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FAMILY COUNSELING: GETTING TO THE SOURCE

As consultant to the Protestant School Board of Greater Montreal I am called upon to assess school children with a wide variety of problems and I have found it very valuable to have an understanding of family functioning and techniques of family assessment. I try to arrange an interview with the child together with both his parents in order to determine the relationship of his symptoms to his family's patterns of interaction.

The importance of the family in child development is basic to sociological theory. A child is influenced by his family's value systems and by its position in the community. He models himself after his parents. Certain patterns of behavior are encouraged and rewarded by them, while others are discouraged and punished, and these patterns often determine role behaviour. The child assumes and is assigned many roles within the family. If these roles are consonant with his age and with his capacities, they will stimulate and consolidate the development of a positive sense of identity and worth. However, children may be assigned roles which are disproportionate to their level of psycho-social development or which impose burdens beyond their capabilities. An example of this is the well known "scapegoat" where one member of the family . . . usually a child . . . is seen by the other members of the family as a source of all their problems. If the child accepts this role, he cannot avoid perceiving of himself as a "bad" person. This has two consequences: firstly, his self image, his sense of identity, will be that of a devalued, destructive, and malignant individual; secondly, he will behave accordingly.

In the treatment of children, family therapists attempt to understand the behaviour of any one member of the family in terms of the total family. Manifest symptomatology of the identified patient indicates not only individual psychopathology, but malfunctioning of the family as a whole. It has been generally accepted that children can rarely be satisfactorily treated in isolation. Child guidance clinics have long operated on the assumption that parents must be involved if treatment is to be effective. Usually a psychiatrist treats the identified patient, the child, while a social worker deals with the parents, attempting to modify their attitudes and encourage environmental changes. This approach is referred to as the classical, child-centered approach.

A *family-oriented* approach differs from the classical one in that it deals with a family *as a unit*, rather than with individuals or with isolated pairs. As described by Epstein, Sigal, and Rakoff, "Our primary therapeutic tool is the conjoint family interview in which the therapist interviews the whole family together. . . . One of the basic hypotheses underlying conjoint family therapy is a concept of the family as a homeostatic unit. In any given family all members attempt to achieve the most complete fulfillment of their own needs (1965, p. 60)."

The awareness of the importance of the family towards the treatment of

children is not new to psychiatry. In 1926, Anna Freud in *The Analysis of Children and Their Upbringing* emphasized the difficulty of treating children without taking their parents into consideration. She described the problems that arose in her treatment of a 6-year-old child who had a severe obsessive-compulsive neurosis. As a result of the analysis, the child became less inhibited, but in a manner that was unacceptable to the parents. This almost led to the termination of therapy. She concluded that the parents must be receptive to the changes of personality of the child, otherwise more conflicts with the child may be created than can be resolved by the treatment.

Confusion and lack of cooperation from parents usually takes one of two forms: firstly, the parents may decide to withdraw their child from therapy just at the point where the therapist feels that significant progress and changes are taking place; secondly, the parents may act so as to sabotage treatment, as is so often seen in cases of children with school phobia.

If the problems of the identified patient are seen as part of the problems of the family as a whole, and if the family is viewed as a complex system in a state of equilibrium, then it is not surprising that to attempt to change one member of the system will demand changes in the other members. In the evaluation of the family, one must pay particular attention to the transactional patterns. That is, it is necessary to understand the manner in which the members influence one another. Don Jackson emphasizes the concept of "circular causality." For example, the parent does not only influence the child, but is in turn influenced by the child. The interviewer does not look for a direct cause and effect relationship, he does not search for who is to blame, but he tries to understand the transactional patterns which have been established.

The following example drawn from clinical material may help to illustrate transactional patterns. The identified patient was a hyperactive boy with perceptual motor problems who was overly aggressive in school and play. To his parents these motor problems had assumed an exaggerated importance, to the point that they gradually came to see the child as entirely bad. When he approached them tenderly or when he showed them that he had done something well, they were generally oblivious to him. But as soon as he would misbehave they were immediately alerted and they would then punish him, usually by hitting him. A younger sister who did not have these same behavioral disturbances was seen by them as entirely good.

The following transactional pattern had become established. The parents would punish the child. His behaviour was so provocative that they felt there was little else that they could do. Indeed, if they did not punish him for small things he would go on to worse and worse behaviour until he literally forced them to punish. Was the child to "blame?" He did in fact misbehave, but this had become the manner in which he was expected to behave. It was the chief manner through which he could gain the attention of the parents. Later in treatment these parents became aware that they would tend to blame him for things which he had not even done.

To the extent that all family members are involved in this pathological transactional system, it is necessary to treat the family as a unit. In the above case it was possible after a considerable amount of treatment to correct some of the disturbances in this family. However, although the boy's behavior improved, it was difficult for the parents to recognize this. Through

the mechanism of scapegoating, the parents had been able to project onto the child those characteristics which they least liked in themselves—e.g. by focussing upon the *child's* greediness they could avoid the father's complaints towards his wife who he felt was too demanding and greedy, and the mother's complaint that her husband always gave less than she needed. Thus they had been able to avoid direct confrontation with each other. Before they could stop scapegoating this child, there had to be a significant change in the relationship between themselves. As long as they had been able to focus entirely upon the child as a cause of their problems, it had not been necessary for them to deal directly with each other. Any change in a family has a "ripple" effect, just as a pebble thrown into a pond causes far-reaching disturbances before a new equilibrium is established.

I should like now to give some examples of the application of this family-oriented approach to the assessment of children referred by the school. I generally use the following routine. The child is first evaluated by the guidance consultant of the Protestant School Board, who carries out the appropriate psychological assessment. She recommends psychiatric evaluation in those cases where she feels it is indicated. The case is next discussed informally by the guidance consultant, the principal, the teacher, and myself. This part of the evaluation is vital. It is essential to have a clear idea of the problems, particularly of the child's relationships with his teachers. I then see the child together with his parents in a conjoint family interview. In the great majority of cases, both parents manage to attend. If only one of the parents comes, this often indicates a problem area in the family, and is always further investigated.

I will now give two brief case histories to illustrate the technique of family interviewing.

Brenda was an 11½ year old in grade 6. The presenting problem was that her grades were falling down. Also, she was shy and she was unwilling to answer questions in class. She was "hard to reach." She seemed very nervous, often biting her fingers. Whenever she was asked to visit the principal's office even for trifling matters she became very anxious.

Psychological tests indicated that she was of at least normal intelligence. There were no perceptual motor problems and she was known to be a very good athlete.

When I interviewed the family, I found Brenda's mother and sister, but her father was absent. The mother said that her husband was unable to leave work to attend the interview. It turned out that he was often away. He was absent from home each night until long after the children were asleep, and he had contact with them only on Sunday when he would watch television. However, we also learned that while Brenda's mother complained bitterly about her husband's absence and of her need to be both "mother and father" to the children, she also encouraged her husband's absence because she looked upon him as a trouble maker. She never expected anything valuable from men since her own father had given very little to his children. We also learned that although she had initially said that her husband was unable to leave work to come, she hadn't even invited him to this interview.

If we keep in mind the ambiguous attitude of the mother and her distorted messages, the next bit of interaction becomes understandable. Mother began to criticize Brenda who then came to the verge of tears. When mother

noticed this, she stopped the criticism, reached out with her hand to caress Brenda on her head, but Brenda recoiled in terror and shrank back in her chair. The mother was totally perplexed. She had obviously not intended to hit Brenda but Brenda reacted as if a blow was coming. The explanation emerged when Brenda said that she could never tell whether her mother was going to hit her or to be nice to her. She had generalized this feeling to include her teachers and the school principal. Whenever she had to deal with people in authority, she could never tell whether they were pleased or angry, if they were going to reward or punish, so she constantly felt frightened and she then tried as much as possible to stay away from them.

From a transactional point of view it is also necessary to understand the mother's perplexity. She had a child who recoiled from her whenever she approached her, even lovingly. This confused and even angered her with the result that she tended to withdraw from her daughter and to criticize her daughter as a girl who didn't care. It is possible that a similar response, although much less intense, had also been evoked by Brenda from her teacher at school.

In this case, the older sister played an important role in Brenda's current problems. This sister had recently moved out of the home to enter nurses' training and Brenda was very lonely for her. Although they had often fought, the older sister had also acted as a substitute mother and as a buffer between Brenda and her parents. After the sister left, Brenda began to be precociously involved with boy friends. This was her way of dealing with the sadness she felt over the loss of her sister. The end result, however, was that she was even further distracted from her important school work.

Based on this interview, it was possible to explain the dynamics of the family to the school personnel and to relate it to Brenda's attitude towards them. Understanding Brenda's perplexity and the source of her withdrawal and rejection made it easier for the teacher to deal with her in a consistent fashion. It was also recommended that a young female tutor, preferably a university student, be made available to replace, in part, the absent and very important older sister.

A second case involved Ken, a 13-year-old boy. The day prior to psychiatric consultation he had spread rat poison over the walls of the school building. Two weeks previously he had told his mother that he had attempted to commit suicide by swallowing some silver nitrate. There was a previous history of petty stealing and of running away from home.

The immediate problem was whether to allow him to continue in school. I saw him together with his parents. On the surface this couple appeared content with each other. But underneath there was a great amount of tension which they had attempted to deal with by avoiding each other. The father worked all day and the mother for several years had worked on the night-shift at a hospital. Thus, they were very seldom together. They rationalized this on the basis of work requirements, but in fact neither had attempted to arrange their work schedules, so that they could spend time together. The precarious balance within the family was upset as Ken entered puberty. Up to that time, he had been generally quite obedient to his very controlling mother. However, as he began to assert his independence and to demand more privacy and separation, there was increased tension between him and his mother and also between his parents.

Ken hardly said a word during the interview. He was an intelligent boy, who generally spoke very little. However, his posture and his expressions indicated that he was extremely involved and responsive to what was being discussed. As we explored the difficulties between his parents, Ken would nod or shake his head in agreement or disagreement. It is an important aspect of the technique of family interviewing to attend closely to non-verbal as well as to verbal communications. This is particularly useful with those children who are negativistic or who are inhibited—so commonly seen in adolescent boys—because the pressure is off them to talk and yet it is possible for them to participate in the interaction.

In summary, Ken was a boy who expressed himself mainly through his behaviour. He was awkward with words. What then did the rat poison and suicidal gestures indicate? The striking feature was that this behaviour was so dramatic. The family interview revealed what he was attempting to express. The growing awareness brought on by adolescence had enabled him to perceive the precarious state of the family relationships. The rat poison was a desperate plea on his part for help. It was his attempt to attract attention to the deteriorating situation in his family.

The situation was explained to the principal and to the teacher. Several recommendations were made. The first was that Ken be allowed to continue at school. The school was an important stabilizing feature of his environment; to suspend him would only involve him even more deeply in a tense home situation. Also, now that the school had responded to his plea for help, it was unlikely that he would find it necessary to repeat it. The second recommendation was for conjoint family psychotherapy. This was initiated through the Jewish General Hospital.

It is not always easy to find the source of a problem in one interview, but the presence of all the family members would often make it possible to come to an understanding which could not be achieved by interviewing the child alone.

REFERENCE

Epstein, N. B., Sigal, J. J., & Rakoff, V. Some issues in family therapy. In Laval Medical, Inc., Report of the First Annual Convention of the Quebec Psychiatric Association, Quebec, 1965.

LA CONSULTATION EN FAMILLE

R. B. FELDMAN

M. le Dr. Feldman affirme que la méthode traditionelle de traiter l'enfant isolé dans une clinique devrait être remplacée par un traitement de la famille entière. De cette façon il peut mieux comprendre les façons de réagir réciproquement qui existent parmi les membres de la famille. Quand une école renvoie un certain élève à la clinique, il veut discuter le problème avec le conseiller, le directeur, et le professeur avant d'étudier la famille. Ainsi peut-il établir des voies de communication entre l'école et la famille.