Theoretical Aspects and Clinical Relevance of the Multigenerational Model of Family Therapy

Philip I. Guerin, Jr. M.D.

Katherine Buckley Guerin, M.A.

By using a three- to four-generational model, it is possible to remain relevant to a family's presenting symptom, and at the same time go beyond it to the underlying patterns of the multigenerational system.

Families can present in many ways. One way is with the symptoms in the child, either a physical symptom like asthma, or an emotional symptom like depression. On the other hand, a family may present with a marital focus—open conflict on the verge of divorce, or just a communicational breakdown. A family may present with emotional or physical symptoms in one or the other spouse. In rare instances a family will present with an extended family problem. And in these days of having to deal with aging and death perhaps more often than in the past, we also see families whose major concern is with an aging parent and whether or not to institutionalize.

Most of the time, however, the symptoms are presented to family therapists clinically as isolated to the nuclear family. Only after tracking and uncovering, and elaborating on the boundaries of the system is it possible to understand how the nuclear family conflicts tie into the remainder of the system. Most frequently the place that the symptom presents in the family is where it seems to be safest for a symptom to reside. For instance, in some families in which symptoms present in the child, it is evident in the first interview that it isn't safe for that family to have a problem in the marriage.

There is a lot of anxiety that if the therapist looks too closely at the marriage, it is going to rupture or break apart in some way. Other families come in with a marital problem, yet symptoms are obviously leaking down a generation to the kids, and if you begin to investigate the parenting function, they get very skittish about that. Every family has safe and unsafe areas, and very often there is one generational level the family finds it difficult to let the therapist in on. Research and clinical experience seem to indicate that most often this is in the extended family Many families don't see the clinical relevance of the grandparent generation to their specific problem, and it's up to the art of the therapist to make the three- to four-generational model relevant.

The family we shall discuss here started out originally as a child-focused family. They have three adopted children, two boys and one girl. The parents are both in their late thirties. The problem presented originally in the daughter. The parents were concerned about her social behavior, considering it sometimes inappropriate. They also worried abot,,i, whether or not she had a learning disability. The parents were seen by themselves; with just their daughter; and with all the kids together. The parents are both Catholic and originally from New York City. The husband is of Slavic origin; the wife is Irish. The husband, a very effective and successful businessman, was clearly an object-oriented overfunctioner. His wife, on the other hand, was a relationship-oriented emotional overfunctioner. She was tied into and anxious about the kids and their functioning, and about her mothering. He was the distant critical expert, especially in relation to the job she was doing with the children. He was very much into his own business and projects around the house, whereas she was underfunctioning and really distant from a lot of the family busy work. There was some activity with the kids on his part, more with the boys than with his daughter.

In a child-focused family it is important not to fall into the trap of trying to sell the parents the idea that what they really have is a family problem or a marital problem. Any such attempt will only trigger already primed feelings of parental guilt and responsibility, and the result will be an increase in the family's anxiety level, and a reinforcement of denial and projection.

Whenever I see a child-focused family, I automatically assume a set of four potential triangles: the central nuclear family triangle of mother, father, and symptomatic child; two auxiliary nuclear family triangles, one involving a parent, the symptomatic child, and an asymptomatic sibling, the other an intersibling triangle among three of the children; and finally, a triangle over three generations involving a grandparent, a parent, and the symptomatic child. There are many other possibilities, but these are the most frequently encountered clinically. As I evaluate the family, I try to search for the active existence of any one or more of this set of potential

triangles. Once I locate the existence and spell out the process, I am ready to intervene. In this family the initial intervention was a two-stage process. The central nuclear family triangle of father, mother, and symptomatic child was clearly spelled out. The father was in the distant critical position, the mother emotionally overinvolved with her daughter and reactively distant from her husband. Since the daughter was exquisitely sensitive to her father's criticism of her, and especially tuned in to her mother's anxiety level, an increase in either one predictably exacerbated the daughter's symptomatic behavior.

In order to set the stage for structurally shifting the process in this triangle and thus shifting the symptom, a detoxification of father's critical expert position had to take place. Therefore, stage one was to instruct father to increase his coaching of mother until she gets it right and daughter shapes up. This was meant to exacerbate the problem to the point where father had to concede this method of proceeding was useless—after which the stage was set for move two.

The second intervention was to encourage mother to move out of her present position and become more interested in some extrafamilial things. She was also instructed to decrease her degree of responsibility for daughter's functioning and well-being. The father was instructed to move into the space vacated by mother. If these steps are carried out by the family, they are engaged, and a shift in the process usually occurs. In this particular family, mother moved out, father moved in, and father began to question whether his distance wasn't something that was affecting the family. As his wife moved out, he began to find that he had a lot of difficulty dealing with her being outside his radar. As long as she was where she was supposed to be when she was supposed to be there, he could go off and do his thing around the house or elsewhere and be calm about it. As soon as she was out somewhere doing something, and her bleep wasn't appearing on his radar screen, he began to get anxious. He developed some somatic symptoms and became somewhat depressed and concerned about himself. The little girl in the middle of this process responded to the attention from her daddy and the decrease in pressure from her mother by showing marked improvement in her functioning. The primary shift had thus occurred. The process had shifted, and the problem been redefined and systematized with the relocation of the symptom in the marriage.

As the marriage is worked on, and the marital fusion unfolds, the process inevitably involves a tie into the extended family. The interlocking character of the three generations comes into view. Pieces from all three of those generations must be worked on at different times, depending on what's going on in the present time frame with the family. Success and progress don't mean that the symptoms and the dysfunction just disappear; instead symptoms will reappear over time in all three generational levels of

the family. For instance, as you get close to the core of the difficulty in the marital fusion a child may pop up symptomatic again in response to the rising anxiety level. In sorting out the nuclear family process, grandmother's part in it may move the focus to the extended family. Working with a family over a long period of time reinforces the view that there is a transgenerational flow, and that isolating an emotional problem inside the nuclear family makes no more sense than isolating it inside an individual's head. The whole three-generational structure of the system, with all of its interconnections, becomes ever clearer. Change is measured in terms of a decrease in the intensity and duration of the reoccurring predictable dysfunction as the process inevitably recycles itself.

Not all families embark on a long term course. Some fail to engage at all, and sabotage interventions with "I can't," or "I won't do that," or some version of "You've got it all wrong, Doc," or "You wouldn't suggest that." Other families will buy the initial intervention; with symptomatic relief, they then gratefully withdraw lest the therapist in his zeal for further change mess it up all over again.

The term *fusion,* in a systems-relationship framework, indicates a blurring of self boundaries. This blurring of boundaries carries with it a constantly fluctuating, momentarily changable reactive state in the relationship. On one end of the spectrum is the time-limited comfort of relationship refuge. On the other end is the discomfort of the furnace-refrigerator phenomenon of active and open conflict. Every married couple I have studied exhibit complementary operating principles and reciprocal functioning. That is to say, people with opposite operating principles marry each other, and these differences in their operating principles provide an attraction and a balancing stability to the relationship. As their interdependence grows, each relies on the other for emotional balance, so that reciprocity of function evolves. The husband, let us say, is the objective overfunctioner, and the wife is the emotional overfunctioner; these characteristics form a complementary bond which operates like a seesaw: if one spouse's functioning is up, the other's must be down.

In this marriage, for instance, the husband is the reasonable, object-oriented emotional distancer. He responds to upset and crisis with rational thought; emotionally he operates on an even keel, only blowing up after long build ups. He keeps active and busy, deplores small talk, and likes to spend his relationship time discussing important nonpersonal issues, or participating in some invigorating activity like tennis, handball, or sex. His wife, on the other hand, is the relationship-oriented emotional pursuer. She reacts intensely to upset and crisis; her facial expression is a mirror of her inner thoughts and feelings. She deposits the byproducts of her inner turmoil into a relationship with anyone who will listen. She explodes easily, but then the fire and smoke dissipate quickly. She likes activity, but likes just sitting

talking best of all, especially when it involves small talk and juicy gossip. Both spouses are competent adults. His distant, reasonable reserve provides a balance for her in the same way that her talkative emotional tolerance for people provides a balance for him So how come they don't live happily ever *after? Well, a lot of funny things happen in human relationships. One of*

them is that people become more like themselves when stress hits a relationship. Distancers reason at feeling; and when this fails, they seek refuge in nontalking-back objects. Pursuers express their feelings from the soul and seek refuge in togetherness; then they wonder why everyone is moving away from them. The balance becomes the itch. So if you ask someone what he or she likes best and what least about the spouse, the answers could be the same, depending on the emotional climate of the moment.

The build up of dependence on the operational attributes of one's spouse atrophies the development of those same parts of one's self. In time of crisis, if a call is made to that part of the self, there will then be nothing there to respond; and the dependence on other to fill that void becomes further intensified. This increasing interdependence builds to the point of producing a reciprocity of functioning, so that when one spouse functions well, the other functions poorly. This may move back and forth like a seesaw, or it may become relatively fixed. The fixed states produce the most emotional symptoms.

A clear definition of the relationship reciprocity is therapeutically important because it educates people to the process they are caught up in, and produces a hope for change. Establishing the way reciprocal functioning swings back and forth over time can validate the emotional experience of the present underfunctioner, and perhaps serve to motivate an attempt at change on his or her part. It should be kept in mind, however, that it is the one in the overfunctioning state at the time they are seen clinically who will have the easiest time changing his or her part in the process.

The issue of self-boundary—how people define themselves and their personal space in relation to others—is another aspect of marital fusion. Emotional pursuers are boundary invaders, always moving into another's personal space. They want to know what everybody else is thinking, and feeling; they also want to take responsibility for helping others. The emotional pursuer's own boundaries usually tend to be nonselective, that is he tends to invite almost anyone in, and lets them know about rather personal matters. This nonselective boundary may foster a state of chaos in which the emotional pursuer feels quite at home. The emotional distancer tends to invade only on object-oriented issues; only rarely does he ask anybody into his own personal space. Even when he seems to want to, his tightly-drawn boundaries make it difficult. Order and quiet, and a mildly cool emotional climate are preferred.

fusion. In this family, for example, both spouses monitored each other's public image. The husband was extremely tuned in to how his wife appeared in social groups, and whether she was making a fool of herself or not. Responsibility for changing the other is something that all of us get into. We get uptight in a situation; our insides put the problem outside of ourselves into the other; and the automatic programmed response is to change the other. A close look at the situation shows each spouse is doing a fine job of being critical of the other's areas of responsibility while not doing his or her own jobs well or at all. Furthermore, each spouse assumes that his or her own behavior can't be helped, but that the other's behavior is on purpose.

This transcript is from the fifth session of therapy with this family The beginning of the shift in the central nuclear family triangle has already happened. I am trying here to dissect the elements in the marital process and to relabel them, and also trying to define the positions of each of the spouses in reference to listening and hearing, with subsequent directives to get into one position or the other. The central issues in this first segment, for the husband, are productivity, organization and public image. For the wife the issues are their relationship, togetherness, and obtaining approval. Some of the component parts of the marital fusion are elicited.

[Parents at session without children have just reported that their daughter is much improved. I take that opportunity to broaden the focus of the therapy to include the marriage.]

Dr. G.: Suppose the kids were perfect? Then life would be—

Ann: Oh, hell, we had six years of that with no children around, and it wasn't—

Jim: It wasn't what?

Ann: We had six years, and we didn't have a peaceful relationship.

Jim: What do you expect?

Ann: Then the animal has to come out, all the nastiness, all the—everybody is human.

Jim: You mean you have some statements about the first six years? You can look back and say they weren't a good six years?

[The husband shows his reluctance to view the marriage as anything but normal and good.]

Ann: I'm not saying that they weren't a good six years.

Jim: They were a six years that had a few problems.

Ann: What I am saying is your disposition hasn't changed, it was rotten then and it still is.

Jim: What? What? What? *(laughter)*

Ann: He was a lousy. . . .

Dr. G.: Was he born like that or did his mother give it to him?

[Therapist participates in the banter, without getting caught up into trying to mediate.]

Ann: Well, not any more but I think she was very difficult when she was young, according to his sister.

Dr. G.: All you gotta do is wait it out. He'll mellow as he gets older. [Therapist continues banter]

Ann: Well, I am not waiting until he is eighty-four years old, though.

Dr. G.: You're going to change him now?

[Therapist labels efforts at changing other; wife shows evidence of assuming her husband's motivation. His toxic behavior is on purpose; hers, she can't help.]

Ann: Yeah, absolutely, I am not going to change him. But he is too intelligent, he is not a dummy, there is no reason, because I think a lot of it is his will, you know, I *think he—*

Dr. G.: You think he could be nicer if he really wanted to be?

[Therapist picks wife up on her assumption of his motivation.]

Ann: Absolutely, I am really convinced of that, I really am, I really feel that.

Dr. G.: Well, if he didn't have the kids to get bugged at you about, what would he get bugged about?

[Therapist attempts to focus the conflictual process around issues, to get away from the attack-defense pattern and sharpen the focus on the relationship process.]

Ann: He can't pick on my weight any more, or my eating habits, because they're together.

Dr. G.: You changed all that for him?

Ann: No.

Dr. G.: You just changed it for you, and he happened to like it?

Ann: Yeah, and he happened to like it. I am not very good at changing things just for him, because he is not pleased even when I do it.

Dr. G.: No matter how you do it, he is not pleased?

Jim: Oh, that's—come on, come on.

Ann: Bullshit, then you try something else. You are going to give me a two-week reprieve here, until you start with the cigarettes, and then you are going to start on that.

Dr. G.: Two main complaints about Jim here would be his criticalness of you and the kids, and your being unable to get underneath his expertise to the real him.

[Therapist tries a process hypothesis, focusing on the husband's tendency to criticize his wife's mothering, and the way her reactiveness to his critical expert makes it difficult to bypass it and get to the real him behind it.]

Ann: Number one is right. Number two, you might be right, but I haven't ever really given it much thought.

Dr. G.: Well, you're talking about his moving around on the table the stuff you put out there, instead of putting out his own stuff.

[Therapist pushes hypothesis.]

Ann: Yes, I would sense you are very right on the second one, but I never really thought about it. There was a thought that went through my mind last week about how I rely on Jim and his expertise, and how much I need his strength. You know, I need his approval of things I do, there's no question about it.

[Wife responds by talking about herself for the first time, describing the other side of the marital fusion—the degree to which she depends upon the parts of him that at other times she labels as toxic and willfully destructive to the relationship.]

Jim: Expertise in what? By the way, that's not true. You have really shown over the last couple of years that you handle the most difficult situations with great expertise, even better than I.

[Husband continues to counter wife's position even in this.]

Dr. G.: Now, when things get wound up between the two of you, both of you have trouble assuming the listening position. You sort of get into buttal, re-buttal.

[Therapist moves to stay in control of of the flow of the therapy session.]

Jim: Yeah, there's a lot of that.

[Husband's first validation of marital conflict.]

Dr. G.: How responsible do you think Jim feels for your happiness?

[Moving quickly back to wife and her reactivity, therapist asks a question aimed at the marital fusion—responsibility for other's feelings—in an attempt to detoxify wife's anxiety, and to get her to on to a new thinking track.]

Ann: That's a question to ask me tonight. I would say not too much.

Dr. G.: You don't think it bugs him when you look unhappy?

Ann: He claims it does. I would say that would be a difference in the past few weeks. For the first time in fourteen years I have had a feeling that he might care whether I am happy or not.

[Wife proceeds to describe beautifully the movement in their relationship which has led to a fixed distance between them. The husband, in response to thoughts developed in an earlier session about his distancing behavior, has attempted to move toward his wife. The resulting process is one in which the wife, from her position of reactive distance, mistrusts her husband's moves toward her, and gets caught in a fixed expectation that once he attempts a change he'll never fall back into old ways.

Dr. G.: What would give you that impression?

Ann: Telephone calls from the office.

Dr. G.: He calls to see how you are?

Ann: Yeah, tells me he is sorry, how much he loves me but he can't do it in person.

Dr. G.: He is moving towards you, and you are complaining about the way he does it. He calls you on the telephone and makes contact with you, and you say he can't do it in person.

[Therapist labels this process in both instances.]

Ann: But then he walks in the house and has a complaint, and I can't see why he bothered calling me.

Dr. G.: You expect that when things get a little better between you, they are going to remain better? You don't expect him to become his old self again? [Therapist labels fixed expectation.]

One of the things brought out in this segment is that the husband has made an effort to change things, to which the wife has responded from her position of reactive distance with the resentment built up over time and stored in her bitter bank. He attempts to move toward his wife in an effort to connect with her; she criticizes him for the way that he does it. That's the kind of thing that happens all the time, and is a significant roadblock to change. The emotional pursuer has pulled back in frustration to a position of reactive distance; the distancer, sensing the empty space, moves in and runs into some version of, "You weren't there when I was looking for you, so buzz off." It's seen as too little too late. The distancer usually then pulls back with a confused, "What can I do, I tried?" and a fixed distance sets into the relationship, which is then set up for triangulation.

Another point of importance is that the therapist validated what's important to different family members, and the differences in what's important to each of them. The wife talks about her social network. True, she is sidestepping the issue of closeness. However, the husband is also invalidating its importance by putting down her interest in the social network. It is

more comforting to his insides if he can isolate her and have her orbit around him, and function as she is supposed to in the house. But that also indicates how her network functions for her: it helps to keep her insides calm in the presence of his distance. Also touched on is the issue of safeness —that is, whether it is safe to put your insides out into the relationship and what will happen if you do.

What about the issue of the therapist taking sides? Have I been triangulated into the relationship in any way? Some may consider that I am obviously on her side and seeing things her way, because I spend so much time talking to her to the exclusion of him. Being triangulated means being emotionally locked into the process in the family in such a way that you see a victim and a villain. It means that the issues being raised by the family trigger something in you so that you behave vi-sa-vis the family or one member of the family in a way that demonstrates you are reactive to their toxic behaviors. As far as the process in this particular session, the husband was more reluctant about being in therapy and about attempting to redefine the problem as a family problem. He is more the distancer; you never chase a distancer, but rather engage him while leaving him a lot of room. The therapist has to watch lest he get reactive to the wife's blatant attacks, or become infatuated with her amusing descriptions; at the same time, he has to assist her providing information.

If the therapist can stay detriangulated, the family is then going to have an experience different from what usually happens to it, for whenever this couple would sit with any one else, or whenever one of them would move unilaterally toward someone else, that person would quickly lose neutrality and choose sides. In addition to staying detriangulated, the therapist has to label the dysfunctions present in the relationship, and challenge the patterns. This is done by pointing out the pattern and asking individual family members what they can do to change it. Or, what would it take to change it? Challenging the pattern gives the family at least a hint that the therapist expects change, and a hope that change is possible. Then the therapist can try to guide them as they form a plan for trying to change things.

How can the therapist deal with his or her personal triggers so as to avoid being triangulated? I stay tuned into my own reactivity by observing what the triggers are for me with a particular family Is it someone talking too much? not talking at all? contradicting everyone in sight? or invalidating what I think is going on? Having isolated the triggers that tend to activate emotional response in me and set me off on a punitive or reactive course toward the family, I try to pick them up and feed them back into the family. If I pick up something that the husband does that bugs me— let's say, being vague—then I feed that back into the system by asking her, " What do you do when faced with your husband's vagueness?" or, "How does your husband's slipperiness affect you?" That is a very effective way

of freeing myself from being pulled into reactivity to that behavior. I assume that if the behavior is bugging me there's a good possibility it also bugs some family members. One good indication that you have been caught in the system is that you notice you don't have any more questions, or any more thoughts, or any sense of where you want to move with the family. Then you know you are incorporated into it somehow, and you are effectively paralyzed.

This next segment begins with my turning to Jim. While I was spending a lot of time talking with Ann, I told Jim to assume the listening position; therefore I had to return to him and ask him what he heard, what was going on with him while he was listening.

Jim begins to concur with the relabeling—that is, he agrees that there appear to be some problems in this marriage. I challenge the pattern by asking what it would take for him to decrease his criticism and get out of his predictable ways of behaving toward his wife. That begins to register with him; then the wife interrupts, and he quickly jumps back to the kids. His jump is a result of her incendiary remark and my having challenged his pattern and tickled him to change. This is a frequent pattern in therapy; as progress is being made in sensitive areas, the anxiety level rises sufficiently to retrigger the presenting complaint. Ann doesn't want to go back to the child focus, and offers evidence that there really are other problems in the family apart from the ones around the kids. At the end of the segment the issue of control in the relationship and how it is exercised comes into view.

Dr. G.: Have you been listening, Jim? what are your thoughts about it?

Jim: I am sad. I guess that there is a problem between us.

Dr. G.: What has you sad?

Jim: I don't know. I am sad because I guess over the last fourteen years or so we have had our share of arguments and fights and all, but I relate, I always relate to a feeling that I have towards Ann. There isn't an altercation that we've had, nor that we ever will have that will change my opinion of her.

[Husband describes his hurt at being criticized, and describes his persistence in caring for his wife.]

Dr. G.: So you care for her, and there are a lot of things about her that you think are A number one. [Therapist recognizes and reinforces positive factors, and then moves to process and asks how often they are communicated to wife.]

Jim: Yeah, something like that.

Dr. G.: How often would you communicate those things?

Jim: Occasionally, not a lot.

Dr. G.: So a larger percentage of your communication would be of the shape up kind.

Jim: Yes, I guess the sexual part of it is the time that I reveal this, or talk about this, or just convey the feeling.

[Husband validates his difficulty in communicating tenderness and positive responses, except in conjunction with sex.]

Dr. G.: So when you are making love you let her know about the positive things about her?

Jim: I think so, I try.

Dr. G.: Is that hard for you to do?

Jim: For me? No, it's not hard.

Dr. G.: Is it hard for you to do when you are not making love to her, just come up to her when she is slopping around the kitchen or something?

[Therapist presses for an expansion of the positive feedback to other nonsexual times.]

Jim: Hard, no. Maybe I have been neglectful of it. I wouldn't find it hard, no.

Dr. G.: What would it take for you to be less critical?

[The press continues.]

Jim: Work.

Dr. G.: What kind of work?

Jim: Hard work.

Dr. G.: You mean you would really have to sit on it?

Jim: Yeah, I would really have to work on it. I would have to have a reminder, I would have to have a string around my finger.

Ann: I could get you some flash cards.

[Wife tosses in a provocative barb.]

Dr. G.: Isn't Ann enough of a reminder when she starts bristling at your criticism? Or is that a red flag to bring the bull on?

[Therapist labels it as red flag.]

Jim: It's funny, but most of these situations occur when the children are involved. I would say that most of it, I disagree—

[Husband reacts, and takes problem focus back to the children.]

Ann: Oh, Jim.

Jim: I am telling you right here and now.

Ann: What about when we go out to dinner?

Jim: Those are situations that occur earlier, they are not the situation at dinner time.

Ann: I am talking about times when we are away from the children when they occur.

Dr. G.: Ann says she senses you are being critical even when the kids aren't involved.

Ann: When we are out with people.

[The pattern has been defined and established as repetitive, and successfully kept within confines of marital fusion.]

Jim: Under certain circumstances, yeah, if you tend to monopolize the discussion or get on the religious situation.

Ann: You're always telling me something that I shouldn't do.

Dr. G.: Could you get less responsible for the way she behaves, and let her be responsible for herself?

[Therapist challenges the pattern by questioning the husband on his ability to change his predictable part in the process.]

Jim: Well, it depends on the circumstances. There are certain people that might be interested in whatever she has to say, and others that are definitely not interested.

Dr. G.: Next time your wife is making an ass of herself in your opinion, why don't you leave her responsible for herself?

Jim: Regardless? Yeah, I'd need work on that.

[After several times around the bush, the husband agrees to give it a try.]

Dr. G.: Otherwise you end up responsible for her. Then she ends up feeling responsible for you as a critical husband who makes negative statements about his

wife in public. Suppose she, suppose you left her out there to catch her own left hooks?

Jim: I would really have to work at that.

Dr. G.: Would she take her own lumps?

Jim: I think she would take her own lumps.

Dr. G.: Why don't you try letting her take her own lumps and see what happens? [Therapist pins down the prescribed change.]

Jim: O.K. Then she is going to take her own lumps.

Throughout most of the next segment the issue of control is the focus as it relates to the marriage itself; eventually the issue of control is tied into the process of the therapy. In relation to the marriage the issue of control is there in every relationship. We all know that people control by different kinds of behavioral variants. At one extreme, being controlled can be a controlling behavior. In most relationships both people are struggling for some semblance of control, and going about it according to their own operating styles. Each sees his or her own behavior from the "I can't help it" position, but assumes the other's actions are on purpose. The issue of control in this particular family was not being verbally expressed. The therapist's thinking-system and feeling-system radar has to remain active to pick up the toxic and invisible issues that are not being talked about, so that he can introduce them into the discussion of family process in such a way that they can hopefully be heard and detoxified. In the process of bringing the issue of control to the surface, Ann and Jim get into a chaotic dance, bouncing off each other and interrupting each other's statements. Since I believe the therapist must not get locked into a position of being the referee, I give them a brief reverse communication—"Could they continue this chaos, and escalate it for the rest of the week?"—they agree they can, and the tension and bickering dissipate. That maneuver on my part is an effort to retain control of the session.

Dr. G.: Would it be important to you to be in control of what is going on around you?

Jim: In control? Not completely, no. I think I have relinquished a lot of control in Ann's area.

Dr. G.: Control has been an issue then. It's gotten better, but it is an issue in the relationship?

[Issue re-emphasized.]

Ann: Never a voiced one.

[Invisibility of issue validated.]

Dr. G.: Would you get anxious inside if you sensed yourself losing control of the situation?

Jim: Out of personal control of the situation, yeah, I guess so.

Dr. G.: You are comfortable when you know what's coming. If things get unpredictable you would start spinning around inside?

Jim: Yeah, but that doesn't happen very often. When it does happen I do get upset but I think my reaction is pretty sound.

Ann: You made a comment that you don't have as much control over me as you used to, what do you mean by that?

[Control and oppression are triggers for the wife, and now that they are visible, she zeroes in.]

Jim: No, no, we are not talking about control over you—

Ann• No, before didn't you say something about that?

[A tiny bit of chaos gets in.]

Jim: Control over you?

Dr. G.: I believe you said you relinquished a lot of control in Ann's area, She wants to know what you mean?

[Therapist clarifies.]

Jim: I meant from the standpoint of functioning as a married couple with a family, with a house, with this and that.

[Husband normalizes.]

Dr. G.: You mean telling her how she had to live her life, that kind of stuff? [Therapist escalates.]

Jim: No, no.

Ann: That's a feeling I have that we get into this every once in a while and never get down to the core. But you ask me, what are you complaining about? What are you talking about? You do what you want, and I don't stop you in any way, you have all the freedom that you want, you finally reached it.

[Wife opens up the issue more widely.]

Jim: All the freedom, no, no. Why do you always say all, everything has to be all.

[Husband complains about wife's all-or-none positions.]

Ann: O.K. most of the freedom. You have relinquished control with regard to me. When we first got married you would come home and tell me what was expected of me.

Jim: You came from a family with a very hip-shooting attitude towards spending of money and—

[The issue around which control is exercised by the husband surfaces.]

Ann: There is something tied up with this money and my attitude and feelings about money?

Jim: Of course.

Ann: You said that money is no problem.

Jim: Ann, if we had urinated our money away, instead of pissed away, we wouldn't have had certain things that we have today and maybe these things aren't important, I don't know, I don't want to get into that.

[A flurry of reactive process emerges around money, control, and who dictates how proper behavior is defined.]

Dr. G.: What's the difference between urinating it away and pissing it away? [Therapist playfully encourages flurry to run its course.]

Jim: She would punch your fucking heart out and I would just— [Husband and wife continue banter.]

Ann: That's awful to say that. You fucked yourself around the whole house yesterday, you used that word every two seconds, but that's all right. Jim, I am going to say punch out your fucking heart. I am not vindictive and I don't like to expend energy in getting even, but I am going to say it, I enjoy saying it, I don't feel there is anything wrong with it and I am not going to stop saying it because you tell me it's a dirty word, when you use it all the time yourself.

Jim: No, no, I don't use it all the time, in fact I don't use it much at all.

Ann: You use it towards me.

Dr. G.: Can the two of you continue this kind of thing for the rest of the night, if you really try?

[Therapist moves to regain modular control of session.]

Ann: If we really try, yeah.

Dr. G.: I think you ought to practice ping-ponging it back and forth with one another.

Jim: I think she's ready, I think she really has her guns out.

[Wife proceeds to make a clear statement of her feeling state. She protests her helplessness to control it, while holding husband responsible for doing his toxic numbers on purpose.]

Ann: I told you before it's not something I work at, it is something that takes place within me that disturbs me, and I get very hurt and very upset and I don't get over it easily. I never used to be this way. It gets worse and worse all the time, and it's not something I'm in complete control of. I got up this morning and I decided, it's not going to bother me. Before a quarter to nine, the kids were out of the house. You know, even before they left at ten after eight I was all stirred up inside, and then after they left, I said it's not going to bother me. By a quarter to nine I had all this to face, and boy, if you were there I would have told you it was on my mind. I couldn't get it off my mind. I had a pit in my stomach all day, I felt shitty all day, you know, it's something I have no control over. I can't turn it on and off like you do.

Dr. G.: Do you think his criticism is more on purpose than your being upset the way that you are now?

[Therapist attempts to refocus with a balancing question, giving wife responsibility for her own behavior.]

The eventual goal here is to work toward the development of one-to-one personal relationships with as many people in the family as possible, in the hope of being able to provide the individual members of the family a degree of emotional freedom from their reactive triggers. That way they won't continually be in a responsive position, caught up in the reactive flow of the family process and behaving like predictable robots; instead, they will have some initiative to move in many different ways within the context of the relationship system.

Ann and Jim did a fine job of getting self-focus and beginning to define themselves in relation to one another. Ann got a sense of the way she operated, the triggers that pulled her into performing her toxic behaviors, and the reflexive character of her blaming those behaviors on Jim so that she held him responsible for her unhappiness. Jim became much less critical; he developed a sense of his tendency to distance from feeling, and saw how much his attempts to control Ann's movements were tied into his internal comfort. They both began to change their own behaviors, and found ways to remain in charge of themselves when their anxiety rose.

The process of defining marital fusion eventually goes back to the family of origin. A focus will develop on each spouse's primary parental triangle. Marriages of grandparents and siblings will be compared. Sometimes there is a very proximate and obvious connection between nuclear and extended family processes so that the transition to extended family focus becomes automatic. Other times something in the extended family will affect the

nuclear family, and thus bring the third generation's part in the process into sharp focus. A mother-in-law's input, or a wife's special relationship with her brother will be perceived as increasing the uptightness in the nuclear family; it may be *coming* out in the marriage, or *even have moved down* another generational step to the children. A child's functioning must be viewed not only in relation to parents, but also in relation to the extended family. Very often a grandmother and a mother and child are involved in a fairly intense triangle which demonstrates itself by dysfunction in the child.

The last segment of transcript occurs after six months of work. The wife is beginning to give some serious consideration to her relationship with her mother. I am trying here to get Ann to focus on extended family relationships. The tracking process starts with the demonstration of triangulation over three generations as related to the issue of the favorite child, and brings out the ambivalent feelings that Ann has for her mother. Sometimes extended family exploration produces a totally bastardized version of a parent. " You wouldn't even ask me to get into that if you knew my mother." Or it may produce an overidealized whitewashed version—"They were great folks"—but without any detail. Asking a family member to paint a family landscape may help to bypass some of the denial. If denial persists, and layers of semigloss continue to hide the view, then an artful dissection and elaboration by the use of a set of questions developed from clinical experience and theory is most helpful.

Nodal events in this family's life cycle—Ann's sister's marriage, and her stepfather's heart attack—are discussed. Ann talks about her relationship with her mother, and how it shifted so that she became her mother's mother. Questioning her about that experience pinpoints the nodal events around which it happened. Focusing in on these nodal events allows other pieces in the historical process to fall into place so that other occurrences over the years that relate to that particular nodal event begin to make more sense, and the past comes into perspective in relation to the present.

Dr. G.: You said your mother works hard on keeping it impersonal and general with you?

Ann: Hmmmm, yes, especially with Bill around. When Bill's around she has to create this intellectual type of climate.

[This emphasizes the importance of getting each parent alone if anything is going to develop. Otherwise the field is contaminated, and the other people present are easy ways to detour working on the relationship.]

Dr. G.: So she is out to impress Bill?

Ann: Yes.

Dr. G.: And when he is not around, what?

Ann: Oh, well, then she is more herself I guess. She is more on a personal level.

Dr. G.: What would be in the content of the communication then?

Ann: Well, she'll ask how the children are, and I'll start to tell her. Then she gets to talk about things like she tells me how Richie is her favorite, and that she

really can't help it, and then I ask her to please try and keep that to herself and not show it to the other two children. I don't think it's a good idea to have a favorite grandchild when you have three, and she knows that I definitely disapprove of something like that.

[Ann begins to develop one aspect of the three-generational triangulation in this family.]

Dr. G.: Do you have some kind of principle that your kids should be equal in the eyes of their grandmother?

[Therapist challenges Ann's position.]

Ann: But, you don't realize, it's not practical.

Dr. G.: Are you trying to protect your kids from not being the favorite or from being the favorite?

Ann: Well, because I was the favorite in my house over my sister, and then I was faced with the same problem myself with the boys and Susan, and I kind of feel it's not a good thing.

[The generational repeat surfaces.]

Dr. G.: How is she going to go around pretending that Richard is not her favorite?

[Therapist continues to challenge.]

Ann: Well, she said it Saturday night in front of him. I kind of appreciated it as something she has been feeling for a long time; and usually she sneaks it in without directly saying it. So Saturday night when she said it, I said, "Why?" She wants to take Richie to the ballet for Christmas, and she doesn't want to take the other two anyplace, and I won't let her do that because I don't feel it's fair. She hasn't taken any of them any place in eight years, and I know that they would really be hurt. So I suggested if you take one someplace that you take the other two too, not necessarily to the same thing, but that you follow up with Eddie and Susan some place. Then she takes Eddie into it and completely leaves Susan out. Then I go through the same thing nicely, you know, I really think it's better to take all three, some time at least. It doesn't have to be all the time.

Dr. G.: What would happen if she took Richard, the kids would start complaining?

[Therapist moves to concretize the process.]

Ann: Yes.

Dr. G.: Eddie and Susan would start complaining that Richard is going on a trip with Grandmother, and she likes Richie better?

Ann: She told Richie that.

Dr. G.: If they complain, tell them to go to your mother. Would they like that? [Therapist suggests surfacing the process in the family.]

Ann: Susan would.

Dr. G.: What would your mother say if one of them said, hey I hear you like Richie better?

Ann: And she'd say, "Now Ann, you know I didn't mean that. I just felt that Richie is more sensitive, and I can't help that I relate to him a little bit more. He was the first in the family, you know," and all that.

Dr. G.: You tell her, tell Susan that?

Ann: But she really doesn't see him very often. That would really be something, I would really like to see that.

Dr. G.: How are the kids going to get a relationship with their grandmother if you are in the middle directing traffic? Maybe it makes you anxious to get out of the middle, and out of the directors' position?

Ann.' I don't know, I'm so confused, I really don't know. After the past couple of weeks, I even thought, how much do I really like my mother? It's the first time, no it's not the first time I ever thought about it, I've thought about it for the past five or seven years. I really don't know how I feel about my mother.

[Ann moves off the kids and into the process between her mother and herself.]

Dr. G.: How much time do you spend just you and her?

Ann: None.

[Therapist concretizes time and space aspects of Ann's relationship with her mother.]

Dr. G.: So there is always somebody else around. How would you work it just to get the two of you alone?

Ann: Well, I'd go out to dinner with her.

Dr. G.: What would that be like?

[Reinforces the idea.]

Ann: I really don't know, I haven't done it, I haven't been alone with my mother I guess for fourteen years.

[More information on distance between Ann and her mother.]

Dr. G.: That's a long time. Is that about how long you've been her mother too functionally?

[The dissection process continues.]

Ann: No.

Dr. G.: How long have you been functionally her mother?

Ann: Five years, six years, maybe something like that.

Dr. G.: How are you going to switch that back?

Ann: I know that's what I started to think about.

Dr. G.: Why did you pick this time to start to think about it?

Ann: I came up with the idea of just how I feel about my mother, and like do I really have deep feeling for her? Do I really? Maybe not. Am I clouded by the last six years or so, if I am being too caring at times and guilty because I don't care enough, don't put myself out enough.

Dr. G.: So it brought in a whole flood of feelings and thoughts and questions.

Ann: Uh huh.

Dr. G.: Have you got the last five or so years put together as to what's going into the thing where you ended up her advisor and counselor and taker-care-of? What's that all about?

Ann: Well, I think it really happened when my father had his first heart attack. Maybe it could even be seven years. It could also be around the time my sister got married and she left. My mother didn't have Jane around once Jane was married. She battles with her all the time, but she didn't have her around as much. She didn't have Jane depending on her as much, maybe it could be that.

[The nodal events surface, and are connected by Ann to the relationship process with her mother.]

Dr. G.: So you would connect it to your stepfather's coronary, and your sister's getting married?

Ann: Yes, I think I could.

Dr. G.: Which happened first?

Ann: Jane's getting married.

Dr. G.: How long after that did your stepfather have his coronary?

Ann: Do you remember, Jim?

Jim: No, I'm very bad about dates and things like that.

Dr. G.: You never connected those two events?

Ann: No.

Dr. G.: Does your stepfather have trouble dealing with your mother when she gets upset?

Ann: I really don't know.

Dr. G.: How would you find out if you wanted to?

[The challenge to continue on the track.]

Now that Ann's thoughts have moved from her children, to her mother's relationship with her children, on to her relationship with her mother, it is time for her to begin to define a self in relation to her family of origin. The goal for the work in the extended family is the same as for the nuclear family—a sense of emotional freedom from her own and her family's automatic emotional responses. To do this Ann must set out to get a one-to-one relationship with each important family member. In her family Ann is the older of two girls. Her mother and father were divorced five years after they were married, when she was five and Jane was four. Her mother then married Bill, and since that time Ann hasn't seen her father. Her mother is the younger of twin girls, followed by a younger sister and then a brother.

First, of course, she had to define what the problems were, and where she and her sister fit into them. How did her mother relate to her and to her sister? Were they adopted by Bill? Did they take his name? What was their relationship with mother and biological father? I found that he had been an alcoholic. I asked Ann what would happen if she looked him up after thirty years. She said that first of all she couldn't do it, because of all the negative stuff. Secondly, it would be disloyal; she wouldn't be able to handle the responses by mother or aunts or sister, and especially by stepfather because of his poor heart. It took several months before she was willing to consider the possibility of connecting with her biological father.

One of the effective questions I asked was, how was she going to get her mother to be her mother again? How could they have an adult-to-adult relationship unless she did manage to get to where her mother was her mother again? I coached her to go to see her stepfather directly when her mother wasn't there, talk about the issue of her biological father, and tell him she was upset about being seen by him as disloyal and ungrateful for all that he had done for her. She did it. Bill said, "I told your mother she hasn't been responsible in not making sure that you knew your father better. So, I think it's a great idea. But expect trouble from your mother and her siblings." Now, the easiest thing in the world when somebody asks you for permission is to say "It's okay with me, but watch out for those other guys." But at least Ann had made meeting her father an open issue.

Then she finally got to the point where she was able to call her father and make a date with him for lunch. They met in a restaurant in midtown Manhattan. Who showed up in the restaurant while they were there? Her

there. She works in Manhattan, but not in the same area. She came into the restaurant, looked around, saw there was a long waiting line, and while Ann sat with her heart in her mouth, then walked out. If you study enough families, you begin to appreciate the power of emotional systems. Crazy things like this happen all the time.

Ann thus had connected with her father; he is a reformed alcoholic who's been married three times. The biggest complication, however, is that he's rich. How was he going to make it up to his two kids?

The response to Ann's contact was negative all around. Furthermore, she learned from her father that her parents had had a clandestine relationship off and on over the thirty years. By connecting with her father, she'd blown this clandestine relationship out into the open. The whole family began to relate to the long-absent father, who became specially close to the younger sister. So Ann, after having done all the work, ended up on the outside. But her mother began to treat Ann as she had when Ann was an adolescent: lots of criticism, lots of shape up. So Ann is definitely no longer her mother's mother.

The issue of sex in their relationship was a problem that Jim defined as Ann's problem, and that she defined as her problem. I touched on it off and on, but she wasn't ready to tie into it and grab hold. When she wouldn't take a direct symptomatic approach to the sexual issue, I tried to get her into the programmatic approach, asking her where her programming came from about sex, and how it tied into her sexuality in her marriage. She said she didn't know, since her mother was a swinger, still a beautiful woman at 58, who still sees herself as desirable, and who is still active sexually. So it wasn't a hang up from mother. Then she began to wonder if it had to do with grandmother and grandfather. Well, grandfather was called the Colonel, and was a compulsive gambler, which led to the premise that her mother was the counter-positioner to her grandmother's strict position about sex. In fact, grandmother even counter-positioned her as an adolescent into marrying Ann's father. Since Ann had lived in the home with the grandparents, she supposed she had picked up and complied with her grandmother's position about sex.

The older of the twins, Aunt Margaret, had in many ways been the functional mother in Ann's family. She was the responsible older twin; Ann's mother was one who flitted around. She lived off in the midwest, married to a man with a couple of kids from a former marriage. She married only after the grandmother had died, and everybody else in the family was settled except one sister who never married.

Aunt Margaret had been a heavy smoker all her life; she had chronic lung disease, and had also had pneumonia many times. She got sick again and it became clear that her lungs had run their course, and she was dying. Ann went to the midwest and connected with her aunt. She opened up these

issues of her father and her relationship with her mother; she also tried to get some information about her grandmother and how that might tie into the sexual thing she was struggling with in her marriage. Margaret got a little bit better, and Ann came home, but a few months later Margaret again ended up in intensive care, and the doctor said that it was probably for the last time. Ann went to see her again, this time with other members of her family. She connected with Margaret in the intensive care unit, and began after that visit to remember how important Margaret had been to her when she was a kid, how when her mother was off having a good time Margaret was always there. Margaret and she were the only ones in the family who open talked about the fact that Margaret was going to die, and they reviewed her life together. Ann went through a difficult time with the other members of her family because of her aunt's obvious response to her as somebody special. Margaret died. Ann came home.

After she was back, she felt different. She felt sexually freer, but she didn't quite understand what it was. Two weeks later, she dreamed she was involved in homosexual activity with a beautiful friend of hers; in the middle of the dream, the friend changed into Aunt Margaret. She woke up in a fright and a cold sweat. In the next three days there was a breakthrough in her sexual relationship with Jim. It was fantastic. He came into the next session with a big smile on his face, and when I said "What's the matter?" he replied, "Wait till we tell you."

What Ann's story has to teach us is how important it is to connect with those who matter to us. However, the people who are moving in have to be in control of their own anxiety, and know what they are doing. If not, they'll raise the anxiety level of the whole system so high there will be a blow up, with all kinds of ensuing havoc. They must have a carefully thought out plan; otherwise the family system will chew them up and spit them back out in the automatic, predictable response to anyone who behaves in a different way, crosses a family boundary line, or breaks some family taboo. As soon as one family member is able to begin to change, it opens up new sets of pathways and new options for the whole system of relationships. Again, any change will be resisted by the system, which will try to push the changing member back into his old position. If you're an overfunctioner, and you begin to underfunction on purpose, the reaction you'll get will be that there's something wrong with you; you don't understand the way things really are, and you had better change back or else. If you're a distancer and begin to move in, you'll be invalidated. If you're an emotional pursuer and you move back and stop your demands, you'll be accused of making those demands anyway, even though you know positively you aren't. That's the way emotional systems operate. And if you can get people to understand their own responsiveness to the system some way, then you make it possible for them to change.