalating the entire situation. The doctors contacted
Nancy wanting her to authorize her mother’s admittance to the state hospital. When
Nancy explained that her mother tended to have outbursts like this and that she
questioned the advisability of the state hospital, the doctors then wanted her to take over
responsibility for her mother. Bowen wrote:

This was emotionally more than Nancy could accept. This is one of the main
issues about which she has battled all her life….Mrs S was always trying to get
into the weak, childish position, and to put Nancy in the position of being the
responsible mother figure. Each time Mrs S tried to do this, Nancy would call
herself stupid, or sick, or someway act more helpless than the mother. In any case,
Nancy thought it would be impossible for her to accept responsibility for her
mother. When she asked more about it, the doctor told her that her mother might
commit suicide that night. If Nancy did sign responsibility, she had to be aware
that this would be a possibility (Archives).

<table>
<thead>
<tr>
<th>DATE</th>
<th>HISTORICAL FAMILY EVENT</th>
<th>RELATION TO RESILIENT RESPONSE MODEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early</td>
<td>Nancy met with Dr. Bowen two times for psychotherapy consultation.</td>
<td>Differentiating Move</td>
</tr>
<tr>
<td>1959</td>
<td>Robert moved into Nancy’s apartment.</td>
<td>Reciprocity</td>
</tr>
<tr>
<td></td>
<td>Nancy cooked for him and maintained the household.</td>
<td>Resilient Response</td>
</tr>
<tr>
<td></td>
<td>Robert complained and was irresponsible.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nancy kicked her father out of the apartment.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nancy worked as a volunteer at a guidance clinic.</td>
<td></td>
</tr>
<tr>
<td>Mid</td>
<td>Liza had an emotional outburst while having sutures removed at a local hospital. The doctors became excited about it and detained her. They contacted Nancy to have her admitted to an institution or to take responsibility for her. Nancy decided that neither option was acceptable. Doctors admitted Liza to hospital. Nancy asked Dr. Bowen how best to handle pressure from her mother to get her out of hospital. Dr. Bowen pointed out that her mother got herself into the hospital and had the responsibility to get herself out. Nancy thought she might try that for the first two visits but then would consider what was best for her mother. She did not see that the hospital would help in the long run.</td>
<td>Anxiety</td>
</tr>
<tr>
<td>1959</td>
<td></td>
<td>Differentiating Move</td>
</tr>
</tbody>
</table>

Figure 45: Differentiating Moves
Nancy refused both to accept responsibility for her mother and to authorize her admittance into the State Hospital. The doctors then took it upon themselves and had Liza admitted the next day. About the doctors' behavior, Bowen commented:

This is one of the beautiful examples about how doctors can respond to such things and deal with them. I feel very sure that Mrs S was not much different than she had been hundreds of times in the past twenty years and she has always been able to somehow pull herself together. When society steps in and takes over in a situation like this, I think is an unnecessary burden and expense to society and we have had some fairly long experience with the capacity of these people to function on the outside (Archives).

In further contact with Dr. Bowen, Nancy expressed her concerns about how to handle her mother's demands for Nancy to get her out of the hospital. Nancy had been avoiding visiting in anticipation of these demands and the inner conflicts that might arise. Bowen reminded Nancy that her mother had gotten herself into the hospital and had the responsibility for getting herself out. He wondered if Nancy could leave that responsibility with her mother. Nancy thought she would try that but reiterated that hospitals are not the most helpful places and that she felt her mother would do better outside of one (Archives). In this incident, Nancy was able to consider her own well-being along with that of her mother. Her decision-making process demonstrated an increased ability to respond resiliently to difficult situations.
Nancy wrote to Dr. Bowen about the delivery of her first child, born normal, which she gave up for adoption. Dr. Bowen responded that her decision to give the child up for adoption might be wisest for Nancy’s long term adjustment and so that the child did not have to live with and share Nancy’s problems. Nancy also reported that the hospital staff were about to discharge her mother at their own risk.

Figure 46: Changing the Trajectory for the Fifth Generation

In correspondence with Dr. Bowen a couple of years later, Nancy shared the fact that she had given birth and had given the baby up for adoption. Dr. Bowen acknowledged her decision as a wise one given the challenges that keeping the baby would have presented for both Nancy and the child. Her decision is interesting to consider in light of resilient responses. It seems that Nancy’s decision was realistic about her ability to care for a baby given the intense fusion that had played out between she and her mother. While it was probably very difficult to give up the baby, perhaps her decision was making it possible for the baby to grow up in a relationship environment that would enhance chances for resilient responses. In addition, the decision reflected Nancy’s own increased flexibility and thoughtfulness. By making a decision in her best interest as well as the child’s, she was responding resiliently. This is an indication that the trajectory of the S Family was moving toward resilient responses.
In summary, the story of the S Family shows how the initial adversity of persecution triggered anxiety and a decision to emigrate on the part of many family members in the maternal grandparent and great grandparent generation. In some cases the emigration was a resilient response, however it also changed the context of the family by introducing cutoff into the family system. Those family members who did not emigrate and were killed became a source of grief for Nancy’s maternal grandmother. As her maternal grandmother and grandfather cut off further from the grandfather’s family of origin once they had immigrated to the United States, the family became more insular. The family process of underfunctioning and overfunctioning reciprocity resulted in one
spouse, Liza's mother, becoming quite ill and dysfunctional. This process, along with Liza's sibling position as the only child left at home, pulled her into a progressively more fused and overfunctioning relationship with her mother.

Soon after Liza's mother died, her father died of an acute disease, which hints at the eroding resilient responses in this family. After these deaths, conflict between Liza and her siblings increased as a way to manage anxiety and family fusion. After this time, Liza made some resilient responses as she sought out family relatives in another state, worked, and saved money. Unfortunately, another adversity, the stock market crash, raised her anxiety. In this atmosphere of increased anxiety with a backdrop of fusion in relationships and in thinking, she quickly settled into an unsatisfactory marriage, a non-resilient response. The marriage replicated her overfunctioning role and grew more and more distant over the 17 years that it lasted.

Liza's husband was the object of child focus in his family and tended to underfunction. He was emotionally unavailable to Liza when two pregnancies ended in infant death. These family adversities added to the anxiety already circulating in this family. Liza and Robert were left to manage this level of anxiety in a highly fused relationship, where there was a tendency for reciprocal functioning and distance within a larger family context of cutoff. After the second pregnancy, Liza's health declined significantly, a non-resilient response. As the distance between Liza and Robert crystallized into a divorce, this branch of the family became yet smaller. This left Liza and her daughter Nancy in a highly fused relationship. More and more unrealistic thinking processes prevailed as a manifestation of the increased fusion. Liza decided to stop working and became dependent on the welfare agency to provide for her and Nancy.
However, she made this difficult on the agency by continuously getting into fights with landlords until the agency had to find a new place for her to live. These repeated non-resilient responses put her family into a constant state of turmoil. They were an outcome of her branch of the family cycling through the figure eight model over and over again.

Nancy mirrored her mother’s non-resilient ‘craziness’ until she got coaching on how to introduce a differentiating move into the system. When she first got her own apartment, the differentiating move was little more than a pseudo-separation, where she attempted to handle the fusion with her mother by not disclosing to her mother where she lived. However, this resulted in the non-resilient response of replicating the fusion in other short term intense relationships. Once she understood how to make the differentiating move while maintaining viable contact with her mother, she began making more resilient responses, such as getting a job. Her mother calmed down to the point where others who had known her for twenty years remarked on the significant change in her demeanor.

Nancy’s small move to change her part in the family system was able to change the trajectory in this family. It moved away from one in which non-resilient responses had evolved to become the norm to one that was more flexible. Her mother was able to relinquish her intense focus on Nancy and find comfort in other ways. Nancy was able to grow independent of her mother and enter into other work and social relationships. As Nancy faced the difficult decision of what to do with an unplanned pregnancy, she made a decision that seems to be in the best interests of herself and the child. In that sense, it was a resilient response for her and her child. With Nancy’s differentiating moves, the trajectory of this family slowly changed in the direction of more resilient responses.
The known history of the R Family begins with the death of Mary Jo’s mother and the desertion of her father, members of the second generation of this family. The death and the desertion represent adversities for Mary Jo, and her extended family, even though not much is known about that story. Not enough is known about the death to understand its context. Could it have been the mother’s non-resilient response to a relationship system that was severely out of balance? Was the father’s desertion just another aspect of that trajectory? Mary Jo was undoubtedly very dependent on her grandmother for her attachment needs. For example, one time, on an outing with Paula, Paula became angry and called her mother by her first name. She told people that she had no mother. Mary Jo was very upset and disappointed and called her 95-year-old grandmother, which she loved and associated her (Archives).

When Mary Jo’s mother died, her grandmother stepped in to raise her, which indicates a level of strength in the family system context. The family has made a difference in Mary Jo’s ability to grow up, get married, and have children. However, the family emotional process by the marriage of one of the members, extreme distancing by her husband who deserted the young couple, and the stress of five children may have added to the source of anxiety for this couple. This anxiety may have manifested in high expectations of each other and a combination of distance and conflict in regard to those expectations.

Figure 48: R Family Diagram

Resilient Response Model as Seen Through Four Generations of the R Family

The known history of the R Family begins with the death of Mary Jo’s mother and the desertion of her father, members of the second generation of this family.
grandmother for her attachment needs. For example, one time, on an outing with Paula, Paula became angry and called her mother by her first name. She told people around them that she had no mother. Mary Jo was very upset and disappointed and eventually called her 95 year-old grandmother to tell her that she ‘loved and appreciated her’ (Archives).

When Mary Jo’s mother died, her grandmother stepped in to raise her, which indicates a level of strength in the family system context. This may have made a difference in Mary Jo’s ability to grow up, get married, and have five children. However, the family emotional process in her marriage obviously led to extreme distancing by her husband who deserted the family when Andy was born. It is probable that there was a high level of fusion that existed between Mary Jo and her husband, as she looked to him to fulfill her attachment needs. Not enough is known about his part in the relationship, except that he eventually chose to leave and that she felt he did not treat her well. His epilepsy and the stress of five children may have added to the source of anxiety for this couple. This anxiety may have manifested in high expectations of each other and a combination of distance and conflict in reaction to those expectations.

The family context, which seemed to involve contact with only a few family members, did not provide a broader relationship network that could support the young couple as they dealt with their challenges. As anxiety rises in a fused relationship system, the family emotional processes among the remaining family members become more extreme to manage that anxiety. For example, one response to high anxiety and fusion is extreme distancing, or cutoff. The cutoff becomes the source of greater rigidity in the
system, less support, and hence adds to problems rather than resolving them. The possibility of resilient responses diminishes.

As family members come to depend less on each other, as Mary Jo had to do with her husband, they may depend more on outside supports to get by. In Mary Jo’s case she depended on public assistance to make ends meet. This was not an ideal situation as funds did not always arrive in a timely manner. Waiting for money and not being able to buy necessities caused additional stress that again, filtered through a rigid family system, added to Mary Jo’s tendency to focus on her children and be extremely disappointed and discouraged when they did not meet her expectations.

Figure 49: R Family at Time of Andy’s Birth and Husband’s Desertion

As family members come to depend less on each other, as Mary Jo had to do with her husband, they may depend more on outside supports to get by. In Mary Jo’s case she depended on public assistance to make ends meet. This was not an ideal situation as funds did not always arrive in a timely manner. Waiting for money and not being able to buy necessities caused additional stress that again, filtered through a rigid family system, added to Mary Jo’s tendency to focus on her children and be extremely disappointed and discouraged when they did not meet her expectations.
For example, Mary Jo felt depressed because she had not received any word from Carol who had recently moved and because Frank had not shown any sign of appreciation for her on Mother's Day. Another time, when Mary Jo returned from a two week visit to her grandmother, she was very disappointed with Carol. Apparently, Carol had offered to stay at her mother's house during her mother's trip, before moving to another state with her husband. She agreed to watch the boys and to assist with house expenses. However, when Mary Jo returned, she found the house in a mess. Carol had left a few hours before her mother returned. Mary Jo received an exceptionally high electricity bill for which she had expected Carol to leave some money (Archives).

While Mary Jo depended on public assistance for financial needs (and often also on her children), she especially turned to her children to meet her emotional needs. Mary Jo seemed to have tremendous emotional investment in how close she and Paula were on weekends (Archives). She seemed to feel that a weekend was successful when Paula took good care of her mother and devoted a lot of time to her. A weekend went well when Paula confided in her and remained at home for the full length of time. Most significantly, a weekend was successful when Paula was considerate of her brothers and took good care of them (Archives). Dr. Bowen gave his impressions of Mary Jo as "a very immature woman....who has somehow managed to function in the role of a responsible person, and she has adjusted by acting out her needs for mothering and attention" (Archives). By immature, he meant undifferentiated.

Mary Jo and her daughter Paula were extremely reactive to each other. Here, the term reactive means anxious focus on the other, probably due to a highly fused relationship and quite a bit of chronic anxiety. It means great sensitivity to acceptance or
rejection by the other. For example, if Paula rejected her mother in any way, her mother would avoid visiting. This avoidance then had serious consequences for Paula’s resilient responses as described in the previous chapter.

An interesting analysis of the reactivity between Paula and her mother was conducted by a subset of the research staff “in an attempt to achieve a broader understanding of the clinical problem and of the puzzling discrepancies in the observations” (Dysinger, 1957/2003, p.121). This study augments our understanding of the resilient response model, so it will be described in the following paragraphs. In

Figure 50: Evolution of Fusion Between Mary Jo and Paula

Dysinger (1957/2003) explored the nature of specific moves that people make. The first, called the approach move, is to take the initiative to make contact with another person. This type of move holds an implicit or explicit request for attention from the other party. The second type of move, the initiating move, is to strike a scene where one person takes the initiative to address another person about a specific issue. Examples of engaging moves include proposals, demands, orders, invitations, offers, and acts of giving (Dysinger, 1957/2003).
particular, the study adds an intricate look at the family system and its processes to manage anxiety as enacted in the microcosm of the mother-daughter relationship.

After charting daily interactions between Mary Jo and Paula over nine and a half months, the researchers sought for a concept that would capture the fact that "shifts in anxiety level, attitude, feeling and action seemed for both more directly related to what was done than to what was said" (Dysinger, 1957/2003, p.121). So they decided to focus on actions rather than expressions of feelings, wishes, or intentions. They limited the scope of the observations to the mother daughter relationship for several reasons, with the most prominent being that "it seemed the major forces governing the course of events were contained in the mother-daughter relationship and that staff relations to either were of secondary magnitude" (Dysinger, 1957/2003, p.122).

In a fascinating description of moves people generally make, Dysinger (1957/2003) defined two kinds of moves of interest to the study. The first, called the approach move, is an action where one person takes the initiative to make contact with another person. This type of move holds an implicit or explicit request for attention from the other party. The second kind of move, the engaging move, is an action where one person takes the initiative to address another person about a specific issue. Examples of engaging moves include proposals, demands, orders, invitations, offers, and acts of giving (Dysinger, 1957/2003).

Dysinger (1957/2003) also distinguished three actions that could be confused with engaging moves, but which were excluded from this study. They are different from engaging moves because they contain vague elements. In the first of these, no one takes initiative or seriously commits oneself to action. A person might hint at something but
not follow through. Second, a person might act something out without addressing another person. For example, someone might act as if they want help without explicitly requesting it. Third, a person might address another about vague content matters. Threats, complaints, opinions, judgments, hopes, regrets, suggestions and recommendations fall under this category. Dysinger also discussed actions such as playing, pretending, supposing, or rehearsing that are not serious moves (Dysinger, 1957/2003).

Responses to approaching and engaging moves either answer or do not answer the implicit or explicit proposal contained in the move. People can answer a proposal on a range from reluctantly acquiescing to ineffectively saying no, or clearly saying yes or no with or without conditions or amendments. Answers can be verbal or nonverbal. Not answering the proposal can take the form of “ignoring the move altogether, changing the subject, moving out of contact with the other and the much used explicit response, ‘no comment’” (Dysinger, 1957/2003, p. 124). Aside from being intriguing ways of classifying behaviors, the various moves, actions, and responses described above are relevant to the resilient response model because they describe the kinds of interactions that do not seem to resolve anxiety.

Dysinger (1957/2003) also described the separation move and the position-taking move. The separation move involves one person taking the initiative “to end a period of contact with the other” (Dysinger, 1957/2003, p. 124). The position-taking move involves one person expressing “a specific position or course of action for self about matters that also concern the other” (Dysinger, 1957/2003, p.124). The position-taking move might lead to more resolution of anxiety. Dysinger indicated that there was insufficient data to determine if separation moves were occurring between this mother and daughter pair.
during the period of study and that the position taking move was not evident during this
time (Dysinger, 1957/2003).

The study team then reviewed the data according to these major moves and the responses to them within this mother-daughter pair. They called this sequence of moves and responses an action dialogue. They looked at each move, its type, who initiated the move, its content and timing, and the response of the other to it. The researchers found distinct patterns in the action dialogue between this mother and daughter. The mother made almost entirely approach moves toward her daughter, when she visited or spent time at the Clinical Center. The daughter responded to these moves in several ways. She either gave her mother attention, asked her mother not to come (an engaging move), or ignored her mother. Asking her mother not to come occurred less frequently after the mother and daughter discussed the mother’s agreement to participate in the Clinic activities (Dysinger, 1957/2003).

It is to be noted, that when the daughter rejected the mother by asking her not to come, the mother would eventually find reasons not to come, usually blaming housework or lack of transportation. There were noticeable periods where the mother did not visit for days or weeks following rejection by the daughter. In a sense, this was the mother’s way of avoiding her daughter, just as ignoring her mother was the daughter’s way of avoiding her mother. The difference was that the daughter had to find a way to avoid her mother within the confines of the Clinical Center, and the mother could come and go from the Center and simply not visit. After periods of two to three weeks when the mother did not visit, the daughter would find a way to approach her mother, often by paying a visit home, even without permission to leave the Clinical Center (Dysinger, 1957/2003).
Dysinger noted that “there is no bargaining, no setting of conditions, and there is never a clear no” from the mother (Dysinger, 1957/2003, p. 127). He commented on the striking absence of bargaining, negotiating, or even delaying in the mother and daughter’s dealings with each other. Neither took a position on any matter. He added, “it was the ninth month before the mother with staff support was able to say her first firm no to a demand of the daughter’s” (Dysinger, 1957/2003, p.128). Even when making requests or approaching the other, neither discussed real considerations involved (Dysinger, 1957/2003, p.130).

The daughter made almost entirely engaging moves toward her mother. She would make proposals, demands or requests of her mother. Many of these requests would be difficult for the mother to fulfill and unrealistic given her circumstances. The mother would often respond to her daughter’s engaging moves by acquiescing to them, even when they would be impossible for her to accommodate (Dysinger, 1957/2003). At these times, she would have to renege on her promise, or simply not follow through. This would upset her daughter further. For instance, one day Paula was excited about her mother’s visit because she expected her mother to bring her a gift. When her mother only brought an excuse for not having the gift, Paula was angry (Archives).

To evade a request, rather than state her own limits, the mother would pretend that some outside situation, such as the hospital rules, made it impossible to fulfill the request. Sometimes she simply would delay coming. For instance, after Mary Jo returned from a two week visit to her grandmother, she did not call the Center for three days. During this time, Paula expected to see her. However, Mary Jo specifically asked the social worker not to tell Paula that she was back. By the next day, Paula was sobbing that her mother
was not there yet. Four days later, Paula arranged a visit home for herself (Archives). One could say that Paula’s tenacity at finding a way to connect with her mother was a resilient response.

There was only one period of several days after a long absence, that the mother engaged the daughter in any way. She asked her daughter to go for a walk with her, she invited her daughter for a visit home, and she asked her daughter to promise to be good. The daughter’s responses to these requests were all acquiescent, even when she could not follow through on them (such as the promise to be good). Dysinger summarized the “telegraphic” sequence as follows:

Mother approaches, daughter demands, mother hesitantly declines; daughter rejects mother’s approach; mother acquiesces to the demand, daughter demands again, mother hesitantly declines; mother rejects mother’s approach; mother stops approaching, daughter approaches and renews demand, mother acquiesces, mother renews approaches” (Dysinger, 1957/2003, p.129).

This sequence is a beautiful description of how anxiety is managed in a relationship where two people are very focused on each other, extremely dependent on each other for their emotional needs, and at the same time allergic to the intense closeness.

The research team then studied the sequence to discern points when major shifts in moves or responses occurred. These points were when one ignored the other in either direction. For example, the mother gave in to the demand to let Paula visit home after a period where her daughter ignored her. Seven times, Paula shifted from her engaging moves to an approach move after her mother had ignored her by not coming for quite some time. “Avoidance of mother by the daughter and the avoidance of the daughter by the mother were actions that were followed by changes in the moves of the other” (Dysinger, 1957/2003, p.129). This description of avoidance that precipitated major shifts
in the action dialogue provides a microscopic view into how threats to fusion generate enough anxiety to motivate action and interaction strategies.

Unfortunately, these strategies did not resolve anxiety. Dysinger concluded that “the sequence of moves appears to constitute a circular stalemate repeated over and over with no agreements reached, plans made, or common effort undertaken” (Dysinger, 1957/2003, p. 131). Overall,

A striking phenomenon which became apparent from an inspection of the whole record was that it divided naturally into four periods of two phases each. The first phase of each period began with the mother’s resuming approaches, the second with her discontinuing them. A new period began then with the renewal of approaches by the mother. The cycle was repeated four times in the first twenty-eight weeks.....The initial phases of each period were of three to five weeks duration. The second phases when the mother made an approach move were two to five weeks long. This is a gross example of a phenomenon seen clinically in such relationships and called the closeness-distance cycle.

Each of the cycles has some characteristics in common. At the beginning of the period (which follows a separation) each readily acquiesces to the move of the other. It is in the latter part of the first phase, that the daughter’s ignoring characteristically occurs. In the second phase when the mother makes no approach, the daughter regularly approaches the mother. It is also in this phase when both relate vigorously to others (Dysinger, 1957/2003, p. 130).

Kathleen Kerr comments on this 1957 paper by Dysinger. She points out that the article gives a glimpse at the “researcher backing up from the subjectivity and detail to see broad recurring patterns of movement between the two” (Dysinger, 1957/2003, p. 132). The description of the action dialogue illuminates an “emotional process underneath the verbiage and detail.” She also summarizes the cycle in simpler terms: “The recurrent cycle: mother approaches, daughter ignores and demands, mother withdraws, daughter approaches, holds each captive. Neither evidences ability to bargain, negotiate, or set limits with the other. No resolution occurs” (Dysinger, 1957/2003, p. 132). Both Dysinger and Kerr describe the action dialogue as a cycle that does not resolve anything.
This is a prime example of how action and interaction strategies that evolve in a family to manage anxiety may do nothing more than bind it in a continuous recycling process. This cycle also describes elements of a non-resilient response. Anxiety was recycled and problems were not resolved. The mother acted on automatic flight responses in reaction to rejection from her daughter by distancing herself and staying away. The daughter often carried unrealistic expectations of her mother and when her mother could not meet them, she rejected her mother. This was accompanied by a sense of helplessness to effect change in the relationship or the environment. Hence, the mother would theorize on "the unrest of the nation" and how such unrest was responsible for the amount of emotional illness in adolescence (Archives). In the next breath she would indirectly blame herself. "I blame the teenage problems on adults. I put the blame where it belongs. If my own circumstances had been different, my children wouldn't be upset. They would have had a more consistent life" (Archives). This is an example of the hopelessness I described in the introduction. Despite her deep concerns and her intense guilt feelings, she is unable to effect change in her children until she begins to change her part in the interactions.

In summary, this story of the R Family began with multiple family adversities in Mary Jo's family of origin. Resulting heightened anxiety then filtered through a context of sparse numbers of family members, adding to greater fusion between the few remaining members. The story gives a microscopic view of what fusion looks like and how it plays out between Mary Jo and her daughter, Paula. The extreme sensitivity to the other and the unrealistic thinking that accompanied fusion were laid out in great detail by Dysinger and his research team.
The case brings to light the family processes that evolved to manage anxiety and its impact on resilient responses. In this example, the management of anxiety between two people in such a fused relationship became bound in the family process of the closeness and distance cycle. As the mother attempted to get comfortable by distancing herself and finding excuses for doing so, this process had serious implications for Paula’s reciprocal tendency to respond non-resiliently. The action dialogue study demonstrates how one can step back from the content of interactions to observe the underlying processes behind a resilient and non-resilient response. The fusion and unresolved anxiety between Mary Jo and Paula became very obvious through this approach to studying the interactions.

The R Family also illustrates how child focus evolved in an atmosphere of few viable family relationships. The family’s estrangement from the father exacerbated the cutoff that made expectations for the remaining relationships more intense. The pressures on the children in the family were greater due to this family process and context. The added adversity of unreliable public assistance raised the mother’s anxiety so that her focus on the children became less tolerant and more critical. While all five children demonstrated the ability to respond resiliently in certain circumstances, two of them struggled with a tendency toward non-resilient responses. When Mary Jo caught a glimpse of the power of a differentiating move when she took a stand with Paula, a more resilient response occurred. The R Family story shows how the components on the resilient response model played out over time. The many cycles through the figure eight diagram gave us an insight into the emotional processes of the family and how they influenced the resilient and non-resilient responses of the children.
The stories of the S Family and the R Family have shown how the generations cycle through the resilient response model. Starting with adversities that trigger anxiety, each story proceeded differently along the model’s path. The processes the families used to manage anxiety resulted in a trajectory toward or away from resilient responses. In the S Family, the processes included reciprocity, conflict, distance, dysfunction in a spouse, and focus on a child. In the R Family, extreme distancing by the husband intensified fusion and the child projection process. These processes evolved in a family system context that had been shaped by nodal family events, sibling position, cutoff, and the number of viable family relationships. Out of this system and these processes, Liza and Nancy S became a focus of family anxiety, as did Paula and Philip R. Each became more susceptible to non-resilient responses.

In the S Family, we saw how the trend was toward non-resilient responses until Nancy made some differentiating moves. In the R Family, we saw how the mother and daughter were locked in a cycle that did not resolve. When the mother tried to distance herself, Paula’s resilient responses plummeted. As the mother became more connected and eventually made an attempt to change her part in the system, Paula responded resiliently.
Limitations of the Study

In the true nature of an in-depth case analysis, the focus of my study was narrow but detailed. My own dual curiosity about Bowen, the development of his theory, as well as its implications for youth resiliency, resulted in a new application of Bowen Theory and the use of his early research data. In the process, this synthesis placed the concept of resiliency within a systems framework. However, there were many limitations to the purity and perfection of my study.

For example, what was the influence of the researchers and the research setting on the family anxiety and consequently the family process? How did the tension between research and treatment goals affect the quality of the research? The archival data stemmed from Bowen's emerging ideas at that time. How much did his ideas color the data set? In addition, since I looked at the data fifty years after the study, how much did my perceptions of the original interpretations taint the actual stories? These are the kinds of questions that this section on limitations seeks to explore.

An aspect of the data that raised questions for me related to the influence of the setting on the families. It was hard to let go of the notion that family processes may have been more extreme in these families, not just because they had a child ill with schizophrenia, but also because anxiety would have been higher for any family that had to make sacrifices of home, job, and normal lifestyle to find a treatment that might help their child. Anxiety would have increased for anyone who had to live in a ward environment with other families that were also very anxious. Anxiety would have been heightened for anyone who had to suddenly face hospital rules (however minimal they were in this project) when they were accustomed to coming and going as they pleased at
home. Anxiety would have been especially high for anyone who was exposed to people who could be potentially and unpredictably violent. However, my assumption was that despite all of this, the same family processes to manage anxiety would still have taken place. Anxiety is still a natural phenomenon and families coped with it as their instinct and history prompted them to do.

Knowing the family histories before their arrival at NIMH also led me to believe that in most cases the setting did not significantly change the level of anxiety and the family dynamics that were present before living on the ward. In some cases, anxiety went down and behavior improved significantly over behavior in other hospital settings. In other cases, the clinic became the focus of anxiety. When the staff tried to give parents responsibility that the parents wanted the staff to take, there was inevitable conflict. The project had a simultaneous goal of research in situ as well as an experimental treatment for schizophrenia. The research staff’s effort to research families in situ meant that they wanted to interfere as little as possible in the family’s natural conflicts and dynamics.

In a draft of a paper, Bowen addressed the tension between the research and treatment goals on the project. The paper compared and contrasted the clinical psychotherapeutic approach to problems of human behavior with the scientific approach:

The clinical psychotherapeutic approach is therefore in much more direct contact with here and now problems and is challenged by the urgencies of the here and now to be more inventive, more radical and more improvising in its methods of dealing with complicated problems for which there are not clear cut solutions. Many times these methods would not meet the criteria of sound scientific methodology so that the conclusions established from them in the form of individual or universal clinical convictions are regarded suspiciously by the methodologist of science with an eye to the history of erroneous conclusions from methodological error.

An organization dedicated to the goal of research in a health field, particularly in mental health, finds itself at the intersection of these two
approaches. The purpose of the founders of such an organization have been molded out of urgencies and aspirations to deal more effectively with a vast health problem in the society now. Research as one ingredient of an effort to move in that direction has been recognized as of great importance. The freedom of the scientist to choose his problem and the urgency to provide practical results are basic themes in conflict (Archives).

This quote is still so relevant today. Clinical therapeutic approaches today have even a greater multitude of practical concerns such as managed care policies and pressures for short term treatment, in addition to the need to help the client.

As a result of Bowen’s desire to bring a scientific approach to the study, nearly everything that happened, daily behaviors, therapy meetings, and meal-time conversations were observed and recorded. The data I looked at were all recorded through the eyes of an observer. Although there was a strong emphasis in the project on being as objective as possible, still each observation was seen, heard, and interpreted through the eyes of the researcher. As much as the researchers tried to be objective, they still chose the ‘key’ behaviors and incidents that would get recorded and emphasized. Plus, the family histories that were recorded relied on the memories and interpretations of the family members or agencies that shared them. My main frustration in using existing written data has been the fact that I was not there to see and hear the various events for myself. Nor was I privy to the conversations during the research meetings where the researchers came to conclusions about significant aspects of the data. However, I did get a strong sense for these discussions through written drafts of papers and reflective notes.

Multiple interpretations and summaries by different researchers of the same events were sometimes slightly different, so my own assessment of the most accurate data added another layer of interpretation to my data analysis. Since even what family
members said were interpreted by the researchers, it is hard to get a pure sense of the
context in which things were said. The project operated on certain assumptions about
relationship processes such as symbiosis and projection, therefore everything that was
recorded was seen and interpreted based on those assumptions. This means that the data
set is limited by what Bowen aptly describes in the following paragraph from the end of
the paper contrasting the clinical psychotherapeutic method to the scientific approach:

In any pursuit of knowledge, assumptions and postulates are not only admissible
but necessary. Problems arise when they are not explicit. Much has been gained in
science by undertaking studies which begin from a variety of assumptions and
postulates. These, however, are not tested in the given study based on them. For a
given study one is free to assume and postulate whatever one wishes and proceed
to develop the study of propositions derived from them. The study is dedicated to
the working out of these propositions; its result does not necessarily reflect one
way or the other on the underlying assumptions and postulates. These
assumptions and postulates may of course by wrong, but the study is carried out
on the basis that assuming these are correct, we notice the following concerning
this interesting proposition (Archives).

Bowen’s assumptions and postulates were unusual but therapeutic. My goal has not been
to prove these ideas but to see what they looked like in the families that participated in
the research study. I wanted to better understand how the researchers saw family
interactions and the sense they made of them. My purpose has been to understand and
apply the ideas and to offer them as alternative paradigms for viewing family process and
its influence on resiliency.

Another constraint I worked with was the fact that I was not allowed to photocopy
records, limiting the amount of data I could record. Especially in the area of daily hourly
observations of each family, this became a drawback in my ability to chart detailed daily
behavior over a long period of time. In other words, this could have been a lifelong
project. Also, the data on each family was uneven. Depending on the point of time in the
five-year research study that the participants were active, different types of data were collected. In addition, depending on the family and its ability to relay historical details, there was variation in the amount of family history that was available. Then there was also the element of what was considered important to focus on with each family and what was worth keeping over the years. As was evident in my presentation of the findings, the data on each family varied somewhat and the uniqueness of each case showed. However, I also did my best to pull out the common elements in the cross case analysis.

In summary, this dissertation research was limited in at least several ways. First, the original researchers recorded data based on their interpretations of the observations, as much as they tried to be objective. The assumptions underlying the family systems paradigm that grew out of the NIMH research determined what was recorded and highlighted. In addition, the accuracy of family histories they recorded relied on the memories and recall abilities of the family members. I then added my own layer of interpretation to the archives as I mined the data for information related to resiliency. Lastly, my ability to view daily observations over a comprehensive period of time was limited by my time and speed at recording data manually due to the restriction on photocopying.
CHAPTER FIVE: IMPLICATIONS AND CONCLUSION

Implications of the Resilient Response Model

This dissertation research represents a new way of thinking about youth resiliency. The concept of a resilient response introduces a systems lens to the conversation on how people who work with young people and their families can effectively impact positive youth development outcomes such as resiliency. Parents and policy makers are equally important as leaders in this conversation. A person representing any of these groups could use a differentiating move to influence the systems they work within, such as schools, families, and policy groups. This awareness offers an alternative way to effect youth resiliency.

Resiliency in a Diverse Society

The ability to differentiate oneself while remaining connected to important others invites a whole new way of thinking about surviving in a diverse society. It gives a way of seeing the fusion that binds families, clans, and a wide range of social, political, and national groups into artificially homogenous units. Once we can fully grasp our own uniqueness and how to differentiate a self within our own family and social groups, we can move beyond the fusion to a more flexible, adaptive, and connected way of functioning. We can then effectively embrace how to differentiate ourselves within the larger heterogenous society. Our focus will be on thoughtfully defining values, separating real threats from imaginary ones, and addressing problems so they get resolved at no one’s expense. Diverse but connected: Is it possible? I believe so. The outcome promises greater resiliency for our children, and even more so for future generations.
Implications for Practice and Policy

The resilient response model has implications for anyone making decisions that impact youth and their families. This can include but is not limited to parents, youth, teachers, youth development professionals, therapists, social workers, human service professionals, corrections officers, and policy makers. The model is useful to anyone working with others in an emotional system. In addition, it offers a new way of thinking to anyone who is trying to understand the behaviors of youth and families.

Embracing the resilient response model requires redefining the role of the helping professional in the family issues of today to a person who manages his or her own anxiety in responsible ways, and who works on his or her own part in the system. In other words, the emphasis of the helper is less on getting the kids or parents to change, as it is on changing the professional’s own way of relating to the parents and children. This often requires personal work to overcome non-resilient thinking in one’s own mind, such as rigid beliefs about others. It also means applying the model in one’s own personal and professional relationship systems. For example, conflict, distance, cutoff, and reciprocal functioning are processes that are alive and well, not only in families, but also in workplaces, schools, and other organizations.

Managing our own anxiety, we may also be able to forego the usual diagnosing and labeling tendency that occurs when people try to cope with problems. We might be able to see behind a behavior, to the complex interaction of processes, contexts, anxieties, and conditions that preceded it. We would be able to see the fluctuation in resilient responses and not get locked into a rigid view of resiliency as a fixed trait. In the NIMH study, Bowen would fill out the diagnosis section on medical reports with statements
such as, "A psychiatric diagnosis would tend to confirm and fix the neurosis and oppose the therapeutic effort. For the record – Immature Personality Improved" (Archives). In the same way, we could view ourselves and others as people who sometimes respond resiliently and sometimes non-resiliently. Having a working definition of a resilient response assists with consciousness about behavior and choices. The purpose of not labeling ourselves as resilient or non-resilient is to leave flexibility and responsibility up to each of us, rather than tangle ourselves in a quagmire of fixed ideas.

Embracing the resilient response model pushes us to move beyond the paradigm of cause and effect to a systems view of behavior. The family systems lens highlights the reciprocal nature of relationships. One person’s action does not cause the other’s action. Together they complete the other in a reciprocal, simultaneous process. An acknowledgement of reciprocity can help us stop blaming parents and stop assigning evil motives to their children. It allows us to appreciate that under conditions of adversity, there is a greater tendency for a family system to move toward over and underfunctioning reciprocity as the family compensates for increased anxiety. If we acknowledge this, we may be able to appreciate how a family can come to function at someone’s expense.

Use of the resilient response model helps us look back in time and understand how families got where they are in the first place. The model helps us view parents as part of a larger, multigenerational system. In doing so, we avoid blaming them for the non-resilient responses of their youth. Parents are seen as participating in the natural processes that evolve in families to manage anxiety. Without the threat of being held liable for the outcomes of processes they did not wish upon themselves or their children, parents can learn how these processes work and how to change their part in them. It is
much more likely that they will be interested and effective at changing their family circumstances under these calmer conditions.

Knowing this inevitably changes the way people in education and the helping professions would think about their work with families. First of all, acknowledging the continuum of adversity and the interplay between external, internal, and family adversities would create an understanding of the kinds of challenges families and youth are up against. Second, attending to anxiety within individuals, families, and groups would precipitate steps to decrease anxiety so that everyone can think more clearly. People can think better when they are calmer. Helping parents find ways to reduce anxiety would help them more effectively address their own concerns. Sometimes this includes helping families connect with each other and with their offspring. In certain cases, it means allowing families to stay in contact in order to lower anxiety.

Third, taking the time to appreciate the family system context would be crucial to an adequate assessment of how families cope with adversity. Scrutinizing the family processes can reveal how much anxiety a family is managing and where the anxiety is going. Is it getting resolved or is it being recycled? Teaching family members how the resilient response model works and the processes that play a role, would help families move themselves into a better trajectory for more resilient responses. Helping parents understand that these processes evolve naturally would support parents without blaming them or pointing the finger at their children. Teaching parents a way that they can strengthen their families by changing their part in these processes gives them a way to effect change so they do not get discouraged. Paying attention to the resilient and non-
resilient responses of individual family members is the final step and sometimes the first entry into learning about the family patterns.

**Fusion and Quick Fix Solutions**

Perhaps if we were to differentiate from the fusion that makes it difficult to think clearly, we could be more realistic about how many generations it takes a family to develop a non-resilient cycle. We could finally admit that the solutions to the problems of children today are not likely to happen in eight sessions of brief solution-focused therapy or other quick fix solutions. Nor can the community bring it about with a one year or five year grant-funded program.

More and more youth development programs are grant funded and usually last only as long as the grant is able to support it. Sustainability plans are made but they often lose momentum and dissipate without funds to drive programs. Politics also determine where money will be spent, and with changing regimes every few years, youth workers have to manage the basic anxiety of whether they will still have money to support their efforts in the community.

Even during the process of writing a grant, people can be swept up into the frenzy of deadlines. This forces quickly designed programs that may not involve all the important stakeholders in the planning process. Although funders are promoting and often requiring collaboration between agencies to address issues, the realities of schedules in the busy lives of professionals, who carry multiple roles as parents and community members, often make this ideal fall short. Even a grant designed to help families access their own strengths can be subtly undermined by the overfunctioning presumption that the grant writer knows what is best for the kids or the family. Later,
when the grant is received, even if it is written with the philosophy of strength-based approaches, it still expects families to participate without their input. Some would argue that it would be surprising if this wins their cooperation.

Focus on Outcomes Without Addressing Processes

Many youth development approaches, reflected in logic models, focus on outcomes for positive youth development such as resiliency. However, trying to effect outcomes without fully understanding the depth and history of the processes that create and prevent them may be ineffective. The resilient response model is based on the paradigm of the family as an emotional unit. It challenges basic notions of how we conceptualize youth development efforts and programming. For example, many social efforts are targeted at youth audiences. However, without an understanding of how youth resiliency is tied into the family system, these efforts might be quite disconnected and ineffective.

Entering into the resilient response model at the stage of fixing a non-resilient response may be too late, at least that time around the figure eight. On the next cycle, it would be better to enter earlier at the stage of adverse conditions. For policy makers, this would be useful, especially when those conditions are something that social policies can do something about. Or maybe avoiding policies or actions that raise anxiety unnecessarily may be the best intervention. Being in viable emotional contact with families may help reduce anxiety. For family practitioners, it would be better to enter at a point where one can address the family emotional processes that lead to the outcomes. Family interviews should take into account contextual factors such as nodal family events and their coincidence with birth dates of children.
In the case studies, the family projection process had major impact on the resilient responses of a child. The power of this process has implications, not only for the family, but also for society. Just as a family focuses on a child as a way to relieve discomfort of anxiety, so can a society focus on youth. Just as focus on a child fills the needs of parents who do not get along, anxious focus on the youth of today takes attention away from the conflicts and distance between people within society. If youth become the recipients of anxious focus of the adults in society, they will be less able to think clearly or respond resiliently. In the meantime, many adults do not address the source of discomfort that comes up in their relationships with significant others, whether emotionally divorced or literally divorced. Problems do not get resolved. Anxiety gets recycled. People remain caught in fixed triangles. This is not usually a conscious process, nor is it intended.

However, if American society wants to make resilient responses a natural outcome for all youth, greater consciousness about the way these things work in a naturally evolving system will be needed.

It may well be that the lack of consciousness about the child projection process stems from fusion within society. Fusion blurs the lines between clear and muddied thoughts. It blurs the lines of responsibility between people, so that as anxiety rises, some people take on more responsibility and others take on less. This is the over and underfunctioning reciprocity. Hidden in many of the reciprocal interchanges between the NIMH families and the staff was the theme of responsibility. Who was responsible for the children? Who was responsible for personal decisions? Where did the project staff's
responsibilities end and the parent's responsibility begin? Where did parental
responsibility end and the child's responsibility begin? Bowen wrote,

A characteristic family relationship pattern is a cyclical blaming of the other one,
defending self, and no one accepting responsibility for family problems. The
pattern tends to blame the weakest one (patient) for the family dilemma and to
also hold this one responsible for change (Archives).

It is quite clear that the pattern described in this quote did not end 50 years ago. It
is alive and well. For example, US divorce rates are still at a high level (a provisional
estimate of 40% per capita in 2002 according to the National Center for Health
Statistics). Over 89 billion dollars are not paid in child support (according to the Child
Support Enforcement Council), and contentious divorce cases are commonplace.

However, divorce itself is not enough to bring on all the issues that come with it. Divorce
is often an endpoint in a long series of family emotional processes that evolve to manage
heightened anxiety triggered by a range of adverse conditions. Unfortunately, by the time
it becomes a contentious battle, people are polarized into rigid positions where the other
is to blame, the other is incorrigible, or the other is the culprit. It is an individually
focused view on family problems and a non-resilient one at that. The natural emotional
process of cutoff is activated when the position taken is that partners are to blame and if
we can get them out of our lives, the problem will be solved.

Unfortunately, this does not usually resolve anything. It may lower anxiety for a
time, but the family emotional processes are bound to repeat in subsequent relationships.
As we saw in the discussion of the resilient response model, conflict and distance
between spouses is driven by a number of contextual and emotional processes such as a
lack of viable contact with extended families, heightened levels of anxiety triggered by

various types of adversities, cutoff between generations, and the coincidence of birth dates with nodal family events.

People who work with families and children who are challenging need to see the adversity and anxiety that feeds the problems rather than only looking at the problems and how to fix them. This is, however, counter intuitive to the classic medical model of change. Medical doctors usually hone in on the problem (symptom) and fix it without exploring the relationship conditions that contributed to the problem in the first place. It might be more important to ask parents what happened in the family around the time of the child’s birth than to ask them how they would describe the child’s problem. It might be more important to ask them how and when they began relating differently around the time of this nodal event rather than to ask them what they have done to try to get their child to behave. It might be far more important to help the family reduce anxiety so they can approach problem solving with a sense of calm and thoughtfulness, rather than to impose sanctions or take their child away. Separating families introduces new adversities that intensify anxiety and the processes families naturally use to manage it.

Bowen’s quote on cyclical blaming of the other and holding children responsible for change also applies on a societal level. In this case parents blame teachers or school systems for failing to adequately prepare youth, and the schools and teachers hold parents accountable for lack of involvement with their children. However, both would tend to see the youth as the problem that needs to be fixed, and would put their effort on finding the right technique so that the child will change. They do not see their own part in a system of emotional processes that promotes non-resilient responses in young people. In other words, “Young people today are typically portrayed as some aberrant and pariah class
suffering its own distinct ‘epidemics’ that are different from behavior of previous
generations and bear no relationship to adult patterns of behavior” (Astroth, 1993, p.2).

In this case conflict, blame, distance, over and underfunctioning reciprocity, and
focus on the child are played out on the societal level. Both blame each other – often by
talking to a third party such as a news reporter or to their own peers. They have a difficult
time discussing negative feelings about each other directly. In this way, parents and
teachers often keep their distance until formally brought together through parent teacher
conferences or the need to complain about teacher negligence or to report on a child’s
misbehavior. Often, school systems and teachers take on functions that the parents are
fully capable of doing with children and sometimes parents assume more than their share
of responsibility for children in this absence of communication with teachers.

Nevertheless, concern about the children is still the predominant emotional process going
on. Usually, teachers look to the parents to get their children to behave, and often, parents
look to teachers to do it. Either way, they are waiting for the child to improve and are not
looking at their own part in the process.

Fusion and Amorphous Responsibility Between Families and Institutions

The following information about how the clinical research staff thought about the
responsibility between staff and families is useful to understanding how societal policies
and procedures grow out of an emotional process. The clinical research staff found the
responsibility topic useful for delineating differences between their treatment approach
and conventional approaches. They outlined major areas of responsibility for an
institution offering treatment to persons with psychotic impairments. These included
responsibility for treatment, protection, and a setting for continued living. Their analysis
of responsibility is intriguing. It shows how the research staff struggled to think clearly about responsibility under pressure from parents to take more responsibility for their children:

The transactions by which responsibility is moved from one person to another is made up of two parts, a bid from the original holder to another to take it and a response from the other accepting it. It occurs also in the reverse order, i.e. the other offering to take it and the holder agreeing to give it. Under certain circumstances responsibility can be transferred by force, especially by the State, through its courts.

Transactions of responsibility are sometimes covert, ambiguous, unclear in scope, ambivalent on one or both sides or they may occur very formally by written contract. When the location of responsibility in a situation is unclear, one can hear those trying to find out ask such questions as “who is it up to”, “whose move is it”, “who are we waiting for”, “who has the ball”, “if it came to a showdown, who would decide.” Persons can accept responsibility without realizing it – “Getting left with the sack” – “Buying a pig in a poke.” Persons can offer responsibility to another in relation to self without being aware of it. Often there are major areas in such dealings that are not explicit. They are simply “understood”, “assumed” or “implied.” It can occur that responsibility is held by an individual and he deny [sic] its location in him. The fact that such transactions are often not explicit and open does not make them any less real, in the sense that they occur and have consequences. The conceptual model is that an area of responsibility is like a commodity and can be transferred from one party to another.

In summary, four areas of hospital responsibility have their counterpart among the responsibilities of the adult citizen. With the onset of psychosis in an adult child in the context of the parental home, these citizen responsibilities become regularly located in the parents. With hospitalization they are transferred to the hospital staff. The scope of the responsible help by the family when hospital treatment is undertaken is least in committed patient situation, next greatest in the private hospital, next in [the family research project in its early years] and greatest in [its later years] (Archives).

This quote is particularly relevant to the implications for the resilient response model on policy and practice. Does it make sense for practitioners in the youth development field to accept responsibility for “teaching” youth resiliency? How would we do this? Does the act of taking on this responsibility belie our own tendency for fusion with a larger society that focuses more on content than on process? Do we contribute to
the non-resilient responses of youth by taking on responsibility for things we do not necessarily have the power to change? Do we make policies that inadvertently promote underlying relationship processes that undermine the resilient responses of youth?

Astroth writes about how youth development educators latch onto the “popular myths circulating in the media about ‘at risk’ youth without questioning their basis” (Astroth, 1993, p.1). He adds, “In public discussion to today’s youth problems, balance and context has vanished. As a result, youth policy and programming are increasingly divorced from research findings, historical lessons, and common sense” (Astroth, 1993, p.1). The resilient response model offers a way for youth development educators to assess their part in the systems that undermine or promote resilient responses.

Furthermore, conceptualizing the resilient responses of youth as outcomes of family process raises questions about how much resiliency as an isolated entity or “life skill” can be taught. If it is the result of a process, then more emphasis probably should be placed on teaching people how the family process works and how to change one’s part in it. The resilient response model changes the unit of focus and offers new ways of thinking about how families can cycle out of repeated adversity and toward increased resilient responses. The multigenerational perspective that the research study presents also expands resiliency to a life long process. In other words, it is never too late to make a differentiating move. The ideas have application to various settings where human groups interact and where people work with families. Also, since any person in the family can change their part in the system, it is not necessary to work with entire families to effect change. Each person can take personal responsibility for changing how they manage their anxiety and for altering their role in the relationship processes.
However, it seems that the differentiating move cannot be made in isolation. Distancing from family to reduce anxiety and get more comfortable is not a differentiating move. Viable contact with significant others is a necessary aspect of differentiating a self from the family fusion. Without it, resilient outcomes for children do not improve. Children and often parents in each family suffered when they were out of meaningful emotional contact with family members.

For example, Liza S’s family contacts became fewer and fewer over several generations of her family until she relied mostly on her one relationship with Nancy at the expense of her own and Nancy’s functioning. Both John and Shelby O decided to marry each other without letting important others know their decision. After 25 years of marriage, they began working on their ability to differentiate themselves from their fusion with each other and their families, and in some cases, staff. Linda L’s tenacious efforts at moving toward her relationship with her mother despite her mother’s helpless dependence on staff to communicate for her, showed the power of the differentiating move on resilient behavior.

However, viable contact without efforts at differentiation is not enough. Everyone in the N Family enjoyed the family contact that the project provided. After about five weeks at NIMH, Jeff described the family research project as follows: “My parents are with me and I feel good. And you can go places with your family too. All in all, you can do nearly all you want with your family to get well.” At about the same time, his mother observed that Jeff was absorbing the unique atmosphere at the Clinic “most desirably and beneficially.” His father noted that Jeff has thrived by being close to his family, and has
shown less fear of other people. He added that Jeff utilizes and enjoys the facilities and shows appreciation for the freedom from locked doors and pressure. However, this family remained caught in anxiety binding cycles (Archives).

The necessity of viable emotional contact to lower anxiety and improve resilient responses has implications for theories of change in education, policy, and of course therapeutic treatment, including the handling of juveniles in corrections. In the latter two cases, when there are severe problems, the tendency is to remove the symptomatic children from their families and place them in residential facilities. The dramatic decline in Paula R’s functioning when her mother stayed away for a month and Paula’s rapid improvement when she was able to make regular contact with her mother speaks to the need to reconsider the unintended ramifications of removing children from their families. Gilbert (2003) advocates for increased attention to the functioning of the family emotional system and its impact on children instead of restricting contact between parents and their children. She writes,

> Common sense in our culture says that in cases involving abuse, neglect, suicide, or risky behavior endangering life, better break the family up and find surrogate parents – the children will be better off in the long run. Bowen theory points out, against common sense, that if people are yanked out of significant family relationships, their anxiety will escalate and their problems will actually intensify (Gilbert, 2003, p.145).

In her article, Gilbert (2003) summarizes the beneficial effects of helping girls in a psychiatric residential treatment center connect with their families. Within a few months of this approach, there were marked improvements in psychiatric symptoms. In addition, there was a decrease in behaviors such as stealing, lying, running away,
fighting, and suicidal attempts. This speaks to the impact of viable emotional contact on the resilient responses of youth.

If we can learn to see non-resilient responses as an outcome of family emotional processes, such as distance and cutoff, we can begin to appreciate the counter-intuitive move of connecting family members as a way to improve resilient responses. This is not easy because the differentiating move raises anxiety at first. However, if people receive coaching and support to implement the move and handle the anxiety, the results can be rewarding and well worth the effort. One way to start is by gradually building relationships with family members, including extended family. If the extended family is unavailable, there are other ways of keeping memories of the deceased alive and viable. These are helpful in gradually bridging cutoff with family members.

Further Directions for Research and Practice

Application of the resilient response model to contemporary families would continue to refine it and move it toward a valid grounded theory. It has usefulness for practitioners on both a personal and professional level. Findings could be compared with those of other researchers across disciplines. Similarities and differences in findings could be further explored and would add to the depth and breadth of the model. It would be especially interesting to communicate with other researchers exploring resiliency from a variety of angles.

An important step for this research is to link the findings to policies and procedures that uphold the American ideals of autonomy and responsibility, while also freeing people from the family processes that result in non-resilient responses of young people. Since the family projection process is prevalent in society as well as in the
family, this may be a place to increase awareness and find ways to diminish its negative impact. Perhaps this could be accomplished by tying the findings to existing models embraced by those interested in youth development, such as Bronfenbrenner’s Ecological Model of Human Development (Bronfenbrenner, 1979), or the Search Institute’s 40 developmental assets (Search Institute, 1997).

The interplay between family process and poverty would also be worth exploring. The fact that Robert S was unable to support himself despite coming from a wealthy family is intriguing. Conley’s (2004) research on sibling differences offers food for thought on this topic. Conley writes that sibling differences account for 75% of all economic inequality in America. Only 25% occurs between families. This is important to note when considering the power of the family as an influence on the resilient and non-resilient responses of its youth. The ability to support oneself is an indicator of a resilient response that relates to developmentally appropriate independent functioning. A non-resilient response involves functioning for others in ways that they can do for themselves. In Robert’s case, he was in an underfunctioning position as a response to the family projection process that was focused on him.

Revisiting the Metaphor

Let us revisit the metaphorical look at individually focused versus systems paradigms that I shared during the introduction. Only this time, I will use it to summarize the major points I have made throughout the text. The metaphor is distinguished from the discussion by italics.

Imagine you have two pairs of eye glasses. One helps you see things from an individually focused paradigm, and the other lets you see things from a family systems
paradigm. Imagine putting on the first pair of glasses. You see a young person holding a bunch of strings. In the NIMH research families, these strings represented the anxious connections between the family members. The anxiety sprang from threats, fears, and adversities of various kinds. Usually the anxiety was directed at the young person who was the identified patient in the family. However, occasionally the anxiety was directed at other siblings, parents, and relatives.

You see the individual engaged in self destructive endeavors and you see others trying to convince him or her to change. The others are each pulling on one of the strings the young person is holding. They are urging the youth to take various actions to help his or herself. Each family member tended to focus on others. Perhaps the most obvious example was Katherine N’s attempts to get Jeff to eat. You watch the individual remain entrenched in his or her behavior and thought world. Many non-resilient behaviors were evident throughout the case narratives of the families, such as self injury, self starvation, dropping out of school, and delinquency.

You go and advise the others on how to get the young person to change. You get mad at them when they don’t follow your directions. You go try to convince the young person yourself with no success. I do not know about you, but I certainly found myself wanting to get Katherine to be less focused on Jeff and to talk Mary Jo into finding a way to get to the Clinical Center so she could visit Jane more responsibly. In a sense, everyone, including you, is pulling on one of the strings the youth holds in his or her hands. The young person either pulls back as in a tug of war, or drops the string so you are left “holding the bag.” I am not responsible for these families, but simply reading about them, I become emotionally involved. I would liken some collaborative efforts to
save the nation’s youth at risk to this tug of war or being left ‘holding the bag.’ This is especially the case when the collaborative efforts promote coercive, presumptive, and brief interventions.

For instance, some programs and methods of handling youth at risk utilize mandatory approaches to effect change. Forcing youth to do something based on the presumption that they are to blame for their actions is not a winning combination. As a matter of fact, neither force nor presumption of blame addresses the elements of the resilient response model in a helpful or effective way. Presuming blame puts people on the defensive and raises their anxiety. It also represents an individually focused way of thinking about human problems that is not useful. Unfortunately, it is often harmful. The act of forcing is the manifestation of an unhelpful reciprocity between the one who forces and the one who is the object of coercion.

Related to this, the model has implications for the treatment of youth who have committed a crime. As a non-resilient response, a crime sets off a range of new adversities for the family. When a child commits a crime, the family often experiences shame and embarrassment. Parents are apt to blame themselves and become isolated. Society does not help this process. As mentioned earlier, standard procedure is to separate the child from family and society, and to punish or rehabilitate the child. Neighbors often react to juvenile crimes with shock. They manage their anxiety by trying to understand the behavior and trying to protect themselves. Neighbors automatically join in the child projection process by supporting measures that try to “fix the child” and try to force young people to change their behaviors. They support policies that remove children from their families and place them in a facility where they will not be a menace to society.
Protection is necessary, however, if it were happening in an atmosphere of connection and the reduction of anxiety, perhaps the outcomes would be more resilient for everyone, including children, family, and neighbors.

Creating a more calm and connected atmosphere requires seeing the child’s behavior as a non-resilient response and an outcome of family processes. It is to understand that these processes have evolved over the generations in response to adversity, anxiety, and the continuing family adjustment to these variables. Knowing that all families experience hardships and sometimes get stuck in a cycle of non-resilient responses puts the child on a level playing field with all the other children who have some form of a non-resilient response. It also puts the parents on a level playing field with other parents. No one is to blame, but each is responsible to for his or her part in the process. This approach lowers anxiety in society and helps each person focus on the piece they can do something about. Instead of spending time trying to rebel against mandatory infractions or finding the right approach to violence prevention, people would focus on themselves, on managing their anxiety, and on behaving responsibly.

Let us return to the metaphor. In the foregoing scene, responsibility is passed around among the players. First, everyone abdicates the power of change to the young person and they each try to make him or her use power responsibly. In the meantime, each person loses sight of his or her own responsibilities and power. Some people stop their own activities until the young person changes. It was evident that the NIMH families put their lives on hold in order to help their children. Several parents took a leave of absence from their jobs to participate in the project. In many ways this was necessary and admirable. However, some parents simply could not work because of their distress
over their child’s illness. Waiting for the child to change took its toll on those involved and in many cases did not benefit anyone.

Imagine now that you take off these glasses and put on the other set of glasses. You see a group of people, each influencing the other. Learning about the NIMH family contexts brings forward the complex nature of symptoms and resilience in these families. Sibling position, triangles, cutoff, fusion and its multigenerational transmission all played a role in how anxiety was routed in a family. The number of living members who were in viable emotional contact influenced the nature of the family’s particular web of anxiety, adversity, and family context. Never was only one person in a family symptomatic. Non-resilient responses comprised most everyone’s repertoire and symptoms shifted back and forth as anxiety was transferred. Parents were often quite symptomatic themselves or had a sibling who was. The identified patients in the NIMH study were part of their own family systems, and all shared some level of the family anxiety.

The young person is part of this group. They are each holding onto a web of continuous string that symbolizes the system of interactions that connects them all. As the case narratives described, all family members contributed to the family processes that evolved to manage anxiety, such as nuclear family process and the family projection process. Tugs and pulls are felt throughout the system. The actions and interactions of family members reverberated throughout the system. Resilient and non-resilient responses were part of these reverberations.

You join the system to feel how it works and you step back to reflect on what you experienced. After several rounds of this, you get a sense for how you contribute to the system. You change the way you tug on the string and everyone experiences the shift.
Everyone connected to the web changes, including the young person. Tugging on the string in a new way represents the differentiating move. In the NIMH study, many family members, as well as project staff, initiated a new way of interacting with the system. It was apparent that everyone connected to the string changed, including the young people who were identified as symptomatic. Resilient responses were more prevalent during these periods.

In the family cases, when parents were able, even momentarily, to set limits based on personal preferences and beliefs, the functioning of the impaired children improved. When parents pretended that the limits were not their own but due to an outside boundary, their children tended to act out. In other words, the accepting or abdicating of personal responsibility by parents for decisions that involved their relationship with their spouse or child had an impact on the child’s tendency to exhibit a resilient response. This reinforces the usefulness of the differentiating move as a way that parents can influence the processes that make a difference in the resilient responses of their children.

This is the systems paradigm of change. As a member of a system, you can effect change by altering your part in the system of interactions. The effort is focused on self in relation to the system rather than getting the other person to change. The NIMH family members varied in their ability to grasp the systems paradigm of change. Even when they seemed to begin to make shifts based on this understanding, they would lose it again later. People took steps backward and forward in learning this process. However, it seems that the overall movement was forward.

The metaphor sought to illustrate the systems paradigm with imagery. By revisiting the metaphor, the paradigm has been applied to the NIMH families as a form of
summary. It provides another angle on the resilient response model and its view of how family process influences the resilient responses of youth.

Figure 51: Inside an Ecological Framework of Youth Resiliency

A Model About Family Process and Resilient Responses

The resilient response model contributes to resiliency research and the ecological model of youth development. The model, as shown in Figure 51, is embedded in the concentric layers of a child’s world, illuminating processes underlying risk and protective factors. It examines the underlying familial processes that make a risk factor a problem for one child in a family and not for a sibling. At present, the quantitative aspect of the
risk and protective factors equation leaves parents with little to work with if they want to affect change in their families. Criteria for resilience tell us what is important but not how to bring it about. They do not show the natural processes that evolve in a family over generations as a way to manage anxiety increased by adversity. For example, lists of risk and protective criteria do not illustrate how nodal family events interact with birth dates to form a context for how the processes will play out in a family. These are important considerations that challenge parents, practitioners, policy makers, and all Americans to see their own actions and interactions as embedded in these processes and to differentiate themselves in the best interest of young people.

The model has demonstrated the link between adversity and a central phenomenon of anxiety. Borrowing from Bowen Family Systems Theory, two kinds of anxiety were identified: acute anxiety and chronic anxiety. Anxiety flows through a family system in particular ways based on contextual factors such as sibling position and its role in how parents and children relate to each other. Bowen Theory concepts such as differentiation of self (fusion), relationship triangles, emotional cutoff, and the multigenerational transmission process, alter the route by which anxiety flows through a family. The number of living members in viable emotional contact with each other is important to the understanding of how anxiety permeates a family organism.

The model illumines the family emotional processes that evolve to manage the anxiety as it flows through the family system. These action and interaction strategies evolve innocently, with the intention of reducing discomfort and preserving some sense of equilibrium. The assumption is that they are natural processes that all families participate in to some extent. When the processes are extreme, they often inadvertently
operate at the expense of at least one family member, though almost everyone in the family suffers. Some automatically stay out of the family emotional intensity. Yet, even if they do not see themselves as part of the process, their non-participation may allow a process that is destructive for some to go on unencumbered.

This raises the notion of resiliency of the entire family unit. In other words, resilient responses of some family members, when they are at the expense of resilient responses of other family members, are not a resilient response for the entire family. For example, it is interesting to consider whether the divorce in the L Family was a resilient or a non-resilient response. In other words, did it bring more flexibility to the family in the long run even though there were difficulties at first? Was Linda’s non-resilient response a warning to the family that prompted it to develop greater resiliency in the long run? Was the divorce a step toward greater flexibility or greater rigidity in the family system? Did the family do better after it found more flexible ways to handle anxiety and consequently deal with Linda on a more realistic level?

Judging from the outcomes after Linda’s other hospitalizations, the increase in resilient responses in this mother-daughter pair would probably not have happened without the interventions provided by the Family Research Project. While resilient and non-resilient responses emerge out of family emotional processes, most seem to be automatic. Some are chosen to a certain degree. The differentiating move offers family members a way to alter the trajectory of the family system toward more resilient responses.

However, the differentiating move is not a natural process. It requires coaching. In a world of increased anxiety, this may be necessary and worthwhile. There is too much
information in this data to suggest that an open setting, where family members are in contact with each other and where families and staff are encouraged to be accountable for self and to relinquish inappropriate responsibility for others, has a calming and therapeutic effect.

Look at the power of hope in the functioning of John O when he anticipated joining the project. Look at how well Jeff functioned during his first weeks on the project. Look at how Linda L stopped rebelling against hospital rules and improved her ability to handle herself responsibly in her family and her community. Look at the difference that Mary Jo’s involvement in the clinical program made in helping Paula come out of seclusion. Look at the fact that Nancy S was able to function lucidly once she became more independent. In the end, she was not considered the psychotic member of the mother daughter pair. There are too many examples of how a differentiating move elicited a more resilient response in the others in the emotional system.

In a rapidly changing society where we have to adapt in ever increasing and multiple ways, knowledge about resiliency is important. In a world with multiple challenges that generate anxiety, we need a better understanding of the automatic relationship processes that evolve to manage it. We need this for our own survival and particularly for increasing and sustaining the resiliency of the future generation. Even though these processes are complex, that should not stop us. In our highly technological society, we are no strangers to complexity. The challenge lies in grasping new paradigms in the emotional realm of our experience where we tend to operate in instinctive, automatic ways, especially to relieve the discomfort of heightened anxiety.
The resilient response model can help people grasp this new way of thinking about automatic and instinctual emotional processes. It shows how these processes link to the resilient responses of future generations. The model offers new ways to enhance adaptability and flexibility for young people, families, and the larger society. This dissertation shared the resilient response model that emerged during the data analysis, highlighted with stories of five families that were part of a Bowen’s pioneering research study at NIMH from 1954-1959. Using Bowen Family Systems Theory as a lens for analyzing family processes, the model shows how these processes inevitably influence the resilient responses of youth.

People wanting to enhance their flexibility, can use the resilient response model as a guide for learning how to change their part in the system. Once people understand how to differentiate a self on a family level, the entire society stands to benefit. Whether a person leads a family or a nation, emotional process is alive and well. The temptation is to join or rebel against the fusion. The challenge is to differentiate a thoughtful course for the present and the future, acknowledging the emotional need for connectedness among family members and within society.
References


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