# Chapter 7
# Psychopathology and Self-Regulation: Assessment, Case Conceptualization, and Intervention

The previous four chapters outlined four models of relational psychopathology: parentification, parental alienating behavior, bullying, and Stockholm syndrome. Each chapter applied relational competence theory (RCT), specifically the deadly drama triangle (DT), to a particular expression of intra- and interpersonal dysfunction. As discussed in Chap. 1, a model is defined not only by the application of an overarching theory but also by underlying dimensions that can be empirically examined. The dimension of self-regulation—along with its aftereffects and corollaries such as (a) the ability to negotiate approach–avoidance and discharge–delay tendencies, (b) the ability to regulate communion and agency motivations, or (c) the ability to intra- and interpersonally differentiate a self-full identity—appears to have relevance for all four models of psychopathology (Cusinato & L'Abate, 2008; L'Abate, Cusinato, Maino, Colesso, & Scilletta, 2010) presented in Chaps. 3–6. Indeed, L'Abate et al. (2010) defined *relational competence* as the ability to self-regulate, arguing that self-regulation may be "a superordinate process" (p. 104).

This chapter discusses the implications of practice behavior, assessment, case conceptualization, and intervention based on relational psychopathology as a manifestation of difficulties in self-regulation. Specifically, this chapter focuses on the clinical tasks of assessment, case conceptualization, and intervention from a systems perspective (Nutt & Stanton, 2011; Stanton & Welsh, 2011). Several principles of RCT and the deadly DT undergird this discussion. The first principle is that intra- and interpersonal dysfunction is inherently "reactively repetitive" (L'Abate et al., 2010, p. 213; see also Karpman, 1968, 2009). The second principle is that the self is "an emergent construct that comes into being relationally" (L'Abate et al., 2010, p. 12). Reactivity primarily implies a difficulty in intrapersonal self-regulation, whereas the notion of a relationally constituted self primarily suggests that difficulty with self-regulation is embedded in an interpersonal context. A lack of intrapersonal self-awareness and a lack of self-in-context awareness (Volf, 1996) characterize the four models of relational psychopathology. The third RCT principle, conductivity, stands in contrast to a lack of intra- and interpersonal self-regulation (L'Abate, 1983; L'Abate et al., 2010). *Conductivity* refers to the nonreactive,

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intentional negotiation of intrapersonal impulses and interpersonal space. Conductivity thus grounds healthy relational functioning in self-regulation.

The critical construct of self-regulation encompasses the notion of an observing self (Bishop et al., 2004). *Self-regulation* can be defined as the ability to self-reflect on internal states and behavior and then modify one's behavior to mirror preferred, prosocial ideals and goals (McCullough & Willoughby, 2009). Self-regulation is a broad construct that incorporates emotional and behavioral self-regulation and the related constructs of self-monitoring, self-soothing, and self-control (Wills, Pokhrel, Morehouse, & Fenster, 2011). RCT and the deadly DT extend this conceptualization of self-regulation to an observing self-in-context, or what Shapiro and Schwartz (1999) described as "intentional systemic mindfulness" (p. 128). Self-regulation and mindfulness are corollary constructs, with mindfulness perhaps best defined as "present-centered attention and acceptance of one's experience" (Coffey, Hartman, & Fredrickson, 2010, p. 248). The practice of mindfulness is therefore one means of increasing self-regulation. Mindfulness practice is representative of a class of contemplative practices that one can employ to improve self-regulatory functioning (Davidson et al., 2012).

Self-regulation difficulty, or self-dysregulation, is increasingly recognized as an underlying dimension of various forms of psychopathology (e.g., Dimaggio, Hermans, & Lysaker, 2010; Greenberg, 2002; Ross & Babcock, 2010; Widiger, Livesley, & Clark, 2009). Given the link between parentification, parental alienation, bullying, or Stockholm syndrome and pathological outcomes, self-regulation and self-dysregulation appear to have specific relevance to these constructs as well. For example, empirical evidence has suggested that parentification exerts a dysregulating influence on the parentified individual, resulting in deleterious consequences (Jankowski & Hooper, 2012). Similarly, studies of bullying have demonstrated empirical associations with self-regulation difficulties in both victims and perpetrators of bullying (Garner & Hinton, 2010). Parental alienation and Stockholm syndrome have drawn considerably less empirical attention than parentification and bullying. Nevertheless, the scant empirical evidence that does exist has indicated that parental alienation is associated indirectly with indicators of self-dysregulation for the individual who is experiencing parents' alienation strategies (Baker & Ben-Ami, 2011; Ben-Ami & Baker, 2012). Victimization resulting from traumatic entrapment is likewise associated with indicators of self-dysregulation (Graham et al., 1995).

Given the preliminary evidence, effective intervention may depend on the clinician's ability to assess and conceptualize self-regulation difficulties as a function of an individual's relational contexts. In addition, effective performance of the clinical tasks of assessment, case conceptualization, and intervention is informed by the clinician's awareness of self-in-relation and his or her ability to self-regulate both intrapersonally and interpersonally throughout the therapeutic process. This chapter explores specific ways clinicians might assess, conceptualize, and intervene in clients' self-regulatory functioning. But first, the next section describes a philosophical framework for conceptualizing the effective performance of these clinical tasks. The next section also describes the importance of the therapists' own ability to self-regulate when working with clients who present with a history of

parentification, parental alienation, bullying, or Stockholm syndrome. In other words, self-regulation has relevance for both the client and the therapist—and consequently for the effectiveness of the therapist's clinical tasks and practice behaviors: assessment, case conceptualization, and intervention.

## Philosophical Grounding of the Clinical Tasks

The notion that the self is "an emergent construct that comes into being relationally" (L'Abate et al., 2010, p. 12) applies as much to the therapist's functioning within the therapist–client system as it applies to the individuals in relationship within the client system. A central premise of systems theory—and of theories informed by systems theory, such as RCT—continues to be the notion of relationality. *Relationality* refers to the philosophical argument that understanding anything, whether another person or oneself, cannot occur apart from understanding its relation to something or in conjunction with someone else (Shults & Sandage, 2006).

Theorists distinguish between first-order and second-order conceptualizations and applications of systems theory (e.g., Hoffman, 1985, 1990, 1991). Similarly, there are weaker and stronger forms of relationality, with stronger expressions described as ontological relationality (Slife, 2004; Slife & Wiggins, 2009). Second-order systems theory can be described as a move toward ontological relationality. Relationality is predominantly a conceptualization of (a) persons as self-contained individuals and (b) relationships comprising self-contained individuals in reciprocal interaction with one another (Slife, 2004; Slife & Wiggins, 2009). In contrast, stronger expressions extend relationality to the constitution of the self and the individual's moment-by-moment experience within relational contexts. As a result, ontological relationality can be summarized by several identity statements: (a) "I am who I am, in part, because of who you are" (Slife, 2004, p. 166); (b) "we are who we are not because we are separate from the others who are next to us, but because we are both separate and connected, both distinct and related" (Volf, 1996, p. 66); and (c) "the self-organization of the 'I' in relation to itself and the orientation of the 'I' to others is already and always mediated by the 'not I'" (Shults & Sandage, 2006, p. 57). The self is therefore in a perpetual state of construction, evidenced through and emerging from social interaction with actual external others and imagined internal others in continuous dialogue with each other (Hermans, Kempen, & van Loon, 1992).

Some have labeled ideas about a relationally constituted self as a third-order systems perspective (Dallos & Urry, 1999). But whether it is labeled as third-order systems theory or ontological relationality, perhaps the most fundamental implication for the clinical tasks of assessment, case conceptualization, and intervention is the conceptualization of the therapist as a participant observer of the therapist–client system (i.e., therapeutic context; see Hoffman, 1985). From the perspective of ontological relationality, the therapist is both connected to and yet separate from her or his clients through a complex process of "[distinguishing] from the other and the internalization of the relationship to the other;…[a process of] 'differentiation' in

which both the self and the other take part by negotiating their identities in interaction with one another" (Volf, 1996, p. 66). As a participant in the therapist–client system, the therapist must continuously reflect on her or his influence on the client subsystem, monitor her or his reactions to the unfolding clinical process, and demonstrate keen attention to the influence of the client subsystem and larger social context on the therapist's own relating in therapy.

Weaker expressions of relationality have received the most attention in systemic formulations of assessment, case conceptualization, and intervention as evidenced by (a) the reframing of presenting problems in terms of dysfunctional relational dynamics and intervening to directly alter the interpersonal behavior of clients (Nutt & Stanton, 2011) and by (b) the numerous formal assessments that are available for quantifying first-order constructs (Carr, 2000). Some have noted, however, that systemic practitioners rarely use formal, empirical assessments (Bray, 2009; Carr, 2000). In addition, Bailey (2012) observed that recommended best practices in assessment for systems practitioners differ little from the individual practice literature and that little about the recommended practices was distinctively systemic. When formal assessments are based on a first-order application of systems theory (Carr, 2000), on the case conceptualization that emerges, and therefore on intervention that follows, these formal assessments tend to focus on commonly described systems first-order constructs. For example, first-order constructs such as structure, boundaries, intergenerational coalitions, intergenerational transmission processes, and fusion, cutoff, and other relational patterns are important to the assessment process (Bowen, 1978). Because second-order systems have been so influential in the advancement of systemic practices, practitioners may misconstrue first-order constructs and their assessment as contrary to a second- or third-order systems orientation (Carr, 2000). However, Carr contended that formal assessment of first-order constructs is not incompatible or incongruent with clinical practice grounded in second-order systems ideas.

Assessment, case conceptualization, and intervention from an ontological relationality perspective are grounded theory efforts (Charmaz, 2000). Clinicians perform these clinical tasks either within a particular relational context, from the bottom up, or ideally—according to Slife and Wiggins (2009)—from "good practice, which cannot be abstracted from specific contexts, [and] must precede and develop good theory" (p. 19). A diagnosis and corresponding case conceptualization may be thought of as a theory. The metaphor for therapy as qualitative research therefore suggests that each clinical task is a unique, contextually embedded, grounded activity (Heath, 1993). Assessment, case conceptualization, and intervention then borrow from the qualitative research metaphor and are defined by (a) clinical utility, (b) fit with the therapist–client system experience within the current therapeutic conversations and interactions, (c) coherence, and (d) the consensus of all involved (Ivey, Scheel, & Jankowski, 1999).

Additionally, clinical tasks from an ontological relationality perspective emphasize self-awareness of the therapist. One increasingly common way of framing the therapist's self-awareness rests on the notion of self-multiplicity and consists of an inner dialogue between parts of the self (e.g., Anderson, 2007a, 2007b;

Anderson & Gehart, 2009; Hermans, 2004; Rober, 1999, 2005). An ontological relationality perspective enables one to navigate the complexity inherent in clinical practice. Toward this end, it is important for the therapist to be aware of moments when a particular part of his or her self may be monopolizing the dialogue and restricting therapeutic conversation. The result may be an assessment of the clients' functioning that simply confirms the therapist's preconceived understanding, rather than a synthesis of therapist and clients' contributions that is grounded in the lived experience of the clients. For example, a clinician might fail to hear how a parentified child experiences both satisfaction and dissatisfaction in the adultlike caretaking role and instead frame the child's experience and the systems' functioning as exclusively pathological. Practitioners might increase their self-reflective skills by employing a strong relationality: effectively facilitating inner dialogue between multiple self-aspects while engaging in collaborative, open dialogic exchange with clients. For example, a clinician might realize that his or her framing of parentification as pathological is based upon the "not I" (Shults & Sandage, 2006, p. 57) and therefore implies something, or is implied by something, that is absent (White, 2000, 2006). That is, the nonpathological alternative also exists, can be known, and can be attended to within the therapeutic conversation. In this example it might mean recognizing that the child experiences a sense of identity, purpose, and belonging as a result of the parentification processes within the family system (Telzer & Fuligni, 2009).

## Systemic Assessment and Case Conceptualization

Systemic practitioners ideally attend to the individual level of analysis, in addition to the family and larger social contexts, during clinical assessment and case conceptualization (Stanton & Welsh, 2011). Systemic practitioners are also encouraged to make use of both formal individual assessments and formal systems-focused assessments of family functioning when conceptualizing presenting problems and establishing treatment direction (Nutt & Stanton, 2011; Stanton & Welsh). In doing so, systemic practitioners focus on intra- and interpersonal aspects of client functioning (Jankowski et al., 2011; Jankowski, Ivey, & Vaughn, 2012). Finally, systemic practitioners ideally synthesize information obtained from formal assessments with that obtained from informal assessments—the latter referring to more intuitively, subjectively, and conversationally derived clinical information (Jankowski et al., 2011). Systemic clinical assessment and case conceptualization reap "the benefits of narratives from multiple sources . . . [and] it may be useful to consider scores from assessment instruments and the implications of these scores, not as global knowledge but as specialized local knowledge arising from conversations" (Carr, 2000, p. 126). To synthesize multiple sources of information, Carr noted, it is helpful to frame each source as potentially useful to understanding the functioning of the client system. This process also requires the clinician to hold and synthesize multiple perspectives simultaneously and to be cautious about privileging one particular perspective over another.

Systemic assessment and case conceptualization are therefore multilayered with multiple perspectives, requiring the clinician to exercise metacognitive skill to attend to myriad internal and external voices during the course of a therapeutic dialogue with clients. Clinicians must negotiate between previously constructed understandings grounded in diverse clinical and personal experiences, while they also attend to clients' verbal and nonverbal communication in the moment of the therapeutic conversation. The clinician's diverse inner voices could consist of theoretical models, research on family functioning, family-of-origin experiences, previous clients, or anything else that is activated during therapeutic conversations. Distinctively systemic assessment and case conceptualization also form a multidimensional process. Clinicians must use seemingly disparate and contradictory sources of information while navigating internal and external dialogues. Within the same clinical session, a clinician may use information based on expert opinion or quantitative data (e.g., formal diagnostic assessments) and synthesize that information with interpretive data, such as subjective experiences of the therapeutic relationship or observations of client interaction—all while receiving ongoing implicit and explicit feedback from the client about the direction of therapy and the helpfulness of the therapeutic conversation. Furthermore, while negotiating client feedback, systemic clinicians can be seen moving along different positioning dimensions (Jankowski et al., 2011, 2012; Vaughn, 2004).

Vaughn (2004) identified three positioning dimensions in the practice of systemic assessment, case conceptualization, and intervention: (a) connection–separateness, (b) expert–nonexpert, and (c) participant–observer. As an example of the first dimension, connection–separateness, there may be times when a therapist needs to move closer to a particular system member, seek shared experiences, and identify with the client—and perhaps do so with different system members at different points within a therapy session. At other times a therapist may need to increase internal and interpersonal space in order to reflect on the therapeutic process. In the second dimension, expert–nonexpert, there may be times when the therapist negotiates between a hierarchical, expert positioning and a more open, exploratory positioning. For example, a therapist may consult a formal diagnostic assessment of one of the family system members as a basis for a particular question. Or she or he may ask a question from a position of curiosity and a sincere desire to understand a client's experience. Finally, in the third dimension, participant–observer, there may be times when the therapist includes himself or herself as a participant in the change process, for example, telling the clients, "we can do this." At other times the therapist may move to an observer position and try to influence a client to take responsibility for change. The latter position may involve utilizing silence to create room in the conversation for the client to wrestle with the implications of a question posed to him or her.

## *Formal Assessments*

Therapists may find it useful to employ an empirical assessment as one source of information about the functioning of different system members. In this section of

the chapter (i.e., discussion on formal assessments), we provide a brief overview of a few psychometrically sound empirical measures of self-regulation. A central premise of ontological relationality is the interdependence of system members, so systemic assessment involves capturing each system member's perspective in a "round-robin design" (Cook & Kenny, 2004, p. 361). A round-robin design allows each level of analysis to be taken into consideration when conceptualizing the case: individual, dyad, and family levels. Individuals can be asked to complete a formal assessment of their own self-regulatory functioning, as in the traditional individual-oriented assessment approach. However, a round-robin design also has clinicians assess other system members' regulatory functioning in the context of different dyadic combinations.

For example, if the family consists of a mother, a female adolescent child, and a younger male child, the eldest child may complete an assessment of the mother's self-regulatory functioning within the mother–daughter relationship, and the eldest child may also assess the mother's self-regulatory functioning as evidenced within the relationship to the younger child. Similarly, the mother and younger child would complete assessments of each family member's self-regulatory functioning within the different dyads. Dyadic scores can then be created by calculating the mean from each person's score in the relationship. For example, the mother–daughter dyad score could be created by calculating the average of the mother's assessment of the daughter's functioning in their relationship and also the daughter's assessment of the mother's functioning in their relationship. Last, a family-level score could be calculated by averaging all scores obtained through the round-robin design.

As Cook and Kenny (2004) noted, the round-robin design enables the clinician to target intervention more effectively, because the dysfunction might be occurring primarily within one dyad within the system and not within the family's functioning as a whole. This finding would not necessarily mean that the other system members are not included in therapy. Rather, other system members might be recruited to help intervene more effectively in the dyad by offering alternative perspectives, openly expressing their experience of the dyad, or perhaps being encouraged to align with or move closer to other system members. Even though the dyad may be given primary attention, the foundational premise regarding the four models of relational psychopathology is that of the deadly DT, that is, triangling processes, or a triadic formulation of dysfunction. The clinician should therefore assess and conceptualize individual and systemic functioning with the triangle as the fundamental unit of analysis in mind (Kerr & Bowen, 1988).

Numerous instruments exist for measuring the broad construct of self-regulation. One common means of measuring self-regulation involves assessing effortful control, which may be assessed at different stages of the lifecycle. *Effortful control* refers to the capacity to focus attention, prevent undesirable behaviors, and overcome avoidance tendencies. The Adult Temperament Questionnaire (ATQ; Evans & Rothbart, 2007; Rothbart, Ahadi, & Evans, 2000), the Early Adolescent Temperament Questionnaire—Revised (EATQ-R; Ellis & Rothbart, 2001; see also Capaldi & Rothbart, 1992), the Temperament in Middle Childhood Questionnaire (TMCQ; Simonds, Kieras, Rueda, & Rothbart, 2007), and the Children's Behavior Questionnaire (CBQ; Putnam & Rothbart, 2006) all involve self-report measures

that can be employed in modified round-robin assessment depending on the age of the children. In practice, the wording of items has to be adjusted to accommodate dyadic assessment of functioning using self-report instruments. Infant and early childhood measures also exist in which parents report on the functioning of their child (Gartstein & Rothbart, 2003; Putnam, Gartstein, & Rothbart, 2006).

Alternatively, the Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004) can be used as an indicator of self-regulation. The DERS measures awareness, acceptance of emotions, and (like effortful control) the ability to overcome feeling states and act in preferred, prosocial ways. Closely related to the DERS is the Five Facet Mindfulness Questionnaire (FFMQ; Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006). The FFMQ is a self-report measure divided into five aspects of mindfulness: nonreactivity, observing, acting with awareness, describing/labeling, and nonjudging of experience. Finally, if the therapist or clinician is more interested in assessing self-regulation along both behavioral and emotional dimensions, and also along intra- and interpersonal domains of functioning, the Differentiation of Self Inventory—Revised (DSI-R; Skowron & Schmitt, 2003) can be used. The DSI-R assesses for Bowen's (Kerr & Bowen, 1988) construct of differentiation of self. Evidence for the construct validity of differentiation of self as measured by the DSI-R supports its use as a measure of an individual's capacity for intra- and interpersonal self-regulation (Hooper, Marotta, & Lanthier, 2008; Jankowski & Hooper, 2012).

The use of empirical assessments is ideally synthesized with information from other sources. Jankowski and Ivey (2001) identified three categories of factors commonly used by clinicians during systemic assessment and case conceptualization: (a) interactional factors, (b) therapist-specific factors, and (c) contextual factors. The first category, interactional factors, consists of the clinician's awareness of the relational processes taking place within the therapist–client system. For example, a therapist may reflect on his or her emotional experience during the therapeutic conversation or observe clients' behavior and then use that information to formulate a problem definition and direction for clinical intervention. The second category, therapist-specific factors, refers to self-aspects of the therapist that he or she brings into the therapeutic dialogue and uses to inform assessment and case conceptualization. For example, a therapist may draw on previous clinical experience with another family and compare knowledge emerging from the current therapeutic conversation with the prior clinical knowledge. Finally, a therapist may be cognizant of and integrate a third category: larger contextual factors within which the therapist–client system is embedded. For example, a therapist may connect in-session conversation about the presenting problem, as well as his or her observations of client functioning, to conditions of poverty or the family's experience of job loss or unemployment.

The genogram (Kerr & Bowen, 1988; McGoldrick, Gerson, & Shellenberger, 1999) can be used to supplement empirical assessment of the system and to visually organize the information gathered during the therapeutic conversation. The genogram is ideally suited to the tracking of triangling processes throughout the system (McGoldrick et al., 1999; Titelman, 2008). The genogram can therefore be adapted to assess each of the four models of psychopathology presented in this book. For example, the genogram can map parentification processes that might include

contextual factors that contributed to and still maintain a child's performance of an adult role within the family. Contextual factors might include chronic illness in one of the parents, divorce, or substance addiction in the parental subsystem (Hooper, 2012). The clinician could also map interactional processes based on observations obtained through the therapy session or the clinical interview. Interactional processes might consist of conflict within the parental subsystem, intense emotional closeness between a child and one of the parents, or a pattern of disengagement in one of the parent–child dyads. Finally, constructing a genogram from the perspective of ontological relationality requires the clinician to include himself or herself in the interactional processes; it specifically requires that he or she be mindful of triangling processes. The clinician must guard against replicating a relational process in the therapist–client system. For example, the clinician might inadvertently reinforce a parental role for a child in a parentified system by privileging his or her knowledge of family dynamics or suggesting that he or she can exercise agency to change the system.

The deadly DT can also be drawn on the genogram. The genogram has application beyond family systems and can be applied to bullying outside the family or to traumatic entrapments such as captor–hostage situations. The roles of victim, perpetrator, and rescuer can be identified, and the role shifts characteristic of the deadly DT can be mapped. For example, a client who has been the victim of traumatic entrapment can describe the movement from the victim of the perpetrator to the rescuer of the perpetrator. Other relational dynamics typical of traumatic entrapment can be identified, including distancing, fusion, and over- and underfunctioning. For example, symbiosis, or fusion, has been used to describe the captor–hostage relationship, thereby distancing would-be rescuers and positioning them as outsiders in the triangle. Would-be rescuers may then be framed as perpetrators, placing the victim at risk by posing a threat to the relative stability of the captor–hostage relationship. Again, the clinician must be mindful of his or her role in the therapist–client system. If the clinician is not attentive to his or her role, he or she could unknowingly reinforce a victim role for a client by ignoring the ways the client exercised resiliency, hardiness, or even posttraumatic growth in his or her responses to traumatic entrapment (or similarly, to parentification, bullying, or parental alienation).

## Intervention

Effective intervention depends on the extent to which the therapist displays conductivity. L'Abate (1983) defined conductivity as "caring and compassioned concern and commitment to creative change through confrontation and clarification of content and context" (p. 278). Conductivity thus requires (a) awareness of the ontological relational self and (b) intra- and interpersonal self-regulation (L'Abate, 1983; L'Abate et al., 2010). Three primary applications to clinical practice and intervention are supported by conductivity. First, the clinician becomes a relational means of self-regulation for the client, or what Feld (2007) has called mutual regulation.

Jackson, Mackenzie, and Hobfoll (2000) described relational means of self-regulation as "self-in-social-setting regulation" (p. 276); from a Bowen theory perspective, the construct of triangling describes relational processes that have a self-regulating function within systems (Lassiter, 2008; Titelman, 2008). In the second application to clinical practice and intervention, mutual regulation rests upon the clinician's capacity for self-regulation. In the third application, differentiation of self becomes a primary goal for each person within the therapist–client system.

Given that each of the four models of relational psychopathology involves reactively repetitive triangling processes that prevent effective emotional and behavioral self-regulation, effective intervention necessitates creating a reflective space for clients to be able to gain awareness of the triangling processes and begin to make changes by detriangling or differentiating self from the system. Detriangling is a Bowen theory construct that typically refers to the clinician's role in therapy and her or his capacity to avoid getting caught up in the relational anxiety of the client system (Kerr & Bowen, 1988). A third-order or ontological relationality application of this construct heightens the need for the clinician to self-regulate her or his emotions and behaviors in therapy and adjust her or his behavior so as not to reactively and repetitively play out the deadly DT. As a potential rescuer, the therapist risks being repositioned by clients as a perpetrator, thereby becoming so isolated and distanced as to be ineffectual. The possibility that disequilibrium may be brought to the system as clients make an effort to change may result in a reactive role shifting in the therapeutic process, whereby a victim is recruited by the perpetrator to align against the therapist, making the therapist the victim and thereby maintaining the relative stability of the client subsystem.

Whereas detriangling typically refers to the clinician's task within the therapist–client system, differentiation of self describes the clinical aim for the clients. Nevertheless, the constructs appear to have equal applicability to clinician and clients within the context of therapeutic work to alter the deadly DT. Differentiating self, like detriangling, refers to the individual's capacity for self-regulation in the face of relational anxiety. Detriangling tends to also focus on the interpersonal processes within the therapist–client system, whereas differentiation of self can refer to both intrapersonal and interpersonal processes. Alternatively the term *mindfulness* can be applied to detriangling, differentiation of self, and self-regulation because all four constructs seem to share the two underlying dimensions of mindfulness. First, noticing one's emotional states and interpersonal behavior underlies the constructs. Second, acceptance is also an aspect of both self-regulation (as defined by differentiation of self) and mindfulness. Nonreactive, nonjudgmental intra- and interpersonal openness to present experience—typical of acceptance (Bishop et al., 2004; Coffey et al., 2010)—is a characteristic of persons scoring higher on measures of differentiation of self (Kerr & Bowen, 1988). For example, highly differentiated individuals are capable of "listen[ing] without reacting…[showing] respect [for] the identity of another without becoming critical…free to enjoy relationships…tolerant and respectful of differences…[and] intense feelings are well tolerated and so he[or she] does not act automatically to alleviate them" (Kerr & Bowen, 1988, p. 107). Detriangling has specific application to relational processes occurring between

system members and the processes occurring within the therapist–client system. Specifically, clinicians must practice noticing and acceptance in the context of multiply embedded relational triangles.

Clinicians who work directly with parents in situations involving parentification or parental alienation might also intervene by educating parents on child development and relational triangles. Differentiation of self is a normative developmental process grounded in an individual's agency needs, specifically the needs for increased autonomy, self-sufficiency, and the resulting interpersonal distance that often occurs as one ages. Triangling is also a normative systems dynamic that facilitates the regulating of self and others' emotions and behavior and interpersonal closeness and distance. Knowledge of child development and triangling can thus offer parents a normalizing experience. The clinician can help parents learn to effectively regulate the anxiety they experience when their children attempt to differentiate. During this therapeutic process, it may be helpful for the clinician to explore parents' developmental experiences and discuss ways in which they themselves attempted to differentiate from their own parents. Parenting is, to some degree, influenced by parents' own level of differentiation of self, so a child's differentiating process offers a chance for the parent to work on his or her own intrapersonal and interpersonal functioning. Effective work with parents therefore involves coaching them to use different strategies to engage emotionally with their child rather than engaging in reactive and repetitive triangling processes. For example, parents can practice open, nonreactive, expressive communication with their child in the presence of a detriangled clinician. It may also be helpful to explore the parent's own family-of-origin relationships and look for ways that the parent can alter his or her behavior in those relationships.

## *Evidence-Based Practices*

The clinical importance of addressing self-regulation difficulties has drawn significant attention. Two evidence-based approaches have obtained empirical support as practices for resolving self-regulation difficulties: emotion-focused therapies and mindfulness practices. Emotion-focused therapies attend to and intervene directly in affect regulation processes and have demonstrated clinical effectiveness with a range of presenting concerns (e.g., Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, 2002; Greenberg & Goldman, 2008; Johnson, 1996, 2002). Mindfulness practices, and the broader conceptual category of contemplative practices, have similarly demonstrated effectiveness with a diversity of clinical difficulties (e.g., Allen et al., 2006; Baer, 2003; Carmody & Baer, 2008; Fjorback, Arendt, Ørnbøl, Fink, & Walach, 2011).

Emotion-focused interventions focus on (a) resolving negative emotions and (b) promoting positive affect and prosocial relating (Greenberg, Warwar, & Malcolm, 2010), whereas mindfulness and other contemplative practices seek to promote change by increasing the individual's moment-by-moment awareness of emotional

experience and behavior. Both kinds of interventions increase awareness, which then allows the person to respond intentionally, not reactively, within social relationships. The goals of increasing awareness to reduce reactivity and then responding proactively align closely with Bowen's (Kerr & Bowen, 1988) ideas about intra- and interpersonal differentiation. Differentiation of self is therefore a construct with the potential to provide a basis for an integrated approach to clinical work that draws on Bowen's family systems theory as well as on emotion-focused and contemplative practices. An integrated approach offers the clinician an effective means for facilitating clients' self-soothing. This means might then be used as a basis for assisting the client to relate differently with significant others outside of the therapeutic context, thereby promoting differentiated functioning. Finally, an integrated approach also offers the clinician effective means of intervening directly in the clients' relationships and promoting increased self-regulation by coaching clients on how to respond differently to each other in the here and now of the session—again facilitating increased differentiation of self.

## Conclusion

Each of the four models of psychopathology consists of a lack of intra- and interpersonal self-regulation, or a lack of awareness of one's multiplicity of voices and self-in-context (Dimaggio et al., 2010). Self-dysregulation therefore results in reactive–repetitive interpersonal relating (L'Abate, 1983; L'Abate et al., 2010). However, under some conditions—perhaps most notably the conditions of traumatic entrapment and parentification—the reactive–repetitive responding may promote positive adaptation. So although assessment and case conceptualization might focus on the underlying dimension of self-dysregulation, systemic assessment and case conceptualization ideally attend to the ways in which the apparent dysfunction might also be functional and engender positive outcomes. An individual who experiences traumatic entrapment might display constricted awareness of self and might have repetitively shifted roles during the ordeal. However, these responses might in fact have enhanced the individual's survival (Cantor & Price, 2007). As another example, a parentified child may take care of a parent and younger siblings—but this might also promote positive growth (Hooper et al., 2008). Systemic assessment, case conceptualization, and intervention are thus oriented toward strength or resilience (Nutt & Stanton, 2011), and "relationship patterns that exist in seriously dysfunctional families are conceptualized as exaggerated versions of the same processes that are present in all families. In this sense, a natural systems orientation is a nonpathologizing theoretical framework that allows family psychology to approach human functioning from a strengths perspective" (p. 94).

Triangling processes are normative (Kerr & Bowen, 1988), and the ability to self-regulate is grounded in the basic human needs for communion and agency (L'Abate et al., 2010). In fact, triangling processes have a stabilizing effect on systems, thereby serving a relational regulating function for system members

(Kerr & Bowen, 1988; Titelman, 2008). Nevertheless, triangling processes can result in psychopathology due to the inherent tendency for triangling to occur at an automatic, implicit, reactive level of intra- and interpersonal functioning. Proactive, intentional acting in the face of the anxiety that fuels triangling becomes the clinical goal, which can be variously defined as growth toward systemic mindfulness (Shapiro & Schwartz, 1999), differentiation of self (Kerr & Bowen, 1988) or—as L'Abate et al. (2010) described—toward the relationally competent style of conductivity. Clinicians might benefit from a perspective grounded in ontological relationality that frames their role as an active participant in the therapist–client system and their ability to self-regulate amidst triangling processes and thereby effectively intervene in intra- and interpersonal regulation processes within the therapist–client system.

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