# Commitment to Principles:
# The Letters of Murray Bowen, M.D.

Clarence Boyd, Editor

With a Special Introduction by Michael Kerr, M.D.

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*Dr. Murray Bowen during an interview for the article: Kicking the feud out of the family, which was published in The Raleigh Times, October 11, 1988. Photo courtesy of The News & Observer.*

Commitment to Principles

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## Appreciations and Acknowledgments

I would like to express my gratitude to Mrs. Bowen and the Bowen family for deeding to the public domain Dr. Bowen's archives, which are the source of this manuscript.

When I approached Dr. Michael Kerr, Director of the Bowen Center, about writing an introduction for the letter project, his response was "how can I say no to that!" Certainly, no one has more first-hand experience with Dr. Bowen, beginning as a third year medical student in 1965. My sincere thanks for Dr. Kerr's contribution to this project.

John P. Rees, M.A., M.L.I.S., curator, Archives and Modern Manuscripts, History of Medicine Division, at the National Library of Medicine, was of major assistance with this project guiding me through the legal and professional protocols to access the archives, retrieving the cartons from storage, making copies of the letters I wanted, and doing it all with an encouraging smile.

Portions of this project were read to participants in various family systems supervision groups. They wanted more.

My wife, Samantha, not only encouraged my doing this project, but also appreciated its importance.

The introductions to the letters were handwritten. Sheila McNamara had the task of typing what I had written, figuring out what was singular or plural, and where to put the apostrophes. Her patience endured through the final product.

Dr. Bowen's archives contain many additional letters. I am responsible for those selected and those omitted.

Introduction I

## Letters

Letters have been important as a major way, and sometimes the only way, of connecting people. Historically, they have been both carefully crafted and carefully read. For some writers their letters become prose and certainly an art form, with a creative brain expressing itself through their letters. Dr. Bowen's letters reflect these creative processes.

There are numerous examples. I'll mention five writers with whom readers will readily connect.

Rainer Maria Rilke's *Letters to a Young Poet* contain ten letters to a 19 year-old young struggling poet [Franz Kappas], who had written Rilke for "advice." The letters speak little of poetry but focus on the importance of listening to and respecting the human struggle in us all.

Reynolds Price's *Letter to a Man in the Fire* is a 108-page letter responding to Jim Fox, a young medical student who had been recently diagnosed with cancer. Fox had read Price's book *A Whole New Life*, which told of Price's cancer experiences. Fox's question to Price was, "Is there a God and does he care?"

Elizabeth Lawrence was a garden writer who lived in Raleigh and Charlotte, North Carolina. She was a prolific letter correspondent with other gardeners all over the U.S. Another interesting fact about her life is she was the third generation daughter to devote a major part of their lives to caring for their mothers after their spouses died. Here is a letter written to a lifelong friend from childhood, Ann Bridges: "Independence is a strange illusion. We are no more independent from the members of our family than we are independent from our stomachs….we are like one strand in a rope bound tightly together and unless we pull in the same direction, we only destroy each other."*

Another example is the volume *The Freud Jung Letters*, which cover a nine-year period of their relationship from 1906-1914.

And lastly, copies of letters written by our grandparents before our parents were even born are certainly a gift. Letters were the only way to communicate when people lived apart. There were no phones and people were often separated for periods of time because of jobs, e.g., one person teaching school in one location and the other staying behind and working the farm.

Bookstores contain numerous volumes of letters, too many to mention, but all worth pursuing—such as Eudora Welty, Truman Capote, or if lucky, the ones saved in your attic.

Now to the Bowen letters.

* From *No One Gardens Alone, a Life of Elizabeth Lawrence* by Emily Herring Wilson, p. 99.

Introduction II

## Commitment to Principles

Dear Dr. Bowen,

Since I have taken on a sizable project that includes your archives, I think I owe you an explanation of what I am up to.

I have a long-term interest in learning about how people think, whether in my own clinical work or in learning from people who think theory is important (e.g., you). For many years when listening to you interviewing family members, I listened to the questions (not answers) you were asking, thinking that your questions were an accurate reflection of your thinking, your assumptions, beliefs, and principles.

My original plan was to trace the evolution of your thinking from Topeka to NIMH to Georgetown. This proved almost impossible for two reasons: (1) The nature of the archives and (2) the nature of your thinking.

After your death, many of your files were placed in the care of the National Library of Medicine at the National Institutes of Health in Bethesda, MD. They are placed in 14 cartons (17.5 linear ft.) dating from 1961-1990. My hope was that the files were going to be in chronological order. However, they are, more or less, filed alphabetically (obstacle #1 to my plan). You didn't throw away much! There are bills, uncashed checks, newspaper clippings, and articles on your patient families, Xmas cards, and, of course, carbon copies* of your original letters responding to patients, colleagues, students, and people seeking your professional advice. The letters are fascinating in many aspects: Your never taking a day off from being the observer and your holding people accountable for being responsible when they mess up. There are numerous letters in which you made a number of drafts before being satisfied with your clarity.

I began the project in July 2003 and made numerous trips to NLM. I went through each folder (#1001) and read all of the letters (over a period of 2 ½ years). I had the NLM staff make copies of those I thought spoke to your principles and were a clear reflection of your thinking. I chose 77 of your letters and decided to use 61 in the final project.

In my opinion, letters are a clear reflection of one's thinking for two reasons. One has to be clear about *what* one is thinking and secondly, *how* to say it.

The second reason for my shifting from my original idea of tracing your thinking evolution over time has to do with your "evolution." As I read the letters, I was struck by your theoretical

* His carbon copies have not been retyped. Patient names have been edited out, as well as the minor paragraphs that have nothing to do with the importance of the letters.

clarity and principles of how emotional systems work in the beginning, the middle, and in the end. There was some minor tuning and clearer articulation, but it was like the theory was always there—it (and you) only got clearer over time.

Therefore, my project shifted. What I have done is select letters that reflect your clarity of principles. I have attempted to write an introduction to each, giving a larger context in an effort to stimulate the reader to think more clearly about her/his assumptions, beliefs, and principles and not just hear your "bottom lines."

I chose the title for the project: *Commitment to Principles. The Letters of Murray Bowen, M.D.*

With sincerest and grateful appreciation,

Clarence Boyd

Introduction III

## The Bowen Letter in Historical Context

**Michael E. Kerr, M.D.**

Murray Bowen died on October 9, 1990. I became Director of the Georgetown Family Center upon his death and have continued in that position for seventeen years. It is a privilege to be able to add an introduction to this collection of many of his letters. I worked closely with Murray Bowen for over twenty years at the Georgetown University Medical School. The Family Center was part of Georgetown until 1990 and then became a freestanding, not-for-profit organization. The name was changed to the Bowen Center for the Study of the Family in 2000 to recognize Murray Bowen as its founder. The Center's mission remains the same as when it was founded: the development and dissemination of Bowen theory and its applications.

This book really consists of two volumes: the Bowen letters themselves and Clarence Boyd's introduction to each letter or group of letters which constitutes an interesting explication of Bowen theory in its own right. The letters offer a glimpse of Bowen's thinking and of Bowen the man that is difficult to glean from other sources. Boyd's work to make the letters easily accessible to others is valuable contribution.

My brief introduction will focus on events relevant to Bowen and to the family movement from the late 1960s until his death in 1990. This will include some discussion of my relationships with him to help place the Bowen letters in some historical context.

I first heard Murray Bowen lecture in the spring of 1965 when I was a junior medical student at Georgetown. He made two points in his talk that made a strong impression on me. The first was that he had observed in his family research that the relationship between a mother and her adult schizophrenic offspring was extremely intense emotionally. They were so sensitive (reactive) to each other that they functioned as if they were one person. The second point was that this level of emotional intensity does not develop in just two generations (parents-offspring), but is the outcome of three or more generations.

I had had enough exposure to conventional psychiatric thinking in medical school by then that the tone of Bowen's presentation and his ideas seemed radically less pathologizing of the schizophrenic person and his family than what I had heard from other psychiatry professors. I was perhaps affected more than many other students by his talk

because one of my brothers had been diagnosed to have schizophrenia just before I started medical school. Bowen seemed to know the mother I knew.

Apart from occasionally seeing Bowen dash through the halls of the medical center like a man on a mission, I did not have contact with him again until several years later during the first two years of my psychiatric residency at Georgetown. He stood out among Department faculty in a way that I find hard to put into words. He was a presence. The Department of Psychiatry did not push the residents to get exposed to Bowen and his ideas. In fact, the curriculum for the residents was such that there was no regular contact with him until the third year of residency. During the first two training years, however, occasional conferences occurred that included Bowen. They were especially interesting to me.

My favorite conference during the second year of residency was one that included Bowen. It was scheduled originally to occur every month, but the department hierarchy canceled it after just three meetings. The way it all played out was quite revealing about Bowen's position in the department.

The structure of the conference was that the residents and faculty would meet at a faculty member's home in the evening. A resident was assigned to present a clinical case. Then one faculty member would discuss the case from a viewpoint of individual theory, a second would respond from a viewpoint of group therapy, and Bowen would discuss it from a viewpoint of family therapy. A memory of the first meeting is that the faculty members representing individual and group therapy recommended a family approach to the case. Well, you might think that Bowen would have been pleased with that, but he recommended individual therapy! My memory of the second meeting is that when it came time for Bowen to respond to the case, he asserted. "I haven't heard one damn word about grandparents!" Silence followed for a time.

I can only guess at what Bowen was trying to do in those first two meetings. In retrospect, I thought he was probably relating to the emotional process of the meeting rather than its content. He was clearly different than everyone else in the room. A measure of his success in doing that came clear when the third meeting came along and it was my turn to present a case. The Residency Training Director called me into his office several days before the meeting and told me not to present a case that had anything to do with family! I did not know what to make of his request at the time, but I felt that I had to comply. He was my immediate boss. When I presented the case, Murray Bowen was

the first discussant. He turned to me and queried, "Why did you choose this particular case to present?" I covered up for my boss. It was the last of those meetings that the department organized.

At the end of my second year of training it became possible to get supervision from Bowen. An organized course with him began at the beginning of the third year. I could relate many experiences from the next two years of supervision with him, but one that stands out the most is a presentation I made to him three months into the supervision sessions. It was in September 1969. By then Bowen was asking residents to make presentations about their families of origin. I keyed in on this immediately and spent much of the summer talking to family members and developing a fairly detailed family diagram. When I presented to Bowen in September, he did not say a word! He just sort of smiled. Believe me, I did not expect that reaction. I thought he would say something positive about my effort. I remained confused by his response for a time. The core message of differentiation is to think for self and take responsibility for self. Don't be yearning for approval.

The 1960s and much of the 1970s were vibrant years for the family movement nationally and there was tremendous activity in Georgetown. This was the case despite constraints in the department designed to keep Bowen from becoming too influential. Bowen founded the Georgetown University Family Center in 1975. He had appointed eleven volunteer faculty members to help teach in the family programs by 1975 and many of us joined him as founding faculty of the Center. Mental health professionals locally and around the country poured into the Center's programs. Most were interested in family therapy and in learning how to differentiate a self in their families of origin. A smaller number were interested in theory. For several years Bowen had been cautioning his faculty to play down the success of our programs to the Department of Psychiatry, lest they get nervous and begin encroaching on our autonomy. This had happened several times in the past. This caution continued in the early years of the Center, but the success of its programs was hard to hide.

Perhaps the high point of the 1970s was the publication in 1978 of Bowen's collected papers, *Family Therapy in Clinical Practice*. It gave even more visibility to Bowen's ideas and it increased the requests for him to travel and conduct conferences. The increased demands definitely reduced the amount of time he had to write. This is one reason his letters are so important. He only published a few papers after 1978. In response to this

change, Bowen began the series of Bowen-Kerr videotaped interviews in late 1979. He wanted to cover details of the theory and therapy that he had not been able to write about. We did sixteen interviews that are an important part of his legacy. I believe the pressure he put on himself — always, but more so after 1978 — contributed to the health problems that surfaced several years later. Bowen knew that he had developed something that was extremely important and he worked incredibly hard to communicate it effectively to others.

At some points during this early period of the Family Center Bowen would emphasize how long it was going to take for the professions and society to accept the new systems paradigm, often estimating a hundred years; at other points he speculated that a few of us would be chairing departments of psychiatry by the end of the century! The latter prediction has not occurred. The conflicting predictions indicate that things were developing so rapidly in the 1970s that some of us believed the family idea might be accepted more rapidly than originally anticipated.

A long description of the factors that may have slowed the acceptance of the family idea is not relevant to this introduction, but I will mention one factor that profoundly affected psychiatry. That factor was the growing dominance of the biological paradigm. The emphasis on "the broken brain" and psychotropic medications marginalized family psychiatry. The change in psychiatry pressured the family movement nationally and it triggered what I call a "failure of nerve." Bold claims for a biological explanation of severe mental illness put most people in the family movement on the defensive, particularly in reference to schizophrenia. Family people were cast as blaming families for a biologically caused disturbance. The critique did not affect Bowen's views, nor did it affect my own, but it did affect the forward movement of the field. An increasing focus on symptoms and on the quick fix, both in health care and in the society as a whole, was another important factor.

A physical illness in the spring of 1981 had a significant impact on Dr. Bowen. He developed a dissecting aneurysm of the thoracic aorta in early March, which did not rupture. He underwent two extensive surgeries during the next three months and it was at least another six months before he was back to anything close to his former schedule. I know it shook me, the rest of the Center faculty and staff, and the national network of all those seriously interested in Bowen theory. I think it also placed Bowen in a new position.

Murray Bowen had great courage and determination. He took on psychoanalysis and effectively challenged its shaky foundations. He valued his relationships with others and

their unique contributions, but knew that to develop and maintain a new theory, he had to lead and lead vigorously. This meant having the energy and will to define a self over and over again in professional, social, and familial emotional arenas. I perceive his physical illness to have placed him in a position of having to rely more on others to provide the type of leadership he had provided for so many years.

One manifestation of his new position is that he was more easily and outspokenly frustrated with how people routinely misunderstood his basic ideas. The larger problem was that people often had no clue that they did not understand. The reactions were not entirely new for Bowen, but having worked with him through the 1970s, it was more pronounced in the 1980s. It was true that most of us did, to varying degrees, misinterpret his ideas.

The upside to the changes with Bowen was that it pushed the Family Center faculty and others in the network to step forward and accept more responsibility for leadership. It also pushed us to give Bowen more room to be Bowen and not get so reactive to some of his critiques. It was also clear to some of us that faculty members needed to work more diligently to be more of a "self" in relationship to Bowen and to the larger professional community. We had left too much of the leadership to Dr. Bowen.

I did not do as good a job as I would have liked at being a "self" with Murray Bowen, but I worked at it consistently. I did not always tell him if I disagreed with his assessments. I had difficulty being direct with him. The problem was more in me than in him. I had watched Bowen get upset with many people, but I never thought that his criticism was personal. It was his unfailing effort to keep theory on track. My differentiation from Bowen was gradual and incomplete, but it was one of the most important efforts I made in my own development.

Despite paralysis of one vocal cord that left him with a raspy voice, a complication of one of the aneurysm surgeries, Bowen did an amazing job of recovering. Most of the 1980s were a very productive time for the Center. One of the most important developments was his leading the Center and its network to renew a focus on theory and science. Family therapy and differentiation of self in one's own family were extremely important contributions, but he thought the importance of theory was getting lost. The focus on science and theory had started in the late 1970s, but it built considerable momentum in the 1980s.

Not everyone on the faculty and in the network was entirely happy about the shift to science. Some struggled to see the relevance of slime molds, ant colonies, and primates to the real business of family therapy. Attendance at conferences and training programs slowly declined and then leveled off in the mid-to late 1980s. A core group of faculty and people in the network were very much on board with Bowen's lead. This change by Bowen and the support others gave to it in the 1980s probably did more to sustain Bowen theory after his death than any other development. Certainly, everyone knew that being able to deal better with their families and other groups was where everyone gained so much personally, but, absent a broader process that kept theory from becoming a closed system, many of us saw that the process of differentiation could easily disintegrate into a set of techniques.

In the spring of 1984, W. W. Norton Publishers contacted me about writing a book related to Bowen theory. Bowen and a small research group at the Center had been working on a system of family assessment or "family diagnosis" for about two years. I got the idea of focusing the book on this subject. Since the basic design of the family assessment was Bowen's, I asked him if he wanted to be a co-author. He agreed and we settled on him writing an introduction to the book and my writing the bulk of the book.

Writing *Family Evaluation: An Approach Based on Bowen Theory*, somewhat changed my relationship with Bowen. I began writing in March of 1985 and submitted the full manuscript in early September 1987. It was an extremely important effort for me because it was a statement of where I stood on Bowen theory. It emotionally separated me from Bowen a little bit because I felt less dependent on him for my thinking about theory. I was a tad more of a "self" by the time I finished the book. One of the advantages of writing for publication is that it can force you to figure out what you think. It is one thing to have a head full of ideas, but it is another thing to *know* where you stand in relationship to those ideas.

Bowen began working on the introduction shortly after Christmas 1987. The publisher was pressing him to complete the introduction because they wanted to bring the book out in the spring of 1988. It was arduous for Bowen to write at that point. In 1986, he was hospitalized for the first of many times over the next several years because of emphysema. He continued to have a few cardiovascular problems, but emphysema was becoming the bigger problem. He was quite ill with each hospitalization and it took time to recover after each one.

My memories are vivid of a late afternoon in February 1988 at the Family Center. Bowen had been working on the introduction at his office at home for about six weeks.

The publisher was making threats to leave the introduction out of the book if they did not get it very soon. This did not help. More importantly, Bowen was no longer writing a short introduction. After he began writing, he began thinking of all manner of things about the development of the ideas that he had never written about. This was not something he would finish quickly.

That February day, Dr. Bowen's wife drove him to the Center. He managed to climb the long flight of stairs to the Center and asked me to come into his office. He was pale and short of breath. The secretions were obviously building up again in his lungs and I was certain he would be hospitalized. What he said to me was, "Mike, trying to finish this writing is killing me! I must stop!" I had no doubt that he was right. What he said next surprised me, "Write me a prescription for an antibiotic. I am going to take it and put down the writing for now." I did not think he could recover at that point without a hospitalization. He did recover! Within about two to three weeks he returned to writing. It was my first awareness that reducing the strain on oneself could reverse a buildup of secretions in the lungs! It was one of the myriad ways I learned from Murray Bowen.

Around March 1, *The Atlantic Monthly* contacted Norton after reviewing the manuscript I had submitted. Norton had sent it out to several magazines to see if they might have an interest in publishing excerpts of the book. Then occurred a sort of miracle of miracles. The publisher of *The Atlantic* wanted to do it. More importantly, they asked that publication of the book be delayed until October 1988! This meant Bowen had several mere months to work on his piece. He finished by early June and was satisfied with it. The delay meant it would be an epilogue and not an introduction. It is among the most important pieces Bowen ever wrote because it provides a broad overview of how he developed the ideas, from the earliest days at the Menninger Clinic, through the NIMH research period, and through the years at Georgetown.

Bowen had become more frustrated than ever by the late 1980s because so many people were mixing the new natural systems theory with Freudian theory. It went on at the Center and in other places teaching Bowen theory. It continues to this day. This makes the section on erosion of theory one of the most important in this book. Despite the frustrations, Bowen conducted his professional career as if the theory could be communicated effectively to the next generation and maintained as an open system. The letters remind us, however, how much discipline is required not to erode systems theory by mixing it with cause-and-effect thinking.

The situation in the last few years of Bowen's life was quite likely compounded by the clear decline in his physical health. His head remained amazingly clear in many ways right to the end. Those who have seen the interview that Bill Doherty did with him at the AAMFT conference on October 7, 1990, two days before he died, can attest to the clarity of his thinking.

In my now seventeen years as Director of the Bowen Center, I have had my own frustrations with the erosion of theory. I think of Bowen whenever I experience the frustration. Despite any erosion, I think the Center and its network have worked hard to keep and succeeded in keeping Bowen theory an open system, not allowing it to devolve into dogma. As Bowen often said, "Theory can be changed by facts alone, not by personal opinion." The viable contact with the accepted sciences has helped keep Bowen thinkers exposed to facts from many disciplines. This prevents one person or small group from taking the theory very far in unproductive directions.

Effective leadership is as important today as when Bowen was alive. Some individuals have more knowledge and ability to lead than others do, but everyone can lead by defining a "self' on the important issues. Defining a "self" is not telling others what to do, nor is it an attempt to constrain their thinking. Situations arise, however, when a leader has a responsibility to respectfully disagree with others' positions and to have the courage to make unpopular decisions.

My vision of the future of Bowen family systems theory and its applications is that it will involve three intertwined threads or resources (1) preserving the Bowen Archives, (2) further developing the Bowen Center and its network, and (3) continue making viable contact with the accepted sciences. This book is an example of the value of the Bowen Archives.

Access to articles, books, and audiovisual media helps people enormously in learning the theory and its applications, but these materials alone are not enough. Differentiation of self is an idea so different from conventional thinking that people inevitably have misconceptions if they just read about it or watch a clinical interview or videotaped lecture. The tendency to try to fit, force really, new ideas into one's preexisting mindset is powerful. An excellent check on this process is to discuss one's developing impressions with those who have acquired a better understanding of the ideas. Ultimately, the experts in Bowen theory are answerable to the facts of the natural world. This is where viable

contact with the accepted sciences comes in. As Francis Bacon said, “The human mind is inherently prone to error. It must have a proper method to weight it down.”

I will close with a special thanks to Clarence Boyd for the time, energy, and dedication he has put into this project.

Washington, D.C.
December 2007

# “ANOTHER WAY OF THINKING” - THE NATURE OF THE LENS

## "Another Way of Thinking" - The Nature of The Lens

Dr. Anne Harrington was the distinguished guest presenter at the 36th Georgetown Symposium in 1999. She raised a number of questions during the discussion periods, which followed the presentations. One question was, "Why do you focus on the 'family' as opposed to other units of observation?" Needless to say, the Georgetown audience thought her question a little odd. There were some attempts to respond to her question, but none spoke clearly to the logic and assumptions of the "family" conceptualization.

There are indeed choices for the selection of the observational unit. There are many levels of "systems," each of which has validity and reality. Some researchers study communication patterns at the cellular and genetic level and how these interactions play a role in certain diseases (e.g., cancer, diabetes, autoimmune disorders). The prevailing and dominant paradigm today remains the focus on the individual, and interactional patterns within the organism (e.g., DSM-IV). The child guidance model acknowledged the importance of the parents, but thought it important to operationalize the therapy process of the child and the parents as separate, though in interaction. Early psychodynamic models focused on patient/mother relationships—such as symbiotic relationships, or "schizophrenogenic mother." It was hard to keep "blame" out of this model, with one backlash result being the NAMI organization of parents insisting that mental illness is a brain disorder within the individual, like diabetes is a disease. Transactional analysis and Gestalt theories recognize the interactional (and internalization) relationship patterns, but limit the focus to the individual and his/her parents. There is no focus on or conceptualization of multigenerational relationships or interactional patterns. Another lens and conceptualization focused on the tribe or community as the healing medium (Ross Speck and Carolyn Attneave). James Lovelock's Gaia conceptualizes the entire earth, and its environment as a single, interacting, self-regulating system. Some astronomers speak of "the life cycle of galaxies," and articulate interactional variables. There is no shortage of lens!

In December of 1978, a family practice faculty member at a Midwestern medical school sent a paper to Dr. Bowen on "differentiation of self in one's culture of origin." Dr. Bowen's response touches on these various "lens" and some of the pitfalls. He also offers his thinking about "why family?" and similarities with other emotional systems.

December 27, 1978

December 27, 1978

Dear Dr.

Thank you for sending the copy of your paper on differentiation of self in one's culture of origin. It is a fascinating subject and I am pleased to hear your ideas and comparisons.

You present a dozen or two interesting ideas about which we could debate for hours. There is no time for all the detail. In general I agree with the notion that emotional process in the family has some striking similarities with emotional process in society.

The notion of the "differentiation of self in one's culture of origin" contains some knotty problems. I will pass along some of my experiences. In the 1972-73 period when I began presentations about "societal regression" people automatically began to think "societal therapy." The most striking example was a two day meeting at a large university. The evening of the first day someone had printed signs inviting conference participants to special meetings the next day to plan "societal therapy." On a practical level the only place the "differentiation of self" can take place is in one's family of origin. That is the only place the relationship system is strong enough to sustain the emotional turmoil of a serious "differentiating" step. It is not possible in families in which the family member is emotionally cut-off and the emotional bondedness is too weak to sustain it. The family further extrudes this family member. It is common for people to make such efforts in their work systems. Anyone who gets serious about this will end up getting fired. I have had personal experience with a dozen or more of these. I know of one minister who began a long term effort to start differentiating moves around the discrepancy in religious beliefs. His footing seemed sound enough for a beginning effort but I doubt if he can make it work on more than a token level. I have not heard from him in about two or three years. The belief system in a culture is on a fairly deep level but it would take some agile footwork to maintain a viable relationship with a previous culture after a person has shifted his beliefs toward another culture. The people who are successful in the cross cultural arena are those who have first made progress in their own families. Then it becomes automatic for them to be different, accepting and understanding in all other relationship systems. To start with another system and work back toward the family is usually an exercise in chaos, frustration, and total futility.

Considering everything, I think it is accurate and “on the mark” to point out similarities between the family emotional system and all other emotional systems but it goes beyond the boundaries of reality to imply that one can differentiate a self in these other emotional systems. Overall, I think the effort in your paper is a commendable one. However I do think your paper would be more effective if you would present it more as another way of thinking than as an explanation for this in the way things are.

If I know you, you will be thinking and working on this problem far into the future. I appreciated the copy of the paper and I will be looking forward to hearing the evolution of your thinking in the future.

Sincerely,

Murray Bowen, M.D.
Clinical Professor
and Director of the Family Center

MB:jrl
Enclosure

# HISTORY AND PROCESS

## History and Process

It is interesting to hear what people "hear" about Dr. Bowen and how they use what they "hear." Even a relatively benign question like "What does the theory say?" travels through a few layers of subjectivity when the answer comes out. There is confusion between what is a fact and what is a process; what is an observation of a process and that which is observed; what is a noun and what is a verb. To paraphrase Gregory Bateson: "The map is not the territory." There is also a fair amount of interpretation in reading of what Dr. Bowen meant, e.g., "causes" of schizophrenia. Numerous chapters have been written by authors describing his theory/therapy development. What determines what the authors focus on and what they leave out? When Dr. Bowen uses the phrase "a science of human behavior," what does he mean by "science"? Some observers attempt to compare Bowen theory to other theories ("he's really talking about transference") which usually adds more confusion and distortion. Some say he's really using psychoanalytic theory when he inquires about a person's relationship with a parent.

In Dr. Bowen's letter of August 1989, he offers a brief historical review of the what and how of the theory development. Of particular interest is his articulation of how his theory includes *both* a scientific and a non-scientific side.

Chevy Chase, MD 8-6-89

Dear

Many thoughts about the session on Friday, especially about writing up the story about the "skunk woman", that might become libel. It was only one personal story, among many in that period. Professional people did not believe a new theory was possible. They believed it was all based on personality characteristics in me, rather than facts about the universe, that anyone could "see", if they tried hard. The world has changed a bit in 40 yrs, but most bypass theory, and focus on personality.

The main things I tried to communicate, were:

1. Lifelong motivation to help Freud move psychiatry toward science-art, generally associated with medicine. Mission impossible.

2. Unexpected success in a decade. Direct focus on "what was wrong" with Freud, was not successful. Success came only with a focus on the accepted sciences. A few FACTS from Freud; plus evolution, could start with the beginning of animate life on the planet, millions of years ago; if the two could be connected with a "systems theory" that connected the ANIMATE with the INANIMATE. Much time went into the development of Natural Systems Theory to fulfill this need.

3. The new theory was developed in Kansas, several years before the move to NIMH. Full time research was necessary to move beyond simple technique.

4. Theory operationalized at NIMH, 1954-1959. Special kind of family chosen to illustrate the concepts. Immediate development of family therapy, and description of numerous concepts that fitted precisely with the new theory. Overwhelming evidence that the new concepts were present in all humans, from the most functional to the most impaired, irregardless of social status, or race, color, or creed.

5. Reaction of the environment, 1954 to present. This has been so consistent, and so divergent, that special categories are listed.

   a. Immediate reaction. I was the only one who could "see" the family clinical phenomenon. Others could see when told what to look for. The professional world guessed the clinical concepts were merely the product of pre-existing theory, plus schizophrenic families, living on the ward together. Others tried to reproduce the research period, without changing theory. Results were largely unsuccessful. The new theory was part of the world wide explosion into family therapy. Family Systems Theory, later called the Bowen Theory, became only one of several techniques of family therapy.

   b. Long term reaction. In the beginning, I thought the world would change, with family experience, as workers discovered the theoretical misfit. It has happened at a slow pace. Names such as "systems" and "systemic" have been used with little academic awareness of the meaning of the terms. Therapists use one or two concepts from Bowen Theory, liberally mix them with individual theory, and truly believe they practice a reliable version of a different theory. Some believe

the "key point" is knowledge of past generations. Books have been written to indicate one has "differentiated a self" by learning a few items about past generations. A diluted version of the theory has become popular with professional readers. Over the years, "thuh [sic] theory" has become part of the public domain. Some writers have become popular through the publication of diluted segments of the total theory. "Dilution" is equivalent to "erosion", or to "lag time" in previous papers. It is an insidious process that operates when the population opinion of the masses is greater than the theoretical sureness of a therapist. It has involved an increasing number of Family Center therapists who are not aware of the force for togetherness and the theoretical gains from specific individuality.

c. Renewed effort. The theory has been the focus. Increased number of conference for Faculty and staff, based on theory. If the central unit knows theory in detail, its influence will spread, more quickly, through trainees and other motivated people. There was no "magic" in "seeing" the new theory. Anyone could have done it, if they had the basic information that went into the creation of the theory, and if they could erase the old theory from their thinking. If the focus is on "what is wrong with the old, the debate will continue indefinitely. If more professional people know "accepted facts" about theory, the profession can move more rapidly, toward an accepted SCIENCE of human behavior.

d. The future. Family Systems Theory (later called the Bowen Theory) is one step toward a new theory of human behavior. It has gained wide acceptance in only 35 years. It is still liberally mixed with feeling items from the old theory, that are not factual. Theorists in the future century, will move more rapidly toward a more factual theory, and ultimately toward science. The human is as scientific as all other cellular life on the planet. The human is also a feeling being, which is not scientific. Past theorists have found it impossible to connect the scientific with the non-scientific. Bowen Theory has conceptualized the human as a scientific creature, that also feels. Feeling items are carefully separated from the scientific side. Feelings are a superficial part of the relation between the humans, including the therapist, and with certain imagined forces. Feelings are handled in the therapy, separated from theory, which moves toward science. When the human can carefully KNOW AND RESPECT the difference, there will be a science of human behavior separate from the non-science of feelings and imagination. Future theorists will know the difference, and help the disciplines comprehend. Sometime in the next century, a science of human behavior, will have structured a bright new future for human beings.

Washington, D.C.
August 1989.

Murray Bowen, M.D.

SYSTEM, SYSTEM, WHO HAS THE SYSTEM?

## System, System, Who Has The System?

There seem to be as many definitions of "systems" as there are people who use the word to describe what they do and how they think. Certain parameters and assumptions are included and others are excluded. Some focus on a particular characteristic, such as "communication patterns" within a system, or "homeostasis" of specific components of a system (e.g., the balance between cell apoptosis and cell proliferation). Some people use an observational/descriptive lens, while others focus on "change" processes within the system. Some refer to systems from a cybernetic/computer model of variable interactions and prediction of possible future outcome (e.g., hurricanes), while others limit the use to natural systems, more grounded in biological principles. Some people within the "natural"/biological system thinking focus on "why" questions and answers. A symptom/disorder focus is an example of this view.

Family therapy system theories also contain wide variety and a selection of assumptions for the observational focus. One school of family therapy has added a two-generation lens (individual and family of origin) to a T.A./Gestalt model. Carl Whitaker insists on the "entire family" being present for therapy sessions. Others will work with anyone in the family who is motivated, and allow the family to decide who comes to the therapy session. Some will focus on "interactional patterns" and "relationships" among members. Some therapists will focus on "helping" members "communicate" with each other. Some therapists link illness (e.g., schizophrenia) with communication patterns (e.g., "double bind theory").

System language is also applied in large organizations, making certain assumptions about the connections and interactions between different levels within the organization, such as a "systems approach" in a public mental health organization including all of components (state, region, local); or criminal justice system. Gregory Bateson took it to a societal/cultural level. For example, what happens to the future thinking and behavior within a society when "deceit" becomes a part of the system's thinking. He was linking WWII as being precipitated by the "deceit" within the treaty that ended WWI.

Dr. Bowen was invited to be a part of a panel on “systems theory” at the May 1977 APA meeting in Toronto (which he missed). In his letter to apologize for the confusion, he offers his thoughts on the confusion within systems thinking as well as clarifying his own position. He also offers observations on how people respond to new and different ideas—either with negative reactivity or incorporating the new ideas into an existing paradigm (psychoanalysis). As usual, he also puts in a principle of staying focused on self.

May 6, 1977

Dear

Most of the reports I have had about the meeting were on the negative side, which was a biased sample from New Haven, Boston, and from people who went there expecting to hear me (great reason is it not). Comments were that it was not very interesting, nothing much new, an abstract thinking model and not a theory, and other comments of that nature. The comments came mostly from people deeply invested in psychoanalytic theory who are not likely to "hear" anything different until the different way of thinking is generally accepted.

If my perception of your theory is within the bounds of accuracy, a negative reaction would not be unexpected. I simply do not know general systems theory, but inso far as I know it, I think you have put together a general systems theory that is much broader than most existing theories that will make a significant contribution to those whose thinking goes in that direction. I have spent my professional life working toward a theory based on the model of systems in nature, which compares human behavior with lower forms of life, and which specifically by-passes behavior and functioning present only in the human. In your theory you have included all the factors which other theories consider important, which I have excluded. You could enlarge your theory to include everything I have included in mine, which in my opinion, puts your theory in the category of a GENERAL systems theory. I would have a hard time putting my factors in your framework without going to general systems theory, which would play havoc with my more specific theory.

I have never been successful in communicating with the main body of psychiatry. Most psychiatrists never get beyond the theoretical system they learned as students. I put a number of years trying to communicate with general systems people but they are born generalizers and they keep introducing so many new factors that I have excluded, that we get lost in detail.

I wanted to get to the Tuesday morning panel to hear what that heterogenous [sic] group would have to say. These are things I would have tried to communicate there. The panelists were mostly senior citizens in psychiatry who have spent their lives talking about what is wrong with psychiatry, but without having a specific direction of their own. The one who really knows general systems theory is [name redacted]. There was who knows culture but he has developed a specific theory about culture and he has not

been known for general systems theory. However the panel turned out in your thinking, or in the thinking of others, I would say to keep going in your own direction, as if you have a choice in that, communicating with those who can listen and hear, and I would guess that it will be general systems people who can hear the best. My approach to this over the years has been to keep a low profile with the background principle of avoiding the hard sell, guided by the notion, "If it is any good the world will some day know about it. If it eventually proves to be no good, it will die on the vine all by itself and no amount of salesmanship will change that". And so goeth the affairs among those who attempt to conceptualize human behavior.

My apology for missing the panel session last Tuesday.

Sincerely,

Murray Bowen, M.D.

# GROUP THERAPY AND FAMILY THERAPY

## Group Therapy and Family Therapy

Over the years, especially in the beginning, this subject has stirred up a fair amount of controversy and (mostly) unrecognized confusion. There have been efforts to incorporate family therapy as a part of group therapy, with similar "techniques" and goals; doing group therapy with a family. Dr. Bowen was invited to a number of these group therapy conferences, probably with some agenda on the part of the sponsors. How does one be connected to these "pulls" without pulling back, without trying to convince the others they are wrong, and be clear about one's own position and principles?

During our professional lives, we experience and react to many "in vogue" therapies, assumptions, and theories. Some are seen as good and of value, while other ideas and approaches are seen as superficial and not dealing with the heart of the matter. "Experiential therapies" were based on assumptions and beliefs carried over from psychoanalytic theory in reference to repressed memories. "Intellectualizing" was seen as a defense mechanism, as a way of avoiding "real feelings." Papers were written on the importance of not having a theory (Whitaker). For a time, weekend encounter groups were all the rage. "Marathon" weekend experiences are still available for those seeking this kind of experience. There was (is) a clear dichotomy between feelings vs. the thinking part of the organism. It is either/or; you can't have both. Of course, dichotomies are still very much a part of our culture. Can one be separate and connected? Can one both think clearly and be connected to one's emotional forces (including feelings)? Can one be a responsible therapist and not be responsible for the therapy? Can one hear and be connected and not "understand"? What is the role and responsibility of the therapist?

Dr. Bowen was invited to participate on a panel at the 1969 American Group Psychotherapy Association meeting. He responds in a letter of February 19, 1968 to an organizer of the conference touching on a number of these themes, not just group therapy; again speaking to important principles.

February 19, 1968

Dear

It is easier for me to "rough draft" a response to your recent letter on my own typewriter, than to do otherwise. First, I will be glad to participate if you organize the panel for the 1969 meeting of AGTA. I would prefer to get far outside the emotional content of the family as possible and, from that distant observational outpost, take an intellectual and theoretical view of the family as it is evolves from generation to generation in definite predictable patterns. This applies if the subject is "The Family in Time and Space". If you decide on a "Family Networks" title, I would prefer also to do something as theoretical and "cut and dried" as possible. Such a detached "scientific" view of the family just might make a little sense to the group therapists. The reason for this is related to some experiences with the group therapists last month.

It is a funny world. Just three weeks ago I sort of resigned from attempts to communicate with the group therapists. Now comes your letter, and I am willing to have at it again if you organize the panel. Maybe I can communicate some of my experiences without wandering too far afield. Over the years the group therapists have claimed kinship and I have tried to point out differences between my approach and theirs, but they cannot hear. There we stand.

In January I participated in two major group therapy meetings. No more than a handful "heard" anything I said theoretically. In such situations, especially if I put energy into it and get off the theoretical and onto personal things, the group therapists begin to "experience" me as a person and something gets through. So, the January meetings were not flops. I learned a great deal about the differences between the group therapists and me, and I had good visits with all the old friends who are group therapists. But still no more than 4 or 5 out of the 150 skilled group therapists were able to "hear". That is awful low yield ore to mine.

My first group therapy meeting was the East Texas Group Psychotherapy Assoc in Houston. I was sponsored by my old friend and GAP roommate, He and I have had some of the craziest experiences in trying to communicate in these 11 years we have been roommates for about 5 days a year. He was President of the American Academy of Psychotherapy last year. from New Orleans attended the Houston meeting, as did who is also an officer in the AGTA. The second group therapy meeting was the annual AGTA meeting in Chicago less than two weeks later. I had been invited by who was AGTA President and who chaired an all day meeting in which four family therapists "treated " the same simulated family. was another of the 4 therapists. It was a great experience for me though people "experienced" me without hearing me. Some of my best friends are group therapists. There is who is beginning to "hear" a little, ,who was one of my residents at the Univ of Maryland in about 1960–61 ( were co-partners in starting Esalen a couple of years ago); a former President of AGTA who was my resident when

I was an intern on Neurology at Bellevue in 1938; and many more. I am tremendously fond of these fellows but none except can “hear”. says if I go on and admit that I do group therapy and stop putting the crazy twists on it, we can resolve this thing.

An over simplification of the group therapy principle is “learn to know your feelings and to express them and come with us into the great togetherness where we can bare our souls and be really honest with self and with the other, so we can really EXPERIENCE each other”. This is a little over-done, but to the point. A good group therapist is one who is not afraid of the soul baring experience who can facilitate this process in the group. My approach is to back pedal out of the emotional system to observe from the “outside” (the soup looks different to the observer than to the noodle in the soup) and when I can stay out,it is predictable that one and then another family member can do the same. I had a fascinating experience with a brief atypical example of a family member “getting out” with the simulated family in Chicago. When I am really out, dead serious family stuff becomes funny. I have come to use my ability to laugh as a gauge and to cultivate just the right degree of laughter for use with the family. I laughed with the simulated family. The daughter’s first response (she told me later) was “The hostile bastard” but she did not have a chance to say it until I had laughed again. Then she thought “This guy is having fun. Why don’t I have some fun too.” Between sessions, and in the long afternoon discussion a full 20 people made comments about my “nervous laughter” with the family.

It is very hard to communicate anything except a “feeling with the situation” to group therapists. I think their basic orientation is so much to join the family feeling system and EXPERIENCE it with the family, that it is essentially impossible for one to hear another approach.

It was these recent experiences with the group therapists that led to my suggestions in the first paragraph. This is why I suggested keeping it intellectual and theoretical. Of course I would want to leave it up to you and the other participants about how to proceed. If the group therapists get something to “emote to” and “feel with”, they are in hog heaven. I’ll bet if I kept my cold and sterile and highly intellectual, and others put in real good emotional case material, they’d crawl on my back. Maybe I could figure out a way to make them emote over some of my intellectual stuff. However it works out, I’ll be in the group therapy things to “have a little fun.” I have given up trying to communicate my “back pedal out of the emotional system” approach to them, but the more I think about the possibilities (as long as I don’t get serious about succeeding with a serious communication), the more I warm up to the possibilities. I am just now getting some thoughts about ways to enjoy that meeting. I have to stop this. I will be interested in hearing what develops. Hope this free associating to the typewriter makes sense.

Sincerely,

Murray Bowen, M.D.

# LIFE FORCES

## Life Forces

Dr. Bowen used the term "life forces" in describing the emotional forces driving people in their relationships. What did he mean? Was he referring to moons and tides, gravity, the heart? A lot of emotions are present in interactions. Are some "stronger" than others? Are life forces only present in the individual, or do they become manifested in interactions with others? How does a life force impact on brain functions—perception, memory, mood, cognition, subjectivity, self-definition, and identity? How does it impact on how one manages with what one is dealing? What is the connection between separateness and individuality? Are they the same? When does individuality become a cutoff? Is individuality driven by emotional reactivity? What is fusion?

Dr. Bowen, in a letter of July 1986 to a sponsor of the Midwestern training center, offers some observations and clues to the questions about the processes and the pitfalls of "individuality" and one's environment.

4903 DeRussey Pkwy
Chevy Chase, MD 20815
July 1, 1986

Dear

(First paragraph edited out)

I have devoted a tremendous hunk of my life toward being "an individual" who makes a monumental effort to relate to "individuals" in the places I go. A high percentage of people get too anxious with individuality, and resort to group stuff and the age old litany of my personal shortcomings. I still try to work my way toward individuality, but the task can become too great unless I can find someone who prizes individuality as much as I do. The individuality is priceless in dealing with an extended family. No one except an "individual" will ever find one's way through the conglomerate that is the family, in which groupness and secrets, and common denominators, fill the air. As soon as the individual externalizes private ideas and actions to someone else, (even a trusted ally), it becomes group stuff and the whole effort of "working with the extended family" (I don't know what that means anymore) is permanently lost (except for diagnosing the one who tried something different). The notion of the "extended family" is lost when push comes to shove. I wish the extended family could become all it can become, instead of a mish-mash of stuff.

A letter is no place to go into the fine points between individuality and togetherness. I think your organization has a tremendous potential for and the Midwest, if can get beyond environmental opinions. A mere difference loses its individuality potential, and becomes a confrontation when it is externalized. is more important to me then most places. I shall be watching your individuality and groupiness with great interest.

Sincerely,

Murray Bowen, M.D.

WHICH FAMILY WERE YOU BORN INTO?

## Which Family Were You Born Into?

A major observation and group of assumptions in family theory is that the family is a highly dynamic system. A family and its members are constantly reacting to, adapting to the environment in which it is connected. Of course, grandparents are suffering, dying, or expecting their children to do certain things for them. One result is that siblings are seldom born into the "same family." Some are more caught up in the emotional realities than others. Some even manage to remove themselves from it all, pretending that their environment doesn't exist.

The Bowen concept that addresses this phenomenon is *sibling position*, which describes various patterns of reaction and various definitions of responsibility—both to others and to self. Dr. Bowen acknowledged and recognized the importance of the research of Walter Toman, a German psychologist and family therapist, and used his research to articulate a core concept in the Bowen Theory. Dr. Toman extended his research studies to include observations and predictions of marital patterns and therapist-patient patterns, both based on sibling positions.

Being in the oldest sibling position in a family is a major variable on the influence on the definition of self, of how one perceives reality, and one's assumptions about responsibility for others. The oldest is especially vulnerable to two family dynamics. If the parents' relationship is problematic, the oldest is often included (confided in) by one of the parents in the intense negativity toward the other, with the result being the child caught between the parents, being a caretaker or even a "therapist" to the parent. The other vulnerability concerns the oldest being the emotional and physical caretaker for the younger children, especially in large families. One end result of these two potential vulnerabilities is for the oldest to have little leftover energy to ask his or her own questions about one's process and definition of self.

This letter is a response to a patient's looking at her own functioning from the oldest sibling position.

April 10, 1966

Dear Mrs.

It has been writ—oldest daughters knew it even before it was writ—that oldest daughters are responsible for the welfare, well being, mothering, and for worrying about all the "children" in the extended kinship system, whether they need it or not. It is good to know you have finally recognized and openly accepted your assigned responsibility. It is all very simple. All one has to do is get the "children" to confess their need for it and then find a way to turn fishes and loaves into food for the multitudes, and you have it made.

It was good to get your letter with the humorous slants on the situation. Best wishes to you in your mission to fulfill your "responsibility."

Sincerely,

Murray Bowen, M.D.

WHO IS IN YOUR FAMILY?

## Who is in Your Family?

Initially, this seems like a simple and straightforward question, but as one begins to ask the question one becomes aware of the amount of variation in people's perceptions and behavior. One becomes aware of how emotional processes drive the answers. It is not determined by percentage of shared genes. Extremes give a clearer reflection of the emotional process. Some people say they don't have a family anymore and behave congruently with this conclusion. Some acknowledge that they have a family, but their connections reflect something different. Some exclude family members they don't know; for example, a parent who died when the child was too young to remember. There are examples of people who lost a father in a war, who grew up having no knowledge or awareness of the father and his side of the family. Some use geography to minimize a family member (and the accompanying emotions) being in one's life and in one's awareness. Another variation is to acknowledge/claim some family members and disclaim others. "We are so different." Another variation is to be emotionally closer to one side of the extended family and cut off from the other side of the extended family.*

The above question (and how one thinks about these questions) defines the nature of the therapy process. Indeed, theory drives the therapy. In looking at various family therapy models, one begins to see the wide variations in assumptions, beliefs, and therapy. Again, extremes are useful in examining the question. Some therapists do family therapy without any other family members involved—role playing, "psychodrama," family reconstruction, sculpting. The other extreme of therapy model requires "all" the family members to be present—parents, grandparents, siblings. There are many practical questions to be asked and answered. Suppose an extended family member lives too far away to attend sessions. What if one spouse refuses to come? Should children be involved?

*An obituary appeared in the local paper reporting the tragic death of a 14 year old girl. In describing time and place of visitation: " Family will receive local friends and relatives Tuesday night from 6-8 p.m. Out of town relatives are not welcome."

Another family variation is the Stanley Kunitz poem which deals with his father's suicide when Kunitz's mother was pregnant with Kunitz. The poem is titled 'The Portrait' and can be found in *The Collected Poems* by Stanley Kunitz.

In a related issue, might there be theoretical principles to guide one through the emotional land mines of biological/ adoptive policy decisions, sealed birth records, termination of parental rights, foster home families/ biological parents policies?

Should a child be excluded or included if he or she is the focus of the family emotional process? Can theory help guide the therapist through these questions?

In November of 1968, Dr. Bowen responded to the editor of a planned book on family therapy and family therapists. A chapter on Dr. Bowen was planned to be included. The editors wanted him to review their draft. In his response to the proposed draft, he clarified his beliefs about "who is in the family," how he orchestrates the above questions, and describes in some detail his process. Also within the letter are theoretical assumptions about how emotional processes operate in family systems. I have not included parts of the letter that addressed the proposed chapter, only the paragraphs that reflect his thinking on who is in the family and how that impacts on the therapy process.

This is on page 25, lines about 20-23. It has to do with seeing one family member alone and imagining other family members present as phantoms. It sounds a bit kooky and spooky and it is inaccurate even as an abstract abstraction. That confounded phrase got into a paper as a descriptive abstraction when I was trying to describe my inability to do individual therapy after I had started seeing families. After starting family, I still continued to do some individual therapy for two or three years. It was impossible for me to ever do individual therapy as before. I was "thinking" family even while doing individual therapy (and then I added the misinterpreted phrase) "as if the rest of his family was present as phantoms".

Most of my work with a single family member is in disruptive families in which the family would give up the effort but for one motivated family member willing to keep up the effort. If this works, I usually end up with a motivated twosome (with me as the potential triangle person) for the productive part of the therapy. Beginning in about 1961 I started a special project of doing "family therapy" with unmarried young adults living in Washington, whose families live far away. I have now done perhaps a dozen of these in which the entire course of family therapy has been with this one family member. In all but one of these I have seen a parent, or both parents, or a sibling when they happen to be in Washington for a visit. I guess there has been one which I never saw another except the single family member. (One time her mother sat outside in the car and refused to come in. I went out and shook hands with her while she stayed in the car). So I do get an hour or so with another family member present during the course of the family therapy.

My usual approach with these unmarried single family members (and also seeing any single family member from other families) is to spend a block of time in didactic teaching about the operation of family systems. Then time is devoted to the part this one plays in the family system and some fundamentals of "differentiating an "I" out of the "we-ness" of the family system, and to changing the part that "self" plays in the system. It is necessary that they arrange fairly regular visits home with their families. One time a few years ago I was asked if the cost of these plane tickets could be deducted as medical expenses for income tax purposes. The "hours" are usually devoted to a review of contacts with family, postulations about what went on, and guesses about the outcome if certain changes were possible. These "hours" are similar to supervisory hours with young family therapists. There are also assignments having to do with "person to person" relationships with a whole spectrum of extended family members and doing a multi-generational family history in depth. When this "differentiating one" begins to change, the family will get negative or reject, at which time it is absolutely necessary that they keep in contact with the family in spite of the rejection. I worked with one young fellow who went to NYC every weekend for over a year (I now rarely see these oftener than twice a month.) He had quite a problem when his parents would leave home and check into some hotel hideaway to avoid the ruckus that would come with his visit. I have had

some perfect results seeing only this one family member, which means fundamental change within the entire family system and my criteria of "change" is more strict than anyone I know in the business. I even had one father from Central America who came one time when he happened to be in Washington for a visit. During the visit he said "thanks for the miracle in Guatemala".

Its is longer and harder to work it all the way through with only one family member but the point is that it can be done. The disadvantage is that the emotional fireworks take place in the visits with the family and the situation does not have the advantage of my help in the emotional situation.

I have now had perhaps half a dozen families in which parents discontinued after symptomatic relief some 6 or 8 or 10 years ago, in which an eldest child would come after reaching adulthood. An "oldest" has tremendous power to change the entire family system if they are motivated to work on it. I have one now in which I saw the parents 5 times in 1959, 13 times in 1961 when the father became anxious while getting a late Ph.D., and 9 times in 1963 after the oldest daughter had a pseudo suicidal attempt. These parents never had the motivation to go beyond symptom relief which came fairly promptly each time. In the Summer of 1968, after the daughter finished college and had her own job and her own apt in town, she came on her own, financed by herself. This is one that will "go all the way." I have never had an oldest child "pull one out" before they were self supporting and financially independent of the family system which resisted change.

No need for more detail. I'd like you to somehow change the lines about "phantoms". To summarize this, most of my family therapy with a single family member is with disruptive families in which only one family member is motivated for a family effort. This is usually preliminary to seeing both spouses or both parents together for the more productive phases of the therapy. It has been possible to do an entire course of productive family therapy with a single family member, with significant change throughout the entire family system. This is longer and more difficult than working with a larger family unit. The goal is to teach the single family member about the functioning of family systems, to accurately define the part that "self" plays in the family system, to modify the part that "self" plays through a clearer "differentiation of self", and to withstand the family anxiety and attack when self does achieve change.

Since you probably have plenty of copies of your paper, and since I would like to keep this for my files, I will not return it unless you need it.

Sincerely,

Murray Bowen, M.D.

FAMILY ANXIETY AND SCHIZOPHRENIA

## Family Anxiety and Schizophrenia

How does one maintain a focus on the family system when there are major symptoms in one member? How does one not fall into the thinking that the parents' anxiety is "causing" the symptoms in the son? How does the therapist keep the focus on each family member doing their best with dealing with their own emotional process? How do parents deal with each other? How do these variables (and others) impact on the family emotional system?

Dr. Bowen's letters to other professionals who are involved with families that he had previously been clinically connected with were carefully written and rich in his theoretical principles that guided his efforts. His letter of September 1962 is to a superintendent of a hospital where Dr. Bowen's former patient has been hospitalized. He describes in detail the "clinical picture" of the young man, but gives more than equal time in describing how anxiety processes played out with the parents and the family. He also points out anxiety patterns that seem to be present in all families where there is a schizophrenia process involved.

One wonders how much the treatment team at Eastern State Hospital "heard" of his observations. The letter is a clear example of the "therapist as a researcher."

September 21, 1962

Dr.
Eastern State Hospital
Williamsburg, Virginia

Dear Doctor,

This is a response to your request of August 14 for information about , 14 year old son of Mr. and Mrs. of Arlington, Virginia. I am sorry this reply has been delayed. Your letter arrived just after I left on vacation. Three days after vacation there was a professional trip which required another one week absence.

I have known the family since the early Fall of 1958 when the father, mother, and became part of a family research project I was conducting at the National Institute of Mental Health in Bethesda, Md. The family joined the project with the knowledge that it would terminate three months later, at the end of 1958. After I terminated my association with N.I.M.H. in 1959, I began to see the family privately in the same kind of family psychotherapy that had been started during the research. With the exception of two brief interruptions of a few weeks and a few months, I saw them about three years terminating in the Spring of 1962. The family psychotherapy was focused on the family, and specifically on the parents, rather than on . I shall not try to describe the details of the psychotherapy but if your staff is interested, the theoretical premise of the research was described in "A Family Concept of Schizophrenia", a chapter in "The Etiology of Schizophrenia", edited by Jackson and published by Basic Books in 1960. The report on the psychotherapy was published as "The Family as the Unit of Study and Treatment" in the American Journal of Orthopsychiatry, January 1961, pages 40-86. The family was "atypical" and not an official part of the study because was the only child in the group and because the family was in the project such a short time. Since they lived in the Washington area, the family spent no more than half time "living in" with the other families.

Since the theoretical orientation was focused on the family, I have much more information abut the parents than about . I saw no significant difference between these parents and the parents of adult schizophrenic patients. The main difference was that these parents did not have the overt parental emotional disharmony

that was so marked in the other families. The parents had an intense deep disharmony that did not show through the calm and pleasant surface adjustment. A very small percentage of the parents of adult schizophrenic patients had this kind of adjustment. In our papers, this was described as a “silent family”. This was associated with a very fixed and severe process. The parents made some significant changes in family psychotherapy. One of the best indicators of parental change was in dreams, which provided a reading on the emotional turmoil beneath the calm surface. The symptoms of the average adult schizophrenic patient can be correlated point by point with overt emotional stress in the parents. This was not true with the because they showed so little overt evidence of stress. After considerable study we found that symptoms occurred in direct response to the parents’ deeper emotional turmoil revealed in dreams. One of intense periods of disorganization occurred during a dream sequence which also showed the intensity of the parental interdependence. The mother’s dreams concerned her being alone just at nightfall, trying desperately to reach home or reach help, and being blocked by adversity, incapacity, and traumatic events. On another level she was concerned about another attack of rheumatic fever which served as a constant harbinger of death. There was no reality to support the fear about rheumatic fever. The father, 8 1/2 years younger than the mother, dreamed of his wish to die before the mother, lest he be left alone.

During family psychotherapy the parental process “loosened up” until it was more characteristic of an average family with an adult schizophrenic patient. During the same period came out of his “autistic like” unrelatedness and he began to relate to his environment, albeit with psychotic symptoms directed more and more specifically to the parents. The most rapid change occurred early in 1961. Later in 1961 there was a series of events, any one of which could have disturbed the family equilibrium. The father’s only sister, a substitute mother, died just as he was planning to retire after over 25 years in the Air Force. Then there was the stress of moving and finding civilian employment. A few months later they bought the first home they had ever owned. In the early Fall the mother developed anxiety with somatic symptoms and “could not stand” the presence of . The father acted immediately to get out of the home. From our family orientation, the situation was the most favorable it had ever been for significant changes with the entire family group. I urged the family to keep at home, at least for a few months longer, to consolidate as much as possible from the new situation. The father

seemed to “hear” and he agreed on an intellectual level but at home, confronted with the anxiety of the mother, his every move was to get out of the home, just as previous moves had been to find ways and reasons to justify keeping at home. This compliance with the anxiety of the mother is, in my experience, a hallmark of the family with a psychotic offspring.

The primary problem in , in my opinion, is childhood psychosis. There is evidence of a psychotic process that goes back to eighteen months when he “stopped talking.” Over the years the parents followed a course that is not unusual with such families. They had examined at several different places and, as usual, came out with different opinions and diagnoses. Some considered him constitutionally impaired or retarded. For a time in the research project we considered the possibility of autism, but he did not meet enough of the criteria of autism. I have never considered retardation as the primary problem but certainly he “functions” retarded a fair amount of the time. It was on 1960-61 that the overt psychotic element came much more to the forefront. He was much more alert, particularly in the specifically directed symptoms. With strangers he was usually mute but at home, and on the research ward, his talk was usually perseverated psychotic jargon interspersed here and there with clearly formed full sentences that were precise and grammatically correct. These sentences would come when he appeared to be lost in his own world and oblivious to the environment. The sentences would indicate that he had been following what went on around him. Then he would lapse back to his sing-song reverie. He was never a serious management problem at home, not even when the mother “could not stand hime.” It was more that his psychosis was more persistent and more specifically aimed at the mother.

In summary, the response of this family to family psychotherapy was more than we expected when we started with the family in the Fall of 1958. The most significant changes were in the parents. It is hard to estimate how much of the change in was related to the change in the parents, and how much was related to a growth process in and to the passage of time.

Sincerely yours,

Murray Bowen, M.D.

# SCHIZOPHRENIA , THE FAMILY, AND PSYCHOTHERAPY
# A SERIOUS WAY OF WONDERING

## Schizophrenia, The Family and Psychotherapy
## A Serious Way of Wondering

Many of the first generation of family therapists had major interest and experience with schizophrenia. This group included Whitaker, Ackerman, Don Jackson, Minuchin, and others, as well as Dr. Bowen. To even think of doing therapy with schizophrenia was going against the prevailing opinion (Freud) that therapy with these people was not possible. Gregory Bateson, an anthropologist not a therapist, should also be included in this early group of people

What was the lens these people brought to their interest in schizophrenia? The predominant force was the effort to learn about something that was very poorly understood at the time. Was it possible to think about psychotic processes? This lens opened the door for exploring multiple questions. These early questions led to enlarging the lens from the individual, intrapsychic, to including the interactional variables present in relationships. For example, symptoms were hypothesized to be a result (and a solution) of communication and behavior (Bateson/Jackson). What is the nature of the interaction between mother and child; what role does a "symbiotic relationship" play in triggering severe symptoms (Bowen)? How might the child's psychosis be functional for the health of the family (Ackerman)?

In the early years, research and hypothesis were the driving forces, not psychotherapy, although Carl Whitaker was trying out all kinds of ideas, e.g., bottle feeding. At some point, it was inevitable that the hypotheses were tested and observed in a therapy process. It is important to note that the therapy was connected to research thinking — testing hypotheses, rejecting some, revising others, enlarging the lens and the questions; in Dr. Bowen's words "years of step by step work on theory." The efforts were largely individual, with each pioneer following his own investigations and the articulation of the important variables involved in emotional processes.

Certain key observations served as a foundation for Bowen in his search for a theoretical framework that would account for the "hows." * These observations included: The individual is connected in relationships and with the larger environment; emotional information passes back and forth among the individuals, one's relationships and one's environment; there is variation in how one responds to these processes and the response becomes part of the relationship pattern; everyone plays a part; what happened before is a part of what happens now and what will happen in the future; if there is variation there must be options; if there is reactivity the brain is involved. Therefore, all of these variables are rooted in biological, interactive processes.

Included are three letters in reference to schizophrenic processes, with the focus on observation, description and hypothesis about the "hows." The letter of July 1973 is to a mother who has one son with schizophrenia and another son going to medical school. His principles and the directions for "lending a hand" are articulated.

The second and third letters of March and September of 1990 are to the parents of a severely impaired grown daughter. He focuses on the processes of schizophrenia, the professional debates of the extremes in their looking for *the* cause. His position is one of continuing to think and "wonder" about the emotional forces and how they work, not what causes it, much like the same lens he began with.

* This obviously is a subjective reconstruction. No one was ever in the head of any of these pioneers. However, there are clues in writings and biographies. There were steps and a logic to the observations, hypothesis, and theoretical concept journey.

July 29, 1973

Dear Mrs.

This is a response Thank you for sending graduation program and for the news of your family. I will return the program to you, since it probably will have more value to someone in your family than to my file. Also, thanks for sending statement about his motivation for Medicine. You have to have much pride in determination, persistence, and accomplishment. Probably enough pride in him to somehow offset some of the utter frustration in life course.

That part of motivation for medicine has something to do with plight, I would have no doubt, but I have long since ceased to give more than passing interest to such things. It is factual that a family member in functioning position in the family, can have a powerful influence (indirect) on a person in position, if he is motivated to learn about family systems and to lend a hand here and there. Any family member can do this, but the best functioning family member can do it best, merely by virtue of being more adept at all kinds of life goals. It works sort of like adding a strong player to any team. It is not a question of any direct help to the weaker player. The strong player just keeps on doing her best, in his own way, and the different life orientation adds new incentive for all.

My orientation to schizophrenia has changed much in 20 years. Back in the NIMH days, I was still confident that somehow, someway, there was an answer to schizophrenia within the immediate family. I have long since given up that kind of idealism, but the family approach is in the right direction, and hundreds of indirect dividends have come from that work. I think the problem is still in the family, but it is multigenerational in depth, and it is not going to be changed on a one generation level. The person in position is not basically unhappy with his lot in life, but he is reactive to attitudes and expectations and guilts in the family and in all other people around him. It usually gets expressed as his unhappiness at being a failure, not because he has basic concerns about failure, but because everyone else is worried about his failure. No time to go into a philosophical dissertation on this here. My guess is that will have as much pride in success as the rest of the family (is proud). cannot envy success, unless that gets transmitted from others. I will shut up and not try to make sense of this in a letter.

If ever has the motivation to talk about schizophrenia and like things, tell him to call sometime when he is here for a visit. Best wishes to you, and your whole family.

Sincerely,

Murray Bowen, M.D.

9-23-90

Mr.

This thing about has been harder than usual to write because she is in the middle of a giant professional debate about the origin of classical schizophrenia. It still rages. A page about it in a recent Am Psychiatric newspaper is longer than usual because I was trying to stay in the middle without taking sides.

The severe side says the original deficit was genetic in origin, that is was knowable from birth, and total collapse occurs, at the beginning of adolescence, when the person shifts from childhood to adult life. That is . I knew it from the beginning, but I tried to stay on the milder side, in the "hope" it could be a psychological state modified by careful handling. It never worked out, despite the efforts of the parents. has been determined to say she can never deal with the rigors of reality.

Non-professional evaluators (mostly social workers) are caught in this theoretical debate. Less severe people live at home with the parents, work a week as a security guard, get fired, go a few months until they get another menial job, get fired from that within days, and on and on throughout life. I knew one recently who worked months to get a job on security at the Washington Monument. He was fired within days, only to begin the search for another menial (paying) job. This is what state evaluators want to make a decision about "self support". never reached that level of inner strength.

In my letter, I tried to cover the various loop holes of inexperienced evaluators. Some would say that a person is okay if they takes drugs. Others would wonder how could exit without you, if you can be away from the home while she gets along without you.

This answers the length of my letter about . I tried to cover the process of "classical" schizophrenia, as an inexorable process that continues through life, no matter what is done. Inexperienced people do not understand, nor know the word "classical". The term "schizophrenia" is all mixed up in this. Schizophrenia is so loosely used that it means no more than any kind of adult psychosis that waxes and wanes with stress. People can get a psychotic episode, and become "self supporting" until the next episode comes along.

Whatever one calls it, has had a deep impairment that goes back to childhood. Her absolute best was continued voices and hallucinations at home, while you did all that could be done to make life easy for her. This confounded debate continues on an international level. The profession has now gone to the severe side, looking for an elusive gene to explain it all. The less severe professional people, refer to the "genetic chase" as preposterous, and cite facts on the other side. People with the sophisticated new "scanners" search for some kind of abnormality the brain itself, and on and on.

The main point of my letter is to say that illness is a deep one, that she has never been "self supporting", and I do not believe she will ever be able to support herself.

I will get this on its way to you.

MURRAY BOWEN, M.D.
4903 DERUSSEY PARKWAY
CHEVY CHASE, MD 20815

TELEPHONE 656-8350
AREA CODE 301

March 23, 1990

Dear Mr.

This is a summary of my professional experience with your daughter, and also with you and Mrs. and other members of the family. I first saw on . You later mentioned she had read something about my work in a popular magazine. I found the copy of the Saturday Evening Post for August 1, 1962. It contained a feature story about “Family Psychiatry”, in which it detailed my effort to create family therapy at the National Institute of Mental Health in the 1950’s. I have continued to see in regular but infrequent appointments through the years.

I was known as a specialist in schizophrenia at the Menninger Clinic in the 1940’s, and also for research in schizophrenia at NIMH in Bethesda, Maryland during 1954-1959. had been different from her more normal siblings since childhood. The original prodromal state erupted into chronic schizophrenia early in her adolescence. The symptoms included psychotic thinking, seclusion, suicidal thoughts, and actions that were not normal. The symptom pattern is well known, but psychiatry has never developed a treatment that goes beyond symptom relief. Since I had been active in the creation of family psychiatry and family therapy, the family was willing to do its best; and I agreed to use my knowledge in the search for clues that would alleviate the situation.

You and Mrs. have had a positive effect on . She is the kind of person who usually would spend the rest of her life in a state hospital. She has used the family home as a refuge where she hallucinates constantly, and responds loudly to imaginary voices. Over the years, we have tried numerous devices that have worked with others. She takes her drugs reasonably on schedule, but strangers are afraid of her behavior and talking to herself. A series of “Network Meetings” permitted neighbors not to respond to loud cries that begin with talking back to the inner voices.

is dependent on you and Mrs. . She keeps the psychosis contained within the walls of the house, as long as she

knows you will return. You have been fortunate in having a long term maid, who functions as a member of the family. As long as you know the maid is available for regular visits, you are free to spend a short time away from the chronic psychosis of home.

is a seriously impaired person who will never function beyond her infantile childishness. She is the victim of what she thinks others think of her. The chronic psychosis permits her to exist within the family home. If this is threatened, she will move toward life in a state institution. She has never made a little spending money through odd jobs or menial tasks. She will never become self supporting in any way. If the family can no longer pay her living expense, she will surely become the object of public funds. This is the nature of her basic impediment.

Sincerely,

Murray Bowen, MD

# THE LADY IN THE FIRE

## The Lady in the Fire

Dr. Bowen was considered an expert in schizophrenia. The Menninger Clinic was one of the few inpatient facilities that believed in psychotherapy in the treatment of schizophrenia. Chestnut Lodge in Maryland was another similar facility. Of course, schizophrenia was the focus of his NIMH inpatient project.* Many of his theoretical conceptualizations on schizophrenia are contained in his formal writings, e.g., *Family Theory in Clinical Practice*. These are a few letters in the archives relating to this subject. The letters do not offer answers to what "causes" schizophrenia, a subject many people want him to clarify. Did he consider it "a disease?" Did ten generations "cause it?" What did he mean when he said, "There is some schizophrenia in us all?" What did he mean when he said that we all struggle with similar issues? People "see" in his statements "causes," when he is describing emotional processes; what drives them, what escalates them, what calms them down, or how they move around in a family system.

Another area of confusion for the therapist in dealing with schizophrenia processes is the assumption and beliefs about responsibility for the patient, family, and therapist. Dr. Bowen's letter of November 1985 is a response to a presently hospitalized patient seeking his advice about a possible therapist in the Washington area. He had been clinically involved with the family 25 years earlier.

*Prior to the refocus on the family with a schizophrenic member.

4903 DeRussey Pkwy
Chevy Chase, MD 20815

Dear

This will acknowledge your letter. There is no way I can work with you personally. My practice is limited and I could not do it even IF you were not limited to Medicare or Medicaid. I do not have time even for the lesser administrative work that goes with viable insurance. The past years my contacts in Montgomery County are too limited to have knowledge of resources there.

I will reduce this page to single space to allow more room. Experience with you and your family was some 25-30 yrs ago. You are an unusual edition of the human struggle, with too little ability to use your intellect, and too much urge to fill the gap with a crazy psychotic balloon, manufactured by your imagination, which gets bigger and bigger, and eventually drives the other beyond endurance. The immediacy of your urge to "do it my way and do it now" eventually drives the other to "put you away" where you end up with a horde of others who have used the balloon mechanism. Most people contain their own personal "balloons" enough to live in the world as defined by others. Maybe you will finally develop more ability to relate to what is, rather than the deadend pursuit of trying to fashion the world according to your impulses.

You are a kind of a museum piece in the world of miscalculation. IF you can manage to restrain your balloon enough; and relate to "what is" enough to satisfy your doctors, you might become an outpatient under your own recognizance. IF you can make it to a viable outpatient status, there might be a slim chance I can find a research oriented person to lend a hand with your underlying life problem. That kind of "research on psychotherapy" is quite different from conventional short term drug oriented research. Very few clinicians are interested. It requires a long term psychotherapy effort, with patients who can be out patients and who are somehow funded, and a clinician who can guide the patients own effort.

You are a person who has always put a lot of effort into your own adjustment. I think a lot of your effort has been misplaced and too much strong minded, but that same energy might someday become your ally, IF you can somehow find a therapist who can make the energy work for you, instead of against you. You have a built-in genius to battle the establishment, whether the establishment is family, social protocol, psychiatry, hospitals, or whatever. The more you battle the

establishment, the deeper you get into the soup. IF you can battle FOR YOU instead of AGAINST SOMETHING, maybe there is a way out.

You are a gifted person with prodigious energy to put into something you believe in. You might spend the rest of your life in and out of hospitals. Thousands do it. The long and short of my posture is to say there might be a way out for you, IF you can cooperate with the hospital enough to get yourself out, IF the contents of this letter can remain private for you alone, and IF it is possible to find a calm therapist who can lend a hand with the hundreds of life decisions that recur and recur again and again. The whole thing is IF-EY at best. Such resourceful therapists are few and far between. Most are not funded by institutions. When they gain that level of expertise, they are not content to spend their lives on minimal fund patients. There might be one somewhere in my Georgetown University Family Center organization who might be willing to start with Medicare payments until you can supplement fees from your own employment when that becomes possible. There might be some capable person who would be willing to try IF I would lend a hand as a supervisor and consultant. I will see. IF your behavior becomes noxious to others, it might be necessary for you to return to the hospital for a time, until you could get yourself out again. I do not know whether it might be possible to find some Georgetown University person who wants to undertake such a project.

The whole course is paved with IF's. From your standpoint it would require that you get yourself out of the hospital without using my name. You can cooperate with the requirements of the hospital and their outpatient services without using my name as a possible resource. I am too much out of contact with Montgomery County to even guess who is available. After you are out, the Georgetown University Family Center is a possible resource. In the meanwhile, I will have at least a month to see IF, perhaps, maybe, there might be a resource at the Family Center. This will all come after you are out and functioning on your own. It will all depend on finding a resource. I might not be able to do it. Those are possible resources for the future, and not for the "here and now" problems.

You have been struggling with this confounded thing for years. The people in the Md State system are all devoted people who do things the way that is right for them. IF they called me about you, it would be necessary that I leave you in their care until you are a free agent, and able to act on your own. IF the Md system does not work, you can make private contact with me at some later date.

I am sure you can do it, IF it is possible for you to respect all the IF's.

Sincerely,

Murray Bowen, M.D.

# FAMILY SYSTEMS THEORY, PHYSICAL HEALTH AND ILLNESS

## Family Systems Theory, Physical Health and Illness

Many patients seeking a therapist's assistance with their emotional distress also have a wide variety of physical complications, such as fibromyalgia, Parkinson's, cancer, asthma, M.S., etc. A question is how to incorporate with the therapy process the awareness of these physical concerns. Thinking about how these connections work is still very much alive, with a long and often barbaric history. Treating the body to improve emotional and cognitive functioning was in vogue in much of the 19th and 20th centuries. For example, purging the body was a practice to treat melancholy (Abraham Lincoln). Castration and other sterilization methods were an early 20th century practice to cure aggression, epilepsy, "mental disease," and "feeblemindedness."* Prefrontal lobotomies were being recommended by leading psychiatrists as recently as the 1950s. Yearly refinements in ECT are predictably reported. Classification systems reflect efforts to label and conceptualize the mind/body symptoms—from psychosomatic to the current "functional somatic syndrome."

From the other side, there are theories that focus on the use of psychotherapy for treating physical symptoms and diseases, such as cancer, "fibromyalgia," and for an extreme example pruritis ani. A more moderate approach recommends support groups for patients with certain illnesses, which still assume that emotions are contributing to the "cause" of the illness. There is still some lingering thinking that the physical symptoms are "all in your head."

Much of the above is driven by and the search for linear reasoning; that the illness or problem is *caused* by one (whatever), and if this cause is addressed the problem will disappear. Much of the drug industry is characterized by such cause/effect thinking. One can always avoid asking about long-term effects of a medicine by issuing a black box label.

* In North Carolina between 1929 and 1973, over 7,600 people were sterilized for these causes.

How does the clinician think about these issues? When does one step into A causes B assumptions? When does the clinician shift from a focus of *managing* of what is on one's plate to a focus of what is on the plate?

In March 1985 Dr. Bowen was invited to do a one-day conference in Massachusetts on "a family systems approach to physical health and illness." Two letters are included, one explaining to the conference organizers how he would structure the sessions, and his thinking behind his efforts (January 30, 1985). A second letter is to a conference sponsor and Georgetown student in response to the conference; what he did, his thinking about it, and how the audience reacted (March 26, 1985).

A third letter is this section is a letter from Dr. Bowen responding to a colleague who has been recently diagnosed with a melanoma cancer (March 14, 1981). Where does one direct one's efforts to when there is no "solution?"

4903 DeRussey Pkwy
Chevy Chase, MD 20815
January 30, 1985

Dear

I will be doing my best to make March 1, 1985 into a significant day for those who attend the meeting. From Georgetown you will receive a bibliography, a biography, and a photograph.

The overall format will focus on "A Family Systems Approach to Physical Health and Illness". The development of somatic symptoms is an extension of the broader aspects of human adaptation as defined by Family Systems Theory. Through knowledge of the variables in theory, the physical symptom appears as part of the total configuration. The best in Family Systems Therapy requires that the therapist know the family as a multidimensional system, that he/she respect the medical consequences of the symptom, and that he never lose sight of the fact that the family plays a part in most situations of health and illness. When family pressure can be modified, the patient does better and chronicity is often avoided. There are numerous subtle points between the usual orientation of medicine, the different orientation of family systems thinking, and helping the patient make responsible decisions about the difference.

The first session might be titled, "Family Systems Theory and Somatic Problems". It will involve a lecture type presentation with chalkboard diagrams. It will involve the total family configuration, the individual development of physical illness as part of the whole, and ways the family can alleviate the dysfunction in the patient.

The second session might be titled, "The Function of the Family Therapist in Families with Somatic Problems". It will include about ½ hr on the role of the therapist, followed by a long period of discussion with the audience about the entire morning.

The third session with be a videotaped demonstration. It might be titled "Videotape Presentation". Introduction of the tape plus the tape itself, will take too much time for much discussion.

The fourth session can be the longest. A title might be "Summary and Discussion of the Day with the Audience". We can decide on written comments and questions at the time. Written comments provide additional latitude for focusing on broad issues, including those made too brief during the day. Second thought—the third

session could more accurately be called *"Video Presentation of Family Therapy"*. Theory is absolutely necessary for good therapy but people are usually more interested in therapy. Discussion of the 3rd session could take up much of the time for the 4th session.

My goal is to present voluminous material in a single day, and to make it interesting and informative to all levels of clinical expertise. The audience usually wants more time than the program permits. If your schedule allows flexibility, I can start early, reduce the time for lunch, and go later.

The only audiovisual aids I will need are a large chalkboard, a clip on microphone which can move about when I do, and equipment for a ½ inch VHS videotape. I do not use xeroxed "hand-outs for broad subjects such as this. People are inclined to read it and act as if they know the detail. My effort is more to stimulate life long inquiry than suggest answers for complex issues. You may xerox any of the bibliography you wish.

The Continuing Education form you sent has been the difficult part that has delayed this letter. In my 30 years of working at this, I have never been as concise as I would like, or to pretend to know the final word in anything. When I am trying to raise the issues rather than provide answers it collides with the specificity of CE programs. I have completed the outline on the CE page, but I would like you to simplify it with comments from this letter. The March 1 meeting should be as helpful to those who have already wrestled with the problems of physical illness, as it will be in providing new vistas for those less familiar with the problem.

I expect to arrive at the Boston airport the early evening of February 28, and to leave for Washington the early evening of Friday March 1, 1985. I will be in contact with Dr. about final travel and lodging arrangements.

Sincerely yours,

Murray Bowen, M.D.

March 26, 1985

Dr
Lynn, Massachusetts

Dear

Your letter provided some good feedback on the recent mtg. It sounds like you have been dealing with questions pretty well.

The session I did with the family with MS was not a typical interview by anyone's imagination. MS is not that kind of an illness. A goodly percentage of physical illnesses are more determined by psychological or emotional malfunction, and psychotherapy can be effective in relieving, or even alleviating the problem. Not so with MS, as far as we know.

MS appears to be a neurological degenerative disease, more genetically determined, that leaves the thinking system relatively intact, and that follows its lifelong slow progress toward oblivion. I started my experience with Multiple Sclerosis over 40 yrs ago, and I have never modified the inexorable progress of the process with anything called psychotherapy. IT IS COMPLETELY DIFFERENT FROM THE MAIN STREAM OF PSYCHOLOGICAL PROBLEMS. The main stream can be modified to a degree by psychotherapy. NOT MS. I tried hard in Topeka some 40 yrs ago, with the focus on the patient. MS marched on. I tried again at NIMH, with the focus on the family. MS marched on. I hoped that psychotherapy might make the disease process slow down. I never found positive evidence for this. Most MS slows down all by itself anyway, while the basic process marches on.

Most of your questions come from people who view MS in the same category as all other physical illnesses. IT IS NOT. At the meeting, there was one "on point" question about continuing family sessions, an "on target"question from a "far out" viewpoint.

MS might well be THE ONE DISEASE, with the clearest distinction between the soma and the sesorium. The soma is not reversed. The patient knows and accepts that WHILE family feelings boil. If the HOPE gets too extreme, in the family, or in family therapists (your mtg was pretty much in that bag), the patient can go into a clown like, rose colored silliness, about life. It befuddles everyone. Denial is extreme.

Someday we will understand MS, Huntington's Chorea, hemophilia, and all those other inexorable conditions. The patient knows and respects the process. I could go on and on, but I won't. My session with the family with MS was COMPLETELY DIFFERENT from what I would ordinarily do with the big bulk of physical problems. The patient is FACTUAL and beyond hurt. I merely tried to use my imperfect knowledge to help the family, and the audience to relate to "what is". With another problem I might have been quite different. Your audience could not hear. Suggest they get into simple problems like schizophrenia and cancer.

It is fortuitous that 2 days before your mtg, we had done a session on MS and ALS at Georgetown. ALS (Antero Lateral Sclerosis) is sort of like MS, except ALS runs its course in 3 to 5 yrs. It is kinder and quicker. Maybe your audience was fortunate in being bathed in MS, when they are still young.

Have to go before this page runs out. Thanks much for your letter.

Sincerely,
Murray Bowen, M.D.

4903 DeRussey Parkway
Chevy Chase, Md. 20015
March 14, 1981

Dear

There have been a few hundred thoughts about you in these weeks since your telephone call and the last letters. I enclose a thing about radiation therapy for a Sunday supplement a couple of weeks ago. You may have seen it if the L.A. papers have a Parade Magazine supplement on Sunday.

Another story. I am currently seeing a Professor of Oncology whose marital problems began a couple of years ago. His work situation played a part in it. In medical school he was excited about the future of Molecular Medicine. He went all the way. There was an exciting 10 or 15 years in which leukemia and other forms of childhood "cancer" was apparently conquered. Now that field has "leveled off". Now the field has moved toward long term rehabilitation and long term relationships. He says he is so tired of being "father" to so many, he is ready to give it up. In addition, he is being "torn apart" by those who relapse and die in early adulthood. The percentage on this is low but when it does happen, he and his wife react as if this was their own child. Maybe I can help them to the point they can do better with the "rehabilitation" and react less to those who die years later. First time I have had experience with a high level physician who has been on the firing line so long.

As I know it, melanoma is one of those borderline things with cells that respond to a combination of chemotherapy and radiation. It is sort of like Hodgkin's and retinoblastoma, if I know it. Now the cure rate with Hodgkin's is as good as leukemia and and enucleation of eyes is no longer automatic with retinoblastoma. Your melanoma might be one that is not going to melt away but the total field is hopeful and the percentages get better each year. From your standpoint, you have the responsibility of coaxing your body to do all it can to reject the melanoma cells.

I think it is healthy to have more urgent projects than you can complete in a lifetime. That was one of the things I liked about . He had a lung cancer with an estimated 100% mortality rate. He refused palliative treatment lest it mess up his head and prevent him completing his book. He was asking for just another month, and another month, etc, to complete the book. He made that book, plus another two books before he died of heart complications abut 2½ yrs later. I think it was his goal directed energy that put his cancer in abeyance. Others cannot do it the way did but I think that somewhere there is an "easy does it" way to help the body deal with cancer cells.

I will be thinking about you and pulling for you.

For now,

Murray Bowen

WHICH WORLD DO YOU LIVE IN?

## Which World Do You Live In?

The mental health world in which clinicians practice is increasingly more difficult to focus on one's own theoretical base and principles. Each new addition of DSM adds more and more "disorders" that reside within the individual. The insurance industry demands the individual disorder diagnosis for reimbursement. "Event tickets" to be completed by clinicians have options for family, couple, non-patient sessions, but the practice or agency will receive no reimbursement. Because of financial pressures, the M. H. agency demands that clinicians only provide services that are "billable." Medicaid, because of escalating expenses, is redefining and reducing which services are "billable." The majority of private H.M.O.'s limit the number of sessions they will cover. Justifications are required for additional sessions and are reviewed by insurance case managers who are charged with reducing costs.

Increasing "confidentiality" laws prohibit clinicians from having contact or communication with family members and the "identified patient," unless permission is granted in advance. Many horror stories occur, such as family members being unable to locate a psychiatric relative, not knowing whether the person is in a hospital or on the streets. Agency/hospital staff feeling caught between the patient and family, and unable to think being connected to both sides of the triangle, perpetuate the escalating emotional process by refusing to communicate with family members since the patient hasn't given "permission." The emotional war within the family continues.

The direction of psychiatric science (not to e equated with neuroscience) moves increasingly towards more and newer drugs, which the pharmacy industry is more than happy to support with "research" dollars. It is rare to read any research/ medication evolution report that is authored by someone who hasn't received funding from a major pharmaceutical company with major interests in the financial success of the "new and better" medicine. This, or course, applies to the entire industry, not just with psychiatric medication initiatives. There is also an increasing acceptance

of physician using “off label” meds to treat psychiatric problems. The current “love affair” with anticonvulsants in the treatment of “mood disorders” is one example. Polypharmacy seems to be the practice norm, with the assumption that more is better. Symptom relief is the criteria rather than looking at possible long-term consequences. The percentage of T.V. commercial time during prime viewing hours and ads in News Weekly Magazines seems to be increasing. Side effects are rapidly mentioned in the last seconds, with the caveat “ask your doctor.”

With all these pressures for one’s well-being, shift to the environment’s definition of solutions to problems and the clinician becomes more and more defined by this eroding process. The realities of the above forces and trends cannot be ignored, but where can one start in defining one’s practice principles while being connected to this hostile environment? If a clinician is so bold as to ignore these realities, unemployment is a predictable outcome.

Dr. Bowen was well aware of these realities and found a way to operate in the environment. Thirty years later the situation has only escalated. His letter of March 29, 1971 reflects his principles in reference to family emotional processes while dealing with requirements from the environment. Again, this is a “both/and,” not a compromised position.

March 29, 1971

Dear Mr. and Mrs.

Enclosed is a bill and the completed insurance form.

A bit of explanation is in order about billing for family psychotherapy. A main advantage of a family orientation is thinking of the problem as a total family problem and "treating" it as if it is a family problem, in contrast to conventional psychiatry which diagnoses and treats the illness in the patient. The more successful each family member in discovering and modifying the part that self contributes, the more quickly the problem resolves. The more successful the family and therapist in avoiding conventional concepts such as "patient", "illness", the making of diagnoses, and the concept "treatment", the faster the resolution. Routine bills are always made to "Mr and Mrs" as equally responsible for any problem in the family.

Family psychiatry is too new and there are too few family therapists for insurance companies to have developed rules and procedures for it. Any attempt to explain "family" to an insurance company results in endless snarls, red tape, and confusion. So, for insurance purposes only, it is necessary to follow the conventional system. In my practice, I permit either spouse to be listed as "patient", bills are made to that spouse along, and insurance forms carry the most minimal diagnosis acceptable. This also permits one spouse to be the "patient" for one block of time, and the other for another block of time. All of this is to explain to you that Mr. is listed as the patient on the bill and the insurance form, for insurance purposes only, and not because I consider him a "patient". Both of you will be ahead of the game when you finally are out of the mold of thinking and acting as if he is the "sick" "patient". That's a good assignment for you.

It is good to hear that things have been going better for you. From the best estimate I can make on July, it looks like the week of July 12 might be one of the more favorable weeks for me.

Sincerely,

Murray Bowen, M.D.

# ONE WAY OF THINKING ABOUT THERAPY

## One Way of Thinking About Therapy

What determines which way people go? This question is relevant for both people seeking a therapy experience and the therapist who wants to offer some assistance. "Schools" of family therapy and training programs evolve based on the answers to this question.

There are major differences in assumptions, beliefs, and priorities of the various "schools." Asking a therapist about his/her theoretical orientation often results in a confusing, contradictory response. Asking about how the therapist defines his/her responsibility and function in a clinical situation only adds more confusion. Added to this confusion mix is the patient's own lack of clarity about what one wants to address or accomplish in therapy.

A large list of questions surface (for both the therapist and the potential patient) as people try to sort out directions and "answers." Is theory important in one's practice? How important are "techniques" and "strategies?" What is a "therapeutic experience?" What drives symptom development? Who knows "best?" Who is the "expert?" What is the nature of the "expertise?" What "helps?" What is the difference between short-term relief and long-term solutions? What is the importance of "change?" What does "working through" mean? What is the importance of past emotional experience? What does "therapeutic relationship" mean? How important is a diagnosis? What is "conventional therapy?" How much of therapy is an art form? What is mental illness? What is a "mood disorder?" What is a "disorder?" How does one think about medication?

It is predictable that some people are "disappointed" in their therapy experience and want to try something different. They ask friends and acquaintances for opinions and recommendations. Many people turned to Dr. Bowen for his advice and recommendations when their therapy experiences had not been useful or not "helpful."

Dr. Bowen's letter of February 1975 responds to a colleague in Pennsylvania who had written to him for advice and possible direction for a family's ongoing struggle to find a therapist that could "help."

Feb 22, 1975

Dear

This is a response to your letter about the . I saw them one time, which I do for very few. Maybe sometime in the future I might see them again, but I have long since learned not to make definite promises. I hoped I might provide them with a different viewpoint. They are part of that army of people that has been wandering through the psychotherapy maze for years, without finding solid answers. They have been personalizing too much, looking too much for answers in the personal "philosophy" and the personality of the therapist, and not paying enough attention to principle and theoretical discipline. The mental health professions help promote this notion that psychotherapy is more of an art than a theory, and that success depends more on the personality of the therapist than the principles that guide the therapist. You have been exposed enough to this orientation at Bryn Mawr.

A good portion of my professional life has been spent with the failures from conventional psychotherapy. Most mental health professionals are not aware of the degree to which their "therapy", especially long term therapy, can create and perpetuate problems. People recommend psychotherapy with religious fervor, in the belief that it can solve all manner of problems. A high percentage of mental health professionals go into psychotherapy of some kind, with the same naïve belief that they are solving problems for the future. The results of their efforts come crashing down into symptoms, either in the marriage or in their children. Years ago I began limiting my practice. I reasoned that my time would be better spent working with people who work with people, than with others. It became necessary to further limit the practice. I ruled out most of the physicians, teachers, ministers, etc, and was seeing mostly members of the mental health professions. Now, a high percentage of my practice is with family therapists, who have had the same life course as the . If they can wait a year or two until I can find a few free hours in my schedule, I eventually can start seeing them. Most live in distant cities and come to Washington a few times a year. This makes me mostly unavailable for problems that require immediate attention.

I agree that the might well continue their circuitous pursuits. There is an urgency about them and they are gullible for yet another version of relationship therapy. I was able to do a referral to one of my very best associates, to whom I refer only "special" families, since his time is also limited. Statistically, their problem is a soluble one. I worked hard in the one appt to help them so see another viewpoint. At least they have a choice. If their new choice does not work out, I will still be here.

Sincerely,

Murray Bowen, M.D.

# RESPONSIBILITY, THE ENVIRONMENT, MEDICATION

## Responsibility, The Environment, Medication

The mere mention of prescribing psychiatric meds creates an immediate emotional, reactive war zone, that fuses genuine pain and suffering, drug industry marketing (e.g., "Neurontin for everything"), legal "responsibility" of the physician, minimum scientific fact, advocacy groups (e.g., N.A.M.I.), and T.V. advertising ("ask your doctor"). Is it possible to find a way to think about these issues and make intelligent decisions?

The interactions and interrelationships between the individual and the environment are always at work. How this occurs determines how the organism functions (thinking, behaving, feeling). This applies to the cellular level as well as the organism as a unit. The issue of medication is superimposed on this core fact which in turn triggers assumptions the individual makes about self and responsibility, which will also trigger a fair "dose" of anxiety. These assumptions are communicated to the physician who either accepts them as factual or explores ways to think about and question the assumptions. A reciprocal relationship begins which can spiral into a point of no return. Assumptions become facts, with no way to back down the process. It is rare when a physician asks the patient what he/she wants the medicine to do that he/she cannot or is unable to take care of at the present time, or "what is your plan for decreasing your need for this medicine?" What is the long-term impact of telling a patient that he'll always have to be on an antidepressant? When do symptoms and symptom amelioration begin to define self? When do the assumptions driving DSM-IV become facts? When one is labeled with a "disorder," medicine is almost automatic, e.g., "mood disorder."

The decisions have to be focused on the choices about responsibility one makes in the relationship with one's environment. What external resources will one use, or not use, in dealing with one's problems? This question also applies to thinking about one's relationships, not just medical choices.

Dr. Bowen's letter of March 1978 is a response to a patient inquiring about the possibility of discontinuing Lithium.

March 16, 1978

Dear

How in the heck are you going to get off lithium if you are dependent on it to maintain your equilibrium and you have to get the environment to approve and assume responsibility for you if the experiment fails?

I think you can develop the ability to maintain full control of yourself without the propensity to respond to environmental stimuli, but the environment does not think so, and you have your own brand of doubts about you. The chances for failure are much greater if you involve the environment in your decision. It probably would be wiser to postpone a decision about the lithium until you can be real sure within yourself and you can accept full responsibility for the outcome. We can talk more about this later.

For now,

Murray Bowen, M.D.

PRINCIPLES OR LEAPS OF FAITH?

## Principles Or Leaps Of Faith?

Once a person is labeled as the "identified patient," it is difficult for the clinician to focus in any other direction. The label pulls the energy and focus onto the person in the identified role, and, of course, there is ample energy in the form of psychotic symptoms that the I.P. brings to the mix. The psychotic symptoms are a reality and there is often a history of multiple hospitalizations that have been necessary to keep the symptoms "manageable" for the family.

Clinic and agency policies require continued focus on the I.P., which translates into medication monitoring and management, case management, crisis management, and minimum contact with family members. Family contact can escalate into resentment and hostility toward a family this is trying to be involved and connected to the treatment process. In many instances, an outpatient setting takes on all the characteristics of an inpatient setting. What part does clinic policy and clinical practice (and the thinking and assumptions that drive it) play in promoting entrenched "backward" chronicity?

Does the functioning level of the patient and the clinician have to be doomed to this escalating reciprocal pattern? Even clinicians who try to "think systems" have difficulty in believing that efforts made with parents in managing their own emotional processes will impact on the emotional process and functioning of the I.P. Does such a direction have to be a leap of faith or can it be grounded in solid theoretical principles?

Dr. Bowen's letter of October 1977 describes his experience with a family over an eighteen-year period of time, with the majority of the contact being with the mother, with the schizophrenic daughter being involved in only a minimum of emotional contact. For the most part, Dr. Bowen's effort enabled the I.P. to avoid hospitalization.

October 27, 1977

Dear Mr.

Thank you for helping to use the telephone conversation with you in preparing the reports on . It is accurate. I can add a few items. I have seen and her mother regularly but infrequently since January 1960 when Mrs. moved from Iowa to Washington to work for Civil Service. They were referred by M.D., a psychiatrist friend in who had been in charge of treatment for a number of years.

I have spent a good portion of my professional life on schizophrenia and is one of the few with whom I have never been able to make emotional contact. She was quietly silly and sort of hebephrenic in 1960. Over the years the symptoms have shifted a little but she is still fixed in a chronic state, that for most, would require lifelong hospitalization. I consider my 18 years of sessions, mostly with the mother, to have been highly successful. Mrs. has been able to "get off back" and to stop doing the things that agitated and sent her back to an institution. When the environment puts pressure on such as urging her to again work as a nurse, she flowers into "acting out" behavior problem psychosis. Once in the mid 1960s when the mother was sort of anxious about a new job, became symptomatic enough for 2 or 3 years in Western State Hospital. The rest of these 18 years Mrs. has been able to manage at home. She lives her life in the apartment and sort of permits to lead a separate life in the apartment, and it has gone rather well. She has been able to remain calm in the face of psychotic thinking, and to joke a bit with the "voices" and outlandish delusions about money. When Mrs. can joke, the intensity of the delusions subsides, and smiles her silly smile.

I have a dozen or so chronic schizophrenic people, now living fairly comfortable lives at home, who had been institutionalized for years. One had been dropped by his family over 20 year. By calming the family environment, it is possible for these people to live more comfortable lives with their own families than would ever be possible in an institution.

is a low risk for harm to herself and others. About the worst that can happen when she is out alone is bizarre gesturing and psychotic verbalization that disturbs others. Mrs. has worked hard to support herself and these 18 years I have known them. I think will have a reasonably comfortable existence as long as her mother lives. After that I see little except that she becomes a permanent resident in a state institution.

Murray Bowen, M.D.

# WHAT MAKES IT SO HARD?

## What Makes It So Hard?

The majority of people seeking consultation and therapy focus on their unrest, discomfort, unhappiness, and attribute these feelings as a result of something coming at them from their environment—often another person, often a family members. Rare is the experience of a person wondering about how one makes oneself miserable.

There is a biological layer to this, in that when one's anxiety is rising the automatic focus is to look for and see the danger in the environment. Survival, in the evolutionary framework, is dependent on this capacity.

Another difficulty in trying to move the therapy toward a self-focus is one's subjectivity and negative editorials about self—"If things are not going well, it's my fault, something is wrong with me", "you're doing (the therapist) the same thing my mother did, blaming me for what my father did to me." Often the anxiety is so high that any expectation that the patient be more responsible (e.g., canceling appointments) is heard as "criticism."

Perhaps a first step is being able to focus on one's reactivity process. The person can still hang on to the "blame" for survival and begin a process to manage one's reactivity to the emotional intensity that is seen as originating from the environment. Perhaps this step will offer some calming and anxiety reduction. However, it is a major leap to go from managing one's anxiety to examining how one contributes, or looking at what part one is playing in the troublesome emotional turmoil.

Very few people can concisely focus on Dr. Bowen's observation (in the context of the NIMH project) "so I began thinking that if problems are not decreasing, I must be playing a part in it. I was being over responsible for the administrative functioning of the entire unit. I was excusing acting out behavior."*

* I have given couples this quote; some have put it up on their refrigerator. But when their miserableness begins to resurface, it's all forgotten and it's back to "you are making me miserable."

This is a letter from November 12, 1976 responding to a patient's question about "confronting" a family member, and his effort to put the focus back on self.

The answer is NO—NO—NO!!!!! After you have grown up enough to stop blaming her for your miserable misfortunes, then its okay.

Instead of focusing on what your grandmother has done to people, why not focus on what a miserable, inappropriate, helpless wretch you are (only the helpless have to blame others), get over the urge to rescue your poor mother (I have an idea you have about the same basic "fused" opinion of your gr-mother that your mother has), and become enough of an observer to find out how your family really operates.

If you have to blame someone, then go out in the field alone and blame either Gerald Ford or Jimmie Carter.

For now,

# THE LONE RANGER

## The Lone Ranger

In addition to the training programs at the Georgetown Family Center, there are a number of training programs throughout the country. Some are still going; some have imploded or dropped out from sight. Most of these programs have been started by people who have attended the post-graduate programs at Georgetown. Motivation for these people's efforts varied. One's enthusiasm for the learning provided, at least initially, a fair amount of energy to start their programs. Many invited Dr. Bowen and his faculty to participate and present at the training programs, which helped keep the programs focused on principles. Of course, no program had a "Dr. Bowen" on board to direct the process though the various emotional minefields. Some were led by a small group or co-directors which necessitated a "group" solving process, with the potential for compromise to and erosion of basic principles. (There are a lot of Second Baptist Churches in America.)

The history of major movements, their leaders, and their followers is full of documentation of how "differences" and individuality was rejected and people being ostracized. Freud, his students, and followers provide many examples. Some of his followers became more "Freud than Freud," fighting wars that Freud had already ended (e.g., approval of lay analysts). Franz Alexander reported a conversation with Freud, asking Freud if he was concerned about enemies of psychoanalysis. Freud replied he was more concerned and worried about his followers than he was about "enemies."

Can one be a serious student of Bowen family systems theory and a practitioner using his principles and not disappear in the pull of fusion? Are there dangers in one becoming "more Bowen than Bowen?"

There are many similarities in the training program processes and the process when one takes on responsibility for defining self in one's family.

Dr. Bowen responded in a letter of April 1987 to a Midwestern program trainee who was caught up in various triangles and was struggling with the "togetherness" forces of the training program and her awareness of her own sense of self. Dr. Bowen is careful not to see these forces just as a phenomenon of this particular program, but a more universal one in both organizations and in people's families. The principles are eloquently offered to guide one through these pulls and struggles.

Monday nite 4-27-87

Old habits are a problem. If I don't respond to a letter immediately, it gets tabled, and time passes. And you are kind of different with your own "go power". I have thought about you many times as I have hacked my way thru "differentiation" with others.

There was nothing in your last letter to refute my original impression! It is a guess that your real estate "self", plus your intermix with , somehow enabled you to be different in the togetherness triad at . You did not ask for that! Your number simply came up, and there you were. As I see it, and are the two major forces at . They need each other too much for either to make a move that does not involve the other. Then you came along, like the day with your two parents, the day you were born. If either of the "other two" is a pure bastard, it is easy to get out as soon as there are wheels that roll. But, what if both are nice people, like ? Get mad and scream — or stay stuck, — or grow out of it? Growing out is the difficult task! You please one, and automatically displease the other. Lock, interlock, frustration! Then, along the way — some 30+ years ago, came the notion of differentiation. Far too complex for the average to understand, but as simple as a sky-dive for one who has the basic equipment (built in by nature), knows the rules (learned), and who has the conviction in one's own head. When the differentiating one can quietly persist, out of one's own head, without fanfare or notions of self gain or without having to prove a point to the others, one's own success then becomes a model for others to follow in their own inimitable way.

Over the years, there have been more failures than successes in the search for the family member who can take the first step. A failure is good for learning the rules of WHAT NOT TO DO. A blown fuse, is a blown fuse, is a blown fuse!!!! One time I spent 5 years recovering from a "blown fuse" in my own family, all advised by a well meaning psychoanalyst. Don't trust analysts!!! They mean more well than parents! Over the years, there has been an interest in the places that teach some version of Family Systems Theory. Most leave out differentiation!!! This included some secret sniffing around at . It was a surprise to guess that you were probably more gifted to "lead off" than those who drive Sevilles and Oldsmobiles.

When one lone person has the courage of his/her own convictions, and the fortitude to quietly stand there, in spite of the flood tide of togetherness inundation, the organism settles down. Then others begin their own versions of differentiation, and everyone automatically pulls to a higher level of self. If my guess about you is accurate, and you can be the quiet YOU, out of your own head, and you do not wither and fade (or counter attack) when the togetherness tide builds up, YOU will automatically have become more important to than riches or gold or material things. If you are really IT, then softly thank your ancestors for the loan of basic equipment, quietly thank you for having the courage to use it, and gently commit the loan to the generations who will follow presently.

Treat your new Integra nicely.

Lest we forget,

Murray Bowen, M.D.

# THE MOTIVATED ONE

## The Motivated One

When the issue of "motivation" arises, many questions are triggered. How does the therapist think about who comes, who doesn't come? Is it really "family therapy" if only one person comes? Is it "family therapy" if only the parents come and the "identified patient" child does not? There is a wide spectrum of thinking about these problems. How does one think about how emotional systems work? What are inherent characteristics of a family system? Should each family member have their own therapist?

Is there a predictable systemic process when only one family members is involved in the therapy effort? How does one stay away from trying to change the other or blaming the other for what is or what is not happening in the family? Does motivation shift from one person to another? One family member can be the initiator or leader in the effort with the partner following the lead, and then the pattern may shift. Can a person be highly motivated for a period of time, then "take a break" from therapy? Can this sequence not be seen as a negative (e.g., "no longer motivated")? Often when the therapeutic process is not progressing "satisfactorily" (ever what that means), the patient is labeled as "not motivated" to work in therapy. If there is enough reactivity going on, the "borderline" diagnosis is pulled out. In the old days, the patient was labeled as "passive-aggressive." The personality of the patient (not the therapist's) becomes the issue.

The major point is that there are a number of interlocking questions in reference to the therapeutic process.

Dr. Bowen's letter of December 1966 responds to a patient's letter who is taking the lead in dealing with her family. Her daughter is the "identified patient." An important point in his letter is the articulation of how family system patterns operate.

December 26, 1966

Dear ,

Response to your letter has been delayed because I have not made time to put thoughts on paper. Rather than delay this longer I will hit some high spots and not bother if thoughts ramble or are not well structured. Since you have chosen to work on this on your own, I will attempt to point out some of the obstacles and some general directions for getting around them.

I believe that defining the problem as a family problem, rather than a problem within , may have provided some relief for her. It sounds like the long session may also have provided you with some directions for your own life. Though changes in your attitude and actions may have reduced the pressure on , and also reduced the symptoms, you should be aware that the basic family patterns that gave rise to the symptoms are still there and that any effort to modify the patterns is a long term project no matter how one approaches it. The fact that symptoms were relieved by relatively simple adjustments is indication of family flexibility, but the fact that a fairly serious symptom did come to the surface is not to be taken lightly.

It is an accurate over-generalization to say that emotional problems come into being by taking the easy way out in a host of critical life situations. An Achilles Heel of any therapeutic system (the hazards are greater with the “do it yourself” effort) is the unwitting continued use of the very mechanisms that went into the creation of the problem in the first place. Emotional problems are created out of what seems logical and “right”. Man can take any theoretical or therapeutic system, mold it to fit his own emotional functioning, and use it to perpetuate the problem. This is one of the devilish complications of the mental hygiene movement with its easy rules, formulae, and blueprints. If you can be aware of this as a near universal human characteristic, and that any course of action requires constant checking, re-evaluation, and questioning; you are less likely to be lulled into complacency.

There is one general rule (there are always specific exceptions to any general rule) that applies to almost any problem involving children. This is to view any problem that focuses in children (whether it be persistent physical illness, emotional disturbance, or impaired functioning in school or social relationships) as a manifestation of an overt or covert disharmony between the parents. There is a good percentage of calm marriages in which a problem in a child is a more sensitive indicator of an underlying parental problem than anything in the parents’ conscious awareness. If parents automatically regard a problem in a child as an early indicator of marital dysharmony, and if they can defocus the child and start a search for disharmony between themselves, they cannot lose.

's tendency to minimize the problem is a familiar one. How do you explain the differences in your perceptions? Are you seeing things that are not there or is he wearing blinders? Either of you could offer solid evidence to validate the separate views. 's reaction recalls that of a father a few years ago. The mother was involved in the emotional complex with the kids and the father was quite outside it. When she complained, he would convince her that the problem was her inability to organize the home front. Both viewed it as the mother's problem. She tried working on it alone. The childrens' symptoms decreased but her energy went into untangling her "ball of yarn" with the kids, she never found motivation to deal with her relationship with the husband, and resolution of the problem was impossible without him. Finally I refused to spend more time on it unless the father would come. He came one time, with a twisted arm. He focused on his childrens' positive qualities and the advantages his income provided for them. He said they were as well adjusted as any kids on their street. He honestly did not perceive a problem and there was no reason to spend time on a problem that did not exist. His visit terminated that effort to work on the family problem. About six months later his oldest was arrested for shoplifting and the police called the father. For the first time HE had a problem and he was in a hurry to do something about it.

I could go on rambling at length but it would be peripheral to the points raised by your letter. The various activities you have started can all serve to strengthen your own functioning and anything that improves the functioning of one family member can contribute to the family. It is possible to learn much about self from working with emotional problems if one can get into the position of a detached observer and not participate too much in the emotional system. This is another area in which one has constantly to be evaluating.

Work on one's family of origin is an extremely long term project but there is a long term dividend there for one willing to work at it. This is one of the main things I am trying to communicate in this letter, namely to approach anything you do in terms of the long term project rather than alleviation of symptoms. I will leave you with a question—If the underlying problem is not causing symptoms and the ultimate goal is resolution of the underlying problem, then how does one determine whether or not one is making progress on the "problem"?

Enclosed is a bill. My regular fee is $25 for a one hour interview but I routinely do some kind of a professional courtesy discount for physicians, psychiatrist (a special kind of physician more accustomed than most physicians in paying such bills), and good friends, for the initial interviews.

Good luck to you and in your effort. It would really be more accurate to say "good luck to you on your effort on ". If you need any help along the way in re-charting your course, let me know.

Sincerely,

Bill for $50 sent.

# ASSUMPTIONS AND THERAPY APPROACHES

## Assumptions and Therapy Approaches

Assumptions come from two directions: the potential patient and the potential therapist. For the person seeking therapy, there are many resource options and making a decision where to turn is usually not a rational one. Advice is often sought from a friend who is in therapy -"You'll really like her." Information about one's therapist options and choices usually does not include information about the therapist's theoretical framework. In this day and time, very few psychiatrists offer psychotherapy, but focus on "getting the chemistry right," and for a person wanting medicine this sets up a "therapeutic relationship" that will increasingly medicalize whatever the problem was that motivated the decision to initially seek assistance. The "literature" is used to support the assumption that the person will have to remain on medicine, with little or no thinkng or discussion about what will be required to go the other way, e.g., making an effort at focusing on self responsibility for dealing with one's problems.

There is some thinking and emotional activity before the decision is made to seek help outside of the family. Often the focus is on a child with there being some "facts" to support the concern, e.g., acting out behavior, falling grades, etc. Couples present with many different twists –"We need help in communicating with each other"; "If you don't get help, I'm going to see a lawyer." Different therapists make different assumptions about these "presenting problems." A core assumption for the therapist is the role of "relationships" in therapy. Certainly, the prevailing clinical thinking today in treatment plans is the first "goal" : "establish a relationship with the patient." This is the cornerstone of many theoretical approaches.

Dr. Bowen's letter of February 10,1976 responds to a woman from a southern university town where he had recently made a clinical presentation. She wrote to him of her concerns about her life and marriage, and asked him about possible therapy directions, even the possibility of traveling to Washington to see him. His letter examines some of the underlying assumptions built into various therapy approaches, while pointing out options for her to consider.

Feb 10, 1976

Dear

You have enough of a balance in your marital fusion that it may be difficult to dialogue. But, if you don't shake it somehow, it will rise up with the symptoms somewhere along the line. One problem is that each neutralizes the effort of the other. You can spend a lot of time talking each other into it, and out of it.

To , I would say that I hear you loud and clear when you say that talking about problems makes them worse for you. Marriage counseling is no more than a sort of piece-meal thing for you. It sounds like you made some real progress with your mother at Xmas. Anything you do within you, to contain emotional reactiveness, will move relationships to a more workable level. I would not go toward individual therapy. You'd be better off if you could get some "give" in your families of origin than anything you can do between you. Individual therapy would probably provide some early relief but individual therapy IS A RELATIONSHIP SYSTEM, there can be long-term complications, and it usually gets the extended family system more negative than it already is.

You asked what you could do on your own. There are two or three methods that go in a direction that is compatible with "differentiation of self", which is the effort to be a "self" in relationship with the other, without holding the other responsible for one's own self. One is Meditation, if one can be careful. TM has become a kind of spiritual movement which I think defeats some of the basic gains in it. Most of the basic TM stuff that goes on within one's own head WITHOUT GETTING INVOLVED IN RELATIONSHIPS WITH OTHERS, can be helpful. I am trying now to develop it as a kind of supplement for a differentiating effort within a family. It can lose its value when one gets "caught up" in the movement. Another method that is theoretically consistent is Yoga which involves a kind of physical and emotional discipline. Some people have done wonders with it. Depends more on the person. At Georgetown we are working at developing biofeedback as a supplement. It is a combination of physical and emotional discipline involving the autonomic nervous system. I KNOW there is something good here, if we can get the garbage out, as it has come into such popular use.

I am biased as you well know. I have spent my entire professional life trying to make theoretical and practical sense out of what I consider basic problems in the very foundations of psychiatry. Psychoanalysis is still the baseline — the ultimate method from which most of the other therapies descended. None of the other methods have as much discipline built into them as psa. The transference is the

moving force on which everything from group therapy to counselling, to encounter groups, is based. Psychiatry professes to have a dozen or two different theories ( better learn all of them good or he will not pass his boards) which I consider one basic theory based on psa theory of the therapeutic relationship. So many supposedly different theories that one has to profess "eclecticism" to survive them. All these theories operate on relationship forces. There is one set of results when one attempts to juggle and balance relationship forces, which is what most people try to do on their own, as far as that will go, and then they get a "therapist" to bring outside help for a better balance. Most methods propose a little individuality, as part of the relationship balancing, which is part of the artistry which says therapy is more art than science. One of the things that motivated my family research, among other deficiencies in theory, was the high divorce rate in psa.

Based on the kind of "therapy" available in the market place in most places, I would say avoid relationship type of individual therapies, especially those in which "liking" the therapist and being emotionally compatible with the therapist is an issue, and keep relationships spread thin until it is possible to clear some of the issues with one's own family. The more you have to run from your family of origin, the more your children will ultimately have to find a way to run from you. The average relationship therapy encourages people to "run" from the past, or it sets up some kooky "make-believe" for pretending to deal with the past.

I will be willing to see you, if you can get the reality of your situation cleared in order to make it here. Your unsureness is part of the problem, which becomes part of my problem in scheduling all the long distance work I do. When I am filling my time with people who come every 3 or 6 mos, and someone gets sick or something else interferes with the appt, I am unable to fill most of that time in less than a month or sometimes longer. That's why I have to charge more to make up for the cancellations and changes in appts, and no one can foresee that. You cancelled about 3 wk ahead and I was able to use 1 hour of that which is the way the game goes. I do not charge for such cancellation time. I up my fees to cover the average of such cancellations. Heck, I have had cancellations when people are seriously ill in hospitals. All I ask is that people do the best they can at staying on schedule. There is no way to figure the cost on these infrequent appts against the cost of frequent individual appts.

The title of the Framo book is "Family Interaction". I will send the reprints and bibliography from Gtn. Good luck to your in your choices and your efforts there.

Sincerely,

Murray Bowen, M.D.

# RESPONSIBILITY OF THE MOTIVATED ONE

## Responsibility of The Motivated One

This letter of 1971 augments some of the principles articulated in his 1966 letter, focusing on the responsibility of the motivated one. Very seldom do a couple come in with equal energy to think about the family system and what is on their plate. Again, the knowledge of how emotional systems operate drives the principles.

Tuesday 5-4-71

Dear

I have one brief communication which I hope may make some sense. It is off this point of your last letter, but it does apply somehow.

Here goes---It has to do with the clank of righteousness, too often worn by the family member who has made an effort to change, whose effort has bogged down or become ambushed, and who then blames the failure on the other, and who makes demands that the other make a similar effort to change. From my experience, the motivation and initiative and responsibility still rests with the one who started the change, and it stays there until the other develops enough motivation to start moving on his own, and if the "other" is really alive, he will usually start a course that the first does not approve.

I think the one who initiates change is the one who is most uncomfortable with the situation. There are no medals nor certificates of commendation for this effort. In fact, the other may be critical of the effort to change. I think the one who initiates the change still has the responsibility for change until the other develops some motivation to change things on his own. Hopefully, there is a stage of cooperative teamwork which is more than compliance. Even after spouses can get into a teamwork project, the initiating one still has the responsibility for defining problems and taking initiative for change until the other can begin to see problems.

Translated to you and , I think you are the one who has the basic responsibility for change, if anything is to be changed, that you have bogged down in your effort, that you are blaming him for your discomfort and unhappiness, that the only problem he knows from his own frame of reference is your unhappiness, etc.

End of communication. I have already talked more than I had planned for this note. From my perception of things at the APA, you are not missing much by staying home.

Sincerely,

# DR. BOWEN AS THERAPIST

## Dr. Bowen as Therapist

Throughout the archive collection, there are numerous letters to other therapists and psychiatrists in other cities where his clinical families had relocated and wanted to continue their therapy. These letters are remarkable in their depth, detail, respect, and compassion for the families for which he had devoted his efforts to "lend a hand."* His optimism in the belief that impossible problems can be made more manageable was, of course, based on his theoretical roadmap that guided his "each step of the way."* Students and other mental health professionals often are curious about this "therapy" and unsure how theory and therapy are connected. The enclosed letter offers multiple clues to these questions.

This letter is <u>part</u> of a seven-page letter on to a colleague in Pittsburgh, where a family he has worked with is moving. In addition to detailed information on his referral family, he writes of his detailed process with an entirely different family that describes his therapy process, his thinking about his therapy, and how the family members respond to this process. Included is the five-page therapy summary of this "other family," plus a two-paragraph summary of part of his "technique," another classic short story. This letter is from July 1968. A question for the reader is do you "hear" the process or only the fascinating content?

*Dr Bowen's words.

July 5, 1968

Dear :

On Friday June 28 I saw and for an hour and a half review of their family situation. I will put down a few ideas about them and some experiences I have had with similar families.

The have a real "stuck" situation in that the emotional bind leaves little maneuvering room for anyone. Since my of my thinking about these revolves around a recent promising outcome with a similar but more intense problems, I will tell you about that first. The story goes back to early 1961. The father was a well-known business man in his early 50s; the mother an emotional and very talkative pretty woman in her mid 40s; the oldest child a daughter of 20 doing well away in college; the second a son of eighteen in college in who had been a fair student and good athlete in prep school; and a youngest daughter of nine in "analysis" with a child analyst. The family was well known in psychiatric circles because they have seen so many different psychiatrists for different lesser problems over the years. It was a psychological "enlightened" family. The father has a who has long been a "name" in psychoanalysis who came in to advise and mess up things periodically. The family problem remained in contained livable state until the son left for college in September 1960. Marital conflict became intense and soon the nine-year-old daughter was in analysis. Two months later the father had moved out and was in an affair with his secretary. Anxiety and acting out was everywhere. It involved detectives, psychiatrists, legal actions, etc. The mother's screeching anxiety was equalled only by the father's quiet legal moves to "do her in". Everyone was "allergic" to her anxiety, including the younger girl's therapist. This was the state of affairs when I came on the scene early in 1961.

The first four or five years I saw mostly the mother. She was the only one motivated but she had played such an adaptive role that she never had the strength to "contain herself" when provoked by the family. There was an early fight when she withdrew the daughter from analysis. I was non-committal about that point. The father, through his brother, built up the arguments for continuing, and against the mother. The analyst wrote me a letter imploring that I do something to "save" this girl by insisting that they continue the analysis. Another fight followed the efforts of the father, the child analyst, and the eldest daughter to have the mother institutionalised. I of course am against solving family problems in this way. The father demanded psychological tests for the mother. I agreed only if both parents be tested. I did not hear from him for about two years after that. I believe that was the last time any family member tried to get me to "take sides" in the setting out.

From then on, I'd only hear about the shenanigans. During that first year the parents moved into the legal arena with divorce accusations; the son began acting out at college, quit before he was kicked out, and returned home; the older daughter continued to the end of the college year and then went "Bohemian" in San Francisco; and the younger daughter was fairly calm at home with mother.

This was a disruptive family. During the early years I saw various combinations of family members together. The father would get mad at the mother and storm out after ten or thirty minutes. One time the father wanted "analysis" for himself. He lasted about three sessions quitting when I failed to "understand" and take his side. The family disruptiveness between the parents was present to a lesser degree with any two family members. About two years out, I saw the daughter a few times after she had returned from San Francisco. She ended up in psychoanalysis which lasted about two years. I saw the son. He was challenging, cynical, and helpless. Part of this was his usual posture toward life and part his opposition to mother's pressure. The parents went through a nasty mud-slinging divorce in which the mother "lost" almost every count. Lawyers, judges, and everyone else would get offended at her anxious attacks. Though divorced for four years, the parents are still emotionally involved with each other, much calmer now than in years. The father has lived lavishly with beach houses, boats large enough for Caribbean cruises, etc., while keeping a series of mistresses. He defaulted in alimony payments and the wife went to work to buy the necessities. Of course she still went overboard bailing out her irresponsible children. She began to do rather well in her own business. She sued him for back alimony. He appeared in court in tattered clothes pleading poverty and trying to prove she had more money than he, and the alimony was unfair. For the first time she kept her anxiety contained and the judgement went in her favor. Over the years I saw the mother less frequently, down to once a month, then four times a year, and then a termination that lasted a year. So my total "hours" with this family has been about 250 hours. The mother just never "had the ability" to become the solidly "differentiated" one who could influence the family.

The main part of the story has to do with the son and older daughter. The son went from bad to worse. He was a wandering "Bohemian" for a year. Then he began working for his father and sharing the father's angry attitude about the mother. He lived with a waif of a girl whom he married after she became pregnant. The father ran out on the son (left him in charge of the business) as he had done with the mother. The son's wife ended up in a mental hospital with the infant son being passed from one to another. The son began using "pot", then narcotics, and then LSD. Within a year he had been arrested for possessing, and for transporting and selling narcotics. The son disappeared into the hippy world, a long haired and bearded disciple of peace who was against the "establishment". His wife took the infant son and returned to her family of origin in the South. Deep parental anxiety about the son was tremendous. They would try to find him or get word about him while he eluded them. Occasionally he would return to demand money and then leave "forever" when they gave only half what he demanded. The older daughter was a "working hippy" who shared an apartment (pad) with a girl friend in town. She worked part time and finished college while living with a series of men hippies. She was active in "liberal" and "anti-establishment" causes. Her analyst was not able to analyse her out of the situation. In the fall of 1966, a year after the analysis was terminated, I began seeing her once a week and then

three times a year.

I was delighted to have an oldest sibling from an unchanging family, motivated to do something for self. The "oldest", functionally if not actually, usually feels tremendous guilt about the family. They have tried in their own inept way to be responsible for the family and have given up in despair. They have a built in "go power" if their energy can be directed to understanding emotional systems and the responsible functioning of self, rather than irresponsibly trying to "help the helpless". Her insides had been almost as attached to the brother as the parents. A friend could say, "I saw your brother and he looked awful" and her stomach would go into spasms which would drive her into action to check up with telephone calls, etc. My suggestion was to try to find a way to get her guts unhooked from her family. A lot of talk and examples went into this, plus defocusing all the explanations she had learned from analysis. She did a pretty good job detaching from her family but was "snookered" by increased dependency on the boyfriend and ended up pregnant. The boy promised to marry her if she wanted him to. Rather than live with this, she decided on and got an abortion within a week. Within weeks she had separated from the boyfriend and his group of hippy friends. This girl was tremendous in her determination to find a way to get herself emotionally unhooked from her brother and her parents. She could maintain fair non-reactivity to and stories about her brother, and even to her mother's anxious reactions to the brother's problem. She heard the brother was living in a "pad" in Philadelphia. She went to see him to test her ability to keep her insides and her "self" calm in his presence. She did well. About this time, with all the emphasis on "treating" hippies, I decided to make a concerted effort on the hippy member of this family. To use the term "treat" in this sense would defeat the whole effort. The daughter was a pretty good student of family systems (about fourteen months after I started with her). The brother was said to be in San Francisco. A hippy is a refugee from his family. The family "chases" him, even though this is expressed only in worry and thoughts, and the hippy knows it. When in trouble, they return sporadically for handouts, leaving angry when only half their demands are met. After deserting the family they "join" a pad but the same disruptiveness exists within the "pad". Then they desert that "pad" and move on to another and another. They exhaust the "pads" in one city and then move from city to city. Any attempt at psychotherapy represents the "establishment" and they have to move on. Some researchers such as have gone in the direction of "joining" the hippies. let his hair grow and emotionally he has come to sort of identify with their "cause", from which position I think change in a real hippy is near impossible.

The running away is the hippy's way of denying his intense emotional attachment to his family. They DO return periodically. My thesis with this family was to leave the boy on the long leash, and not chase him, and to work toward making the family environment one a little more solid when he did return. I already had one family member beginning some "differentiation of self". Once one family member changes and can maintain it, then other family members can change a little. The immediate goal here was to go as far as possible in helping the family detach themselves emotionally, which meant cutting the son out of the family worry, concerns, fears, thoughts, and fantasies, and the action that goes with these subtle feeling states. If the family could make some reasonable progress with this, I could predict that he would return. Of course I was operating only through the daughter and the parents were deeply *(illegible)*

. . . turmoil inside herself and the father by pulling strings, trying to work subtle angles to get him to a psychiatrist, and providing behind the scenes legal aid. The daughter was sufficiently "shored up" inside herself that I suggested she "bug" the parents as a way of desensitizing them to the boy. She would go see mother, kid her for being indifferent and not worrying enough about the son, and say this was evidence she didn't love him. The mother would scream, "shut up. You're playing games again. Don't come here after you have been to Dr Bowen". She even "bugged" the father into showing that he cared by going to San Francisco to find the boy. The father found the boy, had one pleasant "togetherness" evening, donated $200 for necessary expenses, and then was ordered to "get out of town". After four or five months of this, I thought it might be time to expect a visit from the boy. I was expecting a short visit, a shorter return to hippie-land, and a longer visit home, a shorter return to the hippies, etc.

After about six months the son returned "only to straighten up some of the court cases and to clear up his draft status". He brought part of his San Francisco "pad" in a car bought for $25. The group included his hippy "wife" (a teen aged daughter of a minister who sounded almost catatonic); a boyfriend called "God"; and "God's hippy wife who had one of her five-year-old daughters. The last girl had become pregnant in the San Francisco pad from which she had twin daughters, one of whom stayed behind at the "pad". The S.F. entourage set up in a "pad" in downtown Washington and gradually began making contact with family. The son had hair and beard to his shoulders and the beads and weird garb that goes with the movement. People would ask to take his picture, which he permitted and seemed to enjoy. His first contact with family was to go to his sister's apartment and steal some of her blue jeans. She made profitable issues throughout the family in recovering them. The entourage visited the mother and left lice on her furniture. His mother permitted her maid to wash the son's clothes. The maid ran them through the washer four times before she would touch them with her hands. I expected the group to stay around a couple of weeks. Instead, "God" and his "wife" and her child left for a "pad" in New York. The son demanded a $5,000 lawyer fee from parents, and ended up handling his own case in court with some free legal aid, and winning dismissals and probations in every case. His argument that he was "bisexual" convinced his draft board to drop him from their lists. He appeared with short haircut, shave, and conventional clothes "only to get a job". He has now been here six months. He is working regularly and living a conventional appearing life though he still "talks hippy" to his family and insists regularly that his stay is only temporary to "save some money".

The major change has been in the other daughter who has maintained this remarkable emotional detachment from her brother. She manages to maintain frequent contact with him. The parents and younger sister are also much less emotionally invested in him. The mother still cannot be in his presence without intense emotional reaction between them. The daughter says she "has been a person" with him for the first time ever. She can accept him for what he is without being judgmental and is free to be herself. Also during this period she has moved out of her "working hippy" environment with a new apartment and new friends. In speaking of her change, she says there has been a big change in the kind of boys she becomes involved with. Now they are more "body types"

who are more athletic and action oriented. On dates they spend more time doing things. Old boy friends wanted to talk philosophy and “rights”. She says she would like to find men who do not have “this thing about women”, this “fear of women”, and who do not force women to sit in judgment on them. They promise to do something, fail to do it, and it is hard not to become judgmental. Boys now are not pitiful and they don’t need women for ego enforcement as former boys did. Boys now are like little boys trying to show off to impress the girls. This type is not ideal but it is a big improvement over the former ones. I asked what she had done to attract this different kind of man. She says she can be inviting and still keep her distance. She formerly needed too much to be “cared about”. It has been several months since she has found herself saying “You don’t love me” or “You don’t care” to get some positive expression from the boy. She says, “The way to deal with this is to hold yourself back and watch and let things take their natural course.” She says she does not need to control things as formerly, nor does she get into being controlled. Also, “Detachment does not seem the same as it did a year ago. Formerly it meant aloofness. Now it is “being like a flower” and that does not mean hippy flower. It means being yourself for what you are, and just being there without chasing and without withdrawing”. She also says, “I feel my center is inside of me and getting larger. I used to feel my center was outside of me”. These are a few of the changes she describes. The important point here is that this twenty-six year old self-supporting daughter has been changing rapidly, she has worked hard at maintaining frequent contacts with her family, and significant family change has occurred in relation to her change.

I did not intend to go into this much detail about his family but it has been a recent experience and I thought I’d go into the detail to save a copy for my record. I have been pleased with this promising start on a real hard core “hippy” son whose only visit to my office was almost seven years ago. This kind of thing happens when one can find a single motivated family member who can get some differentiation started and WHO WILL MAINTAIN ACTIVE CONTACT WITH THE REST OF THE FAMILY. I found myself thinking of this family as the described who is more a borderline or “acting like a hippy” than being a real hippy.

For a long time I have wanted to write to ask about people's reactions to seeing my videotapes. We first began sending out the tapes about six months ago, most people see them without much previous knowledge of my theory or method, and most saw them "cold". The reactions have run the gamut, people usually interpreting them in their own frame of reference. A common reaction has to do with my "nervous laughter". This is something I have worked on for years. My first move in the presence of a family is to get myself "back peddled" out of the emotional intensity of the family field until I can see the humorous or comical side of it. The human phenomenon is as comical and humorous as it is serious, if one can see that side of it. So, I work on me until I can see the light or the humorous aspects of the problem which is my way of "getting outside" the family emotional field. If I can get me out, then it is usually easy for one family member, and then another, to also get loose and free of the intensity that binds them. This is the opposite of the majority of therapists who "empathize" and "put themselves into the family emotional system to understand". I think a therapist who can stay reasonably "outside" is worth many times as much as the therapist who "feels with" the family. Anyway, a fair amount of my time goes to this "keeping myself out of the family emotional system" and to working with the family from my "outside" position. Often I go real intellectual as a way of tuning down the feeling system until it is "loose" and more workable. Once I am reasonably "outside", comes the problems of the gradations of comments that are possible to those within the system. This has come from experience. The goal is a lighthanded comment that hits the point squarely and that elicits a smile or some lightening of the emotional intensity within the family. A too abrupt comment can be heard by the family as "hostile", and it in fact might be hostile in the emotional context of the moment. So, about half my time goes to me and keeping me "outside" and about half to activating the process within the family. Picking up the opposite of the obvious (reversal) can be one of the most effective ways to make a point.

Anyway, I have had all kinds of reactions and interpretations of the various techniques and approaches that have been developed over the years. If you have any special comments on this, I would appreciate them. Several times this year I have shown videotapes "cold" and I know some of the reactions. Two weeks ago I preceded a tape with a half hour explanation and people seemed to see more and get more out of it, with less guessing about what I was doing. Sometime this summer I think I may do a thirty minutes or perhaps one hour videotapes explaining theory and method, to be sent along with "new" loans, if people are interested. If you have any reactions to this, I'd sure like to hear them.

I know I have wandered in this letter, but it is easier for me to wander than be concise. My apologies for flooding you with words.

Sincerely,

MURRAY BOWEN, M.D.

AN O. HENRY SHORT STORY

## An O. Henry Short Story

I've heard some "professionals" say how hard it is to read Bowen, of course, inferring the difficulty is in the nature of Bowen's writing rather than the obstacles in the reader's mind. I have chosen this letter for a number of reasons. To me, it reads like a well-crafted short story. Secondly, it focuses on what the family is doing, not what the therapist is doing. The drama is in the interaction of the family members, not in the "techniques" of the therapist. Thirdly, it demonstrates a major system characteristic: The interdependence of the interactions of the parties involved. There are also places for the reader to get distracted with content, especially with the sexual themes with the father and son. What system principles are demonstrated in the therapy process? Can a way of thinking avoid the trap of the "the identified patient?" Can a family system change if only one family member is involved in the therapy process? What is the impact on non-involved family members when one motivated member focuses on self, doing what she can do to pull her functioning up a notch, with no effort at changing others? Dr. Bowen, in this letter, also articulates principles that guide his thinking and the direction of his interactions with the mother. For any clinician confused about his/her responsibility in a therapy situation, this "short story" provides major guidelines.

This letter of December 1967 is one of the few letters in the archives that describe to this extent the therapy process with a family. A colleague had written Dr. Bowen asking for his advice in helping "one parent differentiate self from a child."

December 19, 1967

Dear

You assign a "tall" order when you ask for ideas about helping one parent differentiate self from a child. I don't know how I can do with this but I can handle this best by free associating to my own typewriter, which is how I do "rough drafts" of papers. So here goes a lot of rambling stuff which you can sort out however seems best to you.

In the 1st place ulcerative colitis is a fairly severe symptom which can always triangle in one internist. That makes another "triangle" that can become operative in the field. Also a symptom like this is an indicator of one of the more severe levels of problem.

In the kind of situation in which parents cannot work productively together, and the subject cannot "let the child go" even when the child is physically absent, I work with one parent. The picking of this parent depends on the situation. There is nothing wrong with trying one parent and then changing if that one is not up to it.

The following is an example of 32 hours in 24 months. An overfunctioning mother and underfunctioning father and 16 year old son (now about 18 ½ yrs) whose overt homosexuality became known to the parents about a year ago. The father was simply not motivated to work on it, and 30 of the 32 hours have been with mother alone. One time the mother brought the older boy (homosexual one) and the 2 yr younger brother after they'd had a fight and broken out the the front door. The other hour was with father and mother together. His "soul" was so irritated with the mother that he stormed out of the office after half and hour. This session with F&M together was 18 months out. The one with mother and 2 boys was 10 months out.

My whole effort with the mother was to get her to tone down the over-functioning and firm up an "I" for herself, and to get off the family's back. I saw her once a month the 1st year. Her "self" was so hooked up with the boy, and also father and to a lesser extent the other kids, mostly in a nagging, pushing, threatening way that I sort of despaired. She would listen to what I had to say and hear it at the time but back in the emotional system of the family there was little change. Toward the end of the first year she developed some control over "sounding off". Then she started coming twice a month. The next move was to get herself out of the position of family "disciplinarian". Instead of monitoring the behavior of the kids, answering calls about misbehavior at school, etc she began asking the husband what he was going to do about this terrible situation, or when was he going to talk to the people at school. The crescendo of this maneuver came one day when the "passive" father walked up until his nose touched hers and screamed "I am getting GD tired of you asking me what I am going to do about things". With noses still touching she screamed back "Well why in the hell don't you tell me what you plan to do about it?" The first half of the 2nd year, the h-s son was really running high wide and handsome, with the mother staying out of it (almost out) and the father permitting the boy all kinds of liberties, such as threatening to take away the car and then yielding to the boys demands. During the Summer months the son ran up $60 to $70 a month in gasoline bills when he would wrangle the father into getting the car. The home situation got so bad with the son completely out of control (not really because he did not get into trouble with the law-just

monumental bother to the parents) and the house falling into disrepair, etc that the father agreed to come with the mother to “work on the problem”. After 30 minutes the father walked out in a huff. The mother left without making another appt but called a month later. By now, the mother was totally fed up with the father’s refusal to cooperate.

The next phase of this had to do with mother and father. For over 20 years of marriage the father had been a “sex hound”. He just had to have sex every night-sometimes night and morning, just as a matter of course. I had talked with the mother about this many times. She said she did not like it this way but somehow she had gone along with it. Now in her angry phase when the father would not cooperate in the family problem, her self began to rebel at the sex routine. By mid September she began to find an “I” position about sex. When she refused to go along with sex, the father angrily left the bedroom and moved in with one of the kids, where he still is. One night in late September while I was out to a network meeting until almost midnight, I came home to find a call to please call the mother, no matter how late I came in. She was in a motel in Bethesda. This is a family with minimal financing. The father is a foreman of a sheet metal shop and mother a clerk in a finance office with a combined income of perhaps 10,000, so money is a kind of problem. The father does most of the remodeling, etc on the house, which was part of the rassle last Summer. He was putting in an enclosed family room on a back porch and he left his construction in a mess and refused to either clean up or resume work. Back to the Bethesda Motel. She became fed up at home and sort of “automatic like”, packed enough clothes to go to work next day, just went for a drive and found herself checking in at a motel and just going to bed. She wanted reassurance from me that she was not crazy or doing something completely out of line. She wondered what the family would do next morning when they found her not there; how the father would get to work; how the kids would get to school, etc. Actually she was “acting out” running away much as the symbiotic homo-sex boy had done. It at least was something completely new and different for her and I said I did not know what it all meant but I was in favor of anything to shake up the family situation. She got up and drove the car to work next morning, leaving the family to shift for themselves. The next afternoon she returned home. No one mentioned her day away or asked questions, but after that she had a new operating field.

About a month later, in late October, 22 months out, she began to find an “I” position with the h-s oldest son. By now the boy has almost flunked out of school. He was in a commercial course which permitted him to go to school half time and work half time. He was lying about work hours, getting the car from the father almost at will, and spending much time with the “gay” crowd in Georgetown. In the manwhile, the mother in fussing with the father about bills and finances, was now in charge of disburseing family monies. The son is quite a “dresser”. She found that he had been expensive shirts, sweaters, jackets, at Woodies on the family account. He had $195 in charges in one month. She cancelled all charges at stores, except for herself or the father and humbly suggested that repayment of $20 per week (the boy was making about $40/wk in his half time work, might keep him in good standing with the family, and permit him to still live in the family home. There is another old chapter in the family story worth repeating. When I first started to see them, the boy was saying that the family was absolutely impossible and that he was praying for the day we would be 18 yrs old and he could move out on his

own. His 18th birthday passed in the early Fall and somehow he forgot to carry thru with his threat. As late as the Summer of 1967, the father was saying he could move out when he could act like an adult. The boy would respond with "I am already more adult than you are".

Also in the Fall (mid November) the mother began to find some ideas all on her own. It just may have been that I had mentioned these things early in 1966, with repeated examples, etc but the mother started using them as if she had just discovered them, improvising her own special techniques as she went along. The most effective issue had to do with locking the door; locking him out of the house if he was not in by a predetermined time. In the past this boy has "been lost" for days or few weeks at a time, for a weekend, or one or two nights. In calmer periods he might come in anytime from midnight until 7 a.m. They have a house in which the parents bedroom is on the 1st floor and the other bedrooms upstairs. Now that the father is sleeping upstairs the mother has become more conscious of the house being locked. This may have made her stand more plausible in her presenting it to the son. Anyway, she announced one night that the house would be locked at 11 p.m. and anyone who came in after 11 would not get in that night. She had to get her sleep and she was not comfortable sleeping in a house with unlocked doors. The first two nights she was foiled. She locked up and went to bed. One night the father went outside for something and just happened to leave the door unlocked. The next night the younger son did the same thing. The next night she decided to stay up until 11, and to lock it at exactly 11 o'clock. The boy returned that night at 1:30 a.m. He made enough noise trying to get in to awaken mother. She went to a window to sort of "scold" him for awakening her when she needed to sleep and to suggest he might get a bed with one of his boyfriends. About 5 mins later there was a telephone call (they live 2 blocks from a suburban shopping center). Mother picked up the receiver, without speaking. The other person said nothing, she said nothing, the other person hung up, and she hung up and went to bed. Next morning the son came in a 7, got himself some breakfast, and started to go to bed. She discovered this and informed him he could not stay in the house without adults there, that she was getting ready for work and for him to be out by the time for her to leave. He protested mildly but left.

Now the rules of the game have been changed. Formerly he had been fighting to get away — now she is urging him away. Put in terms of the old symbiosis, she is taking action stands to convey that the symbiosis is no longer there. There have been innumerable examples like this in the past six weeks. The father has sort of faded out of this interaction between mother and son. The father still sleeps upstairs but he has been coming and going on a more regular schedule and "almost every day he does some kind of repair job that should have been done a year ago". The younger boy also comes in under the curfew. He is 15 or 16 now. The youngest child, a girl of about 14 has never been much involved in all the stuff. A couple of weeks ago the family had the first Sunday afternoon outing with the entire family in several years. They all went together to see a movie and then out to eat together. Returned about 8 p.m. The boy announced he was going out and would return about midnight. The mother said the door would be locked at 10 p.m. The boy yelled "What! You said the time was 11". Mother said "I'm sleepy tonight and I have to go to bed earlier". As the boy protested the unfairness the mother said she was getting sleepier and now she had decided to go to bed at 9 instead of 10. The boy called her arbitrary, mean, and wishy-washy. Mother said the lack of sleep made her

that way. He went and took a shower, came down for a snack, and as he went to bed at 9 said “Goodnight Mom”. Another night he called about 9 to say he was at a party and would be in about 12. She let him know the latest time for getting into her house that night was 10 p.m. He snorted and protested and then came in a couple of minutes under the deadline.

The mother has been doing almost a stop-watch job on the door. She says it is fabulous to see the boys come in within a minute of the deadline. She thinks they must be staying in the yard until the very last moment or they would not be able to shave the deadline so close. The older boy is so preoccupied with dealing with his mother that he has sort of forgotten about the h-s problem. I mentioned this story to someone who wondered why the older boy did not outdo her by getting his own key. It would be no great feat to steal a key and have his own made. When a parent is this sure of self, the other simply never thinks of defying the parental boundary.

This is hardly a typical example, whatever “typical” means, of working with one parent to define a “self” in relation to a child. It is striking because it is a new and satisfying success in a family in which I never saw much hope. I thought the mother would continue her “compensating” over functioning, the son would run out and stay homosexual, and the other kids would have some kind of major impingement. IF THIS MOTHER CAN MAINTAIN HERSELF IN RELATION TO THIS SON WHO WAS WELL ALONG TOWARD PERMANENT HOMOSEXUALITY, THEN HE CANNOT CONTINUE HIS HOMOSEXUAL WAYS. A year ago he was going to be a hairdresser for women. He had perfectly groomed long hair, well kept and always in place. During the year he has given up his ambition to be a hairdresser and his hair has become about an inch shorter each month. He now spends so much time thinking about his mother, and in being preoccupied with angers and what he is going to do next in relationship with mother that HAS NO TIME FOR HOMOSEXUALITY.

So many things have been left out in this thing of working with mother that I will not even begin to try to list them. I have been very active in teaching and instructing — better said communicating knowledge to her. In this, if one gets in the position of preaching, of if the therapist gets perceived as the one who knows the answers, and her action then become an extension of what “the therapist told her to do” the whole damned thing would have flopped. Much of handling self in this depends on how the therapist’s inner self is calibrated. Also important is the fact that the father was in this ego mass with the mother, that she had to get some working detachment from the father before she could begin to deal with the son. I am not claiming this as a therapeutic success, BUT THE MOTHER HAS SUCCESSFULLY MASTERED THE FIRST STEP and when one can achieve a success like that, then the succeeding steps become a litter easier. Always lurking along the way is the possibility that the situation will become more liveable along the way, with resulting lack of motivation to put the energy into the problem that is required for change.

When I got your letter, I never intended to write this much, but when thoughts get rolling, each is succeeded by another, and here they are all jumbled up.

Best wishes to you and your effort there.

Sincerely,

# STATE OF THE UNION AND DEAD-END ALLEYS

## State of The Union and Dead-End Alleys

There seems to be something in the human condition that searches for the answer and the solution. Somehow finding the answer becomes more important than what drives one's efforts. Is learning a process or a product? Intentions may be laudatory but "side effect" may be worse than the original problem. Much scientific effort is based on extreme reductionism, a search for the smallest unit. The assumption is that a "cure" will follow this "discovery". As a result, more and more drugs are "discovered" and marketed and then demanded by the public. Again, the assumption is that the newer drug is better than the old one (e.g., Ambien vs. trazodone).

An important question is how does one think about major problems, such as emotional problems. Do solutions come from the environment (e.g., more and better medicines)? Will one's efforts be aimed toward the cure answer or on the management process? Is DSM-IV "better" than DSM-I? Is mental illness "like any other disease"?*

How will one direct one's efforts? Are principles involved? Dr. Bowen's letter of May 1970 is a response to one inquiring about a certain family therapist who was both thinking and practicing differently. The assumption of the writer is that dead-end alleys are a bad thing. Dr. Bowen's response reflects on his thinking and beliefs about thinking about major emotional problems and therapy issues.

* See Norton Hadler's *The Last Well Person*, which reviews the scientific evidence behind many current medical practices.

This family world is more disorganized now then ever, with therapists going in all kinds of different directions. The "encounter" and "marathon" movement, which I consider regressive, has taken over many of the well known family centers. I do know that my people from Georgetown and MCV stand out in a group by themselves in any of these gatherings. I went into the NIMH projects with a fairly well defined hypothesis which was extended into a concept by the time that ended. Over the years I have added other concepts which by now make up the general framework of a theory which I think will stand pretty well, at least until something better comes along. The central core of the original concept still stands, not much modified, but the interlocking concepts have been defined and redefined several times since then. When I became completely inundated with practice, I begin training which has been my central effort for some years now. The main gratification from that comes in an ability to help young men master as much in 2 or 3 years as it took me 15 years to grasp. So, I have a bunch of promising young colts who have been carefully chosen and who I hope can advance the ball farther than was possible for me. Thats my goal for now. I am far from ready to fold. It is simply that the job is too big for any one man effort and one needs more people seriously working in several different areas. In the meanwhile, the central body of psychiatry has not yet really accepted the "family" idea and it may be a couple of more decades before family is really accepted by a significant percentage of psychiatrists. What the hell. I will keep on trying. Social institutions change slowly.

It sounds as if you have had the most satisfying experience with Dr. of any in your long experience with a fair sample of what psychiatry has to offer. When one has a profitable working situation on emotional problems, I think its unwise to to start shifting about for something perfect. Psychiatry is too young and there are no single answers for anything. Personally, I think there will never be answers that simple, but who knows what the world will be like in the far distant future. For now, the "right" answer is the one that works and the "wrong" answer is the one that did not work. There is no way of going that does not have both advantages and disadvantages. One estimates the percentages and tries to watch for the disadvantages. You spoke of the wasted time and wasted energy and the blind alleys one encounters in an effort to change. I have spent more time in blind alleys looking for the main road than I ever spend going forward. I wish one had percentage figures on those who spend their entire lives without ever changing. I suspect the figure is higher than we would want

to admit. How do you know that any change noticed in the past ten years could not be accounted for by the fact that we are ten years older? No one has ever answered that question. Any answer is no more than impressionistic. The only answer I have ever found for the “blind alley” problem has been to try to find some way to have fun in the “blind alleys”. At least it is not a total loss.

I am glad you are concerned about the terrible state of the world today. Without plenty of people to do the worrying, we might go to “pot” faster. If we’d all get behind the thing and worry more, maybe we could find an answer quicker. Personally, I am not too concerned about the future of the nation and the republic. I would go along with the notion that the “young” probably have the answers but I would not go along with the notion that the loud mouthed dissidents have the answers. I think the thoughtful, serious youngsters are the ones just as the thoughtful serious ones had the answers for 50 or 100 years ago. I have a lot to say about this whole issue but I would go too far if I opened that subject. There is one big difference between the loud mouths now and the loud mouths of a generation or two ago. Fifty years ago there were the same kids who acted as if they knew everything except the adults considered the irresponsible part of it as the foolish antics of those not yet dry behind the ears. Now for some reason, the adults (who probably have less book education) listen seriously to the irresponsible loud mouthing. The absolute smartest I ever was in my entire life was the year I graduated from high school. I couldn’t convince others that I had all the answers but I secretly knew it. The next smartest stage in my life was the year I graduated from medical school. There was not a single subject in all medicine that I could not discuss like an expert. Since then I have been getting stupider and stupider every year. The more I learn the more I find I do not know. If this keeps up, I will end this like not knowing anything, ready to turn it over to the kids who know they know it and the parents who agree their kids are the smartest.

I am talking too much. Best wishes to you.

Sincerely,

Murray Bowen, M.D.

# EYES, CONSCIOUSNESS, ANXIETY, AND SURVIVAL

## Eyes, Consciousness, Anxiety, and Survival

A lot of adjectives can be used to describe relationships: tricky, wonderful, impossible, necessary, convenient, scary, etc. There is no way to completely exist without them; there is plenty of opportunity to get lost in them.

Vision and perception capacities and their developing neural processes provide the link between the individual and his/her environment (e.g., the relationship environment). Humans begin their lives with their eyes open. The retinal and optic nerves are fully present at birth, with synoptic density continuing to grow, peaking in the visual cortex by eight months. Saying it another way, the eyes are working from the beginning, with the connections to and within the cortex evolving and learning over time. One's visual system is responding adaptively to the world in which the developing organism finds itself. Survival is precarious. The arithmetic of perception and early sensations of anxiety develop "wiring patterns" which extract and interpret meaning from the environment. The brain has the capacity to extract significance via the sensory visual input.*

Given such major survival and evolutionary forces, it takes a major effort to focus anywhere else but on the environment and the people in it. If there is a trace of anxiety in the mix (and there is usually more than a trace), the automatic focus will be external, and if one experiences danger, it will be attributed to the triggers, and not to that which is triggered (e.g., in one's brain).

Dr. Bowen postulated a larger reality, that is being examined in detail by neuroscientists. There is a capacity within the brain (the cortex) that can focus on and think objectively while being connected to the anxiety processes; thus the phrase "<u>both</u> separate <u>and</u> connected."

*For a readable description of the visual and brain developmental processes see: *The Future of The Brain*, by Steven Rose, pages 122-129.

His letter of February 17, 1989 is a response to a patient who was complaining about her daughter "not growing up." He challenges her to focus on herself, the anxiety that automatically comes from that focus. He also points out a few difficult questions and options to guide her effort. His "P.S." adds yet another layer to the difficult yet necessary questions – if one can ask them.

Feb 17, 1989

Dear Mrs.

Some thought following your session today. This is for you ALONE, and it is not to be communicated to others.

It probably is inaccurate for you to blame the infantilization of your daughter on your husband. He is doing what appears to be natural to him, he assumes you go along with him — (just like you always have done), and you are too unsure of yourself to really be different. The problem is YOU, and it will continue to exist until YOU can be different.

What do you do about you?????? You have a few options. Most have been failures!!!! Get angry with your husband, and you did not change. Make loud vocal statements to your husband, while your feelings still baby your daughter, and you are the same. Nothing changed. Still focusing on the other person. Divorce your husband and nothing changed. Still focusing on the other person, and YOU did not change. Tell you daughter you love her, and it is a hollow as words, unless your ACTION is different. It is a little peculiar to tell someone you love them, while you still DO the things that make the other into a child.

Your long term goal is a situation in which you can be a mature woman, and your daughter can be a grown up woman, and your husband can be a mature man. One way you can modify that: One can slowly modify one's self. If one can change one's self, the family will slowly change. Your family somehow got triggered into a situation of fussing at everyone else, without modifying self. The more you focus on changing the other, the worse it has become. You are in a "no win" situation. The worse it becomes, the more the family makes it worse by trying to change back the other.

What are your options????? A few years back, you moved toward improving the situation in your life. It must have created waves in others, but it was for you, and the family came out ahead. Then in the face of symptoms, the family reverted to the great togetherness, of the family "love in". Does NASA still hold possibilities for you? Would you give up NASA to make the family more happy with you? These are issues, all strictly within self, far beyond the superficial issues of changing to make others happier. They involve yourself, and the relationship system in which you exist as a person. They involve everyone in the non-family situation. Something to think about. How do you go about changing you, within the non-family, and still have the family approve of you. How do you become YOU with your husband, without making a big deal about who writes the checks? What do you focus on, if the goal is to be YOU, rather than who likes it?

These are merely a few ideas that might be helpful, if the goal is to change you, without trying to change everyone else. There is some kind of magic if one can focus on one's own self, and take the responsibility for success or failure, without blaming the other. Your husband is not going to change himself in relationship with your daughter, unless you change yourself in relationship to everyone back in Kansas, and NASA, etc.

Sincerely,

Murray Bowen, M.D.

P.S. This is done hurriedly. The overall attitude rather than words, is all important. One cannot pretend a zebra is a mule by painting out the white stripes.

# THINKING, ASSUMPTIONS, RELATIONSHIPS, AND DECISIONS

## Thinking, Assumptions, Relationships, and Decisions

The assumptions one makes drive all thinking – behavior, perceptions, expectations both within the individual and in relationships. Beliefs and values also become part of the process. Work systems are also driven by all of the above. In human service systems, there are often legal mandates as well that drive the entire process (e.g. Child Protection Services).

Given these forces, is it possible for any degree of clarity or will one's reality be governed by all the external parties' assumptions and subjectivity?

Flip Wilson, a comedian of the 1960's recorded a monologue on Queen Isabella sending Christopher Columbus to America to discover Ray Charles. Upon arriving on the shore of America, he was met by a band of Indians. Columbus informed the Indians that he had come to "discover" them. The Indians responded, "How are you going to discover someone who doesn't want to be discovered? You had better discover your . . . away from here."

Clinical relationships certainly reflect major assumptions, both from the therapist and from one seeking something from the therapist. Defining one's clinical responsibility in the process is critical, yet the assumptions about responsibility are seldom clarified or examined, which will result in a situation that keeps both parties "stuck."

Dr. Bowen's letter of November 28, 1966 is a response to a letter written by a patient (not his) who is "stuck" and is seeking his advice about directions she might pursue. His clarity focuses on her assumptions and his. Again, principles drive his response.

November 28, 1966

Dear Mrs.

In your letter you wondered if I could advise a course of action for you. That is easy. All your life you have had all kinds of different advices. Your problem is in finding a course of action that works for you, and if you are realistic, I think you have to be prepared for the possibility that you many never find a really successful course of action. In support of this is the long term fixed nature of your life pattern. On the other side of the coin is your long experience in finding out what does not work. From that you should be able to derive a lot of clues in knowing what does not work.

You speak of no one understanding you. I do not believe it is ever possible for one person to ever "understand" another. At least I gave up that effort a long time ago. Many years ago I worked at that. It is possible to break one's neck trying to "understand" only to have the other person say "you don't understand!" One's success at such an effort is completely dependent on the other person's mood. So I gave up trying to "understand". Instead I began communicating "I hear you", which means that I hear what the other says, but it makes no promise beyond that.

Long ago I discarded the concept of "sickness" with emotional problems. I also never use the concept "patient" nor do I make "diagnoses" except when dealing with the rest of the medical profession. So, I would not agree that you are "sick". I would agree that you are in some kind of state of dysfunction. If one uses the concept "sickness" it implies that the person is a victim of some kind of malevolent force, and it makes recovery or "cure" the responsibility of the therapist or healer. If one is to recover from a state of emotional dysfunction, it has to come from within oneself. Another may suggest or counsel but that is the most another person can do.

One brief story from days before I started working with families, will communicate an idea about the "sickness" thing. This had to do with an experience from Menninger days. A hospitalized young man was permitted to go to town alone. As he started to board the bus to return he began hearing voices that told him "No". He was detaining the bus and other people who wanted to get on. The bus company called to complain about permitting such "sick" people out

alone. Now it was up to me to discuss the incident with him. The usual way would be to tell him that he was “too sick” to go to town alone and he could not go again until he was “well enough”. What could he do about that? Rest in his bed until the “sickness” went away? Instead of calling it “sickness”, I called it “misbehavior”. I told him that he had “misbehaved” and he could not go to town again until he could behave in a way that did not call attention to himself nor interfere with others. Now he had an assignment that he could do something about. He could change his irresponsible behavior. He practiced for hours and days on learning to behave responsible in spite of the voices that said “No”. He asked to go to town again. It worked. He was soon out of the hospital and back at his job, functioning normally in spite of voices that cut in when he was tense. The voices disappeared a few months later when his total life situation improved.

You asked for advice. There are a dozen projects I could outline, and any single one could take years of hard work. No one ever achieves perfection on any of them. Anyone can achieve something on all of them. You feel sorry for yourself and you have the capacity to get others to feeling sorry for you too. Maybe you can never get it to the point that others do not feel sorry for you, but perhaps you can make some progress on not feeling sorry for yourself.
If you wait for symptoms to disappear before you can begin to function, you will never make the grade. If you can find some way to function in spite of the fears and anxiety, then maybe you can make a little progress. If anxiety is too great for you to function in spite of the anxiety, then you are stuck. Tranquilizers, in my opinion, are as much of a trap as they are a boon for mankind. The person who waits for tranquilizers to make him feel better automatically loses motivation to do something about his own life. You could make a project out of your own self centeredness, and perhaps achieve something on that, or you could make a choice to do nothing. When you say that no one knows how you suffered, you are accurate but also extremely self centered. Implied in that is your own lack of awareness of the plight and problems of others. You might “feel” that you have the worst of all problems but if you are objective, you know very well that the “feeling” is inaccurate  You could also make a project out of being aware of the difference between “feelings” and “beliefs” or “principles”. You tend to act on what “feels” right and when one consistently acts on “feelings” one increases the depth of the dilemma. There are times when feelings and principles are contradictory. Unless one can act

on principle, and take a stand against feelings that cry out in opposite direction, then one is stuck.

In the above paragraph I have outlined just a few “do it yourself” projects. Success on any one will pay dividends. The problem with all “do it yourself” projects is that you never know when you are digging the hole deeper with your own efforts. Most people require some outside help in order to “see” when they are immersed in the “feeling” morass. Lacking outside help, can you devise a way to estimate objectivity for yourself? It takes a lot of doing to make a project out of objectivity.

Finally I would ask whether or not the “pain” of working out of your dilemma might not be greater than you would be willing to invest. Personally, I think the short term acute stress of working out a dilemma is more than the long term chronic less severe pain of staying in it. Any problem can be brought to some kind of reasonably successful solution. I do not accept the thesis that problems cannot be solved. However if someone tells me that they have rather live with the problem than go through the pain of changing, I can accept that as a valid decision.

I go into much more detail here than I ever expected when I started this. It is not often that I have time for this kind of an exposition but your letter just happened to come along at the right time. You are in one of mankind’s old dilemmas of wanting your cake and eating it too, which you well know is not possible. There are millions of people caught up in your same dilemma. You have been bogged down in your morass for so long that it might make more sense to accept it, and find a way to live with it, than to try to change it. You have a comfortable place to live and essential needs are met. Maybe you can find a way to join the millions of others and to enjoy it as much as possible. If you decide not to make the effort, maybe you can find a way to stop fretting about it so much. If you make a decision to do something about the situation and you are up to the stress and are willing to take the chances involved, then you would have my moral support and any possible reality support that is possible.

Best wishes to you in whatever you decide to do.

Sincerely,

# SYMPTOM RELIEF AND ENVIRONMENTAL FORCES

## Symptom Relief and Environmental Forces

The current clinical environment that therapists practice in is driven by crises management, medication monitoring, HMO and insurance criteria, all which focus on symptoms. One result is a vicious circle of the therapist defining the patient as his symptoms and the patient defining self as his symptoms. There is little focus and very little interest in addressing emotional processes that drive the symptoms. How does one conceptualize the relationship between problem-solving and "symptomatic relief?" What makes problem-solving a "therapeutic method"? How does one focus on problem-solving when anxiety is high and the pain is very real?

Dr. Bowen saw families and couples in group setting called "multiples." This letter addresses inherent practical problems in doing "multiples." This letter of October 8, 1969 is to a person who was a participant in a multiple group. He clearly speaks to the issues of symptoms and problem-solving.

October 8, 1969

Dear Mrs.

Thank you for the note about terminating the multiple family therapy. I had suspected you were moving toward termination but I wanted to hold your place as long as you wanted to work on the issues.

Enclosed is your bill. In the total series of appointments, the missed more sessions than is average, for which I charged the regular fee. This is a good example of an old issue which has come in sharp focus with me the past two years. On principle, I am opposed to charging for missed sessions, especially in unavoidable situations. I have always had a liberal policy for cancelled and missed appointments. There were always enough people waiting for free time to fill cancelled appointments on short notice. The liberal policy was not possible for multiple families. I have limited time for private practice, a single multiple session requires a 2½ hour block of time, and there is no way to utilize unused time for those who wait. There were enough multiple sessions with only two families, and occasionally only one, that it impaired flexibility, professional efficiency, and income. I had either to return to one family sessions or charge for all scheduled multiple family sessions. Since overall results with multiple are better, and results are important to me, you know my answer to that.

I have one idea about the which might offer you something for the future. In only 12 scheduled sessions you achieved a good level of symptomatic relief which is a good record for any "therapeutic" method. However, your orientation stayed more on seeking relief from problems than finding ways to solve problems; more on avoiding problems than finding ways to meet them; or more on hoping problems would go away than in being challenged by them. It is a "giant leap" from one orientation to another, attained one small step at a time. It is hard for man to develop problem solving methods unless he has a problem on which to work. Perhaps you can keep enough of a problem on hand to keep you working toward a goal. Best wishes in your continuing future efforts.

Sincerely,

Murray Bowen, M.D.

# BRAIN CHANGES

## Brain Changes

For the most part, clinicians have not been trained in natural systems theory. Though given some selected readings in Bowen, Minuchin, Whitaker, Bateson, etc., the basic orientation remains focused on the individual and relationships, with assumptions rooted in psychoanalysis and perhaps a little neurobiology thrown in.

Therefore, when one begins to study and learn about family systems theory, certain obstacles are encountered. With a vague awareness that different theories are built on different assumptions about emotional processes and therapist responsibilities, some clinicians take the "eclectic" route, or even more confusing "do whatever the patient needs." If anxiety is high either with the therapist or with the patient, the automatic thinking often reverts to what one has previously learned. This is probably biologically driven.

Another major obstacle in the muddle in one's mind. For example, how does the clinician define responsibility in the clinical situation? What is the nature of one's expertise? What is the difference between being helpful versus being useful? How does the clinician think about "change"? How does one think about the inevitable complaint about receiving "too much or too little" from parents? How does one think about "PTSD" experiences? What beliefs does one have about emotional catharsis? What about all the thinking about "relationships" that floats around in one's brain? What does one do with the DSM-IV? Different theories have different answers to all these questions.

Personal themes also are a part of a transition to a different way of thinking. What is behind the motivation behind the desire to be a therapist? Where does one fall on the "have to/want to" continuum? Can one ever get the search for "why" answers out of the process? Can one ever get the search for <u>the</u> answer/solution out of the process? Can one ever get "my way is better than your way" out of the process?

Another obstacle is in being part of the culture that defines the whole area of mental health/mental illness with certain simplistic assumptions and "rules." Will the culture's thinking determine the clinician's thinking? How does one live and practice in the mental health environment and still be responsible in the mental health environment?

A subtle obstacle is looking for similarities in Bowen Theory that are "really" psychoanalytic in origin, while not recognizing what and how the brain has to do to make the conversion.*

If one starts from the assumption and belief that family systems theory is indeed a different way of thinking, how can one begin to "hear" the principles that are contained in the concepts? One cannot start with a blank slate. Everyone has an educational history. Perhaps one starting place is to think more clearly about one's obstacles and one's "hearing."

Dr. Bowen's letter of May 1974, reviews a few core properties of family systems theory as well as the therapist's process in clinical practice.

*I heard of another interesting similarity effort in a paper comparing Bowen with Buddhism.

May 20 [?], 1974

Dear Mrs.

Perhaps I assumed that you understood triangles better than you do. I usually go into some detail about this when it involves two sets of people who work in the same office or who are in the same social circle. It is possible to work with both sets of people separately and productively as long as they do not start "gabbing" to each other about their therapy (I do not use the term therapy or therapist, which I can talk about later). When they start gabbing it fuses the whole social system into an emotional amalgam which can nullify progress, if the differentiation of self is the goal. Once the social system becomes an amalgam, progress is limited to what can be done with an encounter, a network, or a group. Another reason I did not go into more detail was a sort of assumption that the relationship between you and Dr.  was more private than it is.

It is impossible to fully explain this briefly. It all works on the knowledge of triangles. I did not invent triangles in my head. God invented triangles. It has to do with the way one human protoplasm relates to another. It is the way people are. It is the way people "triangle" themselves into emotional messes by following the dictates of their feelings. The concept provides an amazingly accurate way of "de-triangling" the mess if they are motivated to learn about triangles and then have the courage to avoid doing the things that create problems. Until people can get a better grasp of triangles, it is necessary for me to have some rules to keep me reasonably de-triangled and to insure the best possible outcome for the total effort.

Most therapists would deal with the thing between you and Dr. with separate "therapists", which has built in limitations. There is a big advantage if it is possible to have a single person who can relate to all segments of the larger system, and still keep self emotionally disentangled. If the "therapist" is able to do this, there is a way out if the various people can learn about triangles and respect them in their daily living. Let me put in one good example, all within the same family. However good "family therapy" may be, it is common to reach unresolvable impasses with both spouses together. Beyond that it is possible to get through that bind by helping one spouse, or both separately, to work toward defining "self" rather than focusing on the relationship. Work on

self is a difficult and private task. At times of uncertainty, people tend to talk to others to clarify their own thoughts. It is okay to go to the literature or to another person outside the emotional system, but the impulse is to discuss it with the other spouse. The moment that occurs, self immediately fuses into the we-ness of the marriage and the effort of self is nullified. I learned about this the hard way, from trying to work with a single spouse who would then go home and discuss everything with the other spouse. How does one go about relating actively to the other while still maintaining a self? That is the size of the problem. There are all kinds of ways of doing it, if one can find a way for self.

As a therapist, I have an option for me too. If I suggest to someone that they are on a collision course, they have an option of continuing on course, or making an effort to modify it. I avoid trying to "tell" them what to do, which is de-selfing in itself. They can insist on their right to continue, and then I have the option, and the responsibility, of deciding whether or not I am willing to invest my time in an effort that I believe will be unproductive.

This is already too long, which happens when I get into this subject. From experience only a fraction of the explanations get through until people know more about triangles. So, the average person interprets most of this sort of thing as "whimsy" or my theory.

Thanks for your letter. It lets me know better where you stand. Perhaps I was precipitous in taking my position. Certainly it was timed with the sudden awareness that the situation was "leaking" over the whole field which would nullify any advantage in my position. Perhaps your reaction was more in you than in the situation.

My position has nothing to say what happens to you and Dr. in your private relationship. I hope I have already communicated that. I made an effort to leave the outcome of the amalgam up to the various people involved. According to my standards, I have done rather well with that thus far. When the system starts triangling me outside the sessions, it nullifies my effectiveness and makes me responsible for the outcome. That is when I start reacting.

These are things that require a lot of talk and explanation. I will try to do my part in making my position as clear as possible.

Sincerely,

Murray Bowen, M.D.

# TIP OF THE ICEBERG

## Tip of the Iceberg

The culture we live in and the thinking that is part of it (and drives it) strives to define all problems as tightly confined within the individual, and of course, finds data and information to justify the perpetuation of the construct. Symptoms are painfully real, whether as part of depression or "fibromyalgia." Symptom relief is what the public demands and how physicians respond. The drug industry certainly has a vested interest in keeping the paradigm in operation.

Hospitals also play a part. Symptoms escalate to a point that they cannot be controlled on an outpatient basis and escalation of symptom management becomes part of the interaction. The hospital will do for the individual what he/she can't do, or the family cannot or will not do. The hospital has the resources to respond to any level of aggressive escalation on the part of the patient – IM meds, 4-point restraints, high "management" wards and in the not too distant past prefrontal lobotomies. All of these practices affirm and confirm that the problem resides within the individual. "The symptoms and behavior have to be brought under control" and once the label is firmly in place, the person is more likely to be defined (by himself and others) by the label. Advocacy groups (NAMI) in their fights for parity and funding increasingly call emotional problems "brain diseases."*

The mental hospital has a defined function that is part of the culture's thinking. An interesting question is what will happen with the closing of hospitals and no one looking at the thinking or assumptions that drive the process.

Dr. Bowen's letter of March 1984 touches on some of these themes. He is responding to a person's request for information about hospital resources for a person with an "eating disorder." He is optimistic in that there is a way to think about and work on these problems from a family systems perspective, which obviously is based on quite different assumptions than what is presently available.

*It is interesting to note that at a NAMI conventions groups of consumers are present to protest this labeling.

4903 DeRussey Pkwy
Chevy Chase, MD 20815
March 1, 1984

Dear Mrs.

Thanks for the tel call on Feb 19. It was good to hear from you again. There have been periodic reports about you, and good intentions to write, but the world wants more than good intentions. I heard, maybe from that you were having more problems with the cancer of the face. If your travels ever make it possible for you to stop in Washington, I will make time for a visit. I remember 's death. It was during the Smithsonian week on something that had to do with "family".

At 71 I am right where I have been since 1956, hobbled somewhat by a chest (aorta) operation in 1981, but I have pretty much recovered from that and back at my parttime practice, and teaching on a reduced level. Have been doing more professional travel in an effort to help the world toward a systems viewpoint. The situation has come father than I dreamed when I started all this 30 yrs ago, but it will take another 50 to 100 yrs before the average in the profession can really "hear" principle and theory.

I do not have much good news about and his wife. I think you said did not write down his name. I get and mixed up. His wife has an eating problem, probably psychological, which is common in young women, but relatively rare in older women. However it came about, the symptom probably opposes something "the other" unwittingly does. Neither he nor she want it that way, but there it is. If he tried to force her to eat, the symptom intensifies. If he forces her into the average hospital, they are likely to regard the problem as something entirely in her, which only arouses the basic antagonism to her eating. The more they "force feed", the bigger the problem. Unfortunately most hospitals regard such problems as "pathological" in the patient, without a way to get at the other half in the important other.

I have not been able to find a hospital, or enlightened outpatient operation that can reliably focus on both sides of the problems. Over the years therapists have learned more about the problem but most hospitals still have a conventional view. It is terribly hard to find a place in which outpatient and in-patient procedures are in harmony. Most therapists go in one direction and the hospitals (motivated by the convention of the chief and anxiety of nurses) go in another direction, which is counter productive. Through the years I have tried to treat all these thing on an outpatient level without getting involved with the imponderables in institutions. It is essentially impossible to change the thinking of conventionally oriented people. If I do get involved with institutions I "work around them." It has worked for me and I think others have pretty much done the same thing.

Over the years others have worked at this kind of problem, and I am sure there are those who have tried to gradually erode the posture of the institutions. You mentioned a hospital when you called. I began looking for some elusive place in which hospital principles were fairly consistent with family and systems practice. I did not find it. Some say they follow systems principles but that is more words than fact. There are two major places that have worked with "anorexia" in younger women, but even they are not consistent with hospital practice. A major authority on anorexia is Dr. who did her active life in New York City and Columbia Univ. She did a fabulous book, "The Golden Cage" I believe, which has never been equaled anywhere. I knew her well in NYC. Some 15 yrs in psychiatry. Now at about 80 she has Parkinson's Disease (shaking palsy) which further limits her. I last saw her when I was in Houston a half dozen yrs ago. She is a kind of oracle around town. Another place that focuses on anorexia is the people around the Philadelphia Child Guidance Center attached to the U of Penn in Philadelphia. Dr. popularized that place, but they focus mostly on outpatient work and I did not find a consistent attitude about inpatient work. There must be other places but I did not find them. I would be cautious about places that talk a good line, without knowing more about how they do it.

The thing that is wrong with most hospitals is a "good line". They usually have a conventional place with a young so called "family therapist" who is too lacking in knowledge who "splits too many differences" with the power structure to have the most effective program. Slowly these places will gain stature.

If I could help with and his wife on an outpatient level, I would be glad to see them for a consultation, and maybe more, if it would be of any help. The other choice they would have would be to struggle through with whatever is available on a local level and see where they come out.

My overall guess is the eating problem is the "tip of the iceberg" to an overall life problem, if they can find a way beyond the eating to the underlying problem. In the last analysis, it will be up to and his wife to make whatever they can out of it. A good family therapist there could help if such a person exists. I do not know of one personally.

I had a full week in San Antonio last week. It was the first conference that I have ever attended that went all the way from child and spouse abuse (the tip of the iceberg) to war. All the piled up work was waiting for me when I returned.

It was good to hear from you. Let me know what evolves.

Sincerely,

Murray Bowen, M. D.

PAYMENT FOR SERVICES RENDERED

## Payment for Services Rendered

Some people seemed to forget they were expected to keep track of their sessions with Dr. Bowen and submit their own insurance claims. Often they expected him to keep all the records and billing information. The insurance issue was often complicated by requirements for a diagnosis for one "identified patient."

There are a number of letters in his archives responding to these requests, stating, in no uncertain terms, his position and practice. The following letter of July 1975 is a typical one.

I refuse to provide you with a statement about your sanity, or lack of it, because I consider it ludicrous for you to even respond to anxious accusations about sanity or psychiatric diagnoses. There might be a place for such a diagnosis when one person is obviously dysfunctional, but this is not the case here. In your family, when people start hurling psychiatric diagnoses at each other, it is a name calling contest. I was so sure that the legal people would be aware of this that I refused to have anything to do with it. A few times in my life, when people have pushed to have a diagnosis made on one person, I have taken the position that I refused to diagnose one unless we also diagnose all the others.

Sincerely,

Murray Bowen

# CONTENT, PROCESS, AND INHERITANCE

## Content, Process, and Inheritance

What goes into the conduits between generations? What is "passed on"? Often family diagrams contain labels along with the names of family members, such as "alcoholic", "bipolar", schizophrenia", "addiction." There is an assumption that if the label appears in two generations (or more) it was "inherited" or passed on from one generation to the next. It is a short leap to then assume that there is an "alcoholic" gene that is inherited. There is a strong "science" effort searching for these specific genes that cause a specific disease. For the most part, the nature/nurture dichotomy has been discarded, recognizing that it is an interactive process between genes and their environment that determines outcome.* The process that drives gene expression contains multi variables in these communications and interactions.

If one can get beyond the A causes B thinking, what are the more relevant questions? The core questions are related to the individual's interaction with his/her environment. What is the impact of the pressures from the environment? How does one manage one's anxiety that is responding to these pressures? How does one manage one's emotional history when a present event triggers the emotional memory? How does one manage one's vulnerabilities? For example, if a person grew up in a family with a parent being hospitalized for "mental illness" numerous times, how does this person manage their own anxiety processes or moods? Can the theory account for who does better or worse with their schizophrenia?

In the clinical setting, parents often bring in a child whose functioning leaves something to be desired in the parents' or school's eyes (e.g., not getting up to go to school, smoking pot, pushing against school requirements). If the clinician can "see" and "hear," it is obvious that the parents aren't taking care of business. A systems perspective says that how the parents manage self (i.e., their responsibilities) automatically impacts other family members. As Dr. Bowen wrote in another letter, "It's the attitude that is important, not the words." Is "responsibility" inherited? Dr. Bowen's letter of September 1985 is a response to a letter written to him referencing an article in Scientific American on multigenerational transmission of incest. He, as usual, raises a number of questions, and points out certain pitfalls in the unclear thinking about multigenerational transmission processes. How similar is today's political thinking to the thinking that produced the Salem witch trials?

*The biological definition of differentiation has to do with this process.

4903 DeRussey Pkwy
Chevy Chase, MD 20815
9-3-1985

Dear Mrs.

I did read the paper in Scientific American when it appeared. I thought it pretty good, as another assumption about the beginning. Your letter came in June. It was a busy Summer for me, and now I am trying to catch up with some back correspondence.

Re the multigenerational transmission of incestuous symptoms! It sounds like you accept the popular notion of the transmission of symptoms. I am aware that TV, the media, and a fair percentage of the population, and also family therapists, go along with this theoretical notion. I do not.

I simply cannot accept this fatalistic view of the future of the race, nor can I say that I have ever been able to use the “differentiation of self” or the notion of “multigenerational transmission process” as more than a beginning effort to understand the process. Thirty years ago, I thought the notion of “differentiation” had merit. I still do,for psychological things, and a spectrum of genetic things, but it is weak on sociological things. That is why I added the notion of “societal regression”. Now, thirty years later, I do not retract anything I said in “differentiation”, but there is much more to it.

Society is littered with complex problems for which there were no simple answers. Looking back, we might say that society went wrong in the burning of witches at the Salem Witch Trials. But, are we doing better, or worse, late in the 20th century? If you want to bring it up to the present, how about the current anxiety about the “Nuclear Holocaust”, or the current fear about “Aids” which drives some school officials crazy. How about a test for “Aids” (we already have one — How do we know it is accurate) in which people with positive tests are isolated forever. What happens when the number of “isolated” people is greater than the number of non-isolated? Crazy???? Maybe. Thirty years ago some scientists developed a test for latent schizophrenia. I think schizophrenia (mostly a psychological problem) is present in most of us. Then it was found that a cup of coffee would create a positive test, after the thing was in general use.

Too many questions for a detailed letter. How about felons and murderers? Worse than incest! Is that characteristic transmitted into the reproductive future? Maybe we should sterilize all felons! Society has already tried that with psychotic people.

Personally I think you put too much emphasis on correlating incest in your husbands past, with the social adjustment of your son. This year I have been more and more interested in the theoretical trends in society. Good luck in your effort to find answers.

Sincerely,

Murray Bowen, M.D.

# PERPETUATION OF MULTIGENERATIONAL PHENOMENA THROUGH THE LENS OF ALCOHOLISM

## Perpetuation of Multigenerational Phenomena Through the Lens of Alcoholism

In spite of more awareness of systems thinking, the push toward labeling symptoms into "disorders" is very much an integral part of today's clinical environment. When people present extended family diagrams, the family members are labeled with their "problems." For example, "There is a lot of alcoholism on the father's side of the family." Symptoms take on a flavor of nodal events and the assumption is made that this is what is "causing" the problems in the latest generation.

Some students complete a family diagram and then ask what does it all mean? "Where do I go with this information?" There are serious questions to be asked as to when do symptoms become patterns? What is the relationship of symptoms, patterns, and emotional processes?

These questions focus on the nature of the multigenerational emotional processes. Which direction will the questions go? Will the questions avoid cause and effect assumptions? Will the focus only be on what the generation before did or did not do? For example, "She never learned how to be a mother from her mother", "The father was never home, and when he was he was never available." What makes siblings' response to the previous generation so variable? What does an only child run into? What does "confronting" a parent perpetuate?

These are not easy questions. People fall back on pieces of Bowen statements, such as "It takes ten generations…" Can one focus on the emotional processes that are seen in the extended family without slipping into a search for answers to why questions?

Dr. Bowen's letter of January 1987 to a sponsor of an upcoming conference on "Children of Alcoholics," outlines some of his thinking about what he will be presenting at the conference, and the theoretical assumptions in the perpetuation of multigenerational phenomenon.

Dear Doctor

Your February 4, 1987 meeting is less than a month away. My major effort has gone into presenting voluminous material into the short 2 ½ hours allotted by your program. I am about as ready as I ever will be. The major strength of you program lies in its focus on the "children" of alcoholics, and the way the symptom perpetuates itself as a multi-generational phenomenon.

My morning plenary session will be devoted to a family systems way to understand the vicissitudes of the emotional process, and the way children and their spouses and descendants become involved in perpetuating the original problem. That is a big order for 1 ½ hours. I will have some transparencies to help hit the high spots of that presentation. The 1 hour afternoon session will be devoted to specific ways that therapists, and certain key family members, can begin to slowly unravel the inexorable process.

They fall on a continuum, based on their degree of emotional involvement in the family, and the way they handle the involvement. At one end of the continuum are those who blame the parents for everything, who are essentially incapable of seeing their own part in the problem. They can marry spouses who develop drinking problems, and unwittingly continue some form of symptoms into the future. In the mid-ground are those who share less blaming of the other, and less inclined to call themselves "normal", but they can still produce progeny who become involved in other symptoms such as substance abuse and anti-social behavior. At the other end of the spectrum are those with less blaming and denial, who have some budding capacity to look at, and do something about their own immaturity.

The problem of being the child of an alcoholic parent may not be as bleak as would appear on the surface. The literature on emotional systems provides clues about the degree of jeopardy in each child, and the degree to which children can help with the family problem. Any motivated child, no matter which degree of jeopardy, has some capacity to reverse the silent process which proceeds inexorably without some reasonable intervention. It is important for the therapist to understand emotional process and not be lured into perpetuation of the family problem.

My presentation will have an upbeat quality. In any family there are mature forces that move toward health and freedom from symptoms. These are opposed by immature forces that take "the easy way out", that passively follow popular opinion and societal regression, and

that move toward a number of regressed and symptomatic states. In most families there are responsible people who can help the family move in a mature direction, if the therapist can lend a hand to help establish leadership. We are living in a period of society passivity in which society condones the beginnings it permits.

System theory involves a number of variables lacking in conventional thinking. A therapist who has an awareness of the vicissitudes of emotional systems, as a multi-generational phenomenon, automatically has a good working notion of emotional strength and weakness among the various family members. In any generation, a family member most involved in the alcoholism, is the one most in jeopardy for alcoholism, or a similar psychopathology for the future. They are least likely to be of value in future therapeutic efforts. Family members who are least involved in the family feeling process, are the ones most capable of seeing ~~beyond the symptoms~~, of staying in viable emotional contact with symptomatic relatives, and working primarily on the differentiation of self. Family, group, or individual therapy, are mostly inadequate for finding self motivated family members. The various "therapies" discover the talkative, feeling oriented people who are too involved in the family problem to be therapeutically significant. Some succeed, but as a group, they are too involved in complaining about the symptoms without changing themselves. The motivated people are discovered through a multi-generational family diagram and personal contact with the therapist. A goodly percentage of motivated family members, in any generation, are capable of slowly reversing the inexorable process that is alcoholism.

The 1½ hours session Wednesday morning is too brief to go into detail about the differences between systems principles and conventional psychiatric theory. For the morning session I have developed a series of transparencies which will hit the high spots, and hopefully help some move more toward systems ideas. The afternoon session will be devoted entirely to therapy, and the dozens of things that motivated family members can do to reverse the inexorable process, no matter where it occurs, or whatever symptom it may develop. Addictions, substance abuse, violence, and anti-social symptoms are only examples of other symptoms.

# MARRIAGE AND THE FAMILY EMOTIONAL SYSTEM

## Marriage and the Family Emotional System

Once one has a reasonable, clear idea and working knowledge of the assumptions and principle of family systems theory, the clinician can practice "family therapy" with whomever one is seeing or with whatever is the "problem" focus – whether it be the individual, parents, the marriage, or the children. The thinking drives the therapy.

I have selected seven letters that use the lens of marriage that Dr. Bowen uses to articulate his thinking about family emotional systems. These letters are not about "marriage therapy," but about variables in emotional systems and how interaction processes play out. These letters cover a period between 1961 to 1975 and address multiple themes and issues such as "emotional divorce," impasses in relationships and predictability, motivation, impact of new arrivals into the system, short-term versus long-term efforts, how marital disharmony fists into other human phenomena, and how anger and anxiety may be related.

The letters, as a whole, address many of the challenges of making a marriage work. The letters also reflect that there is a way to think about these challenges.

April 28, 1962

Attorney

Dear Mr.

Mrs. has asked that I write you about her psychiatric consultations with me in regard to her marital problems. She was referred by Dr. who had seen her and her husband, Dr. in preliminary interviews. I saw Mrs. alone on , together with her husband on , and then alone again on . These four interviews were the ones that had to do specifically with the marriage. I saw Mrs. with her daughter in August and Mrs. alone in for problems other than the marriage relationship.

At the time of the consultations in February and March it was Mrs. who was seeking help and psychiatric understanding about the marriage problem. Dr. was much less motivated to seek help about the problem.

There is not a simple way to conceptualize or describe a marital problem such as the one between Dr. and Mrs. My effort has been to understand the marital disharmony as a human phenomenon in which both people have played a part, rather than a situation in which either one is primarily responsible. Of course in periods of marital conflict it is almost inevitable that there be aggressive incidents in which each blames the other and justifies self. Prominent in the marriage has been an extreme degree of "emotional divorce" which has been present for a long time. This emotional distance between spouses is a common phenomenon — so common that it is present in "most marriages some of the time and in some marriages most of the time". Not many marriages continue for long with the degree of emotional distance that has existed in the marriage for a long time. Before going specifically to the problem, I will describe briefly my concept of how an "emotional divorce" comes to be.

In the growing up process children achieve varying degrees of maturity of identity. Some "grow away" from the parents to attain relatively high levels of autonomy or identity. A fairly high percentage of people have some degree of emotional over-attachment to their parents. After adolescence they deal with this by denying the importance of the parents and acting over-independent. In leaving home, they tear themselves away, or "go away" from the parents instead of "growing away". They are vulnerable to future emotional involvements. As young adults they might

function quite well as long as their relationships are brief and they do not become too involved emotionally. In a marriage they become deeply involved emotionally. It is a clinical fact that people marry spouses with identical levels of maturity or identity, though each has handled parental dependence in a different way. They both long for closeness but when they are emotionally close, they automatically merge into an uncomfortable interdependence which is really a "stuck togetherness". Each deals with the discomfort and conflict of the interdependence as they did the earlier dependence on parents. They withdraw to sufficient aloofness and distance for each to function with as much comfort and autonomy as possible. When neither "gives in" on points of difference, open conflict results. Each sees the other as "dominating" and self as "giving in". Conflict is avoided when one "gives in" but the one who habitually "gives in" loses "identity" to the other who becomes more dominant and stronger. Many such marriages eventually find a satisfactory working equilibrium to the various forces. A common solution that works when children are small is one in which the mother becomes over-involved with the children and the father over-involved with his work.

The emotional distance in the marriage has been great. In the early years she devoted much of herself to the children and his emotional investment went more to academic achievement and his work. Outside the family he functioned on a high level. In the home, which was her sphere of activity, she functioned on a high level as the dominant resourceful one. The distance between them has been so great the past few years that there has been little contact or personal communication between them.

In my clinical experience, not many marriages with this degree of emotional separation ever work out of the problem. A few people do solve such problems and we know that it can be done. However, the forces that caused them to keep the distance during the more active years of the marriage, are still operative — even more operative — in any effort to solve the problem. To work at finding a solution means arousing all the old conflicts, anxieties, and turmoil that caused them to seek the distance in the first place. So, for practical, rather than theoretical or technical reasons, the marital problem in this situation can be considered an insoluble one.

Sincerely yours,

Murray Bowen, M.D.

September 8, 1965

Dear Doctor :

Your letter came on Wednesday September 1 and on Monday September 6 I saw the last time. Your check for $150 covered the bills through May. Enclosed is a bill for the appointments since May, including the final one September 6. The previous bill which listed appointments through August should be adequate for insurance purposes but if you need something else, let me know.

You say your functioning has been better since you have been away from . This is predictable and to be expected when there is a significant level of marital disharmony. This often leads to the automatic assumption that the other is hurtful, or toxic, or "sick", or too overwhelming for self. Implicit in the assumption is that self is inadequate and incapable of dealing with the other. The main problem is there are distortions in the assumptions and one can go on and on, terminating the marriage because the other is "impossible".

Speaking strictly from a psychotherapeutic orientation, whether you and eventually go on to a divorce or not, I would say that you both have much to gain if you both stay on the goal of learning to relate to, and to deal with the other. You expressed concern that you will get back into "the same old mess" if you get back with her. It is to be expected that you will get back into some of the same old bind in relating to her, but if you have a productive therapeutic effort in progress, the intensity of the bind will be less and less, and the net gain to both of you will be greater and greater. You have the mirror image of mechanisms, and she has the mirror image of yours. This is a built-in advantage in a therapeutic effort.

If "nature takes its course" the percentage chances of you and going on to divorce are fairly high, but if you and can act on the intellectual process, instead of the automatic emotional process, an apparent deficit can be turned into a net gain. Even if you eventually go on to psychoanalytic training, the experience of working on the problem with will provide big dividends. If you rely on individual psychotherapy to solve such problems, the results can be disappointing.

I hear you when you say your training program wants concentration on individual therapy. And so it goes with most training programs. You asked about reading in "family". My one suggestion would be the journal "Family Process". The papers pretty much cover the field and the bibliographies are good.

Best wishes to you and

August 5, 1961

Baltimore Maryland

Dear Doctor

Thank you for the report on Dr.

I was not specifically aware of Dr. 's feeling or impression that psychotherapy with me meant separation from Mrs. but, in the context of the present situation, it makes sense. In the brief period of therapy a year ago, Mrs. was able to make some rapid changes in herself. She became much clearer about her own identity and she was able to maintain a firmer stand against her old automatic mechanism to give in and to "mother" his neurosis. In my experience with family psychotherapy, there is a definite course of events in these situations. When the "changing spouse" can begin to maintain such a stand, the "other spouse" begins to feel "unloved", "we are growing apart", "our love is dying", etc. The "other spouse" then goes into a period of intensified symptoms which amounts to a plea for the "changing spouse" to give up the change and to resume the old neurotic response—counter-response "togetherness". At such a point, it is easy for the "changing spouse" to give up the change and to "go back into the neurosis", and to plead with the therapist to do something about the demands of the "other spouse". If the "changing spouse" can maintain the change in spite of anxiety and the flowering of symptoms in the "other spouse", both can then move into dramatic new changes. It is almost identical to a mother taking a stand with a temper tantrum child. When she can finally maintain her stand in spite of symptoms and the increasing demand that she give in, the child's symptoms disappear. In these situation between husbands and wives, I have had the best success by directing attention to the one who is changing; helping that one to understand the situation and to maintain the stand in spite of the neurotic pleas of the "other spouse". When the "other spouse" is present in the hours, it is frequently possible for them to emerge from the emotion long enough to encourage the changing spouse to maintain the change, before going back into the emotional demand that the "changing spouse" give in. I tried to help Mrs. maintain her stand but,at that time,she was hoping for a re-marriage and that was not a favorable situation for maintaining a stand. He was making re-marriage contingent on her again giving in.

I was impressed by the descriptive aptness of your statement

that Mrs. is “exceedingly well motivated to have him under treatment”. Speaking from a family orientation, I think the crux of the problem is somewhere in this area. In their relationship together, she is in the functioning position of the one for whom ACTIVE CHANGE would be easiest, and whose change would benefit both of them the most. Yet, he is the one who ends up seeking help. From his dependant position, I think it is really impossible for him to ACTIVELY CHANGE himself, as long as he is in a living interdependence with her. Their restitutive effort has gone toward PASSIVE compromise in which he seeks to BE CHANGED. Their mechanisms persist in seeking relief of symptoms without changing the basic patterns beneath the symptoms. This was the bind I was perceiving in 1956 when the psychotherapy relationship began to move toward an interminable one and I moved toward involving Mrs. . It is my guess that Dr. next psychotherapy relationship could well go on to become an interminable supportive one, which could permit him to function on a pretty good level as long as he maintained the relationship. There might be some kind of indication for indefinite support but I am opposed to it philosophically and I do not continue too long with an indefinite status quo situation.

In line with the above thoughts I would like to modify my previous statement that I would again be willing to work with Dr. if he wished it. From what you say, he is opposed to further therapy with me and the issue probably will not come up but, if the question should come up, I would change my stand to say that I would be willing to work with him provided that Mrs. was also involved in the effort. I would not insist that they attend hours together, but I would not work with him alone. I say this because I believe basic change is possible only if it can somehow involve both of them.

Your letter filled in information gaps in several areas and I was glad to get it. The ’s have had a long struggle with their neurotic bind. I believe they will profit from their evaluation with you, and I hope that in their next psychotherapy effort they can somehow break through the impasse and get the “sickness” defocused, and find better ways to utilize their individual and combined strengths.

Sincerely,

Murray Bowen, M.D.

June 16, 1969

Bethesda, Maryland

Dear Doctor

The following is a report of my family oriented psychotherapy with Dr.

His marital problem came into acute focus a year ago when his wife began legal steps toward separation and divorce. He was not previously aware of the extent of her discontent. She would not participate in family psychotherapy designed to resolve the problem. She proceeded with separation and established a separate residence for herself and children in New York. The husband was opposed to separation, he is deeply attached to the two children, and he was motivated to work at understanding and modifying his part of the marital problem. In my experience, a fair percentage of such marital problems can be resolved as long as one spouse is seriously motivated to work toward resolution, and the thoughts, fantasies, and actions of the other do not proceed toward remarriage. Some husbands, whose wives and children move out as a prelude to divorce, make more progress working on the family problem alone than would ordinarily be possible with husband and wife in family therapy together.

I have seen Dr. about twice a month for a year, while he has attempted to understand and modify his contribution to the family problem, and to demonstrate the change in his visits with children when he also has some contact with his wife. Progress has been slow but positive. It has been sufficient for me to be willing to continue, and for me to have a moderately hopeful opinion about ultimate outcome. One impediment to faster progress has been the young age of the children which precludes the father's most effective communication with the children, and another is the distance to New York and his lack of control over visiting.

The clinical situation indicates there is better than a 50% chance of resolution of this marital problem to the advantage of both parents and the children, if Dr. motivation continues. The wife shows no significant primary interest in another man, the husband has no interest in other women, and both are deeply attached to the children. These are positive forces that hopefully can be utilized in resolution. On the other side, this is one of those very difficult clinical problems in which the wife's anxiety

goes to impulsive action and the husband is sensitively responsive to her anxiety. The internal dynamics of the family has favorable indicators for eventual resolution of the problem but the wife's emotional trigger is "cocked", she still voices adamant demands for divorce when threatened, and the husband is responsive to her threats. It would be easy for husband, therapist, or other outside advisor to precipitate divorce with loss of "cool" or an inept move. If the husband can keep on course, the chances for a favorable outcome are better that 50%. If his motivation subsides, or he begins undue response to the wife's anxiety, or he begins to fight her "pro-divorce' posture, or if he gets into a form of individual therapy in which the therapist implicitly takes sides against the wife, the chances of divorce are almost 100%.

No matter what happens, this problem is not going to respond rapidly to any kind of "therapy". I have been sort of challenged by the technical difficulties involved. It would be easy for any clinician to trigger this into a "point of no return" divorce. If the problem can be resolved, even if it takes several years, the cost of therapy will be minimal in comparison to the monetary cost and human turmoil, if it goes on to divorce. The wife is not likely to remarry. If they get a divorce, I would predict the wife may get superficially involved with other men but keep her primary emotional investment in the two children, which will impair the future adjustment of the children. I think the husband would eventually remarry but he probably would never become emotionally and financially independent of these two children.

In summary, there has been slow and positive progress on the family problem. If this year of family oriented psychotherapy results in restoration of the marriage, it will have been a great year. If the problem goes on to all the expense and complications of divorce, I would consider this year to have made a lasting contribution to the husband. If he leaves the area this year he will have major decisions in regard to future "therapy". If he remains in the area, I will be willing to continue my interest in the problem.

Sincerely yours,

Murray Bowen, M.D.

7-26-70

Dear

Some thoughts since your telephone call this morning. People can get real worked up over the concept of “manipulation” in a relationship, yet people are constantly “manipulating” each other, if one thinks within that framework.

If you considered the recent sequence between you and in a step by step framework, it might go about as follows — distancing himself and making self unavailable to others (maybe distancing more from and clan than from you — he is administratively hooked to that household and he is not to you which should make you a more free and acceptable relationship). When pressed about the distancing, the lack of a telephone is seen as “the reason”, a real flimsy reason. He is real unsure about wanting the distance. I’d say he wants it but he also doesn’t want it. If he really wanted it, why wouldn’t he have said, “I do not want a telephone because I like my cave where I can hole up away from the demands of the female world, especially from troubled ex-wives and certain other women”. If he had said this, there would have been “no debate” or another subject for debate. Instead the “telephone” became the subject. You engage him on the unreality of the telephone reason. If he responds on the telephone reason, his next reason will become even more flimsy. He has no where to run. You sense “victory” and move in to nail down your point. The next defense, when one is “about to be nailed down” is anger, and a relationship cut-off.

I think that anger is a necessary ingredient in the “manipulation” process. Or one can replace anger with anxiety. I think anxiety is a better concept. In this situation, you’d be aware that you made him angry and you would instinctively avoid the angry panic button in the future. In the past I have said that spouses learn to avoid the touchy areas in the other, which gradually results in the communication cut-off in marriages. From the “manipulation” standpoint, one could say that had “manipulated” you to steer clear of the troublesome issue.

Some ideas — I am fascinated by responsiveness to money issues. One could say that he always had problems with money and his anality should be analyzed. You know what I think about that kind of explanation which fixes the problem in him and ignores the part his mother, and , and you, and others, play in it. I could see his mother having some kind of a “thing” about money so he could always “engage” her on money issues. Then it must have been a deal between and with R having all kinds of reality issues about money and defending, and demanding her rights and defending. As an overall program (you have to decide what you want to try and what is not worth the effort), I would say try to avoid any kind of an issue that has to do with money, unless you are being playful. I can sit here and have a “ball” thinking up reverses and trial balloons on money issues. The old pattern was R bugging him for more money and him holding back. You could wreck some of the old pattern by encouraging frugality and thrift and saving his money for R and the kids. You could spend money on food for him, etc at home and he’d never notice that it cost you a penny but I’d bet he’d choke if you wangled him in going out and rig it so you pay the bill and rig it ahead so he’d have to eat a $15 meal that you paid for. Bet he’d choke on every bite. I am having too much fun just thinking of ways to turn tables. I’ll quit thinking.

Sincerely,

February 17, 1975

Dear Mrs.

Yes, I did see and his parents briefly, about ten years or so ago. As I remember the situation, it was a rather typical example of each having done his or her best, as each saw it, ending up with blaming his parents for his problems, and the parents focusing on his "immaturity" as the cause of the problem. The subsequent course indicates that they chose to deal with the situation by going away from each other.

The disharmony you describe is fairly typical. It has the earmarks of a situation in which the marriage was fairly congenial until the addition of a third person, a child, which upsets the emotional equilibrium in the marriage. The usual human reaction is to seek a short term solution, which goes toward divorce and the creation of a new congenial relationship between mother and child, which lasts until the child reaches adolescence, and then impinges the child in the next generation. And so it goes multiple generations proceed through time.

I am much in favor of long term rather than short term solutions. I am in favor of parents assuming responsibility for their own problems. I am against short term solution that impinge children in the future. You are at a critical time in your life. Society provides plenty of experts who favor the short term solution. Good luck to you in your choices.

Sincerely,

Murray Bowen, M.D.

October 15, 1961

Mrs.

Dear

You describe a pattern that repeats and repeats. How does one go about understanding it? I believe that a high percentage of people live their lives in automatic fixed patterns that amount to "chronic ruts", that most of them never recognize or acknowledge the fixedness of the situation, and that most of the others "get numb" and accept it as inevitable. One wife described it aptly when she said,"Our life never really gets anywhere. On any day it may appear to be progress but that is an illusion. It is more like a tilting pan of water that tilts from side to side. The water is always in motion but it never goes anywhere. It tilts in one direction until that is too much. Then we make a great effort to "change" and we tell ourselves we have solved something, but we only tilt it in the other direction for a time".

I am looking for better concepts to understand this common human problem. Some people do succeed in getting it solved but most people give up and choose to live it out. Inherent in this is some kind of an equalizing, or self stabiling, or self canceling mechanism that automatically operates between spouses. I think it probably operates between parents and children, only at that stage of life it is easy to convince ones self that marriage will fix it. At least in marriages, each spouse has a mechanism that effectively neutralizes the forward motion of the other. As I see it at this point, change within the family (except to tilt the pan) is theoretically impossible. Yet change does occur for some. For change to occur, one spouse has to find a way to stand against the automatic neutralizing mechanism of the other and that is difficult unless one or more significant figures within the family unit can have a relationship outside the family neutralizing mechanism that does not get involved with the intrafamily counter-balancing.

From your description, it is a fairly predictable characteristic for to run into a period of poor functioning and then to consistently come through, even though at the time it may look as if the ship will surely hit the rocks.

I am currently trying to put together some ideas that several have asked me to write down. I thought I would have it finished last week. I will send you a copy. It may still be in rough draft form but perhaps you can let me have any ideas and comments you have. My writing is several months behind schedule but I am working toward the May 1962 deadline.

# STUCKNESS IN TRIANGLES

## Stuckness in Triangles

All clinicians have experiences where the emotional situation stays stuck in spite of intentions of all parties for it to be better. A glimpse of light appears, only to be shot down from another direction at the slightest whiff of anxiety (e.g., a father's attitude to the couple's child). Emotional escalation is a result, with all family members soon out of control, with another lost therapy session, and the family feeling more hopeless.

Dr. Bowen's letter of August 1975 is a response to a person feeling "stuck." He offers a way to think about functions and patterns that play out in these intense triangles within the family emotional system. A key question in his letter concerns not so much what one is doing in the perpetuation, but the resultant anxiety that results in not doing it; there are both advantages and disadvantages to the role in which one is participating and to the other family members. How does one maneuver out of this bind?

August 25, 1975

Dear

Here are some overall guesses about what is going in your family, and hopefully some educated guesses about what you can do with it.

All things being equal, I would expect your mother to be the main generator of anxiety, for her to be responding to her mother and the other way around, and for your younger brother to be soaking up anxiety from mother. His functioning might be a fair barometer of tension in the system and his dysfunction might relieve some of that tension. I would see your father as very dependent on your mother to keep calm, and his dysfunction more related to her than anyone else.

There is lots of evidence to support the notion that your father sees your brother as the generator of problems in mother, which would be part of his power play to enlist the aid of his brother in seeing that your brother was removed from the scene. I would give long odds that your father was trying to calm your mother by removing your brother.

I think your main Achilles heel rests with being the only girl, and the one who sort of absorbs a “fill in” function for your mother, or maybe the mothering function in the whole family. I think you have acquired this by osmosis. I do not remember this from your MCV presentation but your father could well have played his part in this by perceriving you as the best functioner and by making you his ally, ot his helper in encouraging you to make allowances for your mother and to forgive and “understand” her.

Your main problem as I would see it, is in finding away to relate to the whole thing as a “globbed unit” without assuming any responsibility for it. The globbed unit would be your mother, your father and your brother. How do you go about relating to your brother without assuming a role as a substitute “understander” and mother? How do you relate to your mother without becoming a functional part of her? How do you relate to your father without assuming responsibility for being his helper? How do you keep on relating to everyone without feeling responsibility for aiding anyone.

I will sort of leave it to you to find your way out. Of if you don’t, you have been a pretty good replacement mother for the clan for a long time. You have become versatile, accomplished, and competent in your assigned role, with all the advantages and disadvantages that pertain to it. Good luck. I would like to hear sometime how you try to maneuver out of the bind.

Sincerely,

# TRIANGLES ARE ALIVE AND WELL

## Triangles are Alive and Well

A subtitle for this letter could be “no one is immune.” Emotional systems don’t just exist in families. Whenever peoples’ anxieties reach a certain threshold and are playing out in any setting, characteristics of an emotional system begin to be observed and experienced. These characteristics (e.g., anxiety driven focus/blame on others) travel through the connections and conduits of interlocking triangles.

Dr. Bowen’s letter of June, 1973 describes two non-family systems (professional organizations); how individual emotional forces interact and escalate almost to a point of no return.

The first part is a report on an Orthopsychiatry meeting in which Dr. Bowen participated with other family leaders in a panel discussion. An interesting feature is the audience becoming part of the emotional system. The emotional triangle included the audience, Dr. Bowen, and a deceased family therapy pioneer.

The second part of the letter describes the emotional system (turmoil) involved around the publishing of Dr. Bowen’s anonymous paper in a book. It involved Dr. Bowen, the editor of the collected papers from the conference, and the publisher of the book. It was being driven by the anxiety over what might be “libelous.” Of importance is how Dr. Bowen’s clear position stopped the escalation and helped to facilitate the desired outcome for all system participants.

June 27, 1973

Dear

Thanks for your letter about the Ortho panel. I had planned to write to you but my world has been spinning and I still have not caught up with back work.

That was a sort of emotionally reactive audience at the panel. I had no notion of getting into the issues about , but people kept pushing and I had some viewpoints that were different. had kidded himself that through analysis, he had worked out his problems. But, he never touched the thing in his own family and then came the differences between him and , which after death were played out between and , with all the secretiveness and stories and stuff. The thing that amazed me at Ortho were the number of people with over-emotional positive reactions to my comments. Whoosh!

The process of working thru the triangle with Editor, Publisher, and Author for the "Anonymous" chapter was almost as difficult as all the triangles in my own family. In the beginning it was and as editors. There were little questions about the legal difficulties in publishing. When they mentioned their qualms to the pub1isher, there were still more questions. Then Mr. went to his attorney who was , the foremost authority in NYC about legal problems in publishing. She has been legal counsel for almost every important personal book published in the past decade or two. (She is the wife of , editor at the ,who wrote the personal book about the years of psychotherapy and then the suicide of their only son, all of which (suicide I mean) was happening about the time we were meeting about this chapter). (This thing about their son I discovered when their book came out about a yr ago--Don't think it had anything to do with the Anonymous chapter. Also, Mr. was in a symptom free period after his first operation for a brain tumor. He was dead when the book was finally published. I don't think that had anything to do with the chapter).

The push for the Anonymous listing came from . She influenced Mr. and in turn put the heat on . First they wanted me to get signed permission from each member of my

family!!!! My God, they missed the entire message in the my years long effort. I double reacted to that. When the object is the differentiation of a self, one behaves as responsibly as one knows how, and then one acts for one's own self, according to one's own convictions, in spite of opposition. To take a wishy-washy posture in the Ed-Pub-Author triangle could nullify all the courage and conviction that went into my whole effort. I told them to forget publication under such circumstances. I would have nothing to do with it. They brought up the legal stuff. I offered to sign any legal document they could prepare to relieve them of responsibility if my family should sue. Hell, I would sort of like it if they did want to start an issue over that. I could really have a rassle with my family over that, one by one, or all together. They refused that on the grounds that publisher and editor would be equally liable. I didn't care about the Anonymous listing. Everyone knew I was the one who did it anyway, and if the Anonymous thing helped the publisher and , it was okay by me. I worked for 4 years, writing and re-writing, in an effort to tone down the personal stuff and tone up the theoretical. I was in favor of that anyway, because more people would "hear" and fewer would react emotionally, with a more intellectual theoretical explanation. The final and last draft of that thing took up most of my spare Xmas time in 1971. Even that issue was judged by to contain one or two potentially libelous comments.

I didn't mean to go into all the little emotional issues in that professional triangle, but I started and then I was into it.

The Ortho panel was a good experience. I am glad you found the energy to motivate it, and that you invited me. Best wishes to you, and all there.

Sincerely,

Murray Bowen, M.D.

# THE THERAPIST AND TRIANGLES

## The Therapist and Triangles

Anyone having any knowledge of Bowen and his theoretical concepts has learned or at least heard about the importance of the concept of triangles. Yet being able to describe how the concept works in therapy is more difficult. I have heard experienced therapists say that they don't really "understand" triangles. What makes therapy a triangle phenomena? How does one do therapy with a couple and not focus on the relationship emotional content? How does a self "fuse into the we-mess of the marriage?" How do interlocking triangles develop in one's social environment? Are there principles to guide the therapist? Where do options come from? How does a therapist decide what his/her options are in continuing with a couple who insist on perpetuating a "collision course?"

In the majority of psychiatric and mental health settings, the prevailing practice is for each family member to have a separate therapist, a practice which is supported by medical record and billing procedures and "requirements." A lack of understanding of how triangles work in an emotional system probably plays a major role in perpetuating this model.

Bowen's letter of 1974 to a wife of a couple he is seeing addresses many of these questions and articulate the logic underlying his practice principles.

May 20(?), 1974

Dear Mrs.

Perhaps I assumed that you understood triangles better than you do. I usually go into some detail about this when it involves two sets of people who work in the same office or who are in the same social circle. It is possible to work with either both sets of people separately and productively as long as they do not start "gabbing" to each other about their "therapy" (I do not use the term therapy or therapist, which I can talk about later). When they start gabbing, it fuses the whole social system into an emotional amalgam which can nullify progress, if the differentiation of self is the goal. Once the social system becomes an amalgam, progress is limited to what can be done with an encounter, a network, or a group. Another reason I did not go into more detail was a sort of assumption that the relationship between you and Dr. was more private than it is.

It is impossible to fully explain this briefly. It all works on the knowledge of triangles. I did not invent triangles in my head. God invented triangles. It has to do with the way one human protoplasm relates to another. It is the way people are. It is the way people "triangle" themse1ves into emotional messes by following the dictates of their feelings. The concept provides an amazingly accurate way of "De—triangling" the mess if they are motivated to learn about triangles and then have the courage to avoid doing the things that create problems. Until people can get a better grasp of triangles, it is necessary for me to have some rules to keep me reasonably de—triangled and to insure the best possible outcome for the total effort.

Most therapists would deal with the thing between you and Dr. with separate "therapists", which has built in limitations. There is a big advantage if it is possible to have a single person who can relate to all segments of the larger system, and still keep self emotionally disentangled. If the "therapist" is able to do this, there is a way out if the various people can learn about triangles and respect them in their daily living. Let me put in one good example, all within the same family. However good family therapy may be, it is common to reach unresolvable impasses with both spouses together. Beyond that it is possible to get through that bind by helping one spouse, or both separately, to work toward defining "self" rather than focusing on the relationship. Work on

self is a difficult and private task. At times of uncertainty, people tend to talk to others to clarify their own thoughts. It is okay to go to the literature or to another person outside the emotional system, but the impulse is to discuss it with the other spouses. The moment that occurs, self immediately fuses into the we-ness of the marriage and the effort of self is nullified. I learned about this the hard way, from trying to work with a single spouse who would then go home and discuss everything with the other spouse. How does one go about relating actively to the other while still maintaining a self? That is the size of the problem. There are all kinds of ways of doing it, if one can find a way for self.

As a therapist, I have an option for me too. If I suggest to someone that they are on a collision course, they have an option of continuing on course, or making an effort to modify it. I avoid trying to "tell" them what to do. which is de-selfing in itself. They can insist on their right to continue. and then I have the option, and the responsibility, of deciding whether or not I am willing to invest my time in an effort that I believe will be unproductive.

This is already too long, which happens when I get into this subject. From experience only a fraction of the explanations get through until people know about triangles. So, the average person interprets most of this sort of thing as "whimsy" or my theory.

Thanks for your letter. It lets me know better where you stand. Perhaps I was precipitous in taking my position. Certainly it was timed with the sudden awareness that the situation was "leaking" over the whole field which would nullify any advantage in my position. Perhaps your reaction was more in you than in the situation.

My position has nothing to say what happens to you and Dr. in your private relationship. I hope I have already communicated that. I have made an effort to leave the outcome of the amalgam up to the various people involved. According to my standards, I have done rather well with that thus far. When the system starts triangling me outside the sessions, it nullifies my effectiveness and makes me responsible for the outcome. That is when I start reacting.

These are things that require a lot of talk and explanation. I will try to do my part in making my position as clear as Possible.

Sincerely,

Murray Bowen, M.D.

STAYING OUT AND BEING CONNECTED

## Staying Out and Being Connected

Milton Berger organized a major conference, held at the Barbizon Plaza Hotel in N.Y.C., on March 3, 4, 1977. It brought together many pioneers in the family field to address "family systems, communications, theory and techniques with schizophrenia": Contributors included Bateson, Bowen, Haley, Scheflen, Weakland, Whitaker, Wynne and others. The conference was called "Beyond The Double Bind," with the idea being to address what had happened in the family field since the original paper on "The Double Bind Theory" published in 1956. Over 1000 people attended the conference. *

Dr. Bowen's letter of March 17, 1977 is a response to a letter from a friend who had attended the conference. At the conference, Dr. Bowen did a clinical interview, presented a paper "Schizophrenia as a Multigenerational Phenomenon," as well as participated in the open discussion with the other contributors and audience. This letter describes his efforts and the principles involved in both the clinical system and the professional system. Can one be a separate self and be connected to the larger system in which one is interacting? An underlying hypothesis was that the "double bind" phenomenon was a result of not being able to be separate and connected and not a cause of schizophrenia.

* The proceedings were published in 1978 by Brunner/Mazel *Beyond The Double Bind*, ed. By Milton Berger.

March 17, 1977

Dear

Thanks much for your letter about the Double Bind Conference. I have been interested in the spectrum of responses to it. I thought it one of the best meetings in years, from my biased position. It was a very special mtg in that it brought together people who were real involved with each other between the mid ‘50’s and mid ‘60’s, but have not been meeting much (about this subject) for about ten years.

I had two main goals, similar to my goal when I did the paper about my own family in 1967. People have read my papers about “staying out of the emotional system” but no one has really understood it. This time I was going to demonstrate it, without talking about it. First I was going to try to stay outside the emotional system in the demonstration interview. I labored that one on Sunday Feb 6 when I made a special trip to South Beach to make the tape. It was a near perfect interview, from my viewpoint. I did not get “snookered” a single time, and this was a family with schizophrenia which is far more difficult than other families. The deadly serious family got more loose and casual as the interview progressed. I was delighted that I had accepted invitation to make the tape before the meeting. and declined and wanted to do “live” interviews at the mtg. I was glad to have that hurdle behind me before the meeting. Neither nor had families with schizophrenia, both became entangled in the emotional morass in the interview, and both ended their interviews with the families more uptight and polarized. Content oriented viewers would not notice this.

My second goal was to stay outside the emotional system of the people on the stage. I had been rehearsing this in my head for days. The peak of that came in the room, the night before the meeting, when I paced back and forth for about two hours, drinking coffee and thinking up detriangling “one liners” to use during the meeting. I had a great time chuckling to myself as I tried to prepare casual sounding “one liner” comments for every anticipated situation. I was delighted Thurs morning to find that had taped place cards to our positions on the platform and that I bad the “end position”. That also helped me “stay outside the system”. I was prepared for any position but the end position helped. It was not possible to use more than a few of the stockpile of comments. I did better than okay in keeping myself out of the impossible polarized situations. Within myself I was delighted with success as I would define success. It was worth all the time and preparation.

Most people were able to “hear” better this time than ever before but few had really grasped what I had been trying to do. To comments about the smoothness of my interview, I said, “I just happened to get a good family”. People who have considered me “cold and distant” were thrown off by my personal letter to the family the day after I saw them, etc, etc. I was having a good time listening to 1earned opinions of what had taken place.

There was method in my formal presentation Friday morning. People have never real1y inderstood my terminology so I took it out and replaced concepts like “undifferentiation” with simplistic terms like “emotional weakness”, etc. My thinking has not changed except a few minor points. I was merely trying to use simplistic terms people could understand. I was delighted when jumped on the vagueness of the term “weakness”. I knew I had him snookered when he did that. I have known over 20 years. He was the one who did the Hillcrest films back in 1963—65 and he has never really “heard” what I have been trying to say. “Differentiation” and staying “detriang1ed from the emotional system” is an emotional process. It simply cannot be conceptualized intellectually. Preaching about it does not help people to “hear”, so I decided to demonstrate it and let the chips fall where they fell. I was pleased with the result. We will see how things evolve the next few years.

There were a few who were furoius furious with me. It was best illustrated by a woman psychiatrist who delivered a blistering attack while I was talking to the Time Magazine reporter during coffee break. Time may eventually run a story about the meeting. This woman was attacking my sexual chauvinism. I think she was reacting to my comments about “mating” and “breeding” in human reproduction, which I carefully planned to make my point as stark as possible. She was raging. I watched her purple face with detached enjoyment.

Thanks again for your letter. The meeting was a time for re-thinking relationships of long ago. I was also thinking of the time I first met you and in Iowa City in about 1957 and then my later trip to Omaha on that snowly night when you drove me from house to the hotel through the snow. Were it not for energized people like Milt Berger the youngsters of today would have no way of understanding the evolution of the family movement and the many changes that have taken place in the past twenty years.

It was good to see you at the Barbizon Plaza and I am glad the meeting contributed something to you.

For now,

# LAND MINES

## Land Mines

The clinical environment is composed of not only a core triangle but a number of interlocking triangles, including (at least) (1) the patient, her/his issues, and the therapist, (2) the family of the patient, (3) the family of the therapist, (4) and the environment/ setting in which the clinical work takes place, e.g., agency structure, insurance policies, U.R. panels, etc. A lot of emotional forces are pulsating through these conduits which connect these triangles. Not only is the therapist responding to these forces, but certainly adding one's own forces into the mix. "Transference" phenomena, as Dr. Bowen says in his letter, do not do justice to the complexity of the forces. I'll mention a few of the emotional complexities that can evolve from thinking confusions to land mines, to major catastrophes.

Often unresolved emotional issues from one's family of origin drive the initial motivation to become a clinician. When does the clinical job become more emotionally important than the clinician's nuclear family? Can one have an "affair" with work? Can one be more married to work than to one's spouse? How does the therapist respond to the patient's thirst for emotional support that cannot be obtained from the patient's family? What is the distinction between the therapist being supportive and positive vs. emotionally filling a void within the patient? What goes into the conduit from the therapist who says, "I really like that patient?" How does the therapist respond when the clinical environment is more emotionally important for the patient than his or her home environment? Can the therapist clearly articulate what is being put into the conduit with the patient? What is the nature of the clinical responsibility and expertise? (Being "helpful" is not an acceptable answer.) How does the therapist respond if these themes are initiated by the patient? There is no shortage of horror stories, of divorce being triggered by "boundary violations." Some of Freud's followers were known to encourage sexual activity outside of the marriage.* There are also some painful

* See Lawrence Friedman's biography *Menninger*, for some of the details.

examples of how "seemingly" benign social relationships (e.g., playing bridge with a patient and his wife) evolve into something else. There are also examples of a psychiatrist father requiring that his children be in therapy with him.

The whole area of "co-therapy" is full of emotional complications. If the therapist team is a husband and wife, what is the boundary between clinical and family? If the therapist team is not married, how is the professional "closeness" of the team managed?

On a less intense level, how much of the clinical world is brought home for discussion with one's spouse? Or how much of the therapist's family is brought into the clinical environment? Are examples from the therapist's family experiences "shared" in the clinical environment?

Dr. Bowen's letter of April 1977 is a response to the organizer of a panel for an Orthopsychiatry meeting which was to include therapists and their spouses. In his letter, he articulates some of the challenge and the importance of one's clarity of functioning in these interlocking triangles. In the absence of one's ongoing efforts at clarity, the explosion of the land mines is the probably outcome, with multiple casualties.

April 5, 1977

Dear

I intended to write some weeks back but I have been busy—busy—busy, and time has passed too quickly.

My wife, , is not going to be with us at Ortho next week. In the beginning it was if—ey but I thought she would be willing to put in her viewpoint. Now it has worked out that she is not going to be with me in New York. She is involved in her own pursuits and she has other plans. She was real clear on this some weeks ago and I have failed to keep you informed as this year has rushed by.

So, I will be there to convey my viewpoint as best I can. My orientation to this is different than most. Most family therapists are emotionally involved with the families they see clinically, and they are emotionally involved in their own families. What happens in their clinical work is manifested in their own families and what happens in their families is manifested in clinical work. The life effort is then to keep this "emotional undifferentiation" (consisting of clinical families and the therapist's own family) in some kind of equilibrium.

I have spent my professional life on defining and practicing "differentiation" which is usually misheard as emotional distancing. For me, "Differentiation" involves the ability to remain an emotionally contained entity while in the middle of emotional chaos while relating actively to every person in the field. I have spent decades working toward differentiating my own self from my wife and children and from my families of origin, and from families I see clinically. It was a great period in my life when I was able to walk through emotional chaos in my clinical work without getting depressed when the clinical situation became depressed, nor elated when the situation became elated, and when I could operate effectively without the clinical situation getting into my personal functioning. I achieved a fair level of that in the clinical arena before I was able to do it in my own family. The greatest period in my life came with the definition of the triangle concept which contained the key to differentiation in my families of origin, later presented in the "Anonymous" paper at EPPI in March 1967. That contained the 1-2-3 step by step formula for accomplishing the mission whenever I wished to get outside the emotional system.

Insofar as I am able to practice operational differentiation with my wife and children, and with my extended families, and with the people I see clinically, then I am a free agent in the field, able to relate everywhere without the emotionality in any field interfering with my functioning. I could even handle it if my own family mixed it up emotionally with the families in my practice.

If this happens, I simply “detriangle” the situation. In earlier years my “patients” were real interested in what went on in my family and my family had a kind of interest in what went on in my clinical work—transference phenomenon. After I got mostly beyond transference, my clinical families do not even have fantasies about personal things in my and my family and my own family is never occupied with what goes in my practice, other than very broad general things. I have been able to work professionally and most profitably with a wide circle of personal friends and relatives. There is no way this can trip me up emotionally or professionally.

My wife and I have our own personal life, fairly well differentiated from each other, far better than anything in our early married years. I can relate to her as a person, and she to me as a person, without either of us having to “triangle” in my clinical relationships or her social-friendship relationships. These outside relationships are simply not a part of our lives together.

Over the years I have tried to communicate what it means to stay out of a transference but not many people are able to “hear”. It makes no difference to me whether people prefer to work professionally from “within” the system with a “therapeutic relationship” or whether they wish to master the infinite detail involved in differentiating a self. I do like to be able to communicate my theory and what I do. It is average for people not to hear and to start telling me that I misperceive and “What you really mean is that you handle the transference well.” When this happens, communication is no longer possible, the next move is a few years of “detriangling” before better communication becomes possible.  is probably less patient than I with people who cannot “hear” a viewpoint. I have spent years with severely impaired families helping them learn a point here and there. She is not so inclined. She was patient as patience itself with the children when they were small but in relating to adults she is not so patient. She is more inclined to move on to other people rather than get involved in microscopic hassling of small points so characteristic of family therapy meetings. Her life energies and interests go elsewhere. Maybe another year she will be inclined to participate in a meeting such as you have scheduled if she can be convinced that the group wants to hear what she has to say as a person, rather than automatically perceiving her as an extension of me, and the two of us operating as a twosome.

I had no idea of getting into all this when I started the letter. Then I thought I would do a paragraph to state that I will try to communicate at the workshop, and now it has gone too long. I am looking forward to the workshop and to seeing you and all the rest there.

For now,

Murray Bowen, M.D.

LEARNING IN CONNECTIONS

## Learning in Connections

What is the process of learning in a clinical relationship? What does one expect to obtain from the clinical "expert?" Certainly, one assumption expressed is that the therapist is more knowledgeable and the patient "needs" this knowledge to do "better." Early psychodynamic relationship focused theories postulated an internalization of the therapist's "healthier" functioning capacities and knowledge, in order to cure the patient's mental and emotional state. What role does the mental health professional play in setting up such a model?

Learning styles seem to exist on a continuum, from extreme dependence on the other on one end and to extreme self-dependence on the other end. Of course, there are many interactional patterns on this continuum. Some people thrive on interaction, dialogue, and the stimulation of the exchange of ideas. Conferences with discussion periods following expert presentations use this model. Other more experimental models focus entirely on the interactions of the participants with the only expert being a facilitator or consultant to the experimental process (e.g., Tavistock model). Others spend solitary hours in libraries following their own questions*.

Training programs have been created all over the country, some promoting their version of the Georgetown Family Center Training Program. How do trainers "teach" family systems theory? What do trainees think they are learning?

A non-mental health professional trainee in such a program wrote Dr. Bowen after he had presented at a training program. In his response of August 27, 1986, he spoke directly about assumptions about his own knowledge and "expertise" and also the lurking dangers of assuming the experts have <u>the</u> answers. He challenged her to think more clearly about her own learning process.

* "...There are many different forms of learning produced by different patterns and combinations of stimuli and these give rise to two very different forms of memory storage." This quote is referring to neural activity and strength of synaptic connections, and synaptic plasticity. From: Eric Kandell's In Search of Memory Norton, 2006 — pg. 159.

August 27, 1986

Dear

I hope the name is correct. Thats the best I can decipher from your writing. Thanks for your letter. It conveys a pretty good idea about where you stand.

From your letter, I think I did pretty well. The smartest I ever was, was the day I graduated from med school--almost fifty years ago. Since then I have become more stupid every year. I learn a few things but have an awful time trying to put it all together. The best I can do at a session like is to raise questions that may help the other put it together for themse1ves. If the other is confronted with the issues, they seem to do a pretty good job for themselves. It involves a lot of reading and summarizing.

I thought your notion about a semipermeable membrane was pretty much on the point. If you are the ce1l, and you are in a certain state, you automatically absorb the environment to a certain point, but the process stops somewhere. What is the part of the cell, or the nuc1eus that remains stab1e, that does not change? I have never tried to run through the analogy of a cell but I think it could be done.

There are people out there whose “selfs” cannot be distinguished from important others in the family. They are the “no selfs” that I put low on the scale of differentiation. There are those who maintain a fair1y good level of “se1f”, fairly we11 demarcated through all kinds of conditions. Most of us fall somewhere in between the extremes. How does one~ account for the phenomenon? Is it possible £or a lower 1eve1 “se1f” to became better demarcated? I have postulated that it is possible to change this a tiny bit at a time, and to keep on working for life. Most are content to live and die the way they were created. That is their option, if they so choose. I be1ieve it is possible to raise the 1evel of demarcation a little, if people choose that direction.

I think you have one monumental distortion, which is the assumption that Mental Health people know more than you? Where did you get that idea? Another distortion you have wou1d say that your instructors at know all the answers. Maybe they pretend to know the answers? They are struggling like all the rest of us.

Maybe you would be more comfortable amongst people who successfully pretend they know everything? If you successful1y become like a pretender, what does that make you? We will see what we will see come September. If knows all the answers I will learn something. If he is as inept as I, it will be two blind men, each trying to relate his version of something or another.

Keep on traveling, if you choose to spend your life at such trivial things. Thanks for the letter. Sometimes I have time to respond to letters.

Sincerely,

Murray Bowen, M.D.

# ALONE IN NO-MAN'S LAND

## Alone in No-Man's Land

For the large majority, one's beliefs are defined by the culture in which one lives and practices, a culture which responds to the forces that are present at any particular time. The culture prescribes (and often demands) what one is to believe and little variation is allowed, and if the variation is too great the individual is punished. This process is easily seen in the history of psychoanalysis. This process may help explain why followers of Freud were often more "Freudian than Freud", which produced increasing degrees of rigidity and dogma that had little to do with the original principles and purposes.

At the Menninger Clinic where Dr. Bowen trained and practiced for a number of years, there were strong emotional forces within the multigenerations of the Menninger family that impacted on the culture of those who worked in the institution and were a part of the professional family. Dr. Bowen was well aware of the dangers of going against the existing culture both professionally and socially. The Menninger culture was largely defined by the beliefs of Franz Alexander, an analyst and former student of Freud, who was based in Chicago. Many analysts who had fled Europe during World War II were part of the Menninger staff. In addition to this analytic culture, Alexander encouraged a certain morality in reference to family relationships that were no doubt problematic to Dr. Bowen.* It became important for him to focus on "knowing myself, what I believe in, and what I stand for."

His letter of April 1961 is to a former patient of his from his Menninger days with whom he periodically corresponded.

* For some of the sordid details see Lawrence J. Friedman: Menninger, The Family and The Clinic, Knopf, 1990, esp. pages 82-84.

April 27, 1961

Dear

I am going to respond to your letter with a story about me. The past year has been one of the most profitable in terms of my own growth and maturity. Last Summer I spent several days at the Menninger Clinic, the first real visit (more than a few hours) since I left in 1954. One of the best visits was with the business manager, a fellow with whom I have one of the freest and most open relationships I have ever had. We were taking about the future of analysis and psychiatry, and the problems of dealing with some of the deeply imbedded concepts, so jealously guarded by the senior hierarchy in psychiatry, which really represent what is "sick" about psychiatry and, in my opinion society too. He was very complimentary about my efforts in that direction. My essential communication was to ask for his help. His essential response was, "I believe in this effort. It is sorely needed. I will be pulling for you and hoping that you can help turn the tide but I cannot support you actively. I have a family to support and I need my job."

At Christmas I put a note on my card to him. I said that my efforts to write a book were of great help to me toward knowing myself, what I believe in, and what I stand for. I said that during my years at Menninger's, I used to believe that if I was ever successful at knowing what I believed and what I stood for, and if I ever had the guts to stand there, I would find myself all alone in the middle of no-mans-land. The book is bringing me closer to that goal than I ever dreamed would be possible. Now, as I get a little closer, I know that if I ever reach that goal, I will not be alone. There will be an awful lot of new and wonderful people there. He responded positively, honestly, and knowingly on the theme "no man is an island".

The writing continues to help me know me, as nothing else has ever done. Now I have a kind of goal of one day putting together a research staff in which each person is sufficiently clear about his own identity and sufficiently sure about himself, that no one HAS to respond either to praise or criticism, and no one HAS to attack the identity or beliefs of others, and no one HAS to preach or defend his own identity or beliefs.

Best wishes,

Sincerely,

# WHAT TO DO WITH “THE DR. BOWEN THING?”

## What to do with "The Dr. Bowen Thing?"

For anyone continuing to be connected to Dr. Bowen over a period of time, a number of thorny issues arise, some which have been addressed in previous letters. When therapists began to explore their interests in "family therapy" in the early sixties and seventies, they explored various theoretical schools. People seeking techniques gravitated to the brilliance of Jay Haley (and his mentor Milton Erickson), people attuned to experiential and emotional experience sought out Carl Whitaker, people wanting to combine T.A., Gestalt, and family systems turned to the California leaders like Ruth McClendon and Les Kadis. Some found what they were seeking in Sal Minuchin or Nathan Ackerman. The Mental Research Institute in Palo Alto, California promoted a "communications" model. Who gravitated to Bowen and what was the nature of that pull? Who were the people who initially were interested in Bowen, but later rejected him and his theory? People have their own individual stories, reasons, and their own emotional subjectivity—too theoretical, too intellectual, too passive, too… On the other side of the emotional coin, people found him a breath of fresh air from the highly emotional, experiential approaches. Some even gave Bowen credit for "saving" their lives, with the result taking on a religious flavor. "Bowen worship" has a large, devout following. For these people if Bowen didn't say it, it doesn't exist. Is it possible for one to disappear emotionally into the "emotional Bowen brain"? Of course, it is also possible to use the theory to think more clearly about one and one's family life.

So how does one manage a sincere respect for Dr. Bowen and his theory and maintain some sense of separateness and identity?

Dr. Bowen's letter of November 1983 to a leader of a family training center addresses some of these complexities. His response to her was triggered by her request for Dr. Bowen to co-sign attendance certificates with the institute directors.

November 3, 1983

Dear

The days in from Oct 23 to 25 were good ones. I meant to write before now but things have been busy. Slowly I am catching on with problems inherent in systems theory and with individuation which may have more to do with therapy (as practised) than with theory. As far as I am concerned it is all theory but people do not concern themselves much with societal issues think of individuation more as technique. And so it goes.

The other issue is too broad and complex for any except a private communication. I had serious reservations about signing the attendance certificates with you that Sunday evening. For you and I to sign those things together implies an awful lot of group-ey togetherness without much individuation for either you or me. There must be a way for you and your group to have its own identity, and for me to have mine, without getting into too much "we are as one" groupiness. These are the things I was mulling over even while I was in . I wanted some time to talk with you alone about it, but that time did not come.

I know your operation depends a lot on what you gained from the Georgetown program. I would like to help you however I can, but it is to your advantage and mine to be separate from me. How does one do that when the good people are eternally connecting the two? Example was a person in , who I have never knowingly seen, who reported "I am studying <u>under</u> Dr. Bowen". That little problem is not confined to . The same confounded thing is at the Family Center. They are legion in Cal when trainees are required to read my "Anonymous" chapter, who then attended one or two sessions I did personally. It is not unusual for a certain level of person to report, "I have studied under Dr. Bowen". This same erroneous stuff comes in spades at the Fam Cntr. The same thing follows me around at Ortho and other places where I do periodic sessions. Last year a soc worker from Africa who had attended one session I did in the U.S., was blabbing everywhere about having studied under me. I do not know where "under" and "studied" come into the picture. I assign it to a level of about 26 on my scale, the same place I put people who cannot "hear" a definition of "share" or the difference between fact and feeling. These people do not belong in the mental health professions.

When I attempt to correct these distortions personally, or in the profession, or at the Fam Cntr, I am heard as being irrascible or something like that. Last week a young black male, real nice looking, appeared as a salesman at my front door. He wanted to "share" a thought for the day out of a leather bound book. I did not know the meaning of "share". He tried to spell out what he meant. I asked why he had not said that in the beginning. When he said "share", I thought of him wanting me to take a lick off of his lollypop. I kept asking "What are you trying to sell". He left too bumfuzzled to know which end was which. Neighbors reported he did not even stop to see them.

I have my own problems with these crazy distortions. Maybe I am more sensitive than most to these things. Without the sensitivity, I would never have developed the theory in the first place. My Fam Cntr faculty are less sensitive. They permit these distortions to exist as if they are my problems, and as if my objections are all my problems. A year ago I voiced my displeasure about going along with the Fam Cntr people if they were going to continue their lackadaisical, laconic ways. Another name for that is called poor differentiation. They reacted to my "threat" as if the problem was in me and not in themselves. During the year they have worked their heads off on theory and science without hearing other basic things. Like the poor trainees who learn never to say, "I feel", because Dr. Bowen does not like it. They are poorly differentiated people who act out of deference to me (relationship addicts) rather than changing themselves. It is pure technique—ty garbage to change an utterance without changing the self under the utterance.

This has become longer than intended. I had enough reservations about signing the trainee certificates that I wanted to take it up with you personally and there was no time in . I think there are things I can do, and things you can do that will help in this differentiation problem. You did a piece last Summer, to which I did not respond, which had some notions about the size of the iceberg underwater. Maybe over time we can work out some of the problems.

For now,

Murray Bowen, M.D.

# MANAGING DIFFERENCES VIA CLARITY OF PRINCIPLES

## Managing Differences Via Clarity of Principles

The early pioneers in the family therapy field were highly individualistic, with strong personalities and opinions. How does one deal with differences of opinion, differences of perception, differences of conclusions? Can one maintain connection without trying to convince the other of one's "true" position, or try to change the other's position? Can one avoid escalating the process of discounting the other person with a negative conclusion — e.g., labeling the other as too simplistic, naïve, stubborn, or pull out the heavy personality jargon — "narcissistic" or "unresolved oedipal conflict." All of the above are focuses on personalities, which probably has little to do with the content of the discussion. Does difference have to be alienating?

People are faced with these challenges in numerous settings. Siblings disagree about how parents treated them or what parents didn't do for the children. In work settings, how often does one have the same view as the supervisor? In clinical settings, how does the therapist (non M.D.) work as a team with a psychiatrist where differences of views may be considerable? How does one manage differences with a spouse — from sex, "the correct" thermostat setting, decisions regarding parents, etc.? On a more global level, how are religious differences managed, e.g., Christian versus Muslim?

In November 1964 Dr. Bowen wrote a lengthy letter to a colleague who had recently moved to Florida. His letter touches on multiple themes, including how theory guides therapy, how respect for the other's position start from a clarity and respect for one's self, how the community/group of family therapists operate as an emotional system, and the operational similarities in all systems, including families with a schizophrenic member.

November 3, 1964

Dear

I was struck by the analogy of two streams flowing together to describe the loss of ego boundaries. A few years ago I asked a group of residents for their images of the phenomenon and several were in this general area. The closest to this particular one was an image of two clouds forming one. During October I spent 15 days at meetings, the most meetings I have ever attended in one month. In this series of papers I have used an example that has been heard pretty well. This is the idea of two people, at marriage, contributing equal shares to the "common self" but thereafter neither self ever functions with th8 same number of shares that were contributed. The one who functions for both uses more than half the shares. This is the idea of shares being interchangeable. One might not get back the same shares that he or she put in but the shares are all worth the same. I have used this clinically with, three or four families in which husbands and wives hanve had near equal incomes which went into a joint bank account. In all there were quarrels about money. In one of these families they successfully used a separation of "his dollars" from "her dollars" as a vehicle for beginning differentiation of one self from the other.

Beginning last Summer, I have been using the most sucessful device I have found thus far for helping the "differentiating one" to differentiate a "Big I" from the "amorphous We-ness" of the parental axis or from the "amorphous we-ness" of any other relationship in the family. The more impaired the family, the more intense the undifferentiated we-ness. A family with a borderline psychotic offspring deal almost entirely in "we think-we believe-we-we-we all levels of thought,fantasy, and action" or the twin brother of that which is criticism of what the other feels, thinks, believes and does. The family with hard core schizophrenia never really gets to a definite "we" but stay stuck on what outside authority thinks, believes and does. My goal has been to get a clearly defined "I" to crysta1lize and emerge from the amorphous "we-ness" morass which is the family. When a family can begin this, in one family member, the process is on its way. The clearly defined "I" is sure of self and respectful of the other "I's" in the family. I have accidentally stumbled on the phrase "stay off the back" of other family members. Families would come back and say they had been thinking about what I had said. Then I'd find they had heard "stay off the back of". To stay off the back of means to withdraw "other directed" feeling, thinking, action energy from the other and to direct the energy to finding a way to relate to <u>what the other is</u> rather than directing it to praising, criticizing, or any of the "other directed" maneuvers designed to change or influence the other. This provides the differentiating one with a never ending series of behaviors, thoughts,etc in the other to which they attempt to find ways to use "I" without trying to change the other. When the differentiating one can "get off the back" of the other, the other feels like a riderless

horse for a time, but this is brief and in a fairly short time the other appreciates the freedom. When the differentiating one is successful, the rest of the "family mass" goes through a predictable series of steps designed to wangle the differentiating one back into the "togetherness". The assaults on the differentiating one go "You are mean-inconsiderate-selfish-self centered and sadistic", "and whats more, the things you do are part of a diabolical plan to hurt the others". The first pressure comes from the rest of the family. If the diff. one can hold firm, then the rest of the family mass rejects the diff. one with a "to hell with you" pronouncement which brings forth depression, aloneness, and a feeling of having had his membership in the human race terminated. If the diff. one can still hold firm, this will be followed shortly by the most spontaneous and pleasureable of real togetherness.

I am getting too long winded. Here is a good example of what "I" can do. A wife who had long been bossy and dominating, was trying hard to tone it down. She reached a point of being real sweet and diplomatic in her bossiness. They both work in town and ride home together. It annoys the wife for the husband to drive thru the heavy Bethesda traffic when they could go thru the park. She was wondering how to ask him to turn and go to the parkway. After careful thought she said real sweet like, "Honey, why don't you turn at Dorset and miss the heavy traffic". E-E-RUPTION!!! "Damned bossy woman-treating me like a child,etc,etc". She presented this as evidence that the problem was an over-sensitive husband. I said that no matter how sweetly she said it, she did say <u>YOU TURN</u> and I suggested she try the same statement using only "I". A few days later as they approached the turn to the parkway, she said, "I do not like to ride through that heavy Bethesda traffic". The husband said , "Okay" as he turned to the parkway. There are a few hundred little ins and outs to this differentiating business. The ones who fail are those who use the narcissistic "I" which makes demands on the family mass. In these situations, the family mass will "blitz" the narcissistic one.

Since early October, 1 have been on a one track mission to differentiate me from the other people in family work. We had a meeting at EPPI which I think is probably the first and only meeting at which all the family people were together at once. Only then did I become aware of the intensity of the emotional system within that group. I have spent years trying to define a self in relation to families, my own family, psychoanalysis, psychiatry, medicine,etc without being aware of the system among family people. The same stuff was going around that group that goes in any family with a schizophrenic offspring. I spent two days working on me while the other talked about "these families". At the end of the second day I tried a small speech directed carefully at "I" with as much respect as I could muster for the "I" of others. As soon as I had finished, the character sitting next to me said, "Thats what I like about you and your stands. You don't stand anywhere for anything!" The instantaneous rejoinder make me think I must have been partially successful. By the end of October I was doing

better. There was a wonderful two days with . It is easier to describe an interchange with the best known analyst in , who I have known casua1ly for some years. I did a pretty good paper-not the best but good. My old buddy was champing at the bit to get the floor to "discuss". He did about 10 minutes, the essense of which was "There is nothing to this family psychotherapy that marriage counselors have not been doing for 20 years". There simply didn't seem to be anything to say about this in the meeting. At coffee break said, "I guess you want to knock my head off." I said, "Knock your head off! You might need it. Why in the world would I want to knock your head off?" came back with, "Because of what I said!" I said that he and I were in two different worlds and miles apart in what we believed but I respected his opinion. If he respected my opinion that was fine but if he did not respect my opinion I still could not be mad at him. looked like he had been hit with a wet mop. Only six days later and I both attended the Chesnut Lodge Symposium here in Rockville. When I walked into the room, there was old buddy waving for me to come sit in a seat ho was saving for me. You'd think we were long lost brothers who had not seen each other in six years.

I have been real pleased with me and this two month effort this Fall. The more I have been able to define me, the more I can respect the others, and stay out of the emotional system. There were about 400 people registered for the symposium with " ". You know and how he operates. He had been jumping up and down challenging me for a day and a half. At the hotel we had adjoining rooms so we were pretty much in contact. The afternoon of the last day he spent some 20 minutes "taking me apart". The meeting was then behind schedule and the chairman was in a spot. He called a coffee break immediately after finished. The audience wanted this exchange they had been promised and they were pestering the chairman to give me "equal time". As the session resumed, I was sitting by . He asked if I was mad at hime. I asked him if I should be mad at him. He said I certainly should be. I said,"Okay , I am madder than hell". He said, "Thats the stuff. Get up there and say it. It will do you good". The chairman asked if I had anything to say. I said I did have something to say but it would not take too much time. The message was that I had known for many years, that there were basic differences in our concepts and psychotherapy techniques, that we had talked about these at various times over the years and also at this meeting, that the audience might be uncomfortable with widely differing viewpoints and they might like to have "family" consolidated into one neat bundle, but I was not going to permit this audience to wangle me into an argument with my old friend .

It is my impression that this monologue, which is too long and probably too disconnected to make sense, represents my current preoccupation, that it was kicked off by your reference to self, and that it does not have a heck of a lot to do with your letter, but here it is anyway. Best wishes to you and and the family in your new life in Florida.

Sincerely,

# PRINCIPLES, CONTENT, AND THE PACKERS

## Principles, Content, and the Packers

As evidenced by his letters, Dr. Bowen was always the observer and was always thinking about his observations. Nothing was too insignificant; whether the plane was five minutes late or five minutes early, or what make and year the car in which a fellow passenger departed the airport after arriving in Washington. He was also a fan (and observer) of football and often worked his schedule around attending certain games, and was very appreciative when colleagues arranged tickets for him, e.g., at the Gator Bowl in Florida. He was always looking for important principles as well as enjoying the games. For example, he admired Doug Flutie's (a quarterback for New England Patriots) "ability to see the whole field and all the players on it," though he was only 5'8" tall. He also observed coaches, their principles of coaching, and which ones did better at it (e.g., Vince Lombardi).

Clinicians are inundated in waves of content that add to the emotional heat. The content is real and is often interesting. How does one get beyond it? How can one impact on a perception that focuses on content? How does one's thinking influence perception? What is the relationship between one's theoretical base and the principles one "hears"?

Dr. Bowen's letter of July 1984 to a fellow Greenbay Packer fan in Wisconsin was a response to a tape on the Packers that he had received from him. He uses the tape content to clarify theoretical perceptions, principles, and content.

July 2, 1984

Dear

Your call about the Packer tape was a reminder that something slipped in my last letter. I shall always be super responsible for that copy, locked in the drawer of my desk at the Fam Cntr. I shall not allow another copy, nor permit this one to be shown without my permission. That is why I wanted to keep it OUT of co11ection.

My total interest in this thing is theoretical. That is why I want to do some kind of a typed statement about theory to go with the pictures. Without it, peop1e automatically assume I have some personal interest in the Packers. When I do the statement, I will send a copy. In my enthusiasm I guess I made a statement that the Packer story should go to a wider audience. That is purely a Packer problem.

Decades ago I became interested in the "differentiation" qualities that enab1ed certain coaches to pull athletic ta1ents into teams. I think it is most1y intuitive with the coaches. They do not "know" the specific qua1ities. They either "have it" or "they don't". seemed to have more of the magic than the others. His princip1es are wel1 hidden in the Packer tape. People get so hooked on content and feelings they miss the principles. Some fine day, when it is possib1e to get most of the FC faculty together I will do an "in house" run of the Packer tape to see if they pick up princip1es. If my guess is accurate, they will miss the theoretical principles.

A1so in the 1950's, I became interested in the qualities that went into the selection of the origina1 astronauts. That was the reverse side of pro football. It had to do with individual qualities and NASA was shooting blind, doing a lot of conventional tests in the hope they would choose right. They did okay, but the process could be refined better.

Last Thursday night, we did a review of the biography at the 3rd Thurs mtg. Hidden in her little biography are princip1es that I believed guided her thru the maze of genetic detail to a Nobel prize. As expected, the audience focused on content rather than process. Even my faculty was caught up in the run toward the pile on content. Maybe my expectations are too high. I had hoped the theoretical orientation of the facu1ty would enable more of them to ferret out principles from the content.

The thing about Green Bay and "coaching" is merely one fragment of theory. Eventually I will do a brief write up to go along with the pictures to let people know my interest was theoretica1, and that I am not a PR man for the Packers. The statement should help them focus on process and not content. The Packer tape is loaded with hiddle principle from Green Bay, from Lambeau, and from . I will send a copy of my statement. That should alert faculty to look for principle that goes into content. Sometime after that I will do a showing of the tape to faculty to see if they can ferret out principle. I will let you know what happens. There simply have to be a few people in this world who can see beyond content.

I shall regard the tape as private property, not permit it to be reproduced, and never shown without my personal supervision. If the enthusiasm in my previous letter conveyed something else I am sorry.

Sincerely,
Murray Bowen, M.D.

# GETTING IT VERSUS KEEPING ON, KEEPING ON

## Getting It Versus Keeping On, Keeping On

People entering graduate clinical programs are motivated by wanting to "help people who need help." Graduates of these programs have been indoctrinated with a certain language—"helping", "change agents", clinical expert", etc., with mostly unclear assumptions about responsibilities for the therapist and for the patient. There is very little examination and exploration of theoretical concepts and the thinking principles that drive one's clinical efforts. Some graduate programs do recognize the importance of examining one's own history and life course; some even require the student to have their own "treatment experience." This was the clinical context when mental health professionals began to hear the "new" phrase "family psychotherapy." It was the therapy part that attracted their interest. The clinicians observing and listening to presentations from the first generation of family therapy leaders were watching for techniques to use in their own practice. Training programs reflecting various schools sprang up throughout the country. There was a heavy experiential emphasis. Trainees would take turns being the therapist with other trainees being "family members." Trainees would take turns treating a live family while the other trainees would observe through the one-way windows. One tool was for the therapist/trainee to have the listening device in his/her ear and the observers would give suggestions during the therapy session. Then the early years of the family movement chapters were written describing the various "schools" (e.g., Phil Guerin)—Bowen, Ackerman, Whitaker, with some attention to the history of the evolution. But for most clinicians moving toward being a family "therapist" there was little "thinking about thinking." Questions at conferences, for the most part, focused on asking about therapy and "why did you do that?" This level of focus and interest continues in this direction. Conferences that focus on emotional processes and principles, with minimum clinical focus, do not draw many attendees.

Dr. Bowen's letter of January 1985 to a director of a training program, where he had recently presented, addresses a number of important themes that are not usually considered—the historical record, the continuing struggle to focus on the theoretical concepts and principles within these concepts, the forces of subjectivity and distortions, and integration of the processes of theory development with the efforts with one's own family emotional process.

Jan 22, 1985
4905 DeRussey Pkwy
Chevy Chase, MD 20815

Dear

Most of my time the past two months has been spent trying to modify some of the outlandish distortions about the extended family, as a way to bypass the years of meticulous training that goes into psychoanalysis and psychotherapy. I played my part in the distortion, but it was a minor part in comparison to the massive simplicity of others who followed in one horde after another. Each horde made it simpler, easier, and quicker. Each taught dozens more. The hallmark of success was to report a mass of genealogical-emotional trivia in a training session to prove they had "differentiated" a self. My own fairly secure faculty began to slip toward the simplicity of the masses. I was more and more alone, even among my gutless faculty. The professional world became a giant hoax no longer correctible at Gttn. My own faculty became as hoax-ey as the masses wished.

I simply cannot say how much I have slipped, but I have tried to maintain each of the many variables, without simplistic opportunistic, short circuiting any one of them. Some realized they were "off track" and they'd come with family diagrams in hand, believing that a few sessions of "personal supervision" would modify their giant hoaxes. Mostly they have been more victims than benefactors. They believe their long term hoaxes and a few personal hours can do no more than modify a variable or two.

As it stand now, I have made 2 major contributions, (1) the family diagram, and (2) the importance of the extended family. They will stand forever, despite the efforts of the masses to distort everything else. I am going back to "square one" to redefine everything from the beginning and to present it in logical sequence. This effort is more for me than anyone else. I do not plan to re-write anything that has already been written, but I probably will try to write those things that are new, and to touch on those most distorted. Periodically, I will try to put some major principles into BCC teaching tapes. The various sessions are ONLY for those with open minds, who do not know everything, and who are most capable of dealing with mass distortions as they grow greater and greater. That has been my formula the past few months and I expect it will continue. I am still looking for a few faculty and staff people, and a few important others who can KNOW the difference, and who can operate from what they know, instead of their own distorted version of my variables.

There was one glaring error in the thing you gave me to read last October. I intended to mention it when I was there, but forgot. Since then reality has interfered with my writing. You said "family therapy" began with the thing I did about my own family in March 1967. There were some 100 to 150 family therapists there. It is factual that I had been

"thinking" extended family for years before the start of formal research in July 1954; that I developed my own method of family therapy during the Summer of 1955 (I had never heard of it before); that my already worked out plan for family therapy was operationalized in November 1955 when my first full family was admitted; that 3 or 4 of us began to hear of the "family therapy" effort of the others during 1956 (I have written about this and how we each worked in isolation from the others until 1956. started in 1951 but did not attend a mtg until about 1959. did not write about it until the early 1960's. I had fooled around with patients and parents in Topeka in 1951. had written a paper about families in 1937 in the KS Med Journal but there was no therapy. The important people in those early efforts were and . I organized the first Nat'l Mtg for Family Research at Ortho in Chicago in March 1957. It included from Boston, from Houston, from New Haven, and Bowen from NIMH. Amongst those, I was the only one who had an active Fam Ther program as part of my research (I was already doing fam ther in my outpatient work). I used the term "family psychotherapy" in that Ortho Mtg in Chicago in March 1957, <u>following which Fam Ther took off as a technique rocket.</u> THAT WAS THE FIRST TIME THE UNDERCOVER OPERATION BECAME AN OPEN OPERATION. At the Amer Psychiatric Mtg in Chicago in May 1957, the meeting was crowded. In only 2 mos the "word" was out. was there, an officer at the session. heard about it and listened in. At the Ortho Mtg in NYC in March 1957 it was standing room only. attended that mtg, her 1st national mtg. Fam Ther was really fueled by the spring of 1958. The takeoff was exponential.

Before 1957 there were two groups, (1) the <u>researchers</u>, who were a little more legitimate, and (2) the <u>undercover clinical empiricists</u> who dared not tell others. <u>I was the first to be a part of both groups.</u> When I mentioned "family psychotherapy" at the March 1957 mtg in Chicago, the fam therapy thing exploded. There are reasons why the explosion came in March 1957. I have written about that. I was the main player in that. Others may have other stories BUT I WAS THERE.

The presentation at EPPI in Phila in March 1967 was another story. <u>That was the first time that extended family, one's own family, family research, and family therapy were all integrated into a single body of knowledge.</u> I had been "thinking" extended family and using it since the 1940's. I was dedicated to the principle of solving one's own problems (psa) before attempting therapy.

I was always foiled in the effort to do more than that dictated by psa. After the NIMH research began in 1954 I developed the FAMILY DIAGRAM. <u>That was essential.</u> Every principle developed in research was tried on my own nuclear and extended family after 1954. Others were too involved in developing family therapy after 1957, to even think of extended family. I had an active family therapy practice after December 1955. The framework of my basic theoretical concepts were developed in the 1956-57 period at NIMH. Extended family ideas were in everything I did. I moved from

NIMH to Gttn in July 1959. Then came the problems of "fleshing out" the concepts developed at NIMH. In 1959-1960 I put hundreds and hundreds of hours into a microscopic review of 3 clinical families.  was a workhorse. By 1960-61 I set out on a genealogical exploration into my own family, which I had been trying to do for other families.

The yrs 1961-66 were productive for practice and working on the various concepts of the theory. I did an awful lot on family genealogy which got me absolutely nowhere. Each time I went home I would gain a millimeter. I had developed interlocking triangles to the point I was doing a pretty good version of "paradox" or "reversal" therapy. I was not at all pleased with the inability of professional people to hear more than technique. In 1965 I agreed to do the Comprehensive Psychiatry paper. I worked 6 mos—more muddle. I could not do that paper until I had integrated the concepts. I asked to be excused from the paper. After a few mos they sent an emissary to ask me just write down what I knew. Almost another year of day and night and weekends on the proposed paper. It finally "went together" fairly well. I used up half of the family vacation to get back to the final draft and get it into the mail by Aug 1966. I intended to write it all better when I had time. Totally exhausted, I went home for the family vacation I had promised.

The family was in a turmoil but I could see better. I accomplished next to nothing on that trip but I had learned a lot about interlocking triangles in my own family. The learning came from the 1½ years on that paper. From Sept to Dec 1966 there was a series of events in my family that revolved around the sudden death of a sister-in-laws brother. I was already scheduled to go back home on Feb 1967 in conjunction with a medical school reunion. From Sept 1966 to Jan 1967 I spent hundreds of hrs drawing interlocking triangles and letters to those who headed each triangle. <u>NOT ONE DAMNED THING HAD ANYTHING TO DO WITH GENEALOGICAL STUFF.</u> Instead of chasing triangles, I touched important people personally to try to cause them to come to me.

The showdown came Sun afternoon Feb 12, 1967. I was invited to a family living room where important people had gathered to focus on me. By the time we were 30 mins out I was jubilant. I had expected to gain another inch in my circuitous 12 year effort. After untold times of gaining a little on each visit, I expected future visits to be the same. That time I broke completely free of the emotional barrier and made a touchdown on the first play. An important part—I had spent years on my solitary effort without telling a soul. I finally knew my way through the emotional barrier, which is the family, <u>and all that implies.</u> I have written many of the details.

To check my assumptions, I <u>secretly</u> planned to do the same thing on the "family of family therapists" at the mtg in Phila where I was scheduled to do a position paper on March 18, 1967. A month went into that but I had a blueprint to guide me. That worked exactly like my parental

family only a little better. I was “on target” with a paper about family of origin; the first paper about one’s own family; and a blueprint for using the family of origin (the subjectivity of the family of origin) to bypass 500 or 1000 hrs of psa. People have heard what they wanted to hear. It is easier to get 1000 hrs of psa than to venture into the arena of the family of origin. The whole field has become a shambles. People do no more than I had done by 1962, to assume they have bypassed the need for individual therapy or psa. Even the most thoughtful people had done unbelievable misinterpretations. People even teach courses about the extended family, with no more than a guess of what it is about. One big training center with over 200 students requires that each graduate “read” the paper I did. They consider themselves experts. Even my very own faculty has been lulled into simplistic complacency by the crappy assumptions of students. People assume they are free to bypass individual therapy and psa, simply because I said so. People get the family to emoting about death and assume they have done something. People find patterns from the past that are present in the current generation, and blithely assume they have learned something.

This is a long way around to one point, which was your paper that family therapy began with my presentation about my own family. Maybe you meant to say that the focus on one’s own family began with my paper, which was presented 5 yrs before we wangled through the stuff before the paper was published in 1972. I remember you saying you did not know much about history. You can say that 4 or 5 times, and then class it with sayings.

I did not plan to write this much when I started, but here it is. I am currently trying to help the shambles by going back to “square one”. I will keep on trying, but I do not expect the world to be any different than it already is. As it now stands, my major contributions have been the family diagram which goes back to about 1954, and the importance of the extended family, which was highlighted, after 12 years of trial and error, by the presentation about my own family, which was done in 1967 and finally published in 1972.

Whatever you are doing in is probably better than what the average is doing across the nation, and beyond. I will see you when I see you.

Sincerely,

Murray Bowen, M.D.

# THEORY AND HEARING

## Theory and Hearing

What makes it so difficult to hear what the other person is saying? This phenomenon seems to occur on multiple levels. For example, one is already focusing on one's response before the other person finishes speaking. A therapist selects certain data (plus his own subjectivity) to define a "disorder" in a patient. The analyst interprets the dream of the patient, based on his theoretical reference. One hears as "criticism: when the other disagrees with what one says. When a spouse doesn't go along with the other's position, the response can be "you don't seem to care anymore about what I think – do you still love me?" or "Bowen is really just talking about transference." Much of the current level of scientific thinking and selected "facts" drives treatment protocols, seldom questioning assumptions, and ignoring or discounting data that questions the prevailing practice.* There are clinicians who say they practice from a systems perspective, but when they describe what they are doing and how they are conceptualizing what they hear and see, it reveals that not much has changed in their thinking–it's individual dynamics, pathology, and diagnosis.

Dr. Bowen's letter of January 1981 is a response to a colleague at a training center who had requested a Family Center Report featuring Walter Toman. In the letter, he discussed how hard it is for people to hear anything that doesn't fit into their present/existing way of thinking. The not hearing is often accompanied by an attack, much like the spouse who is "feeling" not loved anymore.

* See Nortin Hadler, M.D. *The Last Well Person*, McGill-Queen's University press 2004.

January 9, 1981

Dear

It has been busy around here. I went home immediately after Xmas and went to see her mother, who passed her 87th birthday this week. No way we could both go to Tenn and also to Texas. My mother is hanging on, at almost 94. will return next week.

Sorry to hear about you having to go back to chemotherapy. On the positive side, it may have to do with the courage of your oncologist. Maybe you can stay with it and force your body to adapt.

I had a memorable experience using poisonous drugs at the 95th Gen Hosp in England during WW II. I was Chief of VD and syphilis was rampant. Until that time the only effective treatment was the arsenical drugs, used in small doses over a long period of time, because arsenic is sort of poisonous. Result was that syphilis became latent, but lifelong. The Chief of Syphilology for the Armed Forces was a great man from Philadelphia, Dr. . He devised a plan to put 3 yrs of therapy into 3 wks. It was called "Intensive Arseno-therapy". Patients put into the hospital, with liver and kidney checks every day, and a dose of arsenicals every day that equaled an average monthly dose. Most soldiers tolerated it very well and the percentage of complete cures with new cases went into the 80 to 90% range. My job was a tight wire act. If the kidneys or liver began to fail a little, there was the decision about continuing. Experience provided courage to proceed with things we would never have done before.

The Intensive Arseno-therapy was a major medical breakthru that was never really recognized. Penicillin came out in the middle of 1944 and everything shifted to that. Early penicillin supplies went first to the Armed services, first to serious medical problems and then to VD in the Armed Services. It was some months before there was enough to release to the civilian population. Anyway, the world never really heard about the innovative method developed by Dr. . I remember one Sergeant who had 2 chances (2 new cases of syphilis) in less than six months. Evidence of a complete "cure" each time. That experience taught me that the body can handle far more toxic substances than we ever believed was possible. Not many people were involved in that arsenotherapy program - maybe a dozen of us, each based in a separate General Hosp classified as a "VD Center". That was 37 years ago. Maybe some of that knowledge has filtered down to the present generation of "chemo" therapists who are many times more sophisticated than us fumbling Army doctors in 1943-44.

Your request about the Toman edition of our Fam Cntr Report was passed along to . She is the editor and business manager for the whole operation. She collects the papers, does the editing, does the contract with the printer, keeps the lists, does the mailing, etc. We started with a small report devoted more to mini-papers about our professional activity than the kind of things that usually go into newsletters. It was planned as a free mailing to a relatively small list of people close to the FC. The Report grew, the mailing list increased, and costs went up. Then we opened it up to new subscribers for $5 a year for five reports. Now that has to change The direct cost for each Report is now in the $1.20 to $1.25 range and we are not getting back our direct cost (to say nothing of indirect costs) from the subscriber group.

We will have to decide soon how to handle the Report. and have invested much time and energy into the effort to get the Report on its feet. I am still insisting we absorb as much of the cost as possible and we go slow in charges until we can produce a quality mini-journal on schedule, without too much sweat and bother. A letter has to go out to subscribers very soon. I want to keep up the complimentary list for our good friends and to a few people at the various places our faculty members go to speak. This includes you at .

I did not anticipate the response to Vol 2, No 3 about the Toman meeting. I discussed your request with and suggested she do whatever we can do for you. She got 1,000 copies of that Report, mailed out about 750, and still has about 225. She says she could spare about 100 copies for you. A second choice would be to have our printer to do 300 new reports for you. She guesses the printer would charge about $1.50 for that low number. A third choice would be for you to get the Report reproduced there. You can probably find a printer or a reproducing company who would do it for less than our printer. In that case why don’t you proceed and send us whatever royalty you think is appropriate. We have continued with our regular printer here who saves us time by doing layout and all kinds of things we would have to do with a less expensive printer.

You have my permission to proceed however is best for you. That includes permission to reproduce the Report there.

The Toman meeting last October was an effort to give Walter some recognition, of which he has had all too little. There are a few scattered birth order facts that go back perhaps 100 yrs. He was the first to “put it all together” with his first book in 1961 that culminated years of research. I had worked a little on this in the

1950's with schizophrenia but had bogged down. Walter started with "normal" families and he came out with a precise "system" that made predictions, all things being equal. I read the book immediately and by the end of 1961 was using it in both theory and therapy. By now it is so much "old hat" to my people they do not recognize its importance, or what the world was like before Toman. I was one of the few to do an enthusiastic review of his book in the early 1960's. His career has paralleled mine in many ways. We talked about that on one of our teaching videotapes when he was here in October His work started others in the field and, over time, he is often not mentioned in bibliographies. A couple of years ago NIMH had a task force evaluate the scientific validity of birth order facts. It was a thing of beauty. The Ph.D. researchers reviewed mountains of literature, from their conventional model of scientific method and concluded there was no substantive scientific validity to the concept. Toman was not listed in their bibliography.

The task force appeared unaware of the variable I have called "differentiation of self" in which the characteristics of any person, in any sibling position, can vary from the immaturity and childishness of major mental illness to the highest levels of maturity and responsibility. A beautiful example of the "blinders" automatically worn by the highest experts of conventional theory. This body of experts, assembled to evaluate this fairly popular "new" field and present the findings in an authoritative Public Health Monograph. I wanted some extra copies of this final authoritative word, a little Monograph, or maybe they called it a Report, for use in our training program. It is about 10 pages on 9 x 7 paper for sale at the Gov't Printing Office. Such copies used to cost 15 to 20 cents each. We ordered 100 copies that cost $90.

Another story conveys a beautiful picture of the way the mental health professions have regarded Toman, and also my work. Over the years Toman has come to Gtn many times. I was totally intrigued by the head of a man who could write "Family Constellation." He has been a guest in our home many times and and I have been guests of Walter and in their home in Erlangen, Germany. Erlangen is a sort of suburb or small sister city to the ancient Bavarian capital of Nurenburg. The Univ. of Erlangen-Nurenburg has one building on the public square that dates back to perhaps the 15th century and a sort of large campus of the most modern new architecture. From Erlangen, one can look toward Nuremberg and see it, like the magic city of Camelot, high on a distant hill, 6 or 7 miles away. Nurenburg has ancient cathedrals that go back 1,000 yrs mixed with some of the most modern rebuilding of the downtown area.

Walter and lived in Boston about 15 yrs after WWII and then they returned to Germany to be closer to in Vienna.

In the early 1950's , was about to invite Walter to Harvard for lectures. Walter's factual data about birth order can "predict the future" ALL THINGS BEING EQUAL. orientation considered each child to be born "a blank slate", with the final personality determined by experience after birth. (This is still the prevailing basic orientation in psychology and psychiatry). could not stand Walter's ideas about "pre-destination" and Walter never got back to Harvard.

The professional world still does not comprehend all these FACTS about the early days of systems theory. Walter is loaded with stories about his early experiences. Walter has never really understood my systems theory, but in the 1950's he DID develop an almost perfect systems theory about "birth order", all within the basic framework of psychoanalysis. These facts have never been spelled out in print. While Walter was here last October, I did a color teaching videotaped interview with him in which the entire 1 hr interview was designed to highlight those facts. At least there is now some kind of record of the early days entitled, "Murray Bowen with Walter Toman on Sibling Position". The award I gave Toman at our Symposium last October was designed to recognize the early genius of an important pioneer.

In my writings about my concept of sibling position, I presented it very briefly, as if everyone had read and understood Toman's book "Family Constellation". Slowly I became aware that very few really made contact between what I was doing, and what Toman was doing. I think his 1961 edition is the classic. I am running off the page.

This epistle has to end so I can go on to other things.

I hope your present sojourn with "chemo" is profitable. Will be thinking about you. Let us know how you want to handle the thing about our last Family Center Report.

For now,

Murray Bowen, M.D.

# CAN FAMILY SYSTEMS THEORY AND THERAPY EXIST OUTSIDE THE WASHINGTON, D.C. BELTWAY?

## Can Family Systems Theory and Therapy Exist Outside the Washington, D.C. Beltway?

The environment one works and lives in never has been known to be but so loving and accepting. Clarity and focus on one's beliefs and values has never been of much interest to the environment and the powers that run it. A tension exists (between self and the environment) with it being less anxiety-provoking to do either/or rather than both/and. Cutoffs from the connection with the environment are a short-term remedy but the environment usually takes its revenge, usually when one is not looking. Becoming one with the environmental forces is the least anxiety-producing adaptation. But how does one know when one disappears? (Don't despair, there's always politics as a career alternative.)

Can there be a clear and sustaining focus on principles without one's anxiety turning into dogmatism and arrogance? How important is an organizational structure that is supportive and "understanding" How does one account for some followers of Freud to be more "Freudian than Freud"? Does one have to be a missionary of the good word? What turns the "good word" into the only word?

Subjectivity is always at work. Hearing and perception always take place in and are processed inside one's brain. Students of Bowen theory seem to hear different "versions." Perhaps the best that can be hoped for is to be respectful of the role of subjectivity and not pretend it doesn't exist, and not pretend one is "objective."

Erosion of one's clarity in thinking and practicing systems is a common experience once one leaves the Bowen atmosphere at Georgetown, as a trainee returns home to the real world.

Dr. Bowen's letter of April 29, 1980 is a response to a trainee's report, observation, and questions after returning home. As usual, he doesn't offer solutions to the phenomena, but he does articulate some of the key principles involved in one's effort of making family systems theory an integral part of one's thinking.

April 29, 1980

Dear

Your letter came today. Thank you for a wonderful report. You probably are better able to see the systems in your homeland right now than you will ever be able to see it again. You are fresh back from having been away a long time and from having been well schooled in another way of viewing the human struggle. Make lots and lots of notes now, so you can have a reference for the future. With each passing day you will become a little more indoctrinated back into the old system. Your new orientation can fade so fast and so subtly you never notice the fade-out. Tomorrow you may not be able to remember the observations you would have recorded today.

Now, what are you going to do? Or how do you go about trying to establish a "systems island" in that can remain definable and identifiable and viable when the winds and rains and sun and snow and all kinds of other forces are constantly eroding the structure. How do you go about getting a partner to help you maintain the identity of the structure when the partner never really agreed with the structure in the first place. was one who maintained a reasonable facsimile of his structure by staying in his office, with his license, and refusing to join the APA or those other people who insisted on some modification of the structure before they confer acceptance. How are you going to maintain a structure when you are unsure enough in the beginning, and all others insist you are wrong? How far can you trust your own head when the logic and reasoning of all "important others" seems so logical and right? Do you modify some small detail in one place to pacify the opposition and gain acceptance into the professional world, or do you risk rejection by the profession over some piddling detail?

I had high hopes for you in the beginning. I still have hopes. You have no better compass than your own head. How far can you trust your head when the opposition KNOWS your compass is wrong. On the rightness of your compass, and your ability to trust your own compass, this life endeavor depends. The Georgetown Family Center will be watching with an abiding interest. If your life effort succeeds, we will be interested in the phenomenon. If your life effort is half successful, that will be of interest too. If your life effort falls on its face, like most life efforts, that too is of statistical interest. Now we are down to Faith-Hope-and Prayer, to be employed only when one's head jumps out of gear and the only asset is trust and hope. The Family Center is contemplating the formation of a Committee on Faith-Trust-Hope-and Prayer for those who lose their way in family and societal systems. The FC aims always to support its own. The regular people are always available for consultation as far as they can go. When that fails there is always the Committee of FTHP. Lest you should ever doubt.

As usual,

# “PERSONAL FEELINGS IN A FACTUAL WAY”

## "Personal Feelings in a Factual Way"

In the 1970's, Dr. Bowen made a videotape at Medical College in Virginia in Richmond, Virginia on "Family Reaction to Death." The tape continues to impact on the viewer. One is confronted and challenged by one's own anxieties, biases, and beliefs. The confrontation, which is triggered by the tape, comes from one's own uneasiness over the lack of clarity in one's thinking about the place of death in the process of the "living." American culture and its institutions don't help the confusion either. There are scores of questions that are right below the surface and one prefers to keep the questions there rather than take responsibility for clearly thinking about one's position, then matching congruent behavior with the thinking. What is one's responsibility to one's parents? What criteria does one use for decision making, e.g., driving, power of attorney, living wills, nursing home placement, selling the home? How does one manage the lack of consensus among the children? What does one put into the responsibility of "seeing it through?" Are the "last years" an important part of the living process or separated out as a burden to be tolerated, hopefully not to last too long? When does "she's in a better place" really mean "I'm in a better place"?

The lack of clarity also applies to how the individual defines one's responsibility to self. Does this responsibility terminate at retirement. What is one's responsibility to the gift of being alive? Does living stop at a certain age? Does one become "resigned to life?" Will the increasing "ailments" define self? When does one stop learning? When does one stop being open to the environment? Can one maintain an aesthetic connection to the environment? When does one stop "giving something back"? Answers to these questions are usually implicit, but can be observed as well as the emotional consequence of the answers.

Dr. Bowen's letter of March 1989 describes the experience of doing the "tribute" for his mother-in-law's funeral services. The challenge is to "hear" his last sentence.

March 11, 1989

Dear

Enclosed is a copy of the “tribute” at my mother-in-laws funeral, and a xerox of the funeral program prepared by the church. The tribute was a continuation of previous efforts for my own father, my mother, and my mother’s brother who lived in our home for many years. My mother-in-law heard about my effort, and asked if I would speak at her funeral.

The clergy commonly dampens personal feeling, and substitutes religious ritual. My theoretical posture is to deal with personal feelings in a factual way. Everyone seems to profit from the latter. Several from Georgetown have tried to use my posture in funerals with their own family members. Whether they misestimate their own emotional control, or religious protocol, the clergy often prohibits or controls what a “relative” can say. It even happens in situations in which multiple family members say a few words. There is a relationship way beyond the impasse.

The funeral of my mother-in-law sort of combined religion and psychology. The funeral was delayed several days until she could be moved from the place of death, to “home” near the oldest daughter, who was a member of the congregation. The oldest daughter made plans with the church. The funeral program was given to each member of the congregation as they arrived. A xerox is enclosed. The pastor began the funeral with a few short readings from the scriptures. That was followed by “How Great Thou Art”, which has become sort of standard in Christian funerals. The organ played the music, a clear soloist did the verses, and the choir boomed the choruses. It was my time before I realized what was happening. The content of my remarks set the stage for the entire funeral. By that time the congregation was involved in the feeling process. Everyone in the building sang, “Abide With Me”, with great feeling. The pastor then closed the funeral with a mixture of religious readings and extensions of comments I had made. An open casket (common in that area) provided an opportunity for the congregation to pass the casket (  looked more like 70 than her 95 years) briefly with the extended family. After the funeral there was a “reception” at the oldest daughters house, attended by over 100, with food prepared by women from all over Texas.

The funeral for  just happened. It was about as personal and effective as those I had already done for my own family in Waverly, Tennessee The pastor permitted me to say whatever I wished. Toward the end of his service, the pastor regretted the distance that permitted him to know her by reputation, rather than personal contact. When I combined psychological and religious process, it helped make the past generations into a living part of the present. No one left that service the same as they had been before it. It was not easy for me, but it was good for me too.

Sincerely,

Murray Bowen, M.D.

P.S. I am looking forward to your “Evolution” conference in Anaheim 1990.

# ANXIETY, PROCESSES, AND DIFFERENCE
# "I'M RIGHT, YOU'RE WRONG"

## Anxiety, Processes, and Difference
## "I'm Right, You're Wrong"

George Bateson wrote in "From Versailles to Cybernetics," a chapter in *Steps to An Ecology of Mind*, about the impact on the world's future events when a quality of thinking or attitude is inserted and becomes a part of the thinking process of the culture, which then guides one's assumptions and perceptions about the world one lives in.* A quality of our thinking that permeates much of our thinking and behavior is "either/or" dichotomies. It can be subtle or it can be blatant. The world becomes divided into good guys/bad guys. This thinking permeates religions, cultures, and immigration policies. In relationships the behavior and thinking is one is right, the other is wrong. The other needs to and should change. This way of thinking surfaces in clinical settings: physician versus non-medical therapists, patients versus families, hospital staff versus patients. Differences (in whatever context) can become alienating. Inclusiveness is not part of the brain's "bias," to use Bateson's metaphor.

This thinking characteristic may have been a part since the beginning of time, necessitated by biological survival forces. It was important to be able to make the distinction between external potential threats (the enemy) and family and "friends." Likewise, it is important for the individual's immune system to have the capacity to make a distinction between self and non-self. Failures in this capacity can be life-threatening if the "either/or" distinctions are not made.

These processes of anxiety, external forces, and escalation play out in the larger worlds in which all people live. How these processes are managed impact on the survival of the societies that make up our world.

Dr. Bowen's letter of July 1980 is a response to a letter from a colleague who had written him about "rabble rousing feminists." He speaks of connections between anxiety, escalation, and "regression" in society.

*Bateson was speaking specifically of the impact of "deceit" becoming a built in part of one's way of doing business.

July 14, 1980

Dear

I wish I had plenty of time like you to write all those great letters. I liked your piece on “Rabble Rousing Feminists” in the current AMNews.

APA has had a problem with ERA and conventions in non-ERA states. In 1978 there was stuff about the meeting in Atlanta, non-ERA. This led to a referendum of the total membership, anticipating New Orleans 1981. The membership approved New Orleans. The APA now has about 25,000 members.

was the most vocal of the several radical types doing demonstrations. They started early and continued late. One morning I was awakened by with a bull horn holding a rally of her troops on the street alongside the S.F. Hilton. has a past record on equal rights stuff. He sort of cozied up to . Then, with chairing the meeting, the Bd of Trustees (about 18 with representative of all the district branches) voted to change the 1981 mtg from New Orleans to Anaheim.

A lot of members who voted for N.O in the referendum last year were sort of angry that a small Bd of Trustees would presume to cancel a referendum. Then our APA lawyer got into it. He is also our lawyer for my small Amer Fam Th Assoc and I have come to know him well. He said the Bd of Trustees was not only out of order but ILLEGAL in reversing a referendum, that the APA would become the object of a multimillion dollar damage suit by N.O., and that he did not want the job of trying to defend the APA in a suit in which the APA was clearly illegal. Much turmoil and many red faces in the APA hierarchy. The decision was quickly reversed and now New Orleans is ON. Companion organizations such as the Amer Psychoanalytic are meeting in Houston. For 25 yrs the companion organizations have met in the same city a few days before the APA.

Another recent story from a small society of Animal Biologists, meeting in Ft Collins, Colo. Their 400 or so members meet on college campuses where they can get low cost dorm rooms and cafeteria food. A year ago they voted non-ERA. This year one of the impassioned ones wangled another vote on the same issue. The chairman permitted another vote which went non-ERA by about 52%.

The meeting droned on into the lunch hour and people began walking out to go to lunch. At the very end of the meeting the passionate radical wangled another motion for an ERA vote, the Chairman let him get away with it, and the group finally passed a pro-ERA vote. This is the degree to which the radical ones brow beat the more stable majority into instability. I think it is a beautiful example of the step by step process that operates in families as a delinquency prone youngster starts working on his family and the unsure family give in to settle the argument.

Since the early 1970's I have been writing about this as "Societal Regression." I have postulated the whole thing to be the product of increasing societal anxiety which results in the radical ones becoming more persistent and the more stable ones less sure of themselves. I have postulated the increasing anxiety to the product of population explosion and a decrease in world raw materials necessary for the human to continue his way of life on the planet. In a more normal society, the regression and progression cycles pretty much balance each other. Since 1965 our periods of progession have been brief and regressions have been long and serious. I do not see how societal anxiety can decrease until society goes thru a major crisis and I think our society is still resilient enough for us to avoid a major-major crisis for perhaps another two generations. The pattern of this is very clear in families and smaller social groups. Regression is turned around with a clearly defined leader who can take a calm stand without shouting or taking revolutionary postures. Regression can be turned around if the total anxiety subsides but our society is not about to take such steps as long as we can have our cake and eat it too. When the regressive element goes above 50%, there is no way a democratic form of govt can reverse the trend. The Supreme Court is now making more regressive decisions than progressive ones. And so goeth the world.

Did not intend to get into this when I started the short note. I think you get too much passion into countering the passion of the radical forces.

Have to go. Many memories of the visit on March 1 last Spring. Thanks for doing the letter that stimulated this response.

For now,

# THE “EROSION” LETTERS

## The "Erosion" Letters

In some ways these five letters may be the most important, especially for the people reading them. The letters of his last ten years seem to reflect a major concern and struggle with his own erosion. What are the dangers to one's life efforts (Dr. Bowen's) when a large part of the family professional world embraces Bowen Theory? Can one's self disappear in this acceptance phenomenon? Can self become the "same" as Bowen Theory? How do students and colleagues avoid this danger when one has tried to internalize into one's thinking a powerful and profound conceptual theoretical system and base one's practice from the theory?

Dr. Bowen raised these questions about himself. Would the past accomplishments define the future or does one's future have to be an ongoing effort? What is the cost if one doesn't pursue the continuous effort and struggle? One wonders if any one of his followers would have raised these questions if Dr. Bowen hadn't raised them about himself first. (Freud had a similar problem with his followers.) How does one know when one "disappears"? Is it automatic that one will disappear if one doesn't face the struggle? What is at the core of the struggle?

What is the nature of the erosion forces? These letters describe some of these forces, the nature of the struggle, and the necessity for the commitment to his principles. The pull of "togetherness and society" was the big one, but there are others, including: the seduction of popularity, arrogance ("I have it; you don't"), and complacency in taking the principles for granted. The observer in the researcher remains steadfast to the end; "you can't take a day off." Each of these letters has a brief introduction.

## Theoretical issues vs. Family Emotional Issues

Dr. Bowen's letter of August 1980 is responding to a person interested in the Georgetown Post-Graduate Program. She had written two letters to him, one applying to the program and the second withdrawing her application.

He raises questions about the difficulty and inherent anxiety in moving toward a systems theoretical orientation which necessitates a major shift in one's thinking. Some choose not to; some pretend they can do both (eclectic); some make a decision to move forward. He connects this theoretical process to the anxiety in taking on one's family emotional issues. He also ties these themes into the erosion of emotional forces.

Commitment to principle is a lifelong effort; erosion forces are always present.

August 1, 1980

Dear

Yesterday there were two letters from you in the same mail. The first was your application for the course, and the check. The second was your letter to rescind the course. I opened them in that order. I was sort of pleased to get your application, and not especially surprised to get the second because I know you have had a struggle within you about this course.

I do not have a very clear notion of your struggle with this issue. If it has to do with theoretical-professional issues, I would say "take your time" about deciding. It takes a lot of life energy and commitment to shift from conventional to systems thinking. If the course works, one can spend the rest of one's life being bugged by multiple life issues previously thought to be solved. If the course does not work, it is a waste of time and energy. If your negatives about the course have to do with professional unsureness, do not rush into the course. Let the situation season until it goes one way or the other.

If the negative about the course has to do with your own family, I would do the opposite of "take your time". I have been "there" with my own family and a few hundred others in the same kind of situation. It is easy to resolve to take up a difficult emotional issue, to spend a small fortune on a trip designed to take up the issues, and then to procrastinate until the last moment, and then do a lousy job under the pressure of time. There can never be a "right" time for crossing a "no-no" barrier. It is almost impossible to "coach" others to bridge the impossible when one has not done it in one's own family.

There are a hundred gray areas between the systems reluctance based on pure theoretical issues and those based on family emotional issues. I am not sure just how one separates the two areas. I can do more than point up a few facts for consideration. System Theory is a lifetime preoccupation. Don't sign on unless you are prepared for the ride. Do not fail to sign on if they problem is one's own family. Do not be swayed by anyone. I am not twisting arms nor selling anything. It is necessary for me to be in an "I do not care situation" in order to be effective. I have spent a professional lifetime assembling the most differentiated faculties that discipline has enabled me to assemble. No one else has come close in this endeavor. My faculty is a thing of beauty. Most are still working as I did, guided more by principle than promise of material success. People in the "family" world are wondering if my life principle will live after me. I think it will and that the principle is strong enough to see it through. The majority of family people is guessing that my world will disintegrate, like the worlds of and . Time will tell. However the future is decided, and wither we die or live into the long distant future, I have assembled quite a crowd of great system thinkers into this faculty of mine. There is always the pressure on me to relax the discipline about differentiation, and I am eternally

confronted with the issue of whether my effort to maintain discipline is in fact discipline based on knowledge, or whether it is emotional rigidity in me. The societal forces would have the world believe (societal forces in our era go toward undifferentiation) that my "so called" discipline is in fact a "pathology" in me. And so it has gone around every decision for the past twenty years, at a time when the world is slowly regressing to a lower level of functioning. It is very easy to go along with the world. It is damned difficult to hold onto discipline based on knowledge when the opposing principles also appear solid.

I believe my faculty is solid as long as I am here to "ride herd" on it. I think it has enough discipline to maintain the structure after I am no longer here. Have been working on that for over twenty years.

I am merely free associating to my typewriter. The kind of debate going on within you is a familiar one. Maybe you can pick up a few ideas from this as you continue the debate for the next year.

Have about run out of steam.

Aug 5, 1980

Started this letter to you Fri eve Aug 1. Had several interruptions including family members leaving for vacations or returning from trips. Ended up watching the late evening news and never did get back to this. Then I pulled this sheet out of the typewriter expecting to finish next day. Too much going on everywhere since last Friday.

In re-reading this, I find a lot of detail about things you know already. I am just preoccupied with keeping the shop on a predetermined course. It happens every summer, while my people are making curriculum changes for the following academic year. There are always those who respond more to the popularity pull than to discipline. It keeps me on my toes to keep principle better defined than the erosive forces of togetherness.

If there is anything my crowd can do to lend a hand with you and your situation in let me know. You will have your own brand of problems as you build your own Institute with a crowd of divergent associates, each with a different view of the family world, with emotionally determined coalitions, political parties, and sects, that can go toward secession and splintering if popular votes is the determining force. I will be watching with interest.

There are pleasant memories of my brief visit with you and your group in June. Give my regards to and the children.

Sincerely,

Murray Bowen, M.D.

## Lag Time

Dr. Bowen's letter of July 1985 is to a director of a training program from which he had recently returned. His pattern was to write a letter after his participation in various training programs throughout the country, reflecting on current themes in his own thinking.

In this letter he discusses some of the "chaos" in the field, natural systems thinking and its difficulties, and how popularity and success breed erosion.

July 30, 1985

Dear

Enclosed is the airline ticket stub for my recent trip. Will you please pass it along to whomever on your board takes care of such.

The professional part of my trip went okay, as I saw it. I was glad to have been present for the party in your honor. It was recognition for the hard work that has gone into your operation.

You have a unique place, with good trainees who have inquiring minds. They may some day find their way through the present chaos in the field. I believe there are some factors to account for the theoretical distortion. A natural systems idea, only thirty years old, appears to be sound, but people are people. It takes time for people to shift from one thinking dimension to another. They have no option except to think with conventional theory. They hear a little, unwittingly mix it with conventional theory, and truly believe they have mastered the shift. Another factor is societal process. It becomes a "surge" when teachers, and the proprietors of systems ideas, are more influenced by popular opinion than their own diluted theoretical thinking. This process has slowly eroded Family Center faculty. It seems to occur more on the periphery when teachers do not have time to pursue their academic motivation.

This human process is massive. I have no way to "prove" that I have not been influenced by the lure of popularity. I do not think so. I developed the idea, I had the courage of my convictions when it was not popular, and I have tried to stay on course through the further development of concepts. I say this because critics say I started with an assumption, and anyone is entitled to an assumption. This may be a way to understand the lag time in accepting a different idea, and why the "dark ages" are still alive and well. Systems ideas have become popular in a few decades, but new variables such as population explosion, instant communication, and the resultant increase in the reactivity of the masses, may make it longer than the estimated two centuries before human behavior finally becomes a real science.

My main concern is the Georgetown Family Center. The past few years at Georgetown, and in my other personal appearances, I have tried to focus on critical issues between conventional theory and the ultimate potential of disciplined systems theory and therapy. I hope that I contributed something to your trainees. I believe you have erred in believing the Georgetown Family Center represents a standardized thinking orientation. That was a goal in the early days. Then came the lure of popularity and success, and the slow erosion of theory dictated by the reactivity of the masses. And so it goes when people are more interested in personal gain than the long term future of coming centuries.

Considerable energy went into reducing pages into the few paragraphs in this letter. I shall use the text of this communication in a few other appropriate places. It is an interesting world, don't you think?

Sincerely

(signed "Murray)

Murray Bowen, M.D.

## Theory vs. Therapy and Good Intentions

In a world so driven by subjectivity, how does one keep a focus on theory and not be pulled into the "feeling - technique orientations" in therapy that the mass of therapists want to hear? Good intentions can cause a lot of problems; wanting to be "helpful" can become a moral dilemma for the clinician.

Dr. Bowen's letter of November 1985 is to a director of a well-known training center, whose staff is more grounded than most in theory. Even in this center the "problem" is present, with participants not seeing that his therapy is driven by his years of "step by step" work on theory, attributing his demonstration interview with a family to his personal "magic." If he focuses his lecture on theory, he fears the audience will call the lecture superfluous. This letter offers the reader an opportunity to clarify one's responsibility as a clinician, and what drives that responsibility.

November 29, 1985

Dear

For weeks I have been planning to write but Yogi Berra keeps getting in the way. And he is a nice fellow, too. I heard the sign in N.Y. yesterday when the "new look" Jets shriveled in Detroit's dome yesterday. I was hoping they could make it. That was all because Detroit does not have to mow the plastic grass but once a year.

The January meeting time is better for me than December used to be. I always seem to get overlaps in December. The time with our outfit gets priority and I do not like to crowd the schedule. Come January 7, I will plan on the 10 a.m. EAL shuttle and plan to return on the 8 p.m. shuttle.

The past couple years, a tremendous amount of time has gone into basic concepts, which includes all the professional disciplines, differentiation details about emotional system, and the way the masses of mental health people are triggered into subjectivity and reactivity, in the process of reporting on their own families. The first awareness of "own family" reactivity came in the early 1970's when we no longer permitted more than one good "own family" paper in the yearly symposium. That was a drop in the bucket. Since then it has been devoted to our own faculty, to training, and the eventual integration of theory with science. The 1985 Symposium was among the best. Several former trainees are doing superior work on basic concepts. The whole thing came more into focus a year ago when who had a year of training in Pittsburgh, began his effort to put out a book of "own family" papers. Verbal cautions were unheeded. During the Summer of 1985 he began seeking permission to reprint papers from former Symposia. They had been printed in the paper back "collections" from the symposia. The Fam Cntr followed publishers protocol, and left the decision with individual authors. Most authors either knew why "own family" papers were avoided, or they deferred to my decision. kept on. I will enclose the copy of a letter I did to early in the fall of 1985. <u>See what you think!</u> Some peripheral people went along with who will publish his book. They see my objection as a personal peculiarity in me. They cannot see that every "own family" paper arouses audience feeling, which defeats the ultimate superiority of the therapy. Ho Hum. So goes the world. It is not much different from what was predicted 15 years ago. It will reduce Fam Systems Therapy to the levels of other therapies.

recent letter contained innumerable symptom manifestations of a feeling-technique orientation that does not know theory. I wondered how in the world she has a responsible position at . It was a little bit similar to the situation encountered at Gttn a few years ago, only more so. I wondered if she is an "anomaly" or if she represents the average at .If she is average, then you either have a conceptual problem, or you can join the other "techniquers". I wrote her a "kidding type" response which she cannot "hear", except to call herself "normal", and refer to me as a peculiar personality trait.

This leaves me in a big quandary about January 7. If I focus on theory, most will not hear. Most will hear my stuff either as related to a peculiar personality (all in me), or when is he going to get thru the superfluous boring details, and on to the significant stuff about family

therapy? If the focus in on a “case”, they see the result as some kind of personal “magic” which is strictly within me, rather than yrs of step by step work on theory. Most people want to “easy way out”, which is to build a house of cards on a foundation based on con--?

I do not know the answers to these monumental issues. Thirty yrs ago I was guessing it might be 200 yrs before human behavior could become a science. That estimate decreased for a time, but now it is up again, largely the product of societal forces. For years I have doubted the wisdom of more and more BCC’s as a teaching device. I do not know THE WAY, but I have tried to stay consistent with science and not waste energy on those who follow a more conventional base. It is a free world. People can go in any direction they choose, and I do not choose to be some “tin Diety” who monitors the thinking of the faculty.

A couple of yrs ago, I started a voluntary evening think tank for those interested in science and basic concepts. It is for “know nothing” people who can accept the notion that knowledge is deficient. This automatically includes a large group of faculty who assume they “know it all”, and who have done rote teaching. Some come once or twice and drop out. They say an evening for superfluous stuff is too much for those who already know it. The group started small but has slowly grown. Everyone has reason for participating, which is within self. If someone presents an abstract of a paper from Science or Discovery, the group gets restless or disinterested unless the presenter has a specific point to make. Overtime, a spectrum of rote faculty members have resigned. New teaching responsibility goes to those who have demonstrated awareness. I believe the new attitude at the Symposium this year was a direct result of the volunteer evening mtgs.

I am not about to know the RIGHT WAY. Learning is a forever thing that is far beyond the emotional reactivity of others. It is not a respecter of previous postgraduate training or sex. It is purely for those who can somehow KNOW, and who can sort through the mountains of details to find bits and pieces that fit the science mosaic. The group does not favor those OTHER DIRECTED people who are against the contribution of other authors. It is all for self and not AGAINST anyone.

I have no idea where we will come out. There may be as many misadventures in this effort to separate the wheat from the chaff, as there was in presenting the theory in the first place. Time will tell. At least it is changing the face of the place that used to be known as the Family Center.

Maybe you can see why I am in a quandary about January 7. If I did a lecture on theory, it would be called superfluous by too many, and would not get beyond their previously diluted baseline. If it was oriented around a live family, people could cover the cracks with a “magic” pronouncement that ignored the years of step by step effort. I am going to the Milton Ericsson conference in December where 6500 psychotherapists are trying again to capture some kind of Magic that belonged to Erickson.

Do you have any ideas?

Sincerely,

Murray Bowen, M.D.

## "…My Own Failure"

The last years of Dr. Bowen's life found his thinking focused on the erosion of the "impersonal facts of theory with personal feeling states." He held himself and his faculty accountable. His opinion was that "lag time" would decrease appreciably if he held to his unpopular position of theoretical accuracy.

His letter of May 1989 to a director of a training program with close ties to the Family Center offers his thinking about the subtlety of the erosion process–whether it be with himself, his faculty, or students in training programs.

A larger question not directly mentioned in this letter has to do with much of the "science" efforts in today's world, with results being reported based on unclear theoretical assumptions and concepts, and treatments being implemented on these inaccurate conclusions, again the erosion of theory in the therapy process.*

*See Norton Hadler's book previously referenced.

May 20, 1989

Dear

This is a response to your letter of May 12, 1989. There is a compilation about dates with in Green Bay June 14 thru June 16. I will return the late evening of June 16. is doing June 17. I cannot lend much of a hand to her because of fatigue. Maybe I could see you in Chevy Chase Sunday June 18. I have worked long and hard for this thing with .

In my opinion, you have a major version of the same "erosion" phenomenon, that has insidiously killed the Gtn Fam Cntr program. A copy of my "Erosions" paper has guided my effort since Jan 1989. Maybe it will contain a few ideas. In a few months, the Gtn Faculty has been reduced to a few. The Faculty is human too. It is a long hard road for the precision of theory to stand firm in the midst of popular subjectivity. It is all too human for people to "erode" the impersonal facts of theory with personal feeling states. When theory is eroded, facts like the "differentiation of self" is lost in personal mass of eroded theory.

The long odyssey in Kansas resulted in a completely new theory that bypassed much of the heartland of Freudian thinking. It produced a new way of thinking about the human phenomenon, including a whole series of new "concepts", never previously known to the profession. A "throw away" of that effort was a method of "family therapy", before the profession had heard about family therapy. THE PAST 35 YEARS HAVE BEEN SPENT IN TRYING TO COMMUNICATE THE DETAILS ON THE NEW THEORY. Most of that has been my own failure. Mental Health people pretended they understood. The erosion process was too subtle, and I was too busy to bother with details of training. Slowly there was awareness that theory was being bypassed; that Family Systems Theory was being taught as if it consisted only of a few concepts, own family, the loss that went with death, family diagrams, triangles, and squiggles on the board; that family therapy was little more than a technique appended onto a royal mix of theory that included much Freud; that all the previously discussed details about natural systems and the many forms of evolution, were being lost in the theoretical mush; and that I, and the Faculty must have played a part for so many graduates to get that impression. It was more than Societal Regression. I defined Societal Regression in the early 1970's. By the early 1980's I was wondering out loud. THE WORLD NEUTRALIZED THE THEORY AS IF IT DID NOT EXIST. In my opinion, it missed THE important point of the whole thing. It was present in the Gtn Faculty too. LAG TIME??? Who knows? GTN reacted as if I was an unrealistic fellow. They gave me lip service and humored me, but Freudian Theory was too fixed to be abandoned. got a few points in his book, BUT IT SERVED MORE TO FIX Bowen Theory, as if it was a simple extension of Freud.

May 21, 1989. Too weary to finish this last nite. Mental health professionals probably cannot change faster than "Lag Time" permits. If this be so, it might be decades before "lag time" catches up. How do I spend the rest of my life? Do I applaud the popularity of a watered down version, and increase the "lag time", or do I stay with theoretical accuracy? Obviously, the "Erosion" paper indicates I have chosen the latter. Lag Time will decrease appreciably if I stay in this popular position of theoretical accuracy. Your goal in is a little different from mine. Your staff is struggling for popularity. You have more awareness than the others, and you cannot change without them. I will send this copy of "Erosion" so you will know where I am. was a good experience for me.

(handwritten: Sincerely

Murray Bowen

## Principles and Saying No

With Dr. Bowen's increasing popularity and acceptance, many organizations wanted to recognize his importance and role in the family therapy profession. AAMFT wanted to give him an award at their annual meeting. He declined the "honor."

His files contain this undated letter draft. It is unclear whether this letter is a draft for even if it was sent. The letter was not finished or signed as all of his other letters were.

Principles are principles and if compromised they aren't principles anymore; again, his clarity and commitment.

Dear

The principles that gave me life on the planet force me to decline the kind offer of AAMFT for an award at your annual meeting in San Francisco this year.

I believe that some version of natural family systems theory may have more to contribute to the long term future of the human cause, and to all forms of life on planet Earth, than any development in the millions of years of evolution of the brain of homo sapiens. Perhaps the evolving human brain of the future may discover the natural secrets of the universe.

They are more involved in the immediacy of the human dilemma of this age than the future of the universe and life itself.

If my guess is accurate, AAMFT (and some other polarized family organizations) has chosen to be more interested in the immediacy of human affairs than the overall. If I accepted the award I would be perceived as agreeing with a future divergent with my own. Though good friends of many years have embraced the present course of AAMFT, principle is more important than the immediacy of human recognition.

As one fleeting form of life, on one tiny star, in one galaxy among many, I believe the evolving brain may someday know a tiny bit more about the universe in which homo sapiens is a transient passenger. To each his own. I believe my own minuscule life may contribute more to

# POSTLUDE - ONE LAST PRINCIPLE

## Postlude

Dr. William Doherty of St. Paul, M, taped a series of interviews with the "founding fathers" of the family therapy movement. These interviews were sponsored by The American Association for Marriage & Family Therapy. Dr. Doherty interviewed Dr. Bowen on October 6, 1990. At the close of the interview, Dr. Doherty asked Dr. Bowen, "Do you have any last words for us"?

Dr. Bowen responded:

OCTOBER 6, 1990

"YOU HAVE INHERITED A LIFETIME OF TRIBULATION. EVERYBODY HAS INHERITED IT. TAKE IT OVER, MAKE THE MOST OF IT. AND WHEN YOU HAVE DECIDED YOU KNOW THE RIGHT WAY, DO THE BEST YOU CAN WITH IT."

MURRAY BOWEN

After Dr. Bowen's words, Dr. Doherty asked if he could say "amen" to that. Dr. Bowen responded with a slight smile, "yep".

Dr. Bowen died on Tuesday, October 9, 1990 at the age of 77.

## Bibliography

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