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THE CAUTIONARY TALE OF BRIAN B.

ABSTRACT: The difficulties of providing adequate treatment experiences during training are discussed with reference to the inter-dependence of symptoms within family groups. To illustrate this the treatment of an eleven-year-old boy at a child guidance clinic is described. During this, several instances of gross psychopathology within the family group emerged which exposed the limitations of the initial treatment model. The case is discussed with respect to internalization of treatment models during training.

Counsellors in training can now encounter a wide range of techniques and strategies designed to facilitate a therapeutic role. Under appropriate supervision during the practicum they can, in addition to more conventional counseling approaches, explore behavior modification models (Blackman & Silberman, 1971) and various techniques of desensitization and reciprocal inhibition (Eysenck, 1964; Wolpe, 1964). The implications of such methods for therapeutic practice are ably discussed by Truax and Carkhuff (1967). To use the language of psychoanalysis, they do not require extensive training analyses, do not involve induction of the transference neurosis, include relatively little speculation as to aetiology and are minimally concerned with symptom substitution phenomena. At first sight, therefore, they are eminently suitable for an advanced practicum, provided that the more important professional and ethical safeguards when using inexperienced personnel for therapy can be maintained.

However, even within fully staffed and experienced counselling services, backed up with a comprehensive range of interdisciplinary resources, the therapeutic role encounters many problems for which it is difficult to legislate in counsellor education. Undoubtedly one of the most tangible and unpredictable of these is the apparent interdependency of mixed symptoms manifest within family groups. The recognition of this is of course a central feature of traditional child guidance and current community approaches to mental health. And of course, many writers comment upon the complex psychopathology found in the presenting client's immediate family (Howells, 1968; Laing, 1969; Satir, 1962). Trainees can read about these matters in the technical literature and case files, and may have witnessed the phenomena at first hand. However, a salutary element of early therapeutic experience is that the carefully planned program is inappro-

priate, that the presenting symptom is colluded with and strongly reinforced elsewhere; that hypotheses about its causation seem to require continual revision and that hard, relevant information, particularly about the true nature of feelings, only emerges after a considerable length of time. Thus it is frequently found that previous disclosure of information by the client has been directed towards satisfying a fantasied need of the professional involved and this has totally obscured accurate communication of the problem.

A difficulty of practicum training is that, owing to variations in the nature of the case load and time constraints, a counselor trainee may enter into professional practice without personal experience of the above and a somewhat naive and distorted view of professional realities. Given adequate support on first appointment and a full range of community resources this will eventually correct itself but in the absence of these the lack of appropriate supervised (and interdisciplinary) experience during practicum becomes crucial.

The following case is therefore presented in the hope that it illustrates a number of important issues in the training of counselors and other mental health professionals. In the interests of brevity only salient points in a somewhat complex case history are described.

Brian presented as a nervous alert boy, of good average intelligence but approximately two years retarded in reading skills. He had a poor record of school attendance owing to sporadic attacks of asthma and minor illnesses. As no specialized facilities were available within his school and as the local clinic had at that time an experimental program for asthmatics (using tranquilising drugs) it was decided to refer him to child guidance, if the parents agreed. Mrs. B. was duly interviewed. She appeared to be a sensible if rather anxious woman, concerned but not overly preoccupied with her son's poor school performance. She was very critical of the school principal's attitudes and policy towards slower children. However, as she had heard of a possible connection between anxiety and asthma, she was willing to give Brian a trial at the clinic.

Initial Clinic Attendance

Brian's mother and father were routinely interviewed by the writer and the clinic psychiatrist; Brian by the latter and by the therapist who was to undertake the treatment. At the first conference it was thought that the case might well turn out to be more complex than one of simple reading retardation. Brian's asthma was probably psychogenic in origin, the symptoms being reinforced by his mother who exercized a domineering over-protective role in the family. There was some evidence of high levels of disruptive anxiety in the case history and it was speculated that the non-attendance at school had elements of a phobic reaction. This last aspect of the case was important because, in eight month's time, Brian was due to transfer to a secondary school ten miles away. The place had a well-deserved reputation for toughness and the clinic team envisaged a phobic

reaction if there were to be bullying or punitive treatment by the staff.

In view of this a treatment plan was evolved which required Brian to attend clinic on a weekly basis, the proviso being made that one or other of his parents accompany him. The general aims of the program were to develop ego strength through encouragement of assertive and positive behavior. It was also intended to provide support over possible negative reactions by home and school and to prepare Brian for his forthcoming change. The parents were informed of these aims and were asked to encourage independence, to ignore as far as possible unruly and untidy behavior, and to deal with the asthmatic attacks in a non-emotional way. For these a mild tranquilizer, Librium, was prescribed.

Clinic Attendances

Brian (4 visits) Brian related to the therapist fairly easily. He produced a considerable amount of depressed material regarding his anxieties and preoccupations with bodily ailments. However, he only experienced one asthma attack during the month and by the fourth session was showing aggression in various game-playing situations.

Parents (3 visits) Mrs. B. attended three times, showing a wide range of moods and attitudes. Initially she repeated several times her assertion that the B's were a very happy family, living only for each other. She was very warm about her husband: he was a kindly, considerate man and an excellent provider. At the second meeting she was openly critical of the clinic for requiring her to attend. It was unnecessary and looked as though the staff were trying to blame her for Brian's asthma and poor reading. She then missed the next appointment on the grounds of having a slight cold. However, her third visit was noteworthy for several reasons. Mr. and Mrs. B. were apparently pleased by the improvement in Brian's asthma but very upset by the change in his behavior. He was now insolent and mixing with bad company. Reassurance on this point and a reminder of the aims of the program were not accepted, Mrs. B. being openly antagonistic to the parental roles suggested. She referred to the contrast between Brian and his younger brother, a tough six-year-old who was doing well at school.

Case Conference

Brian's case was reviewed at the end of the first month. As up to this point it had proceeded on more or less predictable lines it was not discussed at any great length.

Month 2

Brian (3 visits) Brian had a very different physical appearance, now being rosy-cheeked, animated, and boisterous. He behaved aggressively towards the therapist and related a number of stories about fights and various misdeeds at school. Apparently his reading had started to improve and he asked for help at the clinic.

Parents (3 visits) Mr. B. attended on the first occasion as his wife was unwell. She was tired and depressed and in need of some sort of a tonic. Mrs. B. was a good wife and manager although she still continued to 'mollycoddle' Brian. As might have been expected, Mr. B. was rather more tolerant of his son's new-found belligerence. However, like his wife he was insistent upon the vast personality differences between Brian and his brother.

Mrs. B. attended the final session of the month. She appeared to be depressed, careworn, and run-down. She complained of excessive tiredness and of having numerous vague aches, pains, and numbness in her legs. Her G.P. had promised specialist help if her condition did not improve. She reported that Brian had been behaving as badly as ever but she was too concerned with her own health to take much notice.

Case Conference

An extremely favorable report was made by the therapist who had also visited Brian's school. He was working well in class and making progress. Behavior was quite normal and he was playing team games with the other boys during recess. The writer and the clinic psychiatrist thought that Mrs. B's controlling relationship with her son was stronger than had been evident in the preliminary interviews. Brian was now acting independently and the depressive reaction was a direct consequence of this. Contact with the family G.P. revealed that Mrs. B. had experienced spells like these before but had snapped out of them.

Month 3

Brian (4 visits). The first visits found Brian in an extremely subdued frame of mind. He reverted to talking about his former symptoms and wanted to read for the therapist rather than play. He questioned the necessity for coming to the clinic as his mother was ill and it was a great trouble for his parents to have to bring him. However, the promise of an impending camping trip with a favorite aunt and uncle seemed to change his emotional state back to its former level.

Parents (3 visits) Mrs. B. attended on three occasions although she requested that the interviews be kept short. Her G.P. had prescribed some sort of tranquilising drug for her. She now had fewer aches and pains, which was attributed to the weather. Mrs. B. did not mention the issue of Brian's termination and clearly had accepted that the clinic was helping him in many ways.

Case Conference

Brian's changes in mood and his ambivalent attitude toward the clinic were discussed and it was hypothesized that these were the result of pressure by Mrs. B. He had relinquished his aggressive behavior to some extent and this obviously suited his mother who had no complaints to make. As the progress of the case had slowed down, clinic

interest centered around how the family would cope with the forthcoming camping holiday.

Month 4 (1 visit only owing to holidays)

Brian. Brian returned from the holiday looking happy and fit. The holiday was a great success, his only criticism being that his mother would not let him stay with his aunt and uncle.

Parents. Mrs. B. was also enthusiastic about the tour. She and Brian's aunt had organized things well. Brian had rather surprisingly suffered no asthmatic attacks although his uncle had been prone to hay fever. She had not allowed Brian to stay behind as she thought that he was getting too excited.

Month 5

Brian (4 visits). At each session Brian appeared to be a perfectly normal and unexceptional boy. He produced little in the way of material and spoke without anxiety about the new school. He did, however, mention that he tended to keep out of the house because his mother nagged him for getting dirty and being untidy.

Parents (4 visits). Mrs. B. spoke much more openly about her marriage. She wished that her husband were not so stolid and unimaginative (although he had in fact just received a minor promotion). In the context of discussing the childless marriage of her brother-in-law the matter of sex came up. She said that there was little sexual activity in her own marriage but as she did not care for it anyway, this was not very important to her. The following week Mrs. B. came in with Brian and said in his presence that there was no need for him to attend. The visits were inconvenient and she was starting to be worried about her health once again. A visit to a consultant neurologist had been arranged.

Neither parent attended the third visit, but Mr. B. came with Brian on the fourth. He came into the clinic rather ill at ease and asked to see the writer about a personal matter. The offer of an appointment with the clinic psychiatrist was declined. Mr. B. then brought up the matter of his sexual impotence. For several years now he had experienced difficulties over erections and during the last two or three years had only been able to have intercourse five or six times. He felt that he was not very strongly sexed but that a fit man of his age ought to be able to do better than this. Four years previously he had seen a psychiatrist who diagnosed the cause of the impotence as anxiety neurosis. Mrs. B. refused to attend with him and in fact her attitudes towards the matter were extremely unhelpful. Early in the marriage when they were trying to have children she met most of his requests for intercourse, provided he got over it quickly. However Mr. B. said that he had never had sex with other women but hoped that they were more responsive than his wife. These difficulties were discussed at length and finally Mr. B. was advised to take up his problem with the family G.P., who was in touch with the psychiatrist and who

in any event was still prescribing tranquilizing drugs. A possible joint husband and wife referral to marriage counseling was considered, for when Brian's clinic attendance was no longer necessary.

Case Conference

As the case had now undergone a pronounced change, the events of the last month were debated in a full case conference. The family G.P. was invited but could not find time to attend. The consensus of opinion was that Brian was now one of the stronger members of the family, had survived attempts by his mother to regain control, and the prognosis for him was good. The change in the material released by both Mr. and Mrs. B. indicated a fairly strong cry for help by the family. Mr. B. might well be identifying with his son in openly criticising Mrs. B., and her control over the family, probably achieved by precipitating and reinforcing various symptoms, was clearly weakening.

It was decided that in view of the relationship established with the family unit, the clinic team should continue as the responsible agency. The pretext was to be that of keeping Brian under surveillance over the changeover of school. Brian was therefore placed in a therapy group of boys who had been receiving the same sort of ego-supportive type of approach.

Month 6

Brian (3 visits). Brian quickly formed a relationship with an older boy within the group and this continued until Brian's move to the secondary school. This took the form of a sort of sado-masochistic ritual enacted via boxing and rough games in which Brian, by far the lighter of the two, invariably came off worse. He did not seek support over this behavior, which was interpreted as reality testing.

Parents (3 visits)

Mrs. B. came to the clinic with an air of quiet belligerence. She wanted to know what her husband had been saying about her. It was a very good thing that she was not interested in sex because Mr. B. was useless. In order for her to conceive two children she had to do it nearly all herself, as he also had difficulties over emission. She tried to help him over his occasional efforts "just to keep the peace." As far as marriage guidance was concerned she thought that the family was basically happy and that it would be a waste of time. She released then considerable criticism of her husband followed by a flood of tears and expression of guilt. She did, however, calm down rapidly.

At the second session Mrs. B. was evidently depressed, and showed some thought retardation. She had been to see the consultant neurologist who had not been satisfied with the results of the tests. The hospital was a considerable distance away and the travel was very inconvenient. Brian was fine but Mr. B's new post kept him away from home much more and he was not much of a help to her. She agreed that it might be a good thing if she saw the clinic psychiatrist at the next session.

The psychiatrist reported to a full case conference on the results of his interview. He said that she was definitely clinically depressed, this being probably due to the fact that she was no longer capable of coping with the new found independence in Brian and his father to any extent. The hostility engendered by this was now expressed intra-punitively. If Brian succeeded in making a proper adjustment to his new school this might be unconsciously construed as total rejection. The possibility of a suicide attempt was therefore considered. After the case conference, contact was made with the family G.P. over the prescription of an anti-depressant drug. As yet nothing was known of the results of the neurological investigations but in any event the depressive reaction had to be treated.

Month 7 (1 visit)

Brian. Owing to a number of vacation activities, Brian was only able to attend the clinic once prior to his move. He talked calmly about the school and was under no threat from the prospect. He had some good friends there. He was happy that he was no longer having asthma attacks and was sure the clinic had helped him. He agreed to write and let the therapist know of his progress.

Parents (1 visit). Mrs. B. attended in an extremely depressed mood, being entirely preoccupied with her own feelings. She was very punitive towards the writer, the clinic staff, the neurologist, her G.P. and doctors in general. Her few references to Brian were to complain of his untidy behavior. She knew that she had to see her G.P. about a prescription but could not be bothered to pick it up.

In fact Mrs. B. did obtain the prescription as Mr. B. telephoned the clinic to say how grateful the family were for the help they had received. Mrs. B. had started to take the drug and was now very much better. He agreed that a school visit to follow up the case might be prudent and gave permission for a home visit should this prove necessary.

RESULTS OF FOLLOW-UP

After four weeks of the new school year Brian was reported as having made a happy start; there were no signs of asthma or excessive anxiety. However, fears by the clinic team as to Mrs. B's mental state proved to be amply justified. Contact with the G.P. revealed that she had attempted to murder her younger son by holding his head under the bath water. Fortunately she had been stopped by her husband who had promptly called the doctor. The case was not brought to the notice of the police as Mr. B. could not be sure that his wife's action was not part of some sort of game. She was sedated and then admitted to hospital for observation. In addition to acute depression a diagnosis of multiple sclerosis was made.

DISCUSSION

Brian B. then represents that fairly common class of children in emotional difficulties who, though ostensibly weak at referral, emerge as

psychologically strong within their family group. He raises the issue of who is the real client in the family. However, as far as he was concerned the case was a therapeutic success in that he was seen to undergo some degree of behavioral change towards autonomy. Brian began to make progress at school, relinquished a troublesome psychosomatic symptom, and overcame a potentially traumatic situation when he moved to his new school. This was accomplished at comparatively little cost in terms of professional time; therapy was carried out on a reality level and progress was visible throughout.

Despite the dramatic nature of some of the material obtained from the parents it is likely that whatever agency eventually came to work with the family would have to cope with Mrs. B., a domineering personality with strong drives towards controlling those around her. The impotence of Mr. B. was probably not a significant issue except for the light it threw on Mrs. B's damaging ambivalence when her husband sought treatment. The extent of her desire for control may have been reflected in her attempted murder of her younger son who, if he was as tough as he was described, would have been reluctant to adopt the submissive roles of Brian and his father. Indeed it was probable that had she been in better health the writer would have had a much harder time with her during the casework. The clinic team of course knew about her various physical symptoms from the beginning but the revelation of a degenerative nervous disease came as profound shock; the depression, tiredness, and numbness were interpreted as somatic manifestions in a neurotic woman.

IMPLICATION FOR TRAINING

The emergent role of the counselor is taken by most to be that of a professional helper operating within a matrix of interdisciplinary cooperation in the broad area of preventive mental health. The nature of the therapeutic relationship within counseling has been closely examined with considerable attention paid to the qualities of those who appear to perform successfully in this task (Truax & Mitchell, 1969). Many models for counselor education have been set up which feature a systems analysis approach and fairly well defined behavioral goals (Thoreson, 1967; Horan, 1972). A welcome aspect of this has been the examination of the supervisor-trainee relationship within the practicum (Austin & Altekruse, 1972; Johnston & Gysbers, 1966). In view of this the writer has been astonished by the lack of reference to symptom inter-dependence in all sections of the technical literature pertaining to the practice of preparation for counseling. Students are trained to adopt initial professional responsibility for the client and within current approaches to mental health this is desirable and inevitable. Clients like Brian indicate that some of the training in decision making should be carried out within an interdisciplinary context in which these problems may, if necessary, be overviewed in a global sense. This should ensure that however limited the range of problems met in the practicum, students acquire internalized models of the following aspects of therapeutic behavior:

1. *The practical and psychiatric consequences of therapeutically oriented contact or referral at any level.*

Brian did not present any outstanding problem at first as his particular group of educational difficulties are common enough. A range of appropriate courses of action are normally available. These might include periodic consultation and prescription of extra remediation programs within the school; periodic consultation on a supportive basis without reference to the educational difficulties; referral to an outside agency such as a clinic for learning disabilities. None of these would demand more than routine contact with the family and would be firmly centred upon the needs of the client. However, difficulties in decision making would probably occur over the way in which the emotional factors in the case would best be treated. In the course of providing educational support the counselor might perceive that the family might need professional support on a regular basis. There then arises the question of which is the correct agency for this; the answer is heavily dependent upon the counselor's concept of his professional competence. In Brian's case the psychologist chose to refer the case to child guidance. The family had not asked for intervention in any way but the referral decision more or less propelled them into a form of psychiatric involvement which opened up a Pandora's box of consequences. Had the professional originally responsible decided to stay with the case and exercize options at a later date, hopefully remaining in control, perhaps it would have been possible to effect the desired change in Brian without the necessity for psychiatric intervention. But equally the situation might have worsened to such an extent that it became out of hand.

2. *The limitation of a uni-lateral approach to therapy.*

The limitations of unilateral disciplinary approaches to therapy have of course led to the proliferation of agencies assuming a treatment role, and an assumption behind the treatment model for Brian was that physical and psychiatric medicine would be required and that skilled social work consultation would be available if necessary. The psychologists concerned were therefore able to take on the therapeutic role with a confidence that most eventualities would be easily covered by community resources. This can also happen in the practicum for counselors when professional relationships are positive and well established. However, if the counselor opts to see both a young client and his parents it is quite probable that a number of technical difficulties may be encountered, not the least of which occur over the receipt of confidences from two parties to the same emotional situation. And should control over the client's case deteriorate, the agency to which the problem is eventually referred may have to operate within a climate of rejection complicated by previous relationships of confidence with the counselor. These issues should always be recognized during the practicum when future therapeutic programs are planned and highlight the need for systematic contingency planning at all stages.

To extend Truax and Carkhuff's observations, there is not only the possibility that the therapist may make the client worse rather than better; there are also the outcomes illustrated by the present history that as one client gets better another gets worse (and the more depressing result where everyone gets worse: including the therapist?).

3. *The inadequacies of information received in preliminary contacts and early work with the client.*

Assuming that the counselor decides to work with both client and parent in similar cases to that of Brian, he should be aware of the deleterious effect of inept handling of the initial discussion of the problem. An uncontrolled release of material might for instance arouse such guilt that further work with the family is impossible. If this side of the case is handled well there still remains the near certainty that the feelings will be expressed in a very guarded form or misrepresented altogether. The counselor's instincts about such matters presumably develop through experience, as it is easy for clients to maintain a defensive front giving information which they know is acceptable and reinforcing to the professional worker. Thus, in training it is often instructive to ascertain from a series of recorded interviews the extent to which contradictory impressions are given and from this devise double-bind situations which facilitate the emergence of true feelings and attitudes. Information from this will be used for

4. *Continual re-appraisal and contingency planning.*

As is shown by the reported conferences the mechanisms for the above were operative in Brian's case yet it is clear that at most stages of the program the clinic was fairly slow to respond to changes in the nature of the materials received and only acted to adopt psychiatric responsibility for the family when the whole feel of the case had undergone a pronounced change. Mrs. B. was originally assigned to an inexperienced psychologist, the possibility of psychopathology in Mr. B. was not foreseen, and very little pressure was exerted upon the family G.P. over background information or the physical illness. The contingency planning by a full interdisciplinary team might well have been carried out too late for Brian's younger brother and indeed the possibility of an extrapunitive response by Mrs. B. was never discussed.

The extension of counseling services downward into the elementary school will mean that counselors will inevitably face practical difficulties of the type mentioned above. They are well known to all workers in child guidance and case work with children. An advanced practicum must therefore include some component of supervised practice with parents and other significant adults, preferably at some time in the context of interdisciplinary cooperation. This must particularly apply to counselors about to work in areas of sparse community resources who otherwise will develop their awareness of such

problems first through exposure to theory and then through long and bitter experience.

RESUME: Cet exposé porte sur les difficultés de fournir des expériences de traitement adéquates durant la formation. Ceci est discuté par rapport à l'interdépendance des symptômes à l'intérieur de groupes familiaux. La description du traitement d'un jeune garçon de onze ans dans une clinique permet de mettre en relief ce problème. Durant la période de traitement, plusieurs cas de psychopathologie flagrante ont surgis à l'intérieur de la famille. Ces cas ont révélé les limitations du modèle de traitement initial. L'auteur discute du problème en tenant compte de l'intériorisation des modèles de traitement durant l'entraînement.

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