CHAPTER 13

A Family Systems Treatment for the Impaired Physician

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Researchers in the field of alcoholism and addiction have criticized the disease model of treatment, with its narrow focus on the individual instead of the family system (Bowen, 1978; Kerr & Bowen, 1988; Lawson & Lawson, 1998; Morgan, 1981; Wallack, 1981). Such criticism is especially applicable to the treatment of impaired physicians and their families.

Recent research supports the notion that adults who have grown up in families with addiction have a tendency to choose careers in the health-care professions (Mansky, 1999). Vaillant, Sobowale, and McArthur (1972) reported that physician vulnerability to addiction correlates with unmet personal needs. According to their prospective study, doctors were more likely to experience problems with drugs and alcohol, require psychotherapy, and have marital problems than were matched non–health professional controls. In fact, Vaillant et al. noted that some doctors choose a medical career to help themselves by helping others. Vaillant et al. concluded that these doctors, dogged by their perfectionism, were dedicated in the extreme to the well-being of their patients, to their own detriment and often that of their families.

Gabbard and Menninger (1989) further concluded that physicians tend to be less happy in their marriages than those in many other professions. Physicians' long hours are not the *cause* of their marital problems, these researchers found, but rather, doctors' excessive work was often a result of their desire to run away from facing marital tensions. Emotional remoteness and withholding of anger are two of seven attributes of physicians identified by Ellis and Inbody (1988). In an early study, Martin and Bird (1959) characterized the troubled medical marriage as the "love-sick wife" and "cold-sick" husband. The notion that relationship difficulties underlie chemical dependency in physicians is additionally supported by the findings of Angres, McGovern, Rawal, and Shaw (2002), who found the percentage of physicians suffering from comorbid psychiatric disorders or marital discord to be 60.3%.

In his review of the psychosocial factors contributing to physician addiction, Coombs (1996) found that physicians were generally ignorant of the developmental and interpersonal dynamics of addiction. More severe marital difficulties have also been found to be highly correlated with physician addiction (McGovern, Angres, & Leon, 1998). Robb (1998) noted that medical schools typically do not include training in alcoholism and addiction. It is alarming that physicians are not trained to recognize or treat signs and symptoms in their patients or in themselves.

This chapter presents a family systems treatment for the impaired physician based upon Bowen Family Systems Theory (BFST). Conceptualizing treatment of the impaired physician from a perspective that includes the partner shifts the focus from the individual perspective characterized by the disease model of treatment to a systems focus that addresses the multiple variables within the physician family that can contribute to addiction and keep it alive. Addiction is seen not as an individual deficiency (Wallack, 1981), but as the result of multiple influences. Lawson and Lawson (1998) concur with the need to conceptualize addiction as a problem in relationship systems. They cite Morgan (1981), who theorizes that the disease model "provides an out for society in dealing with serious social problems by creating a need to treat the individual and thereby legitimizes the problem as based in the individual rather than in the larger system of social relations (the family, the school system, the church, the community)" (p. 360). Thus, in lieu of a reductionistic focus, treatment should identify the systemic and maladaptive family patterns that are transmitted through multiple generations.

A broader, family-oriented approach is especially important for impaired physicians because they tend to have detached interpersonal styles (Sotile & Sotile, 2000), avoidance of intense emotions (Meyers, 1994), a stressful practice (Talbott & Gallegos, 1990), and easy access to narcotics. Clinicians are encouraged to conceptualize chemical dependence as a likely reflection of serious relationship issues in the doctor's nuclear and extended families, between and within generations (Bowen, 1978). Conversely, using an individual treatment approach with the impaired physician is like throwing him or her out of a whitewater current, resuscitating him or her, and then throwing him or her right back into the torrential waters.

To underline the veracity of this metaphor, Talbott (1987) found in an analysis of 500 physicians, followed for 4 years subsequent to treatment, that the relapse rate was dramatically higher when the spouse was uninvolved and untreated. Similarly, a recent study of adult opiate users indicated better outcomes for those receiving family treatment than for those receiving two individually based interventions, particularly for those living with a partner (Yandoli, Eisler, Robbins, Mulleady, & Dare, 2002). In fact, impaired physicians and their families, like any other family suffering with chemical dependence, cannot be treated effectively without a thorough assessment and treatment of dysfunctional dynamics within the family. A paradigm shift from individual treatments typified by the disease model to a family systems treatment as typified by BFST offers an opportunity for lasting change that goes deeper than placing a Band-Aid on a gaping wound.

BFST, with its set of interlocking principles, provides a road map for systemic treatment. Treatment shifts from focusing on the patient to discoveries regarding what part each family member plays in maintaining the problem (Papero, 1990). The patient helps to create a family diagram covering three or more generations as part of a cognitively

focused effort to view the family's emotional process across time (Kerr & Bowen, 1988). After an organized effort to collect facts and identify patterns of family functioning, the client (or clients) in treatment is asked to identify and take responsibility for his or her part in the maintenance of the symptom.

An important part of treatment involves bridging the distance between family members and repairing the emotional cutoff between generations (Bowen, 1978). Treatment involves active efforts by the family to discover how relationships functioned in previous generations, in order to understand how past relationships influence current relationships. Particular attention is paid to identifying the overfunctioning of one member in relation to the underfunctioning of another (Bowen, 1978; Gilbert, 1994). With the family diagram as a blueprint to guide further discovery, therapy is conceptualized as the beginning of a lifelong journey toward increased awareness of how emotional forces and anxiety are transmitted across generations (Kerr & Bowen, 1988).

The Promise of Bowen Family Systems Therapy

In the late 1950s, Dr. Murray Bowen observed that seemingly cured schizophrenic patients relapsed upon returning home to their families soon after they were discharged from inpatient treatment programs (Bowen, 1978). After observing this phenomenon, Dr. Bowen decided to try hospitalizing the schizophrenic along with his or her entire family. Obtaining more favorable results, Bowen came to conclude that the family, rather than the individual, was the proper unit of treatment. His unique approach assumed that all families operated from a highly emotionally interdependent position (Kerr & Bowen, 1988), meaning that the more interdependent the family members are, the more highly fused each individual is with the other (Kerr & Bowen, 1988). Fused family members have little autonomy from one another. In extremely fused families, members are overly involved with one another. If one family member has an itch, for example, everyone else in the family scratches.

Bowen posited that the more highly fused the family system is, the more vulnerable the entire family is to developing symptoms that often are carried by only one family member for the whole system. Bowen (1978) characterized this highly fused family unit as an "undifferentiated ego mass." Families could increase the level of their collective health, Bowen hypothesized, by increasing the level of individuality of each member (Kerr & Bowen, 1988). In essence, individuals could choose when to be separate and when to remain connected (Kerr & Bowen, 1988). If family members are viewed as highly interdependent, then identifying multiple variables to account for symptoms will be more likely to effect real change.

This chapter hypothesizes that when a treatment protocol aims to change the *structure of a system* instead of aiming to change the *behaviors of an individual*, a positive treatment outcome is more likely to be long term. This second-order change means that the game itself has been altered rather than only the rules (Harper & Capdevila, 1990). Within the worldview of BFST, therapists are offered a distinctly different and promising approach to treating emotional problems such as chemical abuse and dependence.

Bowen (1978) posits that "therapists with the motivation and discipline to work towards systems thinking can reasonably expect a different order of therapeutic results as they are more successful in shifting to systems thinking" (p. 262). This change in approach reflects a paradigm shift in the field of alcoholism and addiction.

Research by Talbott and Martin (1986) corroborates Bowen's (1978) theoretical assumptions. They cited family problems as the single most important factor leading to relapse in chemically dependent physicians. Similarly, research conducted by Nyman and Cocores (1991) supports the assumptions of BFST. They found that addicts whose families participate in treatment have better outcomes than do those addicts who are treated alone. Similarly, Mann (1991) asserts that treating the patient as an isolated entity almost guarantees a poor outcome. Thus, research findings underline the notion that without considering the family as the unit of treatment, achieving more than temporary symptom relief may not be possible. Lawson and Lawson (1998), experts in the field of chemical dependency, also emphasize that successful treatment of the impaired family system must maintain a focus on the relationship processes between and within the generations. This focus makes it possible to interrupt multigenerational patterns of chemical dependency, shifting the legacy for future generations.

Unfortunately, in many treatment programs for the impaired physician, family members are virtually ignored, or at best, viewed as support systems cheering on the patient from the sidelines (A. Lawson, personal communication, spring, 2001). Family members are not treated, but are merely provided with psychoeducation to aid them in supporting the identified patient's recovery. Rehabilitation facilities that direct family members to attend Al-Anon or psychoeducational support groups proudly, but erroneously, label such rehabilitation efforts as "family-centered" treatment. As we will see, BFST goes much further in its conceptualization of a family-systems-based approach.

A treatment and relapse prevention protocol for impaired physicians and their families informed by BFST, a family systems model, offers great promise for achieving long-term positive results. Impairment cannot be understood apart from the multigenerational context in which it occurs. Broad application of Dr. Bowen's ideas regarding this symptom and how to effect treatment are outlined below.

Underlying Philosophy and Theoretical Concepts

Bowen (1978) characterized chemical dependence as one of the more prevalent human dysfunctions. Like all dysfunctional patterns in a family, one cannot conceptualize this behavior without viewing it in the broader context of an imbalance in functioning in the whole family system (Bowen, 1978). Treatment is aimed at raising each family member's awareness of the part he or she plays in maintaining the symptom. The treatment is initiated with the family member who has the greatest motivation and ability to modify his or her functioning in the system. Often this is the family member who overfunctions and is in the greatest pain (Bowen, 1978). Pain that is not so overwhelming as to paralyze efforts to move forward but that provides enough discomfort that family

members welcome the idea of change may turn out to be the gateway to resourcefulness. Bowen offered the unique insight that "when it is possible to modify the family relationship system, the alcoholic [or drug addicted] dysfunction is alleviated, even though the dysfunctional one may not have been part of the therapy" (p. 262).

BFST is comprised of eight interlocking concepts. Although it is difficult to conceptualize them apart from one another, key concepts will be reviewed briefly to underline how chemical dependency dysfunction fits into the theory.

Chronic Anxiety Versus Acute Anxiety

Bowen (1978) noted that human beings share more similarities than differences with other forms of life. Perhaps the most salient shared feature is that the organism will react defensively to a real or imagined threat to survival. This survival reaction may be physical, emotional, or a combination of both. The clinician will observe that in some people, anxiety is so continuously present that this heightened reactivity need not necessarily be stimulated by real or imagined threat (Gilbert, 1992). Instead, the anxiety is chronic, an anxiety that has likely been passed along in a family system over many generations.

Whereas chronic anxiety strains or exceeds people's ability to adapt, acute anxiety is a response to a real threat. The reaction to a real threat is of limited duration, and people can usually adjust. Acute anxiety is rooted in fear of what is, while chronic anxiety is rooted in fear of what *might be* (Kerr & Bowen, 1988).

People who exhibit high levels of emotional reactivity in response to minor or even imagined stresses tend to act and react without thinking. One goal in BFST is to move families toward decreasing their reactivity to one another while increasing their ability to respond more thoughtfully (Bowen, 1978).

BFST focuses on the emotional system's struggle with two opposing instinctual life forces: those forces that keep family members connected and the contrary forces that compel people toward individuality (Bowen, 1978). One force is oriented toward togetherness, and the other force is oriented toward separateness. From the perspective of BFST, the two vectors within the familial environment that influence chronic anxiety are people's reactivity to their personal space being intruded upon and their complementary need for connection (Kerr & Bowen, 1988). The cliché "Can't live with them, can't live without them" describes this common dilemma. Patterns of emotional functioning are all related to the ways a family deals with its members' impinging upon one another or, in reaction to impingement, disengaging from one another (Kerr & Bowen, 1988).

When anxiety escalates in a system, the forces for togetherness increase. One can recall how people came together in the United States after 9/11. Over time, the togetherness forces threaten group members' sense of individuality. Family roles and family rules become inflexible, and normal developmental life cycle changes are perceived as upsetting. A defensive measure in the face of such a perceived emotional threat is to distance oneself from the forces of togetherness in order to achieve some separateness and avoid feeling "swallowed up whole." In families with a high degree of fusion, there is an increased risk that one or more members will cut off from their parents in a move

to preserve what little is left of "self." This reactive cutoff is not helpful and can lead to symptoms such as substance abuse (Bowen, 1978).

Two Opposing Life Forces: Can't Live With Them and Can't Live Without Them

Intrapsychic fusion describes a lack of differentiation and clarity between cognitive and affective functioning. Bowen (1978) explains, "The capacity to differentiate between thoughts and emotions allows some choice over being directed by one's 'head' or by one's 'gut'" (p. 62). He notes that what sets humans apart from other species is their ability to think and their ability to be aware of the difference between their thoughts and emotions. However, if the human organism becomes overwhelmed with anxiety, cognitive ability may become compromised or may even shut down. If the cognitive ability shuts down, the human species operates just as reactively and instinctually as other species that do not have the advantage of a highly evolved intellect.

Interpersonal fusion describes a lack of differentiation between oneself and others. It manifests itself in a way that disallows a person from knowing where he/she stops and another begins. When fusion is intense, family members seem to have no separate identities. Intense fusion results in family members making "we" rather than "I" statements. Husbands and wives who complain that they cannot live with their spouse or without them are describing an inability to manage effectively the universal conflict of these opposing life forces.

It has been suggested that a disowning of the need for family ties may be a motivating factor for some people who choose a medical career (Twerski, 1982). The intensity of the hospital environment and long work hours may fulfill a person's wish to feel needed and emotionally connected while at the same time safely distanced from his or her important family relationships. It may be true, as the conventional wisdom goes, that the hallmark of addiction is denial; yet if we look beneath the surface, we can see that it is within the denial of needing others that chemical dependency thrives. Thus, the problem of addiction may be viewed as an outcome of avoiding the task of resolving attachment issues in the relationship system.

The smoothest period between partners is during courtship (Kerr & Bowen, 1988). Predictably, however, relationship tension may escalate to problematic proportions over time. Typically, when two people marry, the emotional patterns that first attracted them to one another may intensify. As the relationship develops and as day-to-day stressors remind them of their heightened emotional interdependence upon one another, each partner may become reactive and even disgusted by the personality characteristics that initially attracted them to one another. McKnight (1998) observed that "the more intensely a person seeks to fill the emotional deficits of the other or to have another shore up his or her life, the more fused the marriage relationship becomes" (p. 272). When people with high levels of need for togetherness marry, each partner invests heightening levels of "self" in the other. This fusion becomes more binding as the sharing of daily living duties heightens their need for one another.

Unlike during courtship, when they experienced more freedom to be themselves, the spouses begin to assume that they can read the mind of the other and begin to

behave as if they know how the other will react. The couple becomes like two cells that have merged and now have one nucleus. Neither individual can chart independent goals. One spouse feels swallowed up in the relationship while the other spouse becomes drained from being hypervigilant lest he or she be abandoned. A heightened sense of dependence on another can raise anxiety levels. Heightened anxiety may result in increased efforts to cope by creating distance. Drinking and/or drug abuse is one way to achieve this distance in the short term, but in the long term, the heightened anxiety that the abuse causes in the individuals who depend on the abuser creates increasingly complex problems in the family system.

The relationship system in each spouse's family of origin influences the degree of the desire for emotional closeness in the marriage. If individuals have emotionally cut themselves off from their respective families of origin, there is enormous pressure upon the nuclear family to be everything to one another. The high degree of investment in their spouses and children is based in a wish to compensate for the emotional deficits from their own families. Disappointingly, the pressure has a deleterious effect on the union, and anxiety rises within such a context.

People may find that they married someone with a similar degree of neediness. As the disappointment, depression, and loneliness mounts, these people experience conflict with their spouses and may look to their children to fill the void of connection with their spouses. The parents then project their inability to deal with relational closeness/distance management in themselves onto their children, and the children become caught in the crossfire of unresolved emotional attachment.

Bowen (1978) noted that when "two pseudo-selves 'fuse' into the emotional 'weness' of marriage, [there is also] a high potential for impairing the functioning of one spouse" (p. 263). The discomfort of this fusion may be handled in various ways. However, almost all fused marriages involve adaptive efforts to create some degree of emotional distance between partners. It is a reactive move based in the survival instinct to preserve selfness.

One way emotional distance is increased is through marital conflict. During the making-up phase, the couple may experience the togetherness that they missed during the distancing period. After tiring of holding onto one's own position and not "giving in," a partner may move back toward the other. And so it goes, in a continuing cycle of tension building, conflict, and making up.

Bowen (1978) believed that the most common pattern for dealing with emotional fusion is an underfunctioning/overfunctioning reciprocity. One spouse assumes a dominant role and the other spouse assumes an adaptive role. The adaptive spouse becomes "wired" to support the more dominant, decision-making spouse. In most respects, the adaptive spouse becomes a functional "no self" (Bowen, 1978). The one who accommodates the most gives up the most self to the other. This adaptive person is more vulnerable to some type of chronic dysfunction.

Bowen (1978) believed dysfunctions expressing systemic chronic anxiety might include one or more of several patterns. Heightened chronic anxiety in the family system may emerge in an individual as physical illness, emotional illness, or a social dysfunction, such as alcoholism or drug addiction. The other common pattern is one in which parents project their immaturity onto one or more of their children. A combination of all of these patterns may be present.

Bowen (1978) noted that when things are calm within a family, these adaptive patterns function to maintain homeostasis in the system without serious symptoms arising in a family member. However, when anxiety escalates, the adaptive patterns lose flexibility. The patterns rigidify until symptoms erupt. Because patterns are multigenerationally transmitted, they are programmed into the nuclear family from the respective families of origin. This means that the family has no conscious choice about the selection of adaptive patterns. Bowen (1978) emphasized that there is greater flexibility in a family with a spectrum of such transmitted patterns than in a family using only one or two patterns.

The quality and degree to which each spouse is in emotional contact with his or her family of origin is the other key variable in assessing the adaptability in a family system. The geographical distance between them and the quality of their relationship interactions can determine emotional distance or closeness to the family of origin. It is assumed that the greater the degree of emotional cutoff from the family of origin, the more likely it is that the nuclear family will be symptomatic (Bowen, 1978).

Differentiation of Self

Differentiation of self is inversely related to chronic levels of anxiety and may be conceptualized as emotional maturity (Kerr & Bowen, 1988). The concept of differentiation of self is core to BFST, and working to increase differentiation of self is a lifelong process (Papero, 1990). The ability to choose between thinking and feeling, along with the ability to differentiate oneself from another person (i.e., knowing where one stops and the other begins) are the basic characteristics of the emotionally mature or differentiated individual (Bowen, 1978).

It is erroneous to equate differentiation with autonomy, individuation, or independence. Kerr and Bowen (1988) emphasize that differentiation describes the *process* by which individuality and togetherness are managed within a relationship system. One's level of differentiation of self is determined by three factors: the level of differentiation of one's parents, the quality of relationship one has with one's parents, and the manner in which one handles unresolved attachment to parents in adulthood (Bowen, 1978).

Levels of differentiation may vary between siblings and between generations. A sibling who receives more of the parents' anxious focus will be less free to grow and develop, because this individual is more fused with one or both parents. From this evolutionary perspective, one can understand how it is that siblings turn out so differently. Sibling variability accounts for one line moving slightly upward with each succeeding generation and another line moving slightly downward with each succeeding generation (Kerr, 2008).

Gilbert (1992) points out that variation in the tendency toward fusion exists in other mammalian species as well, citing Jane Goodall's observations of chimpanzees at Gombe, where Goodall saw a wide range of differentiation. Gilbert (1992) provides the example of one chimp, Flint, and his mother, Flo. They were so emotionally attached that Flint's infancy was prolonged. He would always stay close to his mother, never venturing very far away. As Gilbert explains, "When his mother became old and died, Flint, although he was eight and a half years old (an age of independence for most chimps),

fell into a state of grief and depression. He died three and a half weeks after her death in the same spot where she had died" (pp. 19–20).

The intensity of fusion with the parents will replicate in the marital relationship. Undifferentiated spouses tend to have an external locus of control and measure their worth through the eyes of others. Inside of their "we-ness," there is little solid self. Instead, two pseudoselves marry and have few principles that cannot be co-opted by a pressure to conform to the needs and wishes of the other.

The higher the level of fusion within the marital couple, the greater the risk for impairment in one or both spouses. The lower the level of the differentiation, the more each spouse operates within a reactive, feeling state and the less each spouse is able to call upon cognitive functions or adapt smoothly to change. Instead of thinking through responses to stress, the person with a low level of differentiation or immaturity will blame others for his or her unhappiness. Additionally, at the lower levels of differentiation, a person will look to fuse into an emotional symbiosis with another or, in reaction to the symbiosis, cut off, much as he or she merged with and/or cut off from his or her parents. Relational life takes on the quality of being reactive rather than reflective or proactive. Individuals with low differentiation have little ability to be selves independent of their reactions to what others say, do, or demand. "No-selves" are defined by others and have no internal compass with which to navigate along their life journeys (Bowen, 1978). Bowen believed that people with similar levels of differentiation marry one another.

In assessing the ability of an impaired family to tolerate difference among its members, Gilbert (1992) suggests questioning along the following lines: In what ways can individuals become freer to live their own lives, without instinctively repeating the emotional processes of past generations? Can people think in opposites and tolerate ambivalence arising from internal conflicts? Can people think clearly even amidst the roiling emotional forces that affect the core of their being? Can people react less automatically and more thoughtfully inside of their attachments? Can they tolerate being separate people yet remain connected to other family members, or do they rush to cut themselves off from uncomfortable relationships? Do individuals have the ability to be an "I" when the group is screaming to be a "We"?

The differentiated person has an abiding awareness that no person can change another (Kerr & Bowen, 1988). One cannot regulate another person's life. Taking responsibility for self means that one learns to define self, develops a sense of one's boundaries, and has a clear idea of one's core beliefs and values. Differentiated people realize that charting a course for responsible functioning in a family requires a lifetime of work, trial and error, and trouble shooting (Kerr & Bowen, 1988). One cannot significantly raise one's level of differentiation in a few therapeutic sessions, or even within a few years. However, one can be helped to embrace the course of such a journey and learn to make one's own life a research project. By being responsible for self, the entire family, of which the differentiating member is a part, is affected in a positive way. Differentiating members model their efforts to develop in ways they may not have thought possible prior to treatment.

When one does not experience a sense of self and a separate identity of one's own, defense mechanisms aimed at survival will emerge. People may cut off emotionally

from those who threaten their sense of individuality. Substance abuse is one way that threatened people emotionally cut off from important others, and it is a pattern that is multigenerationally transmitted.

In BFST, the differentiating journey involves finding ways to honor one's own separateness in intense relationships and to become freer of automatic reactions to others. Paradoxically, the extent to which one can honor one's own separateness is also the extent to which one can remain viably connected to the others in the family. To accomplish this goal, the clinician guides family members to become more cognizant of their reactions to the family. If a family member is constantly responding to others' needs, this person is directed to look at internal anxiety not being addressed and to consider the overhelpfulness as a red flag. It is important for family members to understand the systemic concept that one person may carry the anxiety for the system, and that person is most vulnerable to developing symptoms.

Adults are directed to look at patterns and triangles in which they are caught so that they can develop a plan to increase differentiation. The therapist coaches clients to return to their families of origin in a quest to gather new facts about family roles and functioning. The client and therapist may brainstorm a list of questions to ask family members. Clients are coached to engage in one-on-one conversations to gain contextual facts about each parent's family-of-origin experiences. They are educated about detriangling moves and directed to look for key triangles through the generations. Additionally, assertiveness training, practice making "I" statements, empty chair work, and mailed or unmailed letters written by the differentiating members (especially to parents) may be helpful. The emphasis is upon taking responsibility for moving differently in one's key triangles. Taking the focus off another and keeping the focus on oneself requires increasing discipline as anxiety rises.

The effort to define a self is full of twists, turns, and detours. As a person learns new ways to manage in emotionally intense relationships, a stronger sense of identity emerges that allows for clearer life direction. To increase one's functional level of differentiation, the work must be done within a person's own family, whether one suffers from chemical dependency or any other category of human difficulties. The thrust of BFST is to become clearer about one's part in a family system and then to learn new ways of being in relationship that assume increasingly higher levels of self-responsibility.

The goal of becoming more objective when observing one's part in family dynamics may have particular appeal to the scientist-physician. BFST might be defined as a "thinking person's therapy" that is not so much for those who are "broken" as it is for those who wish to become more whole. Clients are taught systemic ideas, and, like Bowen-trained therapists, take on the posture of researchers in their own families. The therapy requires experiential work outside of session, in that clients are called upon to apply new concepts as they explore their family systems.

Bowen (1978) believed that it is possible to move toward a science of human behavior, and his positivist view clearly reflected his assumption that a real world exists that is independent of an observer's subjective perceptions of it (Papero, 1990). This worldview may be attractive to the physician, who is trained to be objective and detached from emotional processes. However, it is important to remember that within the effort to increase one's objectivity by collecting facts of family functioning, one also is increasing one's ability to be in anxious emotional fields without losing the ability to think

and make good decisions. It is in managing this balance of distance and togetherness for oneself while at the same time honoring a significant other's differing closeness/distance needs that one achieves a heightened level of differentiation of self.

Solid Self Versus Pseudo-self

The solid self consists of a person's core, non-negotiable, clearly defined values and beliefs. These are formed gradually and are not easily coerced or changed from outside forces (Kerr & Bowen, 1988). Building or developing a solid self is an important goal in BFST. In contrast, the pseudo-self can be defined as a "pretend" or false self that is acquired by emotional pressure and that can also be changed by emotional pressure (Kerr & Bowen, 1988). It is made up of random, discrepant beliefs and principles, acquired because these ideas were considered "right" by the group. The pseudo-self is a self with an external locus of control that conforms to the environment in order to feel a sense of belonging.

Codependency Versus Fusion

During the 1980s, the field of chemical dependency extended its focus to include the family members of chemically dependent persons, generating a separate body of clinical theory and treatment for codependency. As Lawson and Lawson (1998) explain, "With the broadening of the context of understanding of alcoholism from the alcoholic to the alcoholic family, many nonsystemic ideas became popular in the field" (p. 317). Gierymski and Williams (1986) noted that the term *codependency* originally designated the spouse of the alcoholic, but that it came to be generalized to all family members and the chemical dependent's close social network. Pathologizing labels such as *enabler, codependent,* and *coalcoholic* blamed family members for the alcoholic's or addict's problems (Lawson & Lawson, 1998). The popular literature on codependency offers a plethora of definitions, ranging from "a disease" to "immaturity" to "toxic brain syndrome" (Lawson & Lawson, 1998). There were even efforts in the chemical dependence field to make codependency a diagnostic entity, even though the concept was not supported empirically (Babcock & McKay, 1995).

The codependency movement has been viewed by many, especially feminists, as an attempt to stigmatize and pathologize women (Babcock & McKay, 1995). Feminists have characterized the codependency movement as dangerous in that it revictimizes victims (Lawson & Lawson, 1998). Babcock and McKay allowed that women living with alcoholics did, in fact, suffer and that they often engaged in self-blame, but these researchers took issue with the notion that their behavior constituted a disease (Lawson & Lawson, 1998). Lawson and Lawson describe the codependency movement as one of hysteria, noting that the myriad definitions floating around in popular culture ultimately rendered the term meaningless. They emphasize that blame and pathologizing labels are not congruent with systems theory.

Many in the codependency movement believe that marital therapy may threaten the recovery of the chemically dependent person. Brown (1985) found marital therapy to be contraindicated for the alcoholic in early recovery, a nebulous time period, while Stanton and colleagues (1982) considered the wife to be secondary in importance to the

family of origin for the addict's treatment. Such practices may well have been the death knell for many marriages in which the symptom was alleviated. Unfortunately, for the addict and his spouse, these practices did not address the avoidance of the relationship tension giving rise to the symptom. Marriages may become unbalanced and break apart when the homeostatic balance of the family has been disturbed by a significant change in the functioning of the alcoholic.

Codependency is often confused with fusion, a central concept used in BFST. Fusion is consistent with a systemic view. It is a concept that does not assign blame. The symptom is not viewed as the "problem," but rather is viewed as an attempt at adaptation to relationship tensions. In the closeness of an intense relationship, the emotional selves of each individual blend or fuse together in a common self, a kind of "we-ness" (Papero, 1990). Fusion refers to each partner trying to deal with the intensity of this common self by using mechanisms similar to those he or she used in relationship to his or her parents (Papero, 1990). Conversely, those in the codependency movement believe that the "problem" is rooted in the person or in the substance. This is not a systemic conceptualization. From the perspective of BFST, the problem is not in the person or dyad, but in the multigenerational system, each generation of which has passed on ways to behave in relationship with regard to closeness and distance. The difference between codependency and fusion is very important. To reiterate, alcohol or drugs are not viewed as "the problem," from a systemic perspective. Instead, alcohol or drugs are viewed as one of many possible ways to bind anxiety in response to tension in the relationship system (Bowen, 1978).

Triangles

The triangle is a basic unit of analysis in BFST. It refers to a three-cornered relationship system. Bowen (1978) observed that when tension arises within an unstable two-person relationship system (the dyad), there is a tendency to recruit a third person into the system in order to reduce tension and to reestablish stability. To *detriangle* means to redirect the energy of the triangle back to the dyad that was originally involved in the conflict or tension. Functional triangles are composed of person-to-person relationships among all people involved in the triangle. Interlocking triangles refer to a system consisting of four or more people who share more than one triangle (Kerr & Bowen, 1988).

Some children may occupy a position in a parental triangle wherein the youngster is pivotal to the stability of the parents' relationship. This child may function as a kind of diplomatic messenger or negotiator for the disagreements between the parents. Each parent depends on the child to manage the tension experienced with the other parent. For example, a child may align with a parent who is suffering from the effects of the other parent's substance abuse or dependence. The other parent is shoved to the outside position and feels alone and isolated. The person in the outside position of the triangle may experience increased anxiety as a result of feeling "left out" and disconnected from important others.

Family systems theory posits that the triangle is the basis of all relationships. There are many triangles within a given family. As tension escalates in a family, predictable

patterns emerge. Anxiety in a parental dyad, for example, may be rerouted through one or more children. To manage anxiety in a dyad, one partner may turn to substance abuse and or dependence. In a physician's family, triangles can include relationships in the medical workplace as a third leg in a triangle. Anxiety is spread among three instead of being managed between two, decreasing the intensity and making it more tolerable. For this reason, triangles are more stable than dyads and the basic building blocks of relationship systems (Bowen, 1978). Triangles are used to manage closeness/distance forces. When tension is high enough in a triangle, the outside position may be more favorable as the bonds between two become overwhelming (Kerr & Bowen, 1988).

Medical couples have a ready-made diversion from working out their relationship problems (Meyers, 1994). Work pressures can both cause relationship distress and simultaneously offer escape from facing up to being a self in the context of the relationship distress. Excessive involvement in work is one way to avoid resolving marital conflicts, with avoidance being a multigenerationally transmitted pattern of functioning in close relationships. Work relationship demands thus become a convenient third leg of a triangle. However, as anxiety in the system increases, formerly adaptive patterns will become maladaptive. It is at this point that a person who avoids marital conflict may abuse and come to depend upon substances as a maladaptive way to work out tension in the relationship. In the words of one physician, "I really think the reason I worked so hard at my practice, working to be special and needed, was so that I felt I wasn't alone" (Gerber, 1983).

The Family Projection Process

The *family projection process* refers to the tendency of parents to defuse stress or anxiety by projecting their own problems onto their children. The child most attached to the parents will have the lowest level of self-differentiation and have the most difficulty separating from the parents. The greater the level of the parents' undifferentiation (defined as immaturity), the more they will rely on the projection process to stabilize their relationship with one another and within the system (Kerr & Bowen, 1988).

Multigenerational Transmission Process

From Bowen's (1978) perspective, people have much less emotional autonomy than they think they do. The concept of the *multigenerational transmission process* describes the inheritance of the family emotional field through the succeeding generations (Kerr & Bowen, 1988). Physical, emotional, and interactional patterns are passed down through the generations via this process (Kerr & Bowen, 1988).

The multigenerational transmission process can illustrate how relatively small differences in the levels of differentiation between parents and their offspring, and between members of a sibling group, can lead over several generations to more significant variances in differentiation among diverse lines of the family system (Kerr, 2008). Children develop levels of differentiation of self similar to their parents' levels as a result of parents' actively shaping their children's development and children innately responding to their parents' moods, attitudes, and actions (Kerr, 2008). Different siblings will likely

develop varying levels of differentiation, and the child receiving the greatest degree of anxious focus from the parents will be most vulnerable to symptoms (Kerr, 2008). In fact, the multigenerational transmission process programs the ways in which people interact with others and factors into the level of "self" an individual may develop.

Essentially, the multigenerational transmission process includes two critical concepts. First, people tend to select spouses who have a similar level of differentiation as their own (Bowen, 1978). Second, through the dynamics of the family projection process, there tends to be a focus on the child who is the most vulnerable or the most emotionally connected to the parents (Bowen, 1978). Thus, through the family projection process, certain children will have slightly lower levels of differentiation than others in their sibling group. Over several generations, significant dysfunction will unfold. One possible outcome, for example, might be severe problems with chemical dependency emerging in one generation and becoming increasingly intense in future generations.

The therapist's focus on helping the client to identify and interrupt multigenerational patterns of dysfunction should be balanced with a focus on the identification and building upon of multigenerational resiliencies or strengths. In this way, the therapist scaffolds the client coming from an intense system, so that he or she does not feel doomed to repeat the severity of dysfunction discovered within many previous generations (Cunningham, 2006). Both individual resiliencies and family process resiliencies may be identified (see Wolin & Wolin, 1993, for a list of individual resiliencies and Walsh, 1998, for a list of family resiliencies).

Sibling Position

Bowen (1978) believed that the family birth order, referred to as *sibling position*, contributes significantly to the development of personality. Because of this phenomenon, he paid close attention to each parent's sibling position. Bowen's theory was expanded on in research completed by Toman (1993). Toman concluded that children take on different characteristics, in part because of their sibling position in terms of birth order. Gender has influence as well. He noted that children who grew up to marry people who were compatible with the rank and gender they experienced in their families of origin had a better chance at success in their marriage. For example, an oldest sister of brothers would be most compatible with a younger brother who had older sisters. Both partners would feel comfortable with familiar roles. Toman (1993) described characteristics of each birth position. First-born children, for example, might become leaders, accomplished, and highly responsible members of society. At the other extreme, they might become such perfectionists that they find it impossible to meet their own expectations. As such, a first-born may become an overfunctioner in a reciprocal relationship with a substance-dependent partner.

Emotional Cutoff

Emotional cutoff refers to the process of running away or denying the emotional ties to the family of origin (Bowen, 1978). Emotional cutoff and distancing can be confused with actions of differentiation. Instead, emotional cutoff–behaviors are merely pseudo-moves that do not change the intensity of emotional attachments. In fact, one may assume that

to the extent that one tries to cutoff is the extent to which he or she is fused into his or her family system. Emotional cutoff is a fear-based response or an apprehension that one has lost self in the face of intense fusion. The clinician needs to assess for the extent of cutoff, as this pattern is highly associated with severe symptomology (Kerr & Bowen, 1988).

The Role of the Therapist in Bowen Family Systems

BFST is unique in its emphasis upon the self-development of the therapist. Therapists must continually do their own work on increasing their separation from their families of origin while still retaining good emotional connections with their extended and nuclear family systems. Friedman (1991) points out that "Bowen has consistently maintained that it is hard for the patient to mature beyond the maturity level of the therapist, no matter how good his or her technique" (p. 138). In fact, as Friedman explains, "In Bowen theory, the differentiation of the therapist *is* the technique" (p. 138). In order to maintain a non-anxious presence in the presence of the anxiety of a family suffering with an impaired physician, one must have personal boundaries strong enough to resist fusing into the intense emotional environment.

Bowen (1978) saw himself as an objective researcher who helped his clients become researchers into their own ways of functioning. A goal of this therapy is to help the client make a research project out of a life as lived within a multigenerational family system. The focus is on learning more about the family rather than fixing the family problem. Therapists who become too eager to "fix it" reflect their own reactivity and undifferentiation. As a coach, the therapist asks questions that facilitate the client's thinking process. Therapy sessions are controlled and cerebral. Family members talk through the therapist, and direct confrontations are avoided to minimize tension and emotional reactivity. Throughout treatment, the therapist maintains an emotionally neutral position.

The therapist generally works with the marital dyad, even when the presenting problem involves a child. The belief is that the addition of the therapist to the two-person emotional system creates a therapeutic triangle, which will result in changes in family relationships. A Bowen-trained therapist may also choose to work individually with the more motivated partner for a period of time. The assumption is that when this individual speaks from an "I" position, other family members will follow with the same responsible position. A Bowen therapist may also choose to see spouses individually in cases where the couple presents with a level of emotional reactivity high enough to preclude the conducting of a productive dialogue.

The overarching goal of a Bowen therapist is to remain in good emotional contact with the clients while resisting the pressure to be triangled into their conflict. The therapist's stance is objective and neutral, which serves to stabilize the dyad. The therapist insists that each person focus on the part he or she plays in family problems. The Bowen therapist's demeanor should not be misconstrued as passive. The therapist is

respectful and curious. Thought-provoking questions are asked. Bowen-trained therapists frequently call upon clients to think about what their part has been in the family's relational conflicts, and they request that members of the couple speak directly to the therapist in order to prevent heightened emotional exchanges. It is assumed that escalating anxiety expressed in emotional exchanges between family members interferes with the ability to call upon cognitive resources. An emphasis upon increasing one's cognitive, objective capacity when in the midst of intense emotional environments may have particular appeal to the impaired physician-scientist.

Use of the Family Diagram as a Major Tool of Assessment

The use of the family diagram, a graphic representation of the functioning patterns of at least three generations, is used in the beginning sessions of treatment (Kerr & Bowen, 1988; Papero, 1990). It is a tool that helps the clinician work with a client to identify multigenerational patterns that may be playing out in the current system. Additionally, the family diagram functions to calm people. Knowing facts, identifying patterns of multigenerational emotional process, and acknowledging the universality of these mechanisms leads to more objectivity about one's family. The search for patterns includes looking for triangles that block growth, emotional cutoff, fusion, overfunctioning/underfunctioning reciprocity, substance abuse, divorce, and other ways to avoid managing the self in regard to closeness/distance needs. The clinician tries to establish a broadening context to clarify details of the functioning of the nuclear and extended family systems. Inquiries as to the quality of marriages during times of tranquility and times of distress are useful. Occupational changes and geographical moves may be understood in the context of what else was going on in the family at the time. A client's perceptions of family and individual strengths may be noted.

Assessment is ongoing and is a part of treatment (Kerr & Bowen, 1988). The rigorous and methodical search for patterns may resonate with the impaired physician-patient, who has also been trained to search for underlying causes. Illness may be an expression of increased emotional intensity occurring in the system and may be a ripple effect, for example, of the death of an important family member. Such events are viewed as nodal events, often marking a turning point in the family (Papero, 1990). Marriages, births, deaths, divorces, moves, and problems with substance abuse and dependency may be closely related to events in the nuclear family (Papero, 1990). Emotional shock waves (Bowen, 1978) from the death of an important family member, for example, may create a cascading chain of events in nuclear families. Such ripple effects underline the interdependent nature of family systems (Bowen, 1978).

In constructing the family diagram, it is important to ascertain the members of the family who greatly influence others as well as those members who are peripheral. All triangles are assessed carefully, as they are the basic units of the system (Bowen, 1978).

Assessing for emotional cutoffs in the family of origin is a crucial piece of diagnostic information. Cutoffs from each partner's family of origin increase the pressure for

togetherness in the nuclear family. Cutting off a relationship by physical or emotional distance does not end a fused emotional process. To the contrary, it intensifies it.

Therapists explore the context into which each child is born. What was going on during the pregnancy, as well as immediately before conception and after birth? What is the relative position of each child in relation to each parent? The overarching concept behind family diagram construction is that events and changes in a family do not occur in a vacuum (Papero, 1990). It is important to learn about the frequency and nature of contact that the nuclear family has with the extended family (Papero, 1990).

The clinician's effort in collaboratively creating the family diagram is to embody the attitude of a warm, respectful, and objective researcher (Papero, 1990). The point of creating the diagram is not to "do something" with any bit of information. Instead, each fact leads to further inquiry and a clearer view of how each person fits into the patterns and events of the family. The goal is not to find answers, but to keep asking questions that invite other questions (Papero, 1990). In the creation of the family diagram, the clinician models an attitude of curiosity. Together, the client and therapist put together an ever-broadening picture of how the family has evolved over time. Clients are honored as experts on their own family systems, and the emphasis is upon asking *who*, *what*, *where*, *when*, and *how* questions. There is an avoidance of *why* questions, as such questions imply blame.

For examples of family diagrams with the appropriate symbols explained, see *Family Evaluation* (Kerr & Bowen, 1988, pp. 307–312). Readers may also peruse family diagrams of famous people in *You Can Go Home Again* (McGoldrick, 1995) to increase their understanding of how to properly use this valuable assessment tool.

Broadness of Perspective in Bowen Family Systems Theory: Universalist Concepts

It is not possible to explain the multilayered complexities of Bowen theory within the framework of an entire volume, let alone a single chapter (Friedman, 1991). Diverse populations all share the reality of multigenerational emotional processes that involve the struggle to manage the forces of togetherness and separateness. Thus, whatever the differences among cultures, diverse populations may be considered as different spices in the soup of life. Bowen emphasized the idea that humans are more like than unlike nonhuman life forms (Friedman, 1991). Other theories tend to focus upon differences. A perspective highlighting differences, according to Bowen (1978), decreases objectivity about, and even increases denial of, what really drives human behavior and motivations.

Bowen theory is rooted in the assumption that the human species is part of a stream of evolutionary emotional processes that can be traced back to the beginning of life. When a clinician views a family, he or she must consider the fact that the opposing forces for togetherness and separateness reflect the degree of reactivity in the evolving system. The more reactive a family is to forces of closeness and separateness, the more likely that symptoms will appear in one or more individuals in the system. Also, one

may assume that a family that has a high degree of emotional cutoff is most vulnerable to serious problems such as chemical dependence. Finally, if it is assumed that emotional process is evolutionary, families that contain high degrees of emotional cutoff may be further along in an emotional regression that is generations deep—a regression caused by reaction to intolerable degrees of fusion or togetherness passed on from previous generations. The work in the differentiation process is to help clients become more objective in an effort to get a bit more outside the emotional forces dominating the family. Increased differentiation, as explained earlier, involves being able to remain connected as much as it involves being a separate self.

Bowen (1978) once said,

> There is nothing in schizophrenia that is not also present in all of us. Schizophrenia is made up of the essence of human experience many times distilled. With our incapacity to look at ourselves, we have much to learn about ourselves from studying the least mature of us. (p. 89)

This comment epitomizes Bowen's consistent effort to make continuous what other theories tend to dichotomize (Friedman, 1991). Bowen's idea that the family is the preferred unit of treatment places emphasis upon the emotional forces shared by all families. Similarly, it significantly decreases the focus on which family member is the symptom bearer. Friedman explained, "The unity of perspective turns the therapeutic endeavor of promoting differentiation into a broad-spectrum antibiotic that may be applied to any family no matter what its nature or the nature of the 'dis-ease'" (p. 137). Thus, from Bowen's perspective, asking what unit of treatment a clinician is treating has no meaning. Similarly, whether one sees couples, individuals, or families is irrelevant. The focus is always on universal, systemic factors rather than on specific problems. The clinician's approach is informed less by his or her formal technique than it is by the rigor with which the clinician consistently works on increasing his or her own level of differentiation over the life course.

Common Patterns in Families With an Impaired Physician

Physicians who experience chemical dependency likely handled the emotional attachment to their parents, and especially to their mothers, by a denial of the attachment and by a pseudo-independence or false bravado (Bowen, 1978). This child would insist that he did not need the parent. "I can do it myself," might be this youngster's rallying cry. During the adolescent years, for example, such children would be more defiant than children less fused with their parents (Bowen, 1978). In more differentiated families, parents and teenagers are calmer as the adolescents work toward separation. In fact, in the more differentiated family, there is greater flexibility and adaptation to change as members pass through the various developmental stages in the individual and family

life cycles (Bowen, 1978). Families on the higher end of differentiation may tolerate and even honor differences in individual members.

Bowen posited that all people have a fairly intense level of attachment to their parents. It is not the *level* of intensity that is salient in the case of impairment. Instead, it is the *manner* in which the attachment is handled that is important.

The posture of physicians who spend a lot of their life energy denying this attachment to their parents (and later to their spouses) may be able to function quite well for a long time. Such doctors' functional level of differentiation may appear to be quite high, as they excel in medical school and later, in their profession. These physicians are overly responsible to others and, in many respects, have such high standards that they are impossible to maintain over time. They continue to assume the pseudo-independent posture in their nuclear families. Spouses, children, and society participate in reinforcing this posture by developing the expectation that the physician upon whom they depend will continue to function at an impossibly high level. Sadly, unrealistic self-expectations and an extreme sense of responsibility seriously compromise the overfunctioning doctor's quality of life. In denying their need for others and keeping up a pseudo-independent posture, they become increasingly isolated from their family. The children and the spouse play a part in maintaining the physician's distance in the family system. As the physician feels increasingly burdened, the loneliness and isolation intensify. It is at this point that such individuals may become most vulnerable to developing a relationship with alcohol or drugs, especially if this pattern has been prevalent in past generations.

At the opposite end of the spectrum of attachment patterns are the physicians who are symbiotically attached to their parents, and especially to their mothers. These individuals are so merged with their parents that they are unable to function independently in the world. In their emotional fusion with mothers who had a low level of differentiation of self, these doctors were de-selfed. They used the defense of denial to avoid facing the depth of their need for the mother. This intensity of denial of need replicates in the subsequent marriage(s). As Bowen (1978) explained, this type of individual "collapses into drinking early in life, while loudly affirming his independence and his continuing 'I can do it myself' posture" (p. 265). Bowen identified these individuals as having the poorest prognosis for permanent recovery from substance abuse. He characterized them as social outcasts whose need for emotional closeness is so overpowering that they must go to extremes to deny it, referring to them as "dysfunctional refugees from the family relationship system" (p. 265). Because they run from their families of origin, they will continue to run from their spouses. The spouses, who are similar to the impaired member in their level of differentiation, can predictably be expected to play a reciprocal role in the alcoholic- or drug-addicted dysfunction.

As noted earlier, Bowen (1978) postulated that people marry people with similar levels of differentiation of self. While each partner may present as having opposite ways of dealing with stress, each maintains the stability of the relationship by playing out both sides of the coin of togetherness/distance forces. Conflict, overfunctioning/underfunctioning reciprocity, and a degree of projecting their problems onto their children are patterns usually used in some combination by the medical couple who is threatened with attachment fears. The pattern of one partner adapting or giving in to the other spouse is the salient pattern in problems with alcohol or drug dependence (Bowen, 1978). Both spouses usually believe that they are the ones who are giving in to the other

the most. But it is the one who is, in fact, most accommodating that loses an increasing level of self and then becomes most vulnerable to the development of a problem with chemical dependence. In the recovery process, the de-selfed spouse will regain more functioning self.

It is important for the clinician to alert the family to the probability of increasing anxiety in the face of change. As the accommodating member realizes that in "thinking alike," they have relinquished their ability to think for themselves, there will be a significant amount of intensity in the family system's adjustment to the impaired family member's shift in perception. There will be pressure from other family members to "change back" as the impaired family member progresses in treatment. The whole of a family system is greater than the sum of its parts. This means that the ferocity of systemic forces will challenge the individual to maintain the positive change. The Bowen therapist will predict this challenge to clients and coach them to just "hold on."

A Family Systems Therapy Approach With the Impaired Physician Family

BFST offers the impaired physician family a set of principles for understanding the underlying connections among people that create predictable patterns of interaction in the family's emotional process. BFST pushes the distressed medical family to broaden its lens from seeing only a particular symptom such as alcoholism. Instead, the family is called upon to view the symptom in the context of multigenerational problems within the wider relationship system and in the context of the natural world of emotional patterns of which humans are a part.

From the perspective of this theory, no matter what symptom appears in the family system, the treatment is always the same. The family is directed to look at the ways in which tension in relationships has been avoided and coached to begin to confront the tension. The family learns that if avoidance of relationship pressure continues across the generations, the risk and severity of symptoms intensifies with each generation to come. The emphasis is upon *process* rather than upon *content* or the nature of the symptom.

From the perspective of BFST, alcoholism and addiction are viewed as a human condition that is an outcome of family relationship processes across generations. In this sense, the drinking or drug problem is not viewed as a disease residing in the individual who is impaired, or in his overfunctioning partner. Instead, the anxiety-binding mechanism of chemical dependence is explored for how it functions in a misguided attempt to manage relationship tension. The therapy, in fact, becomes a motivational force that calls upon family members to research the emotional system from which they emerged. When the symptom of alcoholism or drug addiction is seen as one of many ways in which people bind anxiety, the focus upon one person and the tendency to blame diminish. The anxiety of the system is bound in the symptom, and coaching people to let go of the symptom pushes them to redirect the anxiety where it belongs: inside the relationship system. If only one person in the system functions differently, the entire system can be rearranged. The family is coached to develop greater strength

in their collective "emotional muscle." Clients' work of going home again may be compared with achieving greater fitness from a workout in a gym, where *fitness* is defined as tolerance to stay the course in relationships without rushing to cut off or deny the fact of one's own interdependence. It is also defined as the ability to be a self with a core set of non-negotiable principles, even in the face of pressure from a loved one to conform.

Like all families, families with an impaired physician struggle with underlying relationship issues. The problem is not the substance, but rather how severe tensions go unaddressed. When family members relate through drinking or through drug abuse, they are attempting to regulate emotionality and attachment to important others in the family. The medical family's handling of neediness through dependency and caretaking, through cycles of distance and closeness, and/or through overinvestment in the needs of others, such as children, need to be explored in treatment. Alternative ways of handling interdependency needs should be identified and considered.

Information Is Power: Suggested Questions for the Impaired Physician Family

Calling upon impaired physicians and their families to think about the relationship system rather than the defined problem of chemical dependence opens up the possibility of increased freedom to explore the complexity and richness of a family's emotional process (McKnight, 1998). Treatment should pose questions for family members to explore on their own between sessions.

McKnight (1998) suggests questioning along the following lines:

- Can the family shift from viewing the alcohol or drug impairment as an individual problem to viewing the impairment as a family problem?
- Can the family come to view the impairment as a disguised opportunity to allow members to understand their relationship system rather than as a disease to be cured in an individual?
- How do people in the family hold on to their personal boundaries?
- How do family members manage to stay connected?
- How do people play out underfunctioning and overfunctioning reciprocal positions in the family?
- What is the maturity level of each person? Of the system?
- What new directions might people take in an attempt to make more thoughtful and less reactive decisions in a family?
- What patterns can each member of the marital unit identify as coming from their respective families of origin, and how do they think about these patterns?
- How are these family-of-origin patterns being replicated or reacted to in the nuclear family?
- In what other ways do people in the family system bind anxiety, in addition to substance abuse?

- How do people think about their sibling roles and position in their primary triangle with their parents in their families of origin, and how are these roles related to thoughts, beliefs, and behaviors in the nuclear family?

McGoldrick (1995) also suggests myriad questions that may aid the client-researcher (see her *You Can Go Home Again: Reconnecting With Your Family,* which contains useful lists of such questions at the end of each chapter). The idea is to learn wherever and whatever you can, because it may become apparent that a certain piece of information will help you connect pieces of the jigsaw puzzle in a way that creates a clearer picture.

Opening up the family's communication system strengthens the family (Bowen, 1978; Walsh, 1998). Guiding clients in their efforts to gather collateral information from various family members builds an individual's identity within the system. Also, it reduces polarizations, eliminating the notion that people must be assigned labels of "saint" or "sinner." In family systems thinking, there are no saints or sinners; instead, there are reciprocal family processes that serve a function to maintain the stability of the system.

Conclusion

In other theoretical orientations, chemical dependence is typically defined as a problem that resides in the individual. In place of the disease model of alcoholism and addiction, a broader, contextual interpretation of this pattern of binding anxiety is offered here. A significant number of studies have tested the validity of BFST and provide empirical support for the relationship between differentiation of self and chronic anxiety, marital difficulties, and psychological distress (Miller, Anderson, & Keala, 2004).

In treating the medical family suffering from substance-related impairment, the Bowen-trained clinician coaches the motivated family members to explore their roles and multigenerational family patterns rather than keeping the primary focus upon changing the alcoholic or addict. The BFST clinician realizes that a push to change the impaired physician may exacerbate the problem and deny the family a remarkable opportunity to grow and develop in a more functional way.

Therapy based on the set of interlocking concepts and principles developed by Bowen (1978) guides the family with an impaired physician to move into increasingly anxious environments, trying to assume greater responsibility and make more meaningful connections while at the same time holding on to individuality in the face of group pressure to conform.

By embarking upon this journey across time, impaired physicians and their families can triumph in the face of tragedy. They can begin to define a responsible direction in their lives as they learn to think differently about human relationships (Gilbert, 1992). Such an effort insures that if people struggling with adversity remain true to the course of exploration and fact-finding, they can replace shame with "survivor's pride" (Wolin & Wolin, 1993).

Medical students should be taught from the very beginning of their careers that they have as much responsibility for their own mental health and physical well-being as they do for those of their patients. They must realize that it is crucial to pay attention to their connections with their own families even as they attend to their patients. Fulfilling their family responsibilities and nurturing their own relationships not only helps physicians to more successfully navigate the ever-present struggle between the forces of connectedness and those of individuality, but also protects the public from lapses in medical judgment. The development of a sound, systemic view of their own lives as doctors and family members cannot help but to enhance overall functioning, both at home and in the workplace. If clinicians look for patterns instead of causes, see solutions and problems as being inextricably codetermined, and develop the ability to think and apply "systems," medical doctors and their families may come to appreciate the abiding wisdom underlying the injunction, "Physician, heal thyself."

References

Angres, D. H., McGovern, M. P., Rawal, P., & Shaw, M. (2002). Psychiatric comorbidity and physicians with substance use disorders: Clinical characteristics, treatment experiences, and post-treatment functioning. *Addictive Disorders and Their Treatment, 1*(3), 89–98.

Babcock, M., & McKay, C. (Eds.). (1995). *Challenging codependency: Feminist critiques.* Toronto: University of Toronto Press.

Bowen, M. (1978). *Family therapy in clinical practice.* Northvale, NJ: Jason Aronson.

Brown, S. (1985). *Treating the alcoholic: A developmental model of recovery.* New York: Wiley.

Coombs, R. H. (1996). Addicted health professionals. *Journal of Substance Misuse, 1,* 187–194.

Cunningham, B. R. (2006). *A resiliency-based, Bowen family systems approach to treating a sibling survivor of homicide: A case study.* Doctoral dissertation, Alliant International University, San Diego, CA.

Ellis, J. J., & Inbody, D. R. (1988). Psychotherapy with physician's families: When attributes in medical practice become liabilities in family life. *American Journal of Psychotherapy, 42,* 380–388.

Friedman, E. H. (1991). Bowen theory and therapy. In A. S. Gurman & D. P. Kniskern (Eds.), *Handbook of family therapy* (Vol. 2, pp. 134–170). New York: Brunner/Mazel.

Gabbard, G. O., & Menninger, R. W. (1989). The psychology of postponement in the medical marriage. *Journal of the American Medical Association, 261,* 2378–2381.

Gerber, L. A. (1983). *Married to their careers: Family dilemmas in doctors' lives.* New York: Tavistock.

Gierymski, T., & Williams, T. (1986). Codependency. *Journal of Psychoactive Drugs,* 18, 7–13.

Gilbert, R. M. (1992). *Extraordinary relationships: A new way to think about human interactions.* New York: Wiley.

Gilbert, R. M. (1994). Addiction to prescribed medications. *Family Systems: A Journal of Natural Systems Thinking in Psychiatry and the Sciences, 1,* 57–66.

Harper, J., & Capdevila, C. (1990). Codependency: A critique. *Journal of Psychoactive Drugs, 22,* 285–292.

Kerr, M. E. (2008). Why do siblings turn out differently? In A. Fogel, B. J. King, & S. Shanker (Eds.), *Human development in the 21st century: Visionary ideas from systems scientists* (pp. 206–215). New York: Cambridge University Press.

Kerr, M. E., & Bowen, M. (1988). *Family evaluation.* New York: Norton.

Lawson, A. W., & Lawson, G. W. (1998). *Alcoholism and the family: A guide to treatment and prevention* (2nd ed.). Austin, TX: PRO-ED.

Mann, G. A. (1991). History and theory of treatment for drug and alcohol addiction. In N. S. Miller (Ed.), *Comprehensive handbook of drug and alcohol addiction* (pp. 1201–1212). New York: Marcel Dekker.

Mansky, P. A. (1999). Issues in the recovery of physicians from addictive illnesses. *Psychiatric Quarterly, 70,* 107–122.

Martin, P. A., & Bird, H. W. (1959). The "love-sick" wife and the "cold-sick" husband. *Psychiatry, 22,* 245–249.

McGoldrick, M. (1995). *You can go home again: Reconnecting with your family.* New York: Norton.

McGovern, M. P., Angres, D. H., & Leon, S. (1998). Differential therapeutics and the impaired physician: Patient-treatment matching by specificity and intensity. *Journal of Addictive Diseases, 17*(2), 93–107.

McKnight, A. S. (1998). Family systems with alcoholism: A case study. In P. Titelman (Ed.), *Clinical applications of Bowen family systems theory* (pp. 263–298). New York: Haworth Press.

Meyers, M. F. (1994). *Doctors' marriages.* London: Plenum Press.

Miller, R. B., Anderson, S., & Keala, D. K. (2004). Is Bowen theory valid? A review of basic research. *Journal of Marital and Family Therapy, 30,* 453–466.

Morgan, P. (1981). *Alcohol, disinhibition, and domination: A conceptual analysis.* Paper presented at the Conference on Alcohol and Disinhibition, University of California, Berkeley.

Nyman, D. J., & Cocores, J. (1991). Co-addiction: Treatment of the family member. In N. S. Miller (Ed.), *Comprehensive handbook of drug and alcohol addiction* (pp. 877–888). New York: Marcel Dekker.

Papero, D. V. (1990). *Bowen family systems theory.* Boston: Allyn & Bacon.

Robb, N. (1998). Teaching on addiction issues lacking in medical school, specialists told. *Canadian Medical Association Journal, 158,* 640–642.

Sotile, W. M., & Sotile, M. O. (2000). *The medical marriage: Sustaining healthy relationships for physicians and their families.* Chicago: American Medical Association.

Stanton, D. M., Todd, T., & Associates (1982). *The family therapy of drug abuse and addiction.* New York: Guilford Press.

Talbott, G. D. (1987). The impaired physician: The role of the spouse in recovery. *Journal of the Medical Association of Georgia, 76,* 190–192.

Talbott, G. D., & Gallegos, K. V. (1990, September). Intervention with health professionals. *Addiction and Recovery,* pp. 13–16.

Talbott, G. D., & Martin, C. A. (1986, February). Treating impaired physicians: Fourteen keys to success. *Virginia Medical, 113,* 95–99.

Toman, W. (1993). *Family constellation.* Northvale, NJ: Jason Aronson.

Twerski, A. J. (1982). *It happens to doctors, too.* Center City, MN: Hazelden.

Vaillant, G. E., Sobowale, N. C., & McArthur, C. (1972). Some psychological vulnerabilities of physicians. *New England Journal of Medicine, 287,* 372–375.

Wallack, L. M. (1981, April). *The problems of preventing problems.* Paper presented at the Conference on Developing Prevention Programs, Nebraska Division of Alcoholism and Drug Abuse, Lincoln, NE.

Walsh, F. (1998). *Strengthening family resilience.* New York: Guilford Press.

Wolin, S. J., & Wolin, S. (1993). *The resilient self: How survivors of troubled families rise above adversity.* New York: Villard.

Yandoli, D., Eisler, I., Robbins, C., Mulleady, G., & Dare, C. (2002). A comparative study of family therapy in the treatment of opiate users in a London abuse clinic. *Journal of Family Therapy, 24,* 402–422.