Trauma and Family Time

Alan J. Flashman, MD

The Hebrew University of Jerusalem

email: aflashman@gmail.com

Author biography

Alan Flashman MD practices child, adult and family psychiatry in Beer Sheva, Israel since 1983. He teaches family and child therapy at the Paul Baerwald School of Social Work of the Hebrew University of Jerusalem and at the Bob Schapell School of Social Work of Tel Aviv University. He has consulted over the years to many social service and educational programs throughout Israel, including to trauma response programs. Many of his papers and lectures can be found at alanflashman.com

Trauma and Family Time

Abstract

In this paper I address the influence of trauma on family chronology. I focus on the effect of trauma on the level of differentiation of a family. I then propose three forms of chronological passages, the objective, the pragmatic and the subjective. I illustrate such passages through clinical example. I suggest the clinical relevance of these passages in planning intervention with trauma victims and their families. Finally I demonstrate multigenerational passages with the example of kibbutzim formed by young Holocaust survivors.

Keywords Trauma . Multigenerational . Differentiation . Development . Holocaust survivors

Introduction: Diachronic Disaster

That victims of trauma suffer a synchronic disruption is well known. The basic definition of trauma as the overwhelming the defenses is synchronic – the force of the trauma *at one instant* is greater than the force of the defenses. It is not uncommon for the impact of momentary events to distract attention from the effects on the flow of time. Perhaps this is due to the privileged position of right hemispheric functions is relation to emotions. The way trauma disrupts time, its *diachronic* effect, has received less attention. Yet victims of trauma attest to the crucial element of time disruption in the traumatic experience. One could say that trauma overcomes the defenses because it catches them unawares, it disrupts the crucial function of *foresight* (Sullivan,1953) through which defenses are enlisted in anticipation of stress. In addition to disruption of the future, victims of trauma often will report a disruption of the sense of continuity with the past. The more severe and focused symptoms of depersonalization and dereization express this loss of continuity as self-experience and external reality are no longer felt to be continuous with the past.

In this paper I wish to explore the way in which family time is affected by trauma. First, let me define family time. Family members relate to time is a manner special to each family. The simplest example would be the birth of a child, say when parents are 32 and 28 years old, and the paternal grandparents 70 and 65. The child will enter first grade when these ages become 38 and 34 for parents, and 76 and 71 for grandparents. The child's future event now adds a dimension of meaning to these ages, a dimension shared by all family members. This meaning becomes practical as father thinks about coordinating his employment at age 38 with residence proximate to quality schooling. Grandparents may consider their retirement plans coordinated with assisting in schooling of the grandchild. I like to explain a professional's understanding of family time with the assistance of a historical metaphor. Stephen Kern (1984) describes the transcontinental train trip from Washington to San Francisco in 1870. Time zones were more than four decades in the future. A traveler would reset his timepiece with his arrival at each new station on the way, more than 200 times from coast to coast. The prominent clock in each train station would define *local time*. In the same way, a professional entering a family resets his appreciation of *family time*.

Trauma resets the family clock. Trauma occurs at a particular period when family members are engaged together in time passages bearing particular meanings. The traumatic event alters all of these meanings in significant ways. The remainder of this paper outlines an appreciation of these alterations and suggests directions for clinical response and further study.

Clinical Example: Wartime Trauma

I present here a clinical example in order to demonstrate my approach concretely. In 2004 the Rabin family resided in Sderot, the municipality in Israel closest to the border with Gaza. Sderot at that time was subjected to a nearly continuous shelling that originated in Gaza. The nuclear family at the time included Moshe, the father, then 40 years of age, his wife Sara, then 35, two children, Rivka then 11 years old and Benny, age six. The extended family included Sara's mother, Leah, aged 60 and her husband Jacob, 65. One day, when Rivka was in school

and Benny was home with a cold, a missile fell within 100 meters of the Rabin's home. The explosion was preceded by a 15 second warning alarm, which gave Sderot residents barely enough time to scramble for cover. Benny was paralyzed with fright by the impact of the missile, which made his second storey apartment shudder.

Before continuing with the saga of the Rabin family, I feel it incumbent to suggest a parallel situation a mere 20 kilometers to the West, in the municipality of Khan Yunis, in the Gaza strip. There we find the Abdullah family, living on the second floor of an apartment building. The father, Mahmoud, is 40 years of age, his wife Fatima 35, and their two children Mara and Yousef are 11 and 6. Fatima's mother, Nussa, 67, lives nearby. Two hours either before or after the shelling that rocked the Rabin's home, an Israeli smart bomb exploded 100 meters from the Abdullah's home, killing a Palestinian paramilitary activist as he closed the door of this vehicle. The Abdullahs will serve as a "ghost" parallel, since I lack the cultural competence to imagine their saga concretely. As I have suggested elsewhere (Flashman, 2003), awareness of trauma can and must cross the borders of violent conflict. Civil society requires sensitivity to the traumas of both sides, because the cost of ignoring the "enemy's" suffering is demonization.

Differentiation of Self in System

Back to the Rabins. They are a normal family. I will define normality here based on the concept of "differentiation of self in the system" first proposed by Murray Bowen (1978) and by now a dominant conceptualization in family therapy (Flashman, 2000). Bowen proposed an asymptotic scale of level of differentiation, one that always allows for further growth. Bowen suggested that at higher levels of differentiation family members are able to distinguish between emotions and objective reality, and between the emotional worlds of different family members. In this second plane, Bowen made the scale of differentiation easy to operationalize. In higher levels of differentiation family members communicate with each other by giving expression to what he called each member's "I position". The metaphor was

one of dance; it is a stance from which you enter into communication. Each member expresses his own "authentic" world, and pays attention to that of his fellow. In lower levels of differentiation family members either force their particular world on others, or else accept the other's world. The second easily operationalized aspect of differentiation involved communication in triangles. Bowen defined higher levels of differentiation as families in which communication between two members could be completed without including a third member. In lower levels of differentiation, the communication between two members becomes derailed by the need to attend to a third member. A simple example would be a conflict between mother and her adolescent daughter over weekend curfew hours. Rather than hold and resolve the conflict, mother claims that her husband threatens her when the daughter is late. Now mother and daughter triangulate the issue to managing father's anger, rather than make progress on adolescent sexuality and its limits. In a family with a higher level of differentiation, mother and daughter will complete their communication face to face. Afterwards there will be further face to face communication between father and daughter, and between the spouses. Let me stress that such a differentiated communication can take place with all three family members present. It is the *form* of the interactions, in which each dyad performs important direct face to face communication, that is crucial.

Expanding the Concept of Differentiation

In order to make full clinical use of Bowen's theory, I make two additions to it. (Flashman, 2005). The first addition has to do with a lacuna where differentiation is high. Bowen's more differentiated family members commence communication *from* "I positions" and *hold* this communication between two members without triangulation. Then what? What then takes place between the two family members? Bowen and his followers (Kerr and Bowen, 1988) failed to conceptualize this next step. However, in his famous revelation of the therapy he performed on his own family of origin, Bowen had the following to say about the new one-to-one communication that became possible for him with his father:

> At this time it was possible to talk about the full range of important subjects without avoidance or defensiveness, and we developed a far better relationship than we had ever had. This experience brought a new awareness that *I simply did not know what constitutes a really solid person-to-person relationship.*(1978, p. 517, italics added).

For years, teaching Bowen theory, I referred to this phenomenon as "mutual creation." I am more recently pleased to adopt Daniel Stern's term "co-creation (2004)." The result of two-person face to face "I-position" communication is a "present moment" (Stern, 2004) during which two people engage in becoming different, influencing and being influenced, mutual becoming. For families blessed with higher levels of differentiation, these moments allow the family to grow, to communicate more deeply and to bring challenging aspects of reality within the realm of the family's creation of meaning.

The second lacuna involves lower levels of differentiation. By privileging higher levels, Bowen left the lower levels with a "negative" definition – they are *not* differentiated. In relating to my proposed "co-creation," that is what they are *not* doing. But what are they doing? To put it in terms of Kegan and Lahey's masterful work on consultation (2001), if they are not doing *x* then they must be doing *y*. What could this *"y"* be?

Here I propose to apply some of the important developmental insights proposed by Daniel Stern in a much earlier work (1985). Stern studied levels of mother-infant relationship during the first three years. He suggested that during most of the first year of life, mother's "self-object" function is that of the "regulatory self-object." This function refers to such commonplace activities as helping baby quiet down when he is upset, helping him get more interested in an object, helping him to broaden his smile interactively, or just helping him become satiated when he is hungry. The word regulation refers to the fact that the baby is interested in the state mother creates *in him*, not the inner state of mother herself. This level of function reminds one of the "exploitation" that Kohut (1971) described in archaic self-object situations. During the latter part of the first year and most of the second, baby's attention alters and mother assumes a new role, that of "intersubjective self-object." This change refers

to the fact that baby no longer settles for mother merely regulating him; he becomes interested in mother's own internal subjective state. When mother shares with baby her inner state, she first creates within the baby the possibility of creating and attending to his own subjective state. The first *subject* then is mother's, and through intersubjective relating the baby acquires his own subjectivity.

It may have occurred to the reader that this intersubjective function defines quite well the "co-creation" with which we filled the lacuna in the high differentiation theory. It would then come as no surprise that regulation now may fill the low differentiation lacuna. Families with high differentiation are free to engage in intersubjective discourse. Families with low differentiation need to attend to regulation. And, conversely, families burdened by regulatory activity will experience a lowering in their level of differentiation.

Trauma and Differentiation

In 2005 the Rabin family (and the Abdullahs) experienced trauma which resulted in a lowering of their level of differentiation. Let me describe this more concretely. Benny suffered from PTSD. He became less able to regulate functions that had already become auto-regulated. He had trouble with attention, with irritability, with sleep. He required regulatory self-object function from all the females of the family. Sara attended to his sleep, to the detriment of her time with Moshe. Benny needed much more help with schoolwork, and grandma Leah, a retired teacher, assumed the role. This brought Sara into a dependent relation with her mother, from which she had just become free with Benny's entrance into first grade. Benny became difficult at home, getting into fights with Rivka. But Rivka was called upon to perform down-regulating of Benny's nerves, at the cost of her self-expression. The communication within the dyads mother-daughter, mother-grandmother and granddaughter-grandmother became burdened by a triangulation regarding how Benny is doing. Moshe felt left out of all this regulating, withdrew into blaming his women for "pampering" Benny, and busied himself more and more with the local soccer team.

In addition to the need to attend to regulation and the creation of triangles, PTSD creates a significant disturbance in "I-position" communication. Victims of PTSD find it difficult to express fully what exactly they feel. There are elements of the PTSD experience which are enormously difficult to articulate and to hear. These are the experiences which are best described in terms of "autistic-contiguous" experience (Ogden, 1989; Tustin, 1992). This refers to the overwhelming sense of loss of the containing function of the skin. At the time of trauma, and during the more experiential flashbacks, the victim may feel that his soul is dripping or seeping out, that he is in danger of loss of existence, and that the only way to restore any security is to create an autistic "shell" by stimulating the skin in a painful manner. Such experiences create activities that seem "self-destructive" to the observer, but they are profoundly and desperately self-preserving. Pulling at hairs, picking scabs, self-cutting, head banging, compulsive scratching are some of the expressions that may arise. Needless to say, all such experience would be next to impossible for Benny to describe or for his family members to hear. Thus, full "I-position" communication becomes seriously limited, and the responses to Benny's more extreme experiences and activities will be more regulatory and hardly intersubjective.

This, then, is the first way in which trauma affects family time. *Trauma lowers the level of differentiation in the family*. The lower level of differentiation then *compromises the developmental challenges* facing the family at the time of the trauma. Family time has now been altered, and the family's development will now be affected by the drop in differentiation that was caused by the trauma. The clinician now becomes a family developmentalist, considering at what junctures in the future the family level of differentiation may rise or fall.

Family Time and Developmental Fine Tuning

In the Rabin family, for example, we may focus our attention on two pressing developmental concerns. The first has to do with Benny's development of sublimations. Here I will explicate in some detail. Anna Freud devoted the better part of her clinical career to the evolution of a

theory of developmental lines (1966). This three-part concept rewards careful inspection. I think of it in metaphorical terms of the floor, walls and ceiling of development. On the "*floor*" are developmental tendencies with which the child is endowed, for example a "way" of eating, of smiling, of getting excited, of using the body for stimulation and pleasure (Sigmund Freud's [1905] "psychosexual" line). "Temperament" is prominent on this floor (Thomas and Chess, 1977).The baby develops through these tendencies. The "*walls*" of development are the ways in which the baby himself creates "coordinations" between the lines. For a commonplace example, a one-and –a-half year old takes pleasure in pointing at juice and saying "juice." The child's pleasure precedes his receiving the juice, and involves the joy of coordinating speech with eating. This coordination is a moment of "creating the I ('ego')", it is the baby's own doing. Development entails an infinite number of small "coordinations", "stitches" in the fabric of the "I". The developmental *ceiling* involves a global sense of the ability and possibility of continuing to create these coordinations over the developmental span. This sense evolves through many experiences with stitches that can be made and that hold. This sense is weakened when coordinations come together with difficulty or come apart too readily.

Now the central "coordination" task of the latency child is that of sublimations. This involves bring together the sense of pleasure in the body (psychosexual) and intellectual effort. Every teacher recognizes the moments when a child's eyes light up when he has learned something – schoolwork or other work – and his efforts have produced a pleasure that partakes in psychosexual pleasure. For this reason sublimation is not a defense – it does not ward off drive satisfaction but rather provides an alternative route for pleasure – from intellectual effort and achievement. As Peter Blos pointed out long ago (1962), latency is the opportunity for rechanneling drives, while there is some balance between the intensity of bodily drives and intellectual function. Once adolescent "hormones" change this balance, sublimations will be much harder to achieve. As Blos continued, the adolescent needs his already developed sublimations in order to continue to think and learn despite hormonal pressure. The

adolescent without sublimations is emotionally a child, not an adolescent. The insights of developmental lines have tended to be overshadowed lately by the more recent work on "mentalization" (Fonagy, *et al*., 2002). However, to my mind the more recent work both depends on the earlier "lines" and is better understood within the framework of the "lines" discourse (Flashman, 1996).

It should be plain that the PTSD that afflicts Benny at age 6 years puts him at developmental risk. He has less control and self-regulation of his aggression, he sleeps poorly and his attention is impaired. Benny is at risk to miss the developmental opportunity to "stitch" together his drives and his intellect. He and his family – and his post-trauma experts – have six years to put sublimations back on track. There is the risk, of course, that "post-trauma" experts focus on the necessary first step of regulating, but find it hard to then push the family to return to full and robust development.

The second developmental risk is that of Rivka. Our "family clock" notes her age as 11 years. Since the groundbreaking work of Carol Gilligan and her colleagues during the last decade of the twentieth century (Brown & Gilligan, 1992), we have become aware of the developmental risk of "loss of voice" that girls face at the age of eleven years. Girls in the USA – and to my experience in Israel as well – will lose their robust eight year old way of expressing difference and conflict, and instead become excessively concerned to placate and agree, in order to preserve "relations", at the cost of real relations that sustain "inner voice" (a term closely related to "I-position"). Rivka has a brother who needs help, everyone in the family needs her help to help her brother; she is at risk of giving up her own voice, perhaps a voice of protest over residing in such a dangerous place, perhaps over losing precious social time, perhaps over not finding it possible to express her exasperation at her brother's behavior.

An Objective Passage

We can now set the family clock forward to an entirely predictable passage. In seven years time, last year, Benny was thirteen, ready for the Bar Mitzvah passage, and Rivka 18, ready to

enter military service. Moshe was 47 and Sara 42, Leah 67. That much is predictable. The first time I presented this material in Israel, where it was engendered nearly three decades ago, I was informed that only Americans "plan ahead"; in the Middle East life is just too unpredictable. This gave me pause for reflection, and since then I always add this caveat: the point of looking ahead is not to predict the objective future, but rather to map the progress of possible subjective meanings. If a meteor would surprise the Rabin family in 2011, the structure of the family and its developmental meanings would still be understood in the context of what I am presenting here.

An "objective" passage is one that constitutes a change and challenges the structure of most nuclear families. Such passages include entry of new system members (birth, marriage), exit of system members (death, "cutoff") and major changes in function such as the developmental passage I am proposing here. In the case of the Rabin family, the "objective" passage will be burdened by the challenges that were not met since the time of the original trauma. Benny has become an emotional and behaviorally troubled child, Rivka has sacrificed her personal development for the sake of family survival, Sara has become more enmeshed with Leah, Moshe has become more estranged. Now in 2011 both Benny and Rivka face new and predictable developmental challenges. Benny as an adolescent male will require more emotional communication with his father. Peter Blos pointed out that sons develop the ego ideal by way of dyadic relations with father (Blos, 1985). This means that while boys develop conscience (the "no" function of the superego) facing the triadic oedipal father (whose "no" about mother is absolute and becomes internalized), they develop the ego ideal (the "yes" function of the superego) only in adolescence, in a dyadic, face to face relation with father that is not connected to mother. The reader may think of Bowen, triangles and co-creation. Ego ideal creation is surely an example of intersubjective relating. The Rabin family will be challenged to create this one to one relation between a boy who requires so much regulation and a father become distant, while all the relations with the females of the family are triangulated through Benny.

Rivka needed to be "leaving home" (Haley, ; Stierlin).To negotiate this major transition, she would need to be assured by her female partners, Sara and Leah, that the project of taking care of Benny can be sustained in her absence. But in the Rabin family, the opposite was the case. While Leah remained committed to her grandson, her husband Jacob, now 72 and retired was needing and desiring more of her attention. Sara now talked – in triangles – with Rivka about her difficulty in seeing the grandparents declining, and Rivka understood that her leaving home would need to be put off. She opted for a civilian alternative of National Service and stayed at home, being available for Benny and to Sara during Benny's adolescence. Her inner voice has yet to be redeemed.

A Pragmatic Passage

I refer to a passage as pragmatic when it functions like the objective passage in the concrete present, but it involves a change in members of the *extended* family whose presence and activity are central in this *particular* nuclear family. The point in distinguishing pragmatic from objective passages is clinical and didactic, not theoretical. In Western practice it is common to assume that significant passages involve only members of the nuclear family, the dominant family form in the West at least during the twentieth century when most clinical practice was consolidated. By directing attention to pragmatic passages, I encourage the clinician to inquire in each family whether *extended* family members indeed have "*nuclear*" functions, in which case these extended family members are full participants in family time. I learned this first with families of Puerto Rican origin in New York City, where many crises in children were brought about by the grandmother's (abuela) illness or mobility. The same lesson appeared with Palestinian families, where the eldest brother in the father's family of origin often fulfills a nuclear function, especially as a source of authority.

For the Rabins, it is Benny's trauma and its sequelae that have brought Leah into nuclear status. Once there, the transitions in Leah's life now influence family time no less than those of the biologically nuclear members. To illustrate the point, I have placed Leah in the hospital

with a CVA three years after the previous passage, in 2014. Rivka is 21, Benny is 16, Moshe is 50 and Sara 47. What is new is not the developmental passages, which have been active for a few years and are still a "work in progress." What is new is the change in Leah's health.

Leah's stroke creates an impossible situation for the Rabins. The dependent relationship between Leah and Sara has been reversed. Now Sara must give full attention to her ailing and disabled mother. Who will care for Benny? The obvious answer is Rivka, but taking on her mother's and her grandmother's roles in addition to her own is not a sustainable option. None of the females want Rivka to put her young life on hold, and there is no way to ignore such a situation. Rivka 'solves' the "female" dilemma is a classic way. She becomes pregnant and marries. Now she too is called upon to continue a caretaking role, but not with Benny. Benny's behavior deteriorates, the social welfare office is alerted, and the family agrees that Benny's place is in residential treatment.

Together with Lea's cerebral arteries, the family's differentiation has become choked. There is no possibility of "I-position" communication among any of the females. Sara cannot tell Lea how guilty she feels about abandoning Benny, nor can she tell Rivka how conflicted she is about the role that has fallen on her young shoulders. Rivka cannot speak out her dilemma, her loss of 'membership' in the female caretaking club, her inability to communicate with Benny. Her body 'speaks' her impasse. Benny has been the object of regulating activities for years; he has never given expression to his experience with PTSD. Lea's stroke is in the left hemisphere, she cannot talk, period. Moshe has been distanced from Benny and from Benny's care, he makes a cameo appearance in Benny's life in the name of "limits," and then gives up. The welfare workers feel that the Rabins are not a "treatable" family, since neither Sara nor Moshe keep appointments, each for their own reasons. The family system is "opened" by Benny's placement.

An adolescent is "placed" in residential treatment because his grandmother had a stroke? That is exactly the point I am making. The sequelae of the trauma of 2004 have been piling up

unresolved developmental issues; the family's level of differentiation has been plummeting. The entire structure of the family depended upon Lea's activity, which depended on her health. Contemplating a potential pragmatic passage related to Lea's life and health could perhaps have helped Sara to realize that something more than regulating and surviving was necessary. That is the point of mapping family time, including the "invisible" pragmatic passages. Anticipating possible crisis can make it possible for the family to raise its level of differentiation before the next crisis makes this even less possible.

A Subjective Passage

Now we fast forward to the year 2020. Calculating the ages has become habitual by now: Jacob 81, Lea (now recovered) 76, Moshe 56, Sara 51, Rivka 27, Benny (still at home) 23. There is a new member, Rivka's son Eli, who is now six years old.

The school psychologist is asked to see Eli, whose outgoing confidence has become eroded and whose mood has soured. Rivka, a devoted and understanding mother, is perplexed. She feels something is amiss, that she too has lost her confidence in Eli's resilience. As nothing remarkable has "changed" recently in Eli's nuclear family, the psychologist "goes fishing." Anything perhaps in Rivka's past, when she was six? Rivka begins to cry. Six. Her life changed, came to a halt, her family began to collapse, six. No, not when she was six. It was when Benny was six. That missile. The psychologist is stunned. This is not in the books. This happened a full 16 years ago.

Rivka is about to teach the psychologist, just as that my clients have taught me time and time again, about subjective passages. These passages take place in the *next* generation, For Rivka, a six year old boy brings her face to face with her brother at six. Only now Rivka is 27 and a mother, not an 11 year old girl losing her "inner voice." Now Rivka can appreciate what she was unable to understand so long ago. She is able to appreciate her mother's dilemma, her sacrifice, her brother's trauma, even her father's distance. Here is another crossroads for differentiation, this time for the better.

Rivka can now take an intersubjective view, first of Eli. She can appreciate that she is bringing to her relationship with him shadows from her own past. She can relate to Eli and to her husband what happened to her family when Benny was six. Thus she can preserve a higher level of differentiation in her new nuclear family. In addition, she can now speak with her parents about her insights, she can redeem that inner voice that became faint, she can "co-create" with each of them her adolescence in their home, her frustrations and disappointments, her sacrifices and especially her hopes. A new conversation now becomes possible with 23 year old Benny, who can be helped to gain insight into his childhood and youth, his relations with an overwhelmed family, his need for closeness with his father. In short, in this example, in the subjective passage a generation later there is still opportunity to change the course of the family's differentiation.

We most often encounter these subjective passages as the past, as in the Rabin family. For example, we meet a man having new trouble with his wife when his son has reached the age at which the man's parents divorced. A woman becomes anxious when she reaches the age at which her mother became ill with cancer. However, seeing the possibility of subjective passages prospectively gives the clinician a longer, and in my view, a more realistic view of family time. Not everything can be healed in one generation, let alone in one year or in twelve sessions. Family life moves in ways that create hazards and opportunities, some predictable, some understandable, all significant. Clinical interventions take place within family time. These interventions can be customized to the developmental passages facing the family, and to anticipate future passages. The clinician who sets his timepiece to the chronology of the family gives time to what takes time.

Family Time and the Clinician: Family Developmental Tracking

Family Developmental Tracking (FDT) is the name I give to the activities described in this paper. In the case of trauma, the clinician

a. conceptualizes the presence of trauma as a special developmental line.

b. maps the ages of the biological and pragmatic nuclear family.
c. sketches the anticipated objective, pragmatic and subjective passages facing the family.
d. coordinates the anticipated passages with the developmental tasks facing each member of the family.

These four steps, repeated over time, allow family time to become part of the treatment, rather than a cause for consternation and surprise. Let me now demonstrate how FDT could help focus the clinical intervention with the Rabin family:

a. Conceptualization: In 2004 it would be possible to define Benny and his family as entering a new "time warp" determined by the trauma he experienced. The "patient" would be the level of differentiation in the family. Trauma-focused interventions would be evaluated with an eye to their influence on differentiation.
b. Mapping: The ages of all the family members with "nuclear" function are mapped together in a time line.
c. Passages: The objective (2011), possible pragmatic (2014) and subjective (2020) passages can be anticipated.
d. Developmental coordination: The passages are viewed through the prism of the resolution of developmental tasks. Here follows a partial list of examples of clinical interventions informed by FDT:
    a. The goal is set that by age 8 or 9 Benny's regulation should be regained enough to allow development of sublimations.
    b. The goal is set that after an initial phase of desperate regulatory functions, Rivka's parents are to be engaged in a discussion about preserving her inner voice and allowing her to express the "secondary" trauma that she has experienced.
    c. The goal is set to enable Sara to provide for Benny's needs without creating a major change in Lea's role with her. The welfare workers consider this an

effective investment of resources (despite the allure of a volunteering grandmother) with the goal of preventing triangular entanglement in the family and a drop in differentiation.

d. The goal is set that Moshe is to be encouraged to take part in Benny's various treatments, and Moshe's opinions are taken seriously. Attention is paid to maintaining the level of communication between Moshe and Sara. The goal is set to enable Moshe to create the dyadic fathering that Benny will need in his adolescence. This is reevaluated and updated in 1011.

e. Lea's role is defined as elder advisor, not partner. Lea and Sara are encouraged to "co-create" a new partnership through face to face communication about their difficulties with Benny and with each other. The goal is to help increase the level of differentiation, exploiting the trauma to enable "difficult conversations."

f. When Rivka reaches 17 she is encouraged to discuss with her parents how her independence will influence the family's care for Benny. The welfare workers consider extra investment in Benny at this time in order to allow the family's differentiation to be preserved as Rivka leaves home.

g. Benny's "placement" at 16 is considered in the light of Lea's stroke. Working with the family seems a better alternative than removing Benny from the common life shared by the family.

Families High and Low

All of the "interventions" listed above take place in nature without professional assistance. I have learned over and over again that families naturally look at their own time, and all of FDT was imparted to me – sans conceptualization – by families. These are families with a high level of differentiation. Such families sense a downward drift in differentiation as a loss, as something diminished, and they act to correct it. It would follow that families nearer to the high end of the scale need shorter, more focused interventions, because they can do by

themselves large parts of the work of preserving and increasing differentiation. From such families, clinicians can *learn* FDT.

Such is *not* the case with families at the lower end of the scale. These families are highly threatened and engage naturally in regulating efforts almost exclusively. Here large parts of FDT can be significant as a clinical intervention. It is clinically crucial to determine the level of differentiation of the family when planning FDT in the wake of trauma. There is no clinical folly greater than the assumption that "trauma" treatment is uniform. The trauma is uniform, but its effects depend upon the level of differentiation of the family. I am proposing, then, that FDT become a tool for understanding the higher differentiation families, and a guide to active intervention with lower differentiation families.

Clinicians High and Low

I believe that my proposal will meet with no small resistance. Here follows what I believe to be the main obstacles to the adoption of FDT as a staple element in trauma treatment:

a. Overspecialization: Expertise in trauma treatment has become focused on treating directly the symptoms of trauma, not its indirect family effects. Many trauma experts are not trained in family systems.
b. Provider-side Bias. There are two aspects of resistance here:
    a. Training: FDT require a high level of developmental understanding. This is hardly a staple of training in trauma treatment.
    b. Funding: Providers are encouraged to seek brief and focused "solutions" – and to ignore everything else.
c. "Scientific" scruples: FDT is not and cannot become "evidenced based". No one can run a 20 year RCT. I believe that the research desideratum here could well be retrospective and qualitative in method. As Aristotle cautioned when he introduced empiricism, "The method of investigation has to suite the object of the investigation."

d. "Optimism": Some clinicians claim to focus on "strengths" and might find FDT too dreary, "looking for trouble". I believe that clinicians must distinguish between high differentiation families – where the "strength" discourse works powerfully - and the low differentiation families whose family time is at great risk and who require help to rediscover "strengths".

Coda: Generations and Massive Trauma

I would like to close with a long quote from something I wrote together with Susan Baur two decades ago. In it I expressed what I had learned about time and FDT from the survivors of the Nazi Holocaust, surely the most severe trauma ever experienced:

> I was once asked to speak to an entire kibbutz about families. It was arranged that they would gather in the dining room, from oldest to youngest, and that I would stand at the end of the room, and, as therapists do, try to put into words something that they felt but perhaps could not quite say. I hesitated a very long time, wondering whether I should tell them what I saw happening in their communities, or whether I would be causing them pain and retarding their healing. But I went ahead, and this is what I told them.
>
> I said, "Many of the kibbutzim in this region of the Negev were founded in the last years of the 1940s by young people who had recently survived the Nazi Holocaust in Europe. They came to Israel as refugee-pioneers with the most extraordinary mixture of personal tragedy, burning identification with their people, intense idealism, and an adolescent passage –a phase of growing up – that was brutally cut short. All of these people had suffered overwhelming losses. Most were all alone in the world. On this desolate emotional landscape they built the kibbutz, and this community took the place of their families – not of ordinary families of many generations, but a horizontal family with everyone in a single generation. As much as humanly possible these people in their late teens and early twenties turned their backs on what they had lost, and began again. Of course, they could not forget their parents and siblings, but all the rest- the aunts, uncles and grandparents – were allowed to recede into some inner recess of their hearts that remained locked and silent.
>
> "Soon the kibbutz began creating children, and naturally these children formed another horizontal generation. For practical as well as ideological reasons, they were

raised together with their age mates, and seen as children of the kibbutz. No one seemed to notice then that in real time – in family time – an entire generation was growing up with no grandparents – no mothers and fathers of their own mothers and fathers. Now imagine twenty or twenty-five years of group life without a single grandparent around. How could children possibly come to see their parents as "children of" and begin to understand the family drama of which they were a part? They couldn't. In the kibbutz adults were "mommies and daddies of," but beyond that they were only rather abstractly "members of" the kibbutz, as if they had been born to it.

"And then," I told those people sitting in the dining hall, "just add the years as they move slowly along - and you will come to the early 1970s. The first children of the kibbutz themselves became parents. For this society at this time, the birth of the first grandchild in each family is a double birth, for with the birth of the child the first grandparents are born. For a generation, the words "Grandpa" and "Grandma" have not crossed the lips of anyone. But with this first utterance of "Grandpa," voices that have been silently locked in the heart begin to speak, and memory returns. The voice that returns is that of children long ago in Eastern Europe, whose cries and squeals abounded with "Grandpa" and "Auntie." It is the voice, rich and vibrant, of large families who shared real family time with each other. It is the voice of family life as once lived by these now graying once-young pioneers, and it brings back to them their real families where parents were always both "my mommy" and "daughter of." All the grandparents, uncles, and aunts who had been lost in the Holocaust and who had been locked away in the hearts of lonely teenagers began to move then, and without warning the old pioneers – weeping – regained the memories of their families. Images that had receded generations ago arose anew. The enormity of the loss, its boundaries, expands. And with that deep and unexpected shudder of pain every generation on the kibbutz was changed. "My mommy" plain and simple is shaken, and everyone feels the secret and the richness of the family drama in which my mommy has a mommy just like me."

This is the story I told them as I stood before that group in the dining hall, facing three generations in fact, and two more in emotional reality. And as I said the words – 'and then the first grandparent was born' I felt that shudder move again through the hall as it still does through me.

And do you know what has happened since the early 1970s? By the time the first grandchildren of the kibbutz became teenagers, community living had returned to its

natural state. Children are no longer raised in groups. They have all moved home. There are many factors involved in this shift, but I cannot help but think that one factor – one meaning – was the shudder that shook the hearts when the first generation of grandchildren and grandparents faced each other. This moment could not have been hurried into existence any earlier. It is good to remember that therapy needs to fit itself to life and not the other way around. (Baur, 1994).

References

Baur, S. (1994). *Confiding*. New York: Harper Collins.

Blos, P. (1962). *On Adolescence*. New York : Free Press.

Blos, P. (1985). *Son and Father*. New York: Free Press.

Bowen, M. (1978). *Family Therapy in Clinical Practice.* New York: Aronson.

Brown, L. M. & Gilligan, C. (1992). *Meeting at the Crossroads.* Cambridge, MA: Harvard.

Flashman, A. (1996). Developing developmental lines. *PASC* 51:255-269.

Flashman, A. (2000). Review of *101 More Interventions in Family Therapy* (Hebrew). *Society and Welfare* 20(4): 519-521.

Flashman, A. (2003). Security, connection, meaning: Israeli and Palestinian teachers learn about children and trauma. *Community Stress Prevention*, Vol 5.

Flashman, A. (2005). The adolescent and his family: differentiation and dangers (Hebrew). In Flashman, A. & Avnet, H., *Therapeutic Communication with Adolescents*. Jerusalem: Ministry of Welfare, Chapter 7.

Fonagy, P., Gergely, G., Jurist, E., Target, M. (2002). *Affect Regulation, Mentalization, and the Development of the Self.* New York: Other.

Freud, A. (1965). *Normality and Pathology in Childhood.* New York: International Universities.

Freud, S. (1905). *Three Essays on the Theory of Sexuality.S.E.*7:125-245.

Haley, J. (1997) *Leaving Home*. *Second Edition.*Hove: Brunner-Routledge.

Kegan, R. & Lahey, L. L. (2001). *How the Wat We Talk Can Change the Way We Work*. San Francisco: Jossey Bass.

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

Kohut, H. (1971). *The Analysis of the Self*. New York: International Universities.

Ogden, T. (1989). *The Primitive Edge of Experience*. New York: Aronson.

Stern, D. N. (1985). *The Interpersonal World of the Infant*. New York: Basic Books.

Stern, D. N. (2004). *The Present Moment*. New York: Norton.

Stierlin, H. (1977). *Psychoanalysis and Family Therapy*. New York: Aronson.

Sullivan, H. S. (1953). *The Interpersonal Theory of Psychiatry*. New York: Norton. Ch. 22.

Thomas, A. and Chess, S. (1977). *Temperament and Development.* New York: Brunner-Mazel.

Tustin, F. (1992). *Autistic States in Children: Revised Edition.* Hove: Brunner-Routledge.