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Differentiation of Self: Enhancing Therapist Resilience When Working with Relational Trauma

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Clinicians are charged with being diligent in gaining competency in the latest trauma-informed interventions when working with relational trauma. This may invest therapists with an overresponsibility that is not only overwhelming and unrealistic, but serves to reduce autonomous functioning in family members. Therefore, clinicians need to become clear about what they are responsible for and what they are not, particularly when family members present as irresponsible or too anxious to think and act more effectively. Using a case vignette, this paper discusses how a clinician's focus on increasing their differentiation of self, a concept embedded in Bowen family systems theory, protects against vicarious traumatising, secondary traumatic stress, and burnout whilst contributing to more autonomous functioning and better wellbeing outcomes for both clinicians and clients alike.

Keywords: vicarious trauma, secondary traumatic stress, burnout, Bowen family systems theory, self-care, resilience, autonomy

Key Points

- 1 The trauma milieu demands increasing therapist commitment to ongoing and extensive training in a multiplicity of trauma-informed interventions.
- 2 The intensity of this work may leave clinicians vulnerable to vicarious traumatising (VT), secondary traumatic stress (STS), and burnout.
- 3 A focus on enhancing the clinician's differentiation of self, based on Bowen family systems theory (BFST) principles, is imperative when managing issues of risk and safety.
- 4 BFST functions to protect against VT, STS, and burnout by assisting to reduce the heightened reactivity that is evoked when working with the most vulnerable and challenged families.
- 5 This focus enhances resiliency and contributes to more autonomous functioning and better wellbeing outcomes for both clinicians and clients.

Introduction: The Challenges of Relational Trauma Work

Informed by researchers such as Bryant et al. (2010), most clinicians working with trauma are aware that not all clients who have experienced prolonged exposure to overwhelming events develop post-traumatic stress disorder (PTSD), as diagnosed in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5). Nevertheless, many clients, particularly children and adolescents who have experienced relational disruption and abuse, present to therapy with 'a wide range of affective, anxiety, and behavioural symptoms' (Bryant et al., 2010; Levin, Kleinman, & Adler, 2014, p. 150) that are characteristic of the trauma milieu. Most committed clinicians, endeavour, therefore, to understand the neurobiological mechanisms that are compromised in early development in anxious, neglectful, or dangerous environments (Porges, 2011; Siegel, 2012). They devote time and energy to gain competency in the latest evidenced-based trauma-informed interventions, which can include mindfulness, neurofeedback, eye movement desensitisation reprocessing (EMDR; Shapiro, 2001), tapping, and other exposure techniques designed to reduce symptomatology.

Co-morbidity across mental health diagnoses for traumatised children and adults will also require practitioners to be able to assess and work with multiple mental health presentations, ranging from depression and anxiety to diagnosable personality disorders. In addition, clinicians must also understand how culturally and linguistically diverse backgrounds, migration, intergenerational racial abuse, and oppression may be contributing to the multiplicity of symptoms and difficulties. Familiarity, at the very least, is required about interventions that may be useful for clients in addition to therapy, such as 'Cool Kids' (Hudson et al., 2009), 'Circle of Security' (COS; Marvin, Cooper, Hoffman, & Powell, 2002; Cooper, Hoffman, Powell, & Marvin, 2005), parent-child interactive training (Eyberg et al., 2001), adolescent dialectical behaviour therapy (DBT; Linehan et al., 2006), and group domestic violence intervention programmes. If

they are not already working in the family dispute resolution arena, clinicians must also have knowledge about how separation, divorce, and child access and financial disputes impact children and parents/carers in often very adversarial court processes.

Outside any individual, couple, or family focus, trauma-informed practitioners must manage the stress of both prioritising and providing mental health assessments of multiple patients concurrently presenting to emergency. In addition, these clinicians must strategically manage relationships with a range of professionals including other treating clinicians and team leaders, emergency room nursing staff, in-patient mental health clinics, teachers, principals, non-government homelessness, and residential care workers, as well as the child protection and juvenile justice systems. This is in order to maximise the efficacy of the suite of interventions and approaches undertaken as well as to negotiate the demands of risk-averse under-resourced and highly anxious wider systems.

In the day to day of relational trauma work, clinicians diligently utilise cognitive therapies to challenge distorted and self-blaming beliefs and perceptions to assist clients towards a 'reappraisal of the meaning of the trauma' (Cloitre, 2015, p. 3). Therapists working from an attachment perspective attempt to facilitate validating, secure, and safe bonds between carers and children and between two partners in the couple relationship (Ainsworth, 1991; Bowlby, 1988; Farber, Lippert, & Nevas, 1995; Greenberg, Ford, Alden, & Johnson, 1993). Given the privileging of the centrality of the therapist/client relationship within most therapeutic discourses (cf. Bowen family systems theory: Bowen, 1978), attachment-oriented clinicians are charged with the responsibility of being available, consistent, and able to provide a reparative experience that is deemed crucial to reducing the often very severe internalising or externalising symptoms the client brings into the consulting room. This is particularly in the face of perceived or actual incapacity of the adult or parent/carer to manage these trauma sequelae in a contained way for themselves or the young person in their care. The therapist must also sustain commitment and fortitude in working with clients to reduce extreme self-injurious behaviour, sexual promiscuity, suicidality, aggression, and being vulnerable to sexual predation (a constant concern for clinicians working with children in out-of-home care).

Yet despite proven therapist competency and the array of evidence-based interventions that are utilised in work with this traumatised population, many clients do not improve significantly. Marylene Cloitre (2015) writes that despite participation in appropriate intervention, 'approximately 40% of treatment completers maintain their PTSD diagnoses . . . and even among those who no longer have PTSD, the majority still suffer from significant residual symptoms. (Cloitre, 2015, p. 3). Similarly, Bruce Perry (2009) in talking about child maltreatment states:

Children with relational stability and multiple positive, healthy adults invested in their lives improve; children with multiple transitions, chaotic and unpredictable family relationships, and relational poverty do not improve even when provided with the best "evidence-based" therapies. (Perry, 2009, p. 252)

Vicarious Traumatization, Secondary Traumatic Stress, and Burnout

Given these challenges and demands, it is not surprising that therapists have been long considered vulnerable to burnout, secondary traumatic stress (STS), and vicarious traumatization (VT). STS and VT symptoms are perceived to occur because of a therapist's indirect exposure to the trauma narratives related to them by their clients (Figley, 1995; Pearlman & Saakvitne, 1995a,b). According to Figley's (1995) definition, a therapist suffering STS would likely report that they were experiencing symptoms of avoidance, numbing, and hyperarousal. VT involves 'disrupted beliefs in relation to the self, others, and the world from cumulative exposure to client trauma narratives, in addition to trauma symptoms (Makadia, Sabin-Farrell, & Turpin, 2017, p. 1060; McCann & Pearlman, 1990). Taken together, both STS and VT are consistent with some (although certainly not all) of the specifiers of a diagnosis of PTSD.

Burnout relates more closely to the severe 'on-the-job' stress that occurs with increasing client/patient and wider system demands (Morse et al., 2012; Maslach & Pines, 1979; Maslach,

Schaufeli, & Leiter, 2001; Baker, O'Brien, & Saluhuddin, 2007). Symptoms include emotional fatigue, cynicism (which may be directed towards clients/patients, management, colleagues, and the value of the work itself), and a diminished sense of self-efficacy (Awa, Plaumann, & Walter, 2010; Stalker et al., 2007). Factors that contribute to burnout include extreme workloads, limited autonomy in relation to decision-making processes, role conflict, and minimal supervisory and collegial support (Morse et al., 2012).

Just as not all persons exposed to overwhelming, even life-threatening, events develop PTSD or trauma-related symptoms, prolonged indirect exposure to accounts of traumatised clients is not an inevitable predictor of either STS or VT (Levin et al., 2014, p. 149). However, there are conflicting findings. Makadia et al. (2017), in a cohort of 564 intern clinical psychologists, found no correlation between the symptoms associated with VT and trauma work, although they did find that there was a relationship between indirect exposure and symptoms of avoidance, intrusion, and arousal – symptoms consistent with STS. Environmental variables, such as those associated with burnout, were nevertheless found to be predictive of increased distress and disturbed belief systems (Makadia et al., 2017). VT was reported in other studies of psychotherapists working with traumatised clients, as well as with social workers working in family violence, although vicarious resilience, that is, psychological growth in the face of exposure to trauma work (Calhoun & Tedeschi, 1999), was also found to be experienced concurrently in many cases (Arnold, Calhoun, Tedeschi, & Cann, 2005; Ben-Porat & Itzhaky, 2009; Gartner, 2014; Gil, 2015; Puvimanasinghe, Denson, Augoustinos, & Somasundaram, 2015).

Protective Factors

A clinician's vulnerability to VT and STS has been found to be influenced by gender (cf. Baum, 2016), age, personal trauma history (see also Dagan, Ben-Porat, & Itzhaky, 2016), fewer years of trauma-informed training, fewer years in the field, poorer coping behaviour, and reduced social and supervisory support (Makadia et al., 2017). Recent Israeli studies, however, have found inconsistent mediators of resiliency in relation to VT and STS. Exposure to threat whilst working with traumatised clients increased VT symptoms in social workers; conversely supervision that was perceived as constructive protected workers against VT (Peled-Avram, 2017). In contrast, a study examining differences between social workers working in social service versus child protection contexts found that factors such as the clinician's sense of self-efficacy, as well as more years of clinical experience, protected against STS, whereas a perception of positive social and supervisory support did not (Dagan et al., 2016), which is a finding consistent with studies of STS variables for clinicians working with Israeli women experiencing domestic violence (Ben-Porat, 2017).

Further, stressors associated with the child protection role such as dealing with, and high exposure to, the 'pathology' of actual child maltreatment, the burden of responsibility for protecting children from further harm, and a 'chaotic, unstructured, and unpredictable work environment' compared to workplaces that were more 'functional [and] structured,' were more likely to increase STS (Dagan et al., 2016, pp. 208–209; Pross & Schweitzer, 2010) and burnout (Killian, 2008; Morse et al., 2012; Awa et al., 2010). Finally, in a study using a Bowen family systems lens (Bowen, 1978) to account for resiliency factors, Halevi and Idisis (2017) found that higher levels of emotional maturity protected against the symptoms and the blurring of boundaries between the therapist's and client's worldview that is characteristic of VT.

From a research perspective, differing sample sizes, the context of the trauma work, the specific research method, and factors including demographic variables – age, gender, years of professional experience, and degree of grounding in trauma-informed work etc., are all implicated in the divergent results related to factors associated in increasing or decreasing vulnerability to VT and STS. Nevertheless, efforts to understand how clinician resiliency and self-care can be promoted, not just after a taxing clinical day, but also in the room with clients, deserves continual scrutiny and reflection for individual clinicians and in supervision. So in what

follows I discuss the usefulness of a Bowen family systems theory approach to this clinical work and its application to a case study followed by practice reflections.

Bowen Family Systems Theory

Bowen family systems theory (BFST) consists of eight core concepts: differentiation of self, emotional cutoff, triangles, the nuclear family emotional process, the family projection process, the multi-generational transmission process, sibling position and the societal emotional process (Bowen, 1978). While it is beyond the scope of this paper to go into detail about these important theoretical principles, some discussion is necessary to examine how they can provide a framework for increasing the *therapist's* resiliency in their work with traumatised clients and their families.

In BFST, the ability for a person to sustain emotional mature action in stressful situations is impacted by their degree of sensitivity or *emotional reactivity* to the distress, the need for attention, and expectations of, and affirmation from, others (Bowen, 1978; Kerr, 2008). This reactivity is influenced by two counteracting potencies of *togetherness* and *individuality*, which are evoked by the human imperatives to experience both “‘love”, approval, emotional closeness and agreement’ as well as to be emotionally separate and autonomous (Bowen, 1978, p. 277). The lower a person’s hyper-sensitivity to others, the higher their level of emotional maturity, or *differentiation of self* (DoS: Bowen, 1978). Bowen saw levels of emotional maturity and immaturity as resting on a continuum.

The *Differentiation of Self Scale* is a psychometric measure developed by Skowron and Schmitt (2003), which assesses key characteristics of higher and lower DoS. These markers, which will be explained in further detail below, include the ability of a person to hold an ‘*I-position*,’ their level of emotional reactivity to others, the degree to which a person distances from others via *emotional cutoff*, and a person’s degree of *fusion* in relationship with people significant to them (Bowen, 1978; Halevi & Idisis, 2017, p. 3; Skowron & Schmitt, 2003).

Anxiety significantly impacts a person’s reactivity to the behaviour and emotional states of others. It can be *acute*, based on an assessment of real or current threat to the integrity or safety of self or others, as with relational trauma. With *chronic anxiety* – there is no actual danger to life or limb, but the person can maintain a high level of anxiety about the possibility of censure, rejection, or conflict with another (Bowen, 1978, p. 361). The greater a person’s reactivity to others, the more a person may emotionally respond ‘in the service of relieving the anxiety of the moment’ (Bowen, 1978, p. 179), rather than acting from thoughtful, principle-driven principles.

Thus, the ability to distinguish between affective and cognitive states (Bowen, 1978) is a characteristic of DoS. A person with a higher level of DoS may feel highly anxious, and concerned about another person, or alternatively, angry and blaming of them, but they are able to act with less reactivity in relation to this person’s distress or attacking behaviour. They can set appropriate limits, speak about their difficulties directly to the person without blaming them or being judgmental, sustaining a sense of personal autonomy whilst staying connected and contributing to the relationship with the other. They manage the intense discomfort of the other person disagreeing with them, without distancing or moving to accommodate the other’s views at the expense of their own clear thinking (Bowen, 1978; Noll, Clark, & Skowron, 2015).

A person with higher DoS can maintain an I position, which, according to Bowen:

...defines principle and the taking of action in terms such as, “this is what I think or feel or stand for” and “this is what I will do or not do.” This is the responsible “I”, which assumes responsibility for one’s own happiness and comfort and well-being. It avoids thinking that tends to blame one’s own unhappiness, discomfort, or failure on the other. The responsible “I” also avoids the posture of the irresponsible or narcissistic “I” which makes demands on others with “I want or deserve” or “This is my right or my privilege.” (Bowen, 1978, p. 218)

Maintaining such an I position depends on the ability to manage the anxiety of the moment, which is particularly high when working with distressed and dissociative clients (MacKay, 2012). This capacity is related to the individual's degree of *unresolved emotional attachment* (Bowen, 1978, p. 263) to one's parents. The BFST notion of attachment is very different from the concept used by attachment theorists. In Bowen theory, attachment is constituted by other-directed single-mindedness that involves over-caring, or *over-sensitivity* to the feeling states of others. Bowen calls this over-involvement *fusion* (Bowen, 1978, p. 384). This relationship state is more indicative of the early symbiotic mother–infant bond that should otherwise reduce in intensity as the child grows and matures and takes more responsibility for their own functioning. That is, as the infant then child-then adolescent-then adult matures, the limits of their own ability to soothe themselves in the face of emotional dysregulation and relationship stress increases, although this capacity can be compromised with sustained exposure to acute stress and transgenerational trauma.

An individual may not only find it very difficult to *self-soothe* in the face of relationship disharmony (Wright, 2009). This person may feel driven to meet the emotional needs of others, as if it is their responsibility. It is normal in life to function for others when they suffer some temporary challenge, such as when they are sick, or grieving, or experiencing some other adversity, however many individuals find themselves automatically *overfunctioning* for others (Bowen, 1978, p. 197), that is, doing for the person what the person could, at least, begin to do more for themselves. Sustained overfunctioning in any relationship, beyond the dependency needs of an infant or child, creates a vulnerability to symptom development. Overfunctioning for others also creates a vulnerability to continuing to automatically *underfunction for self*. An example of sustained under functioning that is maintained from childhood into adolescence and beyond by parental overfunctioning, is when a child's anxiety is deemed too great to allow the child to struggle with the discomfort of going to sleep by themselves; so much so that the anxiety of the parent(s) about the child's anxiety impedes the parental capacity to set limits and manage their own distress about the child's distress.

In family therapy settings, it is common to hear that a child remains in the parents' bed, or one parent sleeps in the child's bedroom into early adolescence, due, the parents say, to alleviate the child's anxiety about sleeping alone. In this way the child may develop 'a permanent functional impairment' (Bowen, 2017, p. 260) that persists into adulthood: as anxiety increases, the possibilities for autonomy, personal mastery, and greater emotional maturity decrease. Other siblings, who to some degree have been protected by the anxious focus of their parents on the other child, may be freer to be more functional and autonomous as they mature. The underfunctioner may persistently feel abandoned by others who do not assist them to manage their emotional states. In this sense, another's *availability* becomes an imperative that may temporarily support the underfunctioning person, but eventually over stretches the resources and capabilities of the overfunctioner. The overfunctioner may eventually 'drop the ball,' distance, or emotionally cut off from the symptomatic young person without being aware of their contribution to the underfunctioning of the other.

The most significant component of any emotional system is the triangle. When anxiety rises due to the actual or potential for conflict between a two-person system such as the parents of the child who has trouble staying in their own bed, a third person, the child, may be recruited to assist in reducing the tension between the dyad (Kerr & Bowen, 1988, p. 135). This recruitment can be subtle or obvious. A child who has been difficult to settle as a baby or is struggling with peer relationships at school may become the focus of sustained concern by a parent, even when the child's difficulties reduce. In the environment of that concern, the child can become wired to be over-attentive to both parental distress and expectations.

One parent may already have become symptomatic due to the anxiety of managing tension in the couple relationship. The parents may continue to triangle the child, for example, stay focused on the child's anxiety about sleeping in their own bed, rather than work with as much emotional maturity that they can find to resolve the difficulties that are occurring between the couple dyad that are, often subtly, relieved by the child's symptoms. Keeping the child in the parental bed in

response to the child's increasing anxiety maintains the increasing distance between the parents. In this example of the mechanisms of the family projection process (Bowen, 1978, p. 127), both parents and child are contributing, however unconsciously, in the transmission of the issues that belong between the parents to the child.

For individuals who find it difficult to self-regulate in the presence of another's emotional state, intimacy is too anxiety provoking. Self-directed action is also too anxiety provoking if it involves upsetting someone close. Some such individuals will distance and either emotionally or physically cut off to reduce the immediacy of their feelings of anxiety. They may appear cold and indifferent as they behave with an 'exaggerated facade of independence . . . tear[ing] themselves away to achieve a pseudoseparation' from others that belies a highly anxious affective state and a lower level of DoS (Bowen, 1978, p. 92).

The effort to increase DoS is undertaken in coaching (Bowen, 1978, p. 310). In this process, the therapist works to gain a neutral multi-generational view of the person's family system to assist the person to do the same. According to Bowen, this research-observer stance requires a decrease in the focus on the other, which is motivated by the desire for the other person to change their behaviour. The therapist, too, is charged with the same task in terms of their own family of origin work and any reactivity they have which is expressed in the desire to change the client or another family member. Instead attention is shifted to increasing DoS through the 'changing of self':

The changing of "self" involves finding a way to listen to the attacks of the other without responding, or finding a way to live with "what is" without trying to change it, of defining one's own beliefs and convictions without attacking those of the other, and in observing the part that self plays in the situation. (Bowen, 1978, pp. 178–179)

For couples in relationship therapy, a focus on increasing functional levels of DoS has been demonstrated to significantly reduce distress and increase each partner's sense of wellbeing (Bartle-Haring & Lal, 2010, p. 106). Indicators of emotional wellness have also been shown to correlate to higher emotional maturity levels (Skowron, Holmes, & Sabatelli, 2003), as well as to account for co-dependent functioning more significantly compared to the traditional measures of relationship satisfaction, such as 'dyadic satisfaction, cohesion, consensus, [and] affective expression' (Lampis, Cataudella, Busonera, & Skowron, 2017, p. 162).

Assisting adolescents to manage their reactivity to other family members in DoS oriented individual coaching has been shown to alleviate the degree to which the young person engages in maladaptive internalising cognitions (Knauth, 2004; Kolbert, Crothers, & Field, 2013). Adolescents with higher levels of DoS demonstrate increased problem-solving capacity, academic application, and reduced adolescent risk behaviour; lower markers of teenage and young adult DoS have been correlated with higher levels of anxiety, sexual promiscuity, and drug abuse (Knauth & Skowron, 2006; Peleg-Popko, 2004).

Research into relational trauma undertaken by Elizabeth Skowron and colleagues at the University of Oregon has clearly demonstrated that levels of DoS are indicative of child abuse risk, impaired rupture and repair processes, reduced positive autonomy support, and resiliency in children who experience family violence and physiological indicators of impulse control such as respiratory sinus arrhythmia which is a marker of increased risk of harm by a caregiver to a child (Cipriano, Skowron, & Gatzke-Kopp, 2011; Creaven et al., 2014; Lunkenheimer, Ram, Skowron, & Yin, 2017; Skowron & Dendy, 2004; Skowron, Kozlowski, & Pincus, 2010; Skowron & Platt, 2005).

Increasing Clinician Resiliency – Applying a Bowen Lens to Working with Trauma

Exhausted when saying yes, guilty, when saying no – this tension is between giving and taking, between other-care and self-care . . . It is just more intense for those who are, by nature and inclination, emotionally attuned to the needs of others. (Skovholt & Trotter-Mathison, 2016, p. 4)

A high level of differentiation of self facilitates . . . a clear sense of self, good adaptability, and efficient coping abilities when under stress . . . The therapist's ability to maintain both clear and flexible personal boundaries . . . allows him or her to uphold an effective separation between the patient's emotional world and his or her own. This separation is essential to reduce possible damage to basic cognitive schemas, and to lessen the risk of developing vicarious trauma caused by exposure to aversive content in the course of clinical work. (Halevi & Idisis, 2017, p. 5)

Case Illustration: 'Alice,' 'Daria,' and 'Steve'

Background and referral

Fourteen-year-old 'Alice' was originally referred to a CAMHS team by her school counsellor after a contingent of Alice's Year 8 friends told her that Alice (who the counsellor had met only once some months prior) said she 'hated her life' and had made social media posts stating she 'might as well be dead.' Despite contact from the school about this issue, Alice, her mother, Daria, and stepfather, Steve, failed to attend the urgently scheduled first appointment. Daria phoned the service 10 minutes before the scheduled appointment to say she had been forced to work late. The clinician did not meet with Alice and her family until after Alice had been admitted as an in-patient to an adolescent mental health unit with high suicide risk. This occurred after another parent contacted the police to say her son was trying to persuade Alice not to throw herself off 'The Gap,' a high cliff notorious for suicide overhanging the Tasman Sea in the Eastern Suburbs of Sydney. Emergency services arrived in time to restrain Alice and take her to the local emergency department.

Alice parents separated when she was eight years old after it was discovered her biological father had been sexually abusing her since she was four. Alice's father served time in gaol for this offence and now lived in another state. He blamed Alice for the abuse and had no contact with her since his incarceration. Alice had counselling in pre-school and kindergarten and Daria had participated in COS. By the time Alice started Year 1, her symptoms, which included nightmares, sleeplessness, inappropriate sexual behaviour, somatic symptoms such as stomach and headaches, bedwetting, and aggression towards others, had greatly reduced, and contact with child protection and therapy services had ceased.

Alice's mother, Daria, at the time of the CAMHS referral, was 36 years old, and remarried Steve when Alice was 11 years old. Alice had been an only child until her young half-brother was born nine months before the incident at the Gap. Daria, who had recently returned to work as an accountant, reported she had started to see a psychologist as it was so difficult to be the parent of a 'difficult' adolescent and a baby, and to be working full-time. Daria, an only child, had been raised by her hard-working single father since adolescence. Daria's mother had multiple hospitalisations due to depression and anxiety and died from suicide when Daria was 12 years old. Steve, who was a 40-year-old Indigenous Australian, was raised in a family where he was the only male of three male siblings not incarcerated due to drug-related offences. Steve worked long hours as a truck driver and was often away for days at a time. Both Steve's parents died from alcohol-related symptoms when he was in his early 20s.

Alice's more recent acute symptoms appeared to settle over the holiday period, which coincided with Alice spending much of her free time with her new 15-year-old boyfriend, Jayden. As a result, she was eventually discharged from CAMHS and referred to me for family therapy with Steve and Daria. I had a positive collegial relationship with the referring clinician as I had provided some consultant supervision for the service Alice and her family had attended. With the appropriate agreements in place around permission to exchange information (and this included Daria's individual therapist, whom she had begun seeing shortly after the birth of the baby), I was informed of many of the details of the family history as well as that Alice had been very difficult to engage in therapy at CAMHS. The clinician expressed high concern that Alice's unwillingness to talk about anything to do with her feelings, her birth father, her trauma history, or her current family relationships, nevertheless kept her at high risk of relapse.

Family therapy sessions

In my first meeting with Alice, Daria, and Steve, Alice remained moodily silent and picked at the skin around her fingernails. When Alice refused to respond to any direct questions, Daria became visibly distressed, and said: 'See what I am up against? There is nothing I can do! She is like this at home. She only speaks to me when she wants something!' Steve appeared to be watching Daria during most of the session. When asked about his concerns, he said, 'Alice keeps making it hard for Daria. I try to support her with Daria as much as I can. But we would not have any tension in the house if Alice wasn't like this!' Before I could ask more, Alice swore and stormed out of the room. Daria sighed, and then asked Steve to stay in the room whilst she went after her daughter. The session finished shortly after.

In my second session with the family, I decided to see Alice on her own, not because I was convinced I could engage any better with her than the previous CAMHS therapist, but more to lean into Daria and Steve's perception of her behaviour as the problem. The hope was that her parents would calm down enough to engage in therapy in a more thoughtful way and begin to look at the system of interactions that may be contributing to Alice's symptoms and the family anxiety as a whole.

What happened next took me completely by surprise. Alice, after delivering a scathing diatribe on the faults of both her mother and Steve, suddenly quieted and began to ask me how she might get in contact with her birth father. When I asked what motivated her to want to contact him now, she burst into tears and told me she wanted to tell him what a bastard he was for ruining her life. She then proceeded to tell me details of what she remembered about the abuse she had suffered, details that included how threatening her father had been towards her for 'telling.' Finally Alice ended her heartrending narrative with the admonition: 'I don't want my mum to know! She will only get upset and tell me that I can't blame her; that it's not her fault; that she didn't know; and whether I think she is a bad mother – all stuff about her and not me!' When I attempted to ask her how many times she had tried to talk to her mother about how she felt, Alice said, 'Lots of times!' Before I could gather more information, she said she had done enough talking and walked out to the waiting room, slumping into a chair in the corner. Despite Alice's visible distress both parents appeared preoccupied with their little boy, who they said was tired and hungry, so they decided to end the session.

Prior to the third session, Daria contacted me to say Alice had spent the night before in Accident and Emergency after the school had insisted Daria take her to the hospital when Alice's maths teachers had reported she had overheard Alice telling a friend she 'might as well walk in front of a car.' When I asked Daria what else may have happened that might have triggered Alice, Daria told me that before school, she had also had a fight with Alice about spending too much time on social media and not doing her homework. And, as if it was an irrelevant afterthought: 'Oh, and Alice yelled at me that the reason she was texting Jayden was that he said he was going to break up with her.'

I immediately noticed I was starting to feel quite anxious as I was talking to Daria, who did not seem to be conveying an appropriate level of affect in terms of any worries she had about Alice's safety. As I took a second or two to think more about this, Daria handed the phone over to Steve to talk to me whilst she tended to the baby. Steve told me he was fed up with 'all these shenanigans' but then laughed and asked me whether the family would have to pay for the next session if they couldn't come at short notice, 'if Alice throws herself under a bus, or whatever.'

Despite my observation of these family system dynamics, I started to wonder whether the therapy session with me had contributed to an escalation in Alice's symptoms. Had her talking about her abuse and feelings towards both her birth father, mother, and Steve contributed to her decompensation? Alice had seemed contained enough in the room, and I had done a safety assessment in any event, twice in the course of Alice's narrative, but I worried that I had not done enough to ensure Alice's emotional and psychological safety.

I also became quite concerned neither parent nor step-parent seemed to be cognisant of the severe risk Alice presented. I asked Steve to put Daria back on the phone and began to tell Daria how much I was concerned for Alice's safety. I noticed that I felt a rising anger at what I perceived was Daria's lack of responsiveness to this critical situation. My reactivity had also been heightened because I had been copied into an email sent to Daria from Alice's school principal. The email expressed the principal's reservations as to whether it was safe for Alice to attend school given her degree of suicidal ideation. I knew the school system was already highly sensitised to any threat of suicide by a student as it had lost both a Year 9 student and a teacher to suicide the year before.

I was already feeling overwhelmed because of an excess of paper work to which I had not had time to respond, overdue student papers to mark, and anxious about how well one of my own daughters was coping having just ended a relationship. Significantly, I had also recently attended a family dinner in which relatives had made comments after watching a news report as to 'How terrible child abuse is!' seeming to make no connection to the child abuse that had occurred in my own family system. Feeling shocked, I had not been able to access more mature functioning in the moment, and had instead retreated into distance by staying silent for some time before re-joining the conversation, as if nothing had been said.

The next day, I received a phone call from Daria's private psychologist, who told me that she believed Daria was suffering post-natal depression and that I 'should go gently' with her. I too had hypothesised whether Daria was depressed, given her presentation. I noticed that I felt more 'dazed' than angry after this phone call and felt somewhat disconnected from my own body.

A few days later, Alice turned up for therapy by herself. Daria had given her apologies but said she had to run an errand. Steve was absent because he was interstate for work. I felt nonplussed, given Alice's overnight stay in emergency, not a full week before. However, I did relax slightly as Alice calmly walked into the room, threw herself into the chair and exclaimed how happy she was to have started therapy with me. She said:

You just seem to "get" me . . . No one else seems to. You are the first person who seems to understand that my parents are just focused on themselves, the new baby, and that they really don't care about me the way you seem to do.

It is hard to describe the feelings of ambivalence that passed through me. I felt pleased that Alice felt so engaged in therapy. But I believed that if Daria and Steve were unmotivated to look at their contribution to Alice's difficulties sustained change was unlikely to occur. I also felt vaguely superior to the colleague who had much less success engaging Alice, although I tried to push that away. And, I felt an uncomfortable sense of responsibility for Alice in the face of her disconnection from her parents. Here I worried that Alice's lightness of mood was a precursor to increased, rather than reduced, suicidal ideation and found myself thinking: 'I just have to keep hanging in there with Alice, because no one else is. There just seems no point in working with the parents.'

When I could centre myself enough to think, I began to see how much I had become caught in the contagion effect of anxiety that had so quickly transferred from the inpatient adolescent mental health team clinician, the school, the friends, and parents of Alice's friends, from the parents, to me. 'Emotional contagion' is the term used by Miller, Miller, Stiff, and Ellis (1988) to describe how one person may inadvertently experience similar affective responses to another, which effectively contributes to professional burnout (Miller et al., 1988, p. 254; cited in Baum, 2016, p. 231). However, using a BFST lens allowed me to see I was being pulled into increasing fusion with this family. My own thinking was becoming increasingly 'catastrophic' as I experienced both 'profound helplessness [and] dissociative processes' (Papero, 2017).

Reflections on Practice

Conceptually, a Bowen therapist would hypothesise that the angry and blaming behaviours conveyed by Daria and Stephen are reactive and therefore anxious responses to feeling out of control and helpless to intervene with Alice. In this sense, even parents who may appear indifferent and neglectful may be using distancing and cutoff strategies to manage their own hyper-aroused states according to emerging research into parenting and child maltreatment (Prof. Elizabeth Skowron, personal communication). Much of my work with both Daria and Steven would involve me working to stay more neutral to gain information about the 'facts of functioning' the what, how, when, and where of the family members' reactions to each other and events (Bowen, 1978, p. 415). Bowen very much cautions against becoming focused on 'why' something has happened as it places responsibility for the problem or symptoms in perceptions about the pathology of a person.

For example, if I was to simply hypothesize that Daria's lack of concern for her daughter was because of her post-natal depression, I start to lose curiosity about the ways in which she may be able to lift her functioning at other times, given there is evidence that she is extremely attentive to her young son or responded appropriately to Alice when she was symptomatic as a younger child. I can think about how well Alice's parents have negotiated her transition into adolescence. I can wonder how easily Daria is managing Alice's move into increasingly independent behaviour. Is it possible that appropriate autonomy-seeking by Alice is met with criticism and then distance? Are Alice's efforts to separate met with positive support?

Further, if I was to hypothesise that all of Alice's symptoms are a result of the abuse she experienced, I do not begin to wonder how her behaviour is embedded in the system of person-to-person family interactions that may function to keep some of these symptoms in place. I stay too linear. I become too easily caught in thinking 'the reason for this is because of that,' rather than viewing family behaviour as recursively driven and how greater or lesser capacity to manage one's reactivity under stress depends on how well a person can function from principles rather than affective reactivity. If I can do this, I can ask questions that assist me to explore multiple hypotheses.

BFST would suggest that Alice's symptoms are also maintained in the triangle via the family projection process. To explore this, I can ask about how the couple manage conflict between them, if, as it may appear, that the only 'tension' in the house, according to Steve, involves Alice. I can be curious as to whether the couple otherwise avoid conflict and wonder if one or both use distance or accommodating behaviours to do this. Daria's depression may be exacerbated by not being able to manage the anxiety of potential conflict with Steve, particularly given what may lie unresolved between her and Alice's father, details for which I have scant information. Also if Steve finds it hard to self-soothe when Daria is upset, then this may contribute to his high reactivity to Alice's behaviour. It is therefore possible that any unresolved issues between the couple are contributing to a negative focus on Alice with Alice's behaviour contributing to the maintenance of this focus.

A BFST view assists me to widen the focus to gain a multi-generational view of the family's emotional process. But, perhaps more integral to this challenging work, it increases the capacity of the therapist to reflect on their own reactions and anxious responses to Alice and her family, before, during, and after therapy sessions and in interactions with different parts of the family's wider systems (Meyer, 2014). The therapist takes time to pause and reflect as to what they are observing in self as they find themselves 'having to act' or 'to help' or 'to fix' in an anxious and less thoughtful way. BFST emphasises that therapists maintain a posture to 'assume-responsibility-for-self,' not only because this encourages more objectivity in their work but because it improves outcomes for wellbeing outcomes clients and therapists alike (White, 2011, p. 117).

Taking this stance requires the therapist to ask questions about the facts of her functioning across a number of domains. For example, in terms of the therapist's case conceptualisation –

who or what does the therapist see as 'responsible' for the dilemma? How might this reflect her unresolved emotional attachment in her own family of origin? This is never more obvious if the therapist can reflect on the degree to which she may be alternating between blaming and wanting to rescue family members. What is the therapist's reactivity to the wider system and to issues of safety? How is she becoming vulnerable to absorbing anxiety that belongs to others and over-functioning in terms of her actual responsibility in this case? What would her I position look like, if she could articulate this in a non-reactive way, in terms of what she sees herself as responsible or not responsible for?

Questions for the Therapist In relation to my conceptualisation of the issues

*Am I being caught into only seeing the problem as 'in' the child?
Am I being caught into only seeing the problem as 'in' the parent(s)?
Am I being caught into only seeing the problem as 'because of the abuse'?
How might this assist/reduce my ability to be more of a resource to family members?*

In relation to the facts of my functioning in my own family of origin

*How does my own undifferentiation make me vulnerable to being pulled into this role with this child and her family, in this way, at this time?
What points of undifferentiation do I need to target in my own family of origin work?
How does my 'staying silent' during a difficult conversation help/hinder me?
What does being more of a self at family functions look like?
What if I could find a way to manage my reactivity better and speak something of my own experience without attacking, confronting, distancing, or cutting off?
What benefit might this give me to my own functioning in my family?
How might this assist me to be less reactive and fused with clients whom I also experience as indifferent and cut off?
How can I continue to reduce the degree to which I (over) function in my family (i.e., as rescuer, peacemaker, the 'special' one) to assist me to resist similar implicit invitations to step into this role with client families?
How am I vulnerable to clear thinking when I lean into the narcissism that is inherent in being the 'only one who understands'?
How does this play into the functional position I had in the triangle with my own parents, in which I was recruited as a confidante?*

In relation to the facts of my functioning with family members

*What do I notice about the level of anxiety I am experiencing before the family even enters the room for therapy?
Is my sensitivity to avoiding conflict and a focus on wanting a client to 'feel' better stopping me taking a clear I position with family members about ALL family members attending, not just Alice?
How can I challenge this?
How can I address the triangle that has formed between Alice and me as her family therapist, which, if I continued to lean into it, would function to keep Daria more on the outside, and less of a resource to her daughter?
Can I be clear to Alice that whilst I am pleased she has been able to talk about very hard, painful things in therapy, that I see it as my job to assist her to be able to share these things with her mother, given a parent is the most important resource an adolescent can have in her life?
Furthermore, can I make clear to both that I am not willing to rob Alice and her mother of the opportunity to find connection and support with each other in this way?
With this in mind, how might I now make overt what information I am willing/not willing to keep secret, given I did not do so at the start?*

In relation to wider system reactivity

How does my anxiety about the wider system response to Alice's unwavering suicidality contribute to me working too hard here?

To which wider system am I the most reactive?

In what way does this organise my functioning with Alice and her parent?

How might I manage myself, aware that I am at risk of accommodating to Daria's individual therapist's anxiety, rather than any facts of functioning that I may glean in relation to Daria in this regard?

How might I make overt the challenges of working with a family member that is engaging in individual therapy that may conflict with my own conceptualization of the case, without attacking or being defensive or distant?

How can I respectfully ask Daria about what is useful about her individual therapy, and how she might work out for herself what information or insight she might privilege, if either of these therapeutic interventions conflict?

In relation to safety

What do I need to do to manage the proportionate level of acute anxiety related to Alice's suicide risk?

What do I need to say to Alice, Daria, and Steve to assist me to define my responsibilities and the limits of what I can and can't do?

How do I stay clear and act from these principles when parents are not maintaining their functioning in this?

Did I clearly state to Daria and Steven that I see them as overtly responsible for the safety issues?

Can I be truly curious as to how it is the parents are not more worried about Alice, given the concern I and other professionals have for her? If not, what is stopping me from doing this?

Alongside the therapist's own work to manage her reactivity to this challenging family presentation, family sessions would focus on gathering information about Steve and Alice's multi-generational family systems, their own responses and that of ex-partners, parents and grandparents, to autonomy-seeking behaviours, to conflict, and to adverse events, as the therapist tracks the way DoS and acute and chronic anxiety play out. If Alice does not want to participate in these family sessions, she does not have to – I may spend some time with her, but I will be clear about what information needs to be shared with her parents and not be kept private, in my quest to keep 'safety first' (Bickerton, Ward, Southgate, & Hense, 2014, p. 150). As my focus of intervention is the whole family system, therapy with Alice focuses on tracking her reactivity to significant others and assisting her to find more mature functioning, for example, when she experiences her mother distancing or Steve being critical. Similarly, this is the focus of work with Daria and Steve as I assist them to become thoughtful about the system of interactions to which they contribute, which function to keep Alice's symptoms 'stuck.' The goal is to increase thoughtfulness and to encourage more autonomous thinking and behaviour whilst staying purposefully and empathically connected to significant others. As Meyer points out:

As the neocortex beings to think in new ways about old emotionally laden history, a new level of objectivity emerges that acts to lower anxiety . . . The individual learns that developing the capacity to think about emotional process in the family and in self provides an entirely new ability to act based upon facts, in spite of intense feelings . . . And can remain focused on those facts in the presence of intense feeling. (Meyer, 2014, p. 281)

Conclusion

This paper describes and illustrates from a BFST perspective how to be more responsible for personal and professional self-care and reduce heightened reactivity in working with vulnerable, challenged, and trauma-affected families. This thinking has developed over some years in conjunction with my own family of origin coaching, which involves managing anxiety and being more self-differentiated in stressful relationship interactions, particularly in relation to my own personal trauma history. It is my limited attempt to illustrate that 'the way a therapist thinks about a problem can be more important than what the therapist does in therapy' (Bowen, 1997, p. 186), specifically as this thinking manages to reduce the pull towards overfunctioning, blaming, rescuing, and the myriad reactions that come with working with the intensity of relational trauma.

Paradoxically, this thinking does not occur in therapeutic work with clients alone: it occurs in the doing of one's own family of origin exploration, as challenging as that may be when considering one's personal contribution to any ongoing relational difficulties. As a means of protecting against VT, STS, and burnout, this focus on enhancing the clinician's differentiation of self not only serves to improve family functioning when managing issues of risk and safety, but is also central to improving resilience, self-efficacy, and autonomy for both the client and the clinician.

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