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We Don't Need Your Help...

By Jenny Brown

...But Will You Please Fix Our Children

SYNOPSIS: This paper will examine the dynamics of 2 family therapy cases where parents expressed an anxious focus on fixing their children's symptoms and reluctance to exploring the possible interconnectedness of their own issues. These cases will be used to explore this common presentation in child & adolescent mental health where the parents are concerned for their children but are also anxious to not open their "can of worms". The presenting problem in the first case was violent sibling hostility between adolescent sisters and in the second case was an adolescent's anorexia. Drawing on client feedback, reflections are presented on the therapy process behind two divergent case outcomes. In case one the parents were willing to venture into the uncertain places of their own troubled relationship and family of origin, while in case two the parents remained focused on fixing the adolescent and discontinued therapy when family of origin dynamics began to be explored. Bowen Family Systems' concepts of triangles and the family projection process are used as a lens for viewing a child's symptoms as embedded in the broader family patterns. The article opens up suggestions for how the therapist can evoke parents' curiosity about their role in anxious family patterns, without them feeling blamed.

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In the current Australian climate of child and adolescent mental health where individual diagnoses are matched with specific treatment protocols, the focus is often about treating the child with only secondary attention to his/her context. For example the Australian National Outcomes and Casemix Collection (NOCC) has seen the introduction of a suite of standard measures into routine clinical practice in child and adolescent services in order to assist assessment and treatment planning (Coombs, Burgess, & Pirkis, 2006). For clinicians this may be onerous, while at the same time containing in its prescriptive certainty. For anxious parents, who may understandably be concerned about being blamed for their child's difficulties, this manualized child focused trend may be less threatening than approaches which involve them.

Without a systems view, problems in a child will be explained with linear cause and effect thinking. When parenting deficits are seen as primary contributors to a child symptoms, the tendency is to separate children from their parents to assist them in building more resilience and to use psycho education to improve parent effectiveness. When biological deficits are seen as causal in a child's symptoms the parents are viewed as requiring education about the nature and treatment of the illness. In a family systems framework the child's symptoms are seen as embedded in patterns of reactivity from all members of the family and in societal process (Bowen, 1974 &1975; Smith, 2001). Even when the symptoms have a biological basis, they are still viewed as being impacted by the degree to which the child is anxiously focused on and how the child responds in the reciprocal pattern that emerges (Kerr, 1988). An intense child focus, which can be positive or negative, presents significant developmental challenges to the young person as they come to function in reaction to others. This leaves them with little emotional breathing space to grow in thinking, feeling and acting for themselves (Donley, 2003; Maloni, 1998; Gilbert, 1999).

This paper will draw from parents' feedback in two cases in an effort to shed some light on the conditions that may facilitate a parent's willingness to consider looking at their own contribution to the circular relationship patterns in which symptoms have emerged. The clients' comments also provide insight into how the therapist can maintain a respectful engagement with parents who are distressed about their child's symptoms, and also open up a broader systems exploration.

Even when parents and other family members are agreeing to attend the family therapy sessions, it is often difficult to shift the focus from discussing how to "fix" the problems of one child or sibling relationship. From a Bowen Family Systems perspective a goal in therapy is to ask about how family members are responding to the presence of symptoms as opposed to what might be causing the problem. This aims to increase the parent's focus on themselves in the system. It invites family members to more awareness of them self (differentiation) and their impact on others as well as their reactions to others in the system. The distinction of the actions and reactions of self in the web of relationships is seen as a preferable alternative to inviting a focus on others through family members expressing their views about how to change or blame others (Papero, 2000). The tightrope the therapist walks in this approach is how to ask questions that bring forth reflections about the impact of their own behaviours on the symptom bearer and others without taking on a "blame the parents" tone. It is quite understandable that parents, who are asking for help, are generally trying their best and would feel vulnerable to anything suggesting a shift in blame away from external factors or individual factors inherent to the child. For example if a therapist asks the parents to describe their own relationship without a clear connection to the presenting problem, this can readily "lead to a battle over what constitutes the *real problem.....* there may not be any readiness to address marital issues and the family may withdraw from therapy" (Nicholson, 1993:76). The therapist confronts a common dilemma of staying with the parents "fix the child" focus in order to engage them, versus expanding their view to consider their possible part in the child's symptoms with the risk of them dropping out of therapy. On one side of the dilemma the parents may feel relieved that a professional is willing to join them in their efforts to fix their child. On the flip side, the attention to the child's difficulties may lay a heavy burden on the child for taking on the responsibility for change. It may also leave uncovered the underlying relational process that fuels the maintenance of problems; so that symptom relief is either short lived or the problem focus shifts to another member of the family.

From a literature review of journal articles pertaining to treating children's symptoms, a good deal of attention has been given to the trend in family therapy to exclude children with therapists preferring to work with adults and couples (Notably: Sanders C., 2003). Therapists may be more anxious about managing the complexity of whole family interactions where "children are renowned for spilling the beans and may lay bare a family's troubles much more rapidly and frankly than any of the adults (including the therapist) are prepared for" (Sanders, 2003: 179). There has been a healthy critique of exclusionary practices in family therapy where it has become a trend for therapists to exclude children from their sessions and concentrate on the marital relationship(Cox, 1997). Little has been written however, about how to engage parents in seeing their own part in the family system in which their child's problems have emerged.

Case Example 1: When family therapy broadens the focus from the children's symptoms

The Larson family came to therapy because of intense rivalry between the two eldest daughters in a family of four. Sarah aged nineteen and Cait aged seventeen were frequently fighting over territorial issues of phone, computer and TV usage, and Cait borrowing and not returning Sarah's clothes and makeup. The fights had escalated to violent episodes of breaking things and hitting each other. The parents (Mark and Julie) brought their daughters to therapy with them reluctantly agreeing to one session. Therapy continued over a fourteen month period. Seven of these meetings were family sessions with the parents and elder daughters, with two sessions involving the younger two siblings. Sarah and Cait came to three sessions on their own and one session together. Mark and Julie attended 11 sessions together and were each seen individually twice. Towards the end of therapy Julie came to five individual sessions to focus on family of origin issues. Mark and Julie wrote about their experiences of therapy at my request six months after finishing their work.

The following are direct quotes from their feedback:

Parent's initial view of the problem

Mark:

* Almost everyone I know would look at us and say "Oh, they are OK. They have a wonderful marriage and model children." Facades are a wonderful thing.

* To be frank, I did not go to family therapy with a view to solving my marriage problems (the burning resentment I felt for my wife). I went because of the kids. They seemed to hate each other and indulged in never ending verbal and physical fights at every opportunity.

* Somewhere deep in my subconscious I probably recognized there was a link between my marriage and our kids' behaviour but I did not want to think that the process would move towards the two of us...I was frightened about the possibility of discussing such personal matters with my wife and a stranger.

Julie:

* I had thought that the difficulties in my marriage could be kept separate from the children and that they would not be affected if we remained civil to each other. I also thought that my husband's sexual difficulties were his problems that he needed to sort out. Equally my own problems were for me to sort out.

Parent's experience of focusing on the presenting problem

Mark:

* Perhaps I felt safe behind the barrier of my kids and solving their problems.

* The therapist seemed realistic in tackling our problems. After getting background information we moved on to a pretty quick fix for the kids. The first step was for me to accept that I got angry which was not easy for me. The second required me to step back and identify my flash points. Next we had to notice the triangle pattern of dealing with the kids that we were locked into. The fourth was to deliberately change this pattern. Next each child and the two of us agreed to a code of conduct based on reasonable behaviour....on our part as adults as well as the children.

* What I liked about family therapy was it was very directed, focused on the presenting issues and required us to think about changing unhelpful or destructive behaviours. Our therapist said the process would not solve all our problems but would allow us to do things differently and give us a chance to understand what was going on.

Julie:

* The therapist had the right balance between being approachable and warm and yet business-like and determined to get on with the task without being cold and detached.

* My children, all adolescents, liked her which shocked me...They said that she treated them with respect, listened to what they said, was not condescending and seemed to understand what was going on for each of them.

* She was real and honest. She said things like "I don't expect that you will like or even get on with your sister, some people don't but don't they think there needs to be reasonable behaviour while you are living together."

Discussion: Expanding the View from the Presenting Problem

Julie and Mark's reflections emphasize the degree of anxiety that any client brings to therapy and the importance of each person experiencing being attended without side taking. Looking at patterns in the fights rather than the content of arguments, including who was right or wrong in the disputes, assists in avoiding blame and adding some hope that things could improve.

Calming the System

From a Bowen Family Systems approach the first goal in any therapy is to calm the anxiety escalation through a combination of engaging with each person and conveying a sense of thoughtful investigation. The therapist "aims to reduce client's anxiety about the symptom by encouraging them to learn how the symptom is part of their pattern of relating" (Brown, 1999: 97). As the therapist asks questions about family patterns in a neutral manner, the goal is that one or more family members are able "to think more objectively about intense emotional processes, that is, for family members to reflect as well as feel"(Kerr & Bowen, 1988:284). With every effort made to be a relatively non anxious presence, the therapist works to avoid side taking which inevitably leads to getting entrenched "in the client's problems by becoming automatically and inadvertently triangled into the process" (Herz Brown, 1991: 23). While the therapist endeavours not to respond negatively or positively to the emotional reactions of clients, they do ask questions that seek to connect with the details of the family's anxious concerns with "the focus of the therapist being on target for the family or individual" (Meyer, 1998:76). Mark and Julie's feedback validates the importance of connecting with their presenting concerns in the beginning of therapy. Digging prematurely into family history or the marital relationship would most likely have intensified their tension and potentially sabotaged their engagement in therapy. (*This may be different in couple therapy where a move away from marital conflict to family of origin relationships can be quite calming*)

Externalizing feelings and exploring behavioural sequences

The focus on behaviour as opposed to explanations and feelings was commented on as helpful by the father. This was guided by Bowen's approach to lowering reactive anxiety in the therapy room by focusing on what can be observed and described by everyone, rather than inviting individual subjective viewpoints. Feelings are externalized by asking the client to "think and talk about the feeling, rather than expressing it" (Titelman, 1998: 37). This is to assist clients in becoming aware of the stimulus-response system of feeling reactions in their relationship that includes mannerisms, facial expressions and tones of voice. For example the therapist asks the client: "What are the main issues that trigger your tears?" rather than, "Can you describe how you are feeling right now?" The more a client learns to "observe the negative stimuli in their relationship by defining them in as much detail as possible they may be able to diffuse their responses without any instructions from the therapist" (Bowen, 1978: 250).

The basics of family therapy engagement

Julie and Marks' feedback is a reminder of some of family therapy's basics which are often left out of academic writing. Such fundamentals of engaging a family without expending emotional energy in trying to be liked or be helpful: to give every one equal say; to invite everyone's input in problem solving: and suggesting concrete tasks, such as to define a reasonable code of conduct for family arguments.

Setting realistic expectations:

It is also interesting to hear from these clients that they valued the toning down of expectations for idealized harmonious outcomes. This intervention is guided by the Bowen Family Systems' perspective that the higher the stress in families, the more heightened the pull for harmony and fusion becomes. "As anxiety increases, people experience a greater need for emotional contact and closeness and, in reaction to similar pressure from others, a greater need for distance and emotional insulation"(Kerr & Bowen, 1988: 121). When a parent's anxious focus to create idealized connection is defused, it often follows that family members (particularly adolescents) are more able to hold their sense of autonomy without needing to deploy reactive individuating responses such as rebellion and cut-off.

Dismissing the kids - The transition to parent and couple issues

Mark:

* We spoke about the families we came from but did not dwell on our personal tragedies. Rather we looked for triangle patterns of communication that went around the 3 corners of the triangle rather than one on one communication.

* The question was: who were the oppressor, the oppressed and the rescuer in this triangle? - Where did this occur in our family of origin? How did it occur that my father never spoke to his brothers or his father despite the

fact that they lived close together and does that pattern repeat in my generation? What does that say about my own behaviour and how I deal with conflict or loss?

* The process took several weeks....but it was a satisfying process because I was learning and progressing as the weeks passed. More importantly there were signs of progress_ fewer arguments, signs of co-operation, less bad language. Finally the children were done and the moment of truth arrived. I had to deal with my marriage.

* We had already touched on major aspects of our relationship that affected the kids. There was a gentle but urgent inevitability about moving to the darker recesses of our marriage.

Julie:

* I learned to see the pattern we kept repeating with the girls. When the two of them fought, Mark would get angry, especially with Cait. I would then try and appease and smooth over the conflict which ended up increasing the tension between Mark and me.

* Dealing with the presenting issue of warring children was less threatening than beginning with our marriage. However very quickly we were helped to see that there were serious unresolved issues that we as a couple had never addressed.

* Over the years we had developed some very negative habits of not communicating directly (I was especially not good at this), of blaming, scapegoating and feeling entitled to our bad behaviour because of the other's bad behaviour.

* The most helpful thing for me was to understand that tension and difficulties anywhere in the system affected the whole family.

Discussion: A shift away from the child focus

It is clear from the parents' comments that staying with the presenting problem of their daughter's fights, was productive in helping them to see how they were inadvertently involved in maintaining the destructive patterns. Exploring sequences (emotional process) of who does what during the violent incidents was helpful in opening up a systems view for those present (Breunlin, Schwartz & Kune-Karrer, 2001). This avoids subjective explanations of the conflict which potentially take the therapy into a debate about who is most to blame. A focus on the patterns or process of the fights helped the parents to reflect differently on their part in the dynamics. Feedback reveals that both parents began to see that Mark's quickness to intervene angrily, followed by Julie's attempts at mediation and damage control, left both of them feeling unsupported with bottled up resentments surfacing. This also left both daughters caught in a cycle of negative affect that was larger than their own territorial battles. Viewing the reciprocal patterns of reactions and functioning, leaves little room for blame of an individual with "all relationships seen as the product of the participation of all its family members....all families are composed of people struggling to survive in a sea of anxiety"(Kelly, 2003: 143). If the focus had been on the content of the fights, or an effort to find a solution to disagreements, this would have continued previous unsuccessful attempted solutions to changing the daughter's behaviour. Principles of healthy disagreements and codes of conduct are generalized to all family members rather than holding anyone more responsible for change than another. This enabled the conversation to move away from who was most to blame for causing the disputes to what might each person be doing that contributes to the maintenance of the fighting.

Adolescents as a treasure trove of systems insights

If the adolescents had been dismissed prematurely from the sessions it may have constituted a form of "ecology chopping" in which the therapist misses the rich feedback of multiple perspectives. "As family therapists.....having as many family members as possible participate in therapy makes it easier to identify constraints" (Breunlin, Schwartz, Kune-Karrer, 2001: 366). If the therapist worked only with the parents at this early stage, it is likely that their defensiveness about their own relationship could have escalated. Without the useful descriptions from the daughters about what they observed to be the behaviour of other family members, it would have been easy for the parents and therapist to align in an effort to focus on fixing the sibling relationship.

How a focus on the child can reinforce current triangles

The parents clearly found it enlightening to explore their relationship patterns and to hear their daughters' perspectives. For the therapist to either dismiss the parents to address the sibling relationship, or to be too quick to dismiss the adolescents to do parent education, would have been likely to reinforce a narrow child focus which threatens to intensify the very patterns of reactivity which can keep the problems from being resolved. An over-focus on the child's symptomatic behaviour may assist in maintaining the child in a triangle position that functions to detour anxiety from what is not being addressed in the parents relationship. This predictable detouring of parental anxiety is now receiving research attention in the therapy field (Fivaz-Depeursinge & Favez, 2006). Bowen's described how this occurs using his concept of the "family projection process" where over a period of time "a child/children responds anxiously to the tension in the parents' relationship, which in turn is mistaken for a problem in the child. A detouring triangle is thus set in motion, as attention and protectiveness are shifted to the child" (Brown, 1999: 96). When symptoms are present in one or more children, it may be that anxiety from other parts of the family are bound in one section through an intense positive or negative focus on a child. Anxiety in the marriage can be diffused with this focus, but when tension is high "the projection process intensifies, creating an emotional crowding effect for the child, which ultimately gives the child less emotional room to develop" (Donnelly, 2003:148).

It was interesting to hear how readily the parents came to see the pattern of triangles where they stepped into predictable roles of the mediating "peacemaker" and the outside "oppressor". Julie could see how her stepping in to smooth things over was undermining of Mark and aligning with her daughters. Mark was beginning to see that the sisters' arguments gave him a forum for indirectly expressing anger towards his wife for his experience of being excluded by her protective and confiding relationships with the children. Triangles provide an expression for predictable patterns in families "when the inevitable anxiety in a dyad is relieved by involving a vulnerable third party who either takes sides or provides a detour for anxiety" (Brown, 1999: 95). The therapist uses their knowledge of triangles to ask questions that reveal the presence of alliances, such as:

"Who gets involved in the argument? When do they step in? What do they say and do? How is it responded to? Who would be perceived as Cait's supporter? The mediator? Who is invited to help Julie in this effort? How does this happen?"

This is done as a form of joint research with family members where they are invited to look for clues to the repetitive patterns in which they are involved. A collaborative approach that enlists the clients' curiosity and problem solving resources means that the therapist is not working too hard in a solo effort to address the family's problem. It seems from Julie and Marks reflections that they found this time of joint exploration an important ingredient to increasing their commitment to the therapy process.

Readiness to work on the couple relationship

Mark:

* Early on we had to hear each other's pain and empathize with it without being defensive or accepting the blame (our typical pattern). Hearing, really hearing your own part in someone's pain is a very sobering experience.

* I saw the pain I had inflicted on my wife for being a workaholic...being emotionally absent from my family...and there was the revenge I had inflicted on my wife by withdrawing from sex because she had inflicted pain on me.

* We had to choose whether or not our marriage was worth saving....did we want to continue to live with the patterns that had brought us to where we were? For me this meant resuming sex and not behaving in a revengeful way...for my wife it meant less complaining, trusting me to change and helping me back into the family.

Julie:

* I needed to acknowledge my own anxiety and over functioning concerning the children. I needed to be more honest with my husband and with myself and focus more on what I needed and wanted and ask for it rather than trying to have those needs satisfied in a more manipulative and less honest way.

* I found it extremely difficult and confronting to discuss the intimate details of our sexual relationship...It had become such a huge unspoken secret, just talking about it diffused a lot of the anxiety.

Discussion - Couple Work

It is clear in these quotes that the degree of anxiety about the pain in the marriage was high. This prompts a reflection on the therapist's role in helping anxious parents to speak about their relationship to a calm third party who does not respond anxiously to what is being said by taking sides or taking on responsibility for trying to relieve the pain. This increases the likelihood of each spouse being able to hear the other with some objectivity. The shift from anxiously reactive behaviour to thoughtful reflective discussion is assisted by the therapist engaging with attentive questions that invite the clients to think and reflect on their relationship patterns.

It is not easy for a therapist to maintain a sense of calm in the face of anxious defensive parents/ spouses however, this is likely to be the most significant contribution a therapist can make to the parents willingness to risk exploring their relationship. "Therapists, standing on the sidelines of the natural system and serving as consultants, try to keep themselves from entering or being pulled into the family emotional field, while developing a reality-oriented, open and hopefully warm and respectful relationship with the individual who is consulting them" (McGoldrick & Carter, 2001: 283).

The outcome of therapy:

Mark:

* We have continued over weeks and months now maintaining our changed behaviour...I am sure there will be times when we fall back into bad habits but the emotional bank account between us is filling up.

Julie:

* We are more able to talk honestly about what we want and discuss our way when there are differences. We are not the Brady Bunch but there is an honesty and calm in our family now. Our kids can just be themselves....we know there will be difficult times but I feel as a family and as individuals we are better equipped to know how to deal with them.

Discussion - Outcome

The outcome of this case reflects a work in progress as opposed to a neat fix of the problems. Symptoms did abate in this instance, not only in the violent incidents but with the cessation of the eldest child's symptoms of depressed mood and suicidal ideation. The parents report that they have gone beyond symptom relief to having some new resources and awareness for dealing with the inevitable stressful situations that must be negotiated in future.

Key learning drawn from the parents' feedback highlights how helpful it is to stay with relationship process which enables patterns to be identified without blaming any one person in the family. With interactional patterns there is no clear starting point or cause, just an emergence of predictable cyclical responses to a stressful situation in which the distancers have just as much contribution to make as do the central active players.

Inviting clear thinking about choices available in response to what has been discussed in the session, also appears to have facilitated helpful engagement for both parents and their daughters in the early phase of work. Encouragement for the parents to focus their main effort of observing, clarifying, discussing and experimenting during the period in between sessions, assists in creating a collaborative process where the work for change is not left in the hands of the therapist. It is clear from the parents' reports that the therapist had an important role in validating the courage it takes to risk doing things differently. It was also helpful to the parents' sustained efforts that they were prepared for "change back" reactions where members of the system react in a manner that increases anxiety and seems to pressure the person to return to their predictable role. The systems oriented therapist cautions clients not to underestimate family members reactions to any change efforts which are "likely to be intense, and will take you off guard if you are not prepared" (McGoldrick & Carter, 2001: 296).

Case Example 2: When family therapy fails to shift the anxious child focus

The Peters Family

Prior to beginning this period of family therapy there had already been five professionals involved in "treating" Tricia Peter's anorexia. While Mr. and Mrs. Peters demonstrated great commitment to being involved in their daughter's therapy for over a year and a half they appeared to stay locked into the view that therapy was about helping the therapist to fix their anorexic daughter. Defensiveness intensified when there was an invitation to consider whether or not family dynamics may be contributing to the intransigence of their daughter's symptoms. Over a twenty month period there were thirty two sessions with the identified patient Tricia and her parents Susan and Gary, four sessions with the whole family (including two older siblings who had left home), five sessions with the siblings, four sessions just with the parents, three mother- daughter sessions, four individual sessions with the mother and four individual sessions with the daughter Tricia. While there were periods of improved functioning for Tricia in terms of maintaining weight and increasing self directed activity such as a part time job, it seemed that these improvements were followed by an increase in Susan's (mother's) anxiety symptoms and distancing. In response Tricia became distressed at her mothers condition, blaming her self for causing her mother so much trouble. Gary would then be drawn into a more active role in supporting Tricia to relieve the burden from Susan. In turn Tricia would intensify her restrictive food regime and her functioning became more helpless. In therapy a conscious effort was made to explore these patterns without any blame agenda, however Susan's sensitivity to judgment remained high throughout the work. The following are her comments about her experience of therapy six months after ending family therapy to send Tricia to another individual therapist.

Quotes from Susan (Mother):

* The first family therapist told me to stop sticking my nose into things. He told me I had a lot to answer for. He wanted to be Tricia's best friend.

* In most of Tricia's treatment I felt very judged as a parent. I was shocked that anyone could question me as a bad mother and I had been exactly the same parent to both my daughters.

* My husband Gary didn't feel judged. I think because he has such a calm personality, therapists thought he was very together but he has a lot of eating disorder problems in his family.

* I felt biases from you at times but because you were very professional I always felt I could feed this back to you. I don't think you understood enough how much stress I carried into starting therapy from nearly having my daughter die and from feeling shut out of her treatment. The way I let it all out in therapy is not a true indication of how I am most of the time.

* I know you thought that our extended family problems were important in the end but we didn't find it helpful. We had already addressed everything and it probably shouldn't have been talked about in front of Tricia."

* The most helpful thing about family therapy was that it helped us all to understand the pain and torture Tricia was going through. And I never would have understood how to help her around food.

* The least helpful thing was feeling judged by what I did in an hour session. Sometimes I was scared to say anything.

Discussion:

Susan's comments are certainly salutary. Clearly her experience of feeling like an outsider in therapy triangles was not conducive to her being able to consider alternate perspectives on the patterns of her daughter's symptomatic behaviour. In line with a Bowen Family Systems' view that at least "50% of the work of therapy is the therapist's effort to stay out of the clients' emotional system" (McGoldrick & Carter, 2001: 283), it is vital that I examine my own contribution to the context in which one family member continued to react defensively. I can see that I did at times get drawn into trying to get Susan to see that her own anxious reactions were closely linked to Tricia's symptom levels. While descriptions of behavioural sequences did seem to provide evidence for this, it is important that members of the family are the ones that speak this view rather than the therapist becoming

anyone's mouthpiece. If I could patiently persist with exploring process in the family, asking each person to comment on what they are seeing and learning, I would not need to instruct anyone. The family system would decide when it is ready to expand its view of the problem. The therapist is reminded to pull back from over functioning for family members.

"One of the most constructive attitudes a therapist can have when he/she approaches a clinical family is to regard the family as a tremendous resource for the therapist's learning.....If a therapist can ask questions that do not express an opinion or assume an answer, then she/he can learn about the family and in the process the family can learn about itself" (Kerr & Bowen, 1988: 292).

The invitation for the therapist to subtlety take sides is ever present. To stay de-triangled, my feedback would need to draw on the reports and comments of family members and not from my own opinions. It would then have opened up the space for each family member to speak directly to each other about what they needed in their relationship rather than me unwittingly becoming anybody's advocates. An understanding of triangles, with Gary being seen to adopt the mediator position between his wife and daughter without speaking on his own behalf, assists the therapist to see that his conflict avoidant stance is as much a contribution to family intensity as was Susan's anxious focus on Tricia. This view also helps avoid placing undue responsibility on the mother to tone back her anxious focus on the child. Without a view of triangles involving both parents, therapists can too easily blame the mother for simply doing what she has been socialised for. "That she (mother) complies to the extent that she does is then often seen as her pathological need to serve or control or to remain central" (Carter, 1988: 28). Gary as the distancing silent male is as much a part of the repeated patterns of tension in the family as is Susan.

Susan's helpful feedback also reminds me of the importance of keeping in mind the history of the family's relationship with other professionals. If other professionals are reported by a family member as having taken sides, it is useful information to the therapist about the potential for loss of neutrality.

The need for an adequate level of symptom relief before expanding the therapy focus

I am also reminded from Susan's feedback that the first task of family therapy in to calm down the anxiety in the system in order to achieve a reasonable degree of symptom relief (Brown, 1999). This is achieved through the calm presence of the therapist who asks questions around the presenting problem without aligning with any person's view of the problem. With the serious and chronic nature of anorexia, the therapist would do well to remember that heightened anxiety from a parent is completely understandable and arousal levels are likely to remain at a heightened level that undermines cognitive awareness until there is a reasonable period of symptom stability. (I.e.: being outside of the life threatening range.) This is consistent with the assumption that when symptoms are severe and longstanding, the arousal level of "the anxious individual tends to override the cognitive system and behaviour becomes increasingly automatic" (Papero, 1990: 42). Whenever symptoms remain severe, the intensity of anxiety will most likely be a restraint to expanding the families view to broader system or family of origin issues.

Bowen did caution of the difficulties of shifting the anxious focus on a child when the intensity of anxiety is high. In such cases he preferred to dismiss the child as quickly as the parents could tolerate it and to give priority to the relationship between the parents as they were responding to the symptomatic child.

"The usual approach in family therapy is to soften the intensity of the focus on the child and to gradually shift the focus to the parents, or between the parents and families of origin. This might be relatively easy if the process is not intense, or it can be so intense that little is accomplished beyond symptomatic relief and easing the pressure for the child" (Bowen 1975: 298).

Susan did remark on the unhelpfulness of exploring family of origin cut offs. The exploration of the parents cut off from the husbands extended family comes from the hypothesis that "a cut off with the parent generation can fuel the anxiety in the parent child relationship...primarily because the blame and sensitivity to others that contributed to the cut off in the previous generation can now slip into blame and sensitivity between parent and child in the new generation" (Donley, 2003:151).While the issue of cut off between the generations may be a significant feeder of anxiety in the nuclear family, the therapist needs to ask questions that make this connection relevant to the client, such as "what do you think has been the impact of lack of family support on your relationship with your

daughter?" Susan also reminds me of the importance for the parent with the most proximity to the symptom bearer to be able to vent their distress and to know that this has been heard without judgement by the therapist. At the same time the therapist remembers that the most important validation or experience of being heard needs to be invited from within the family rather than the therapeutic system.

Conclusion

The therapist walks a tenuous line in any case where parents insist that their child be fixed without addressing broader family issues. The balance between respecting the parent's view, alongside the potential unhelpfulness of increasing the burden of responsibility on the child, presents a core dilemma for the therapist. Parent feedback provides useful insights into the process of therapy that can lead to reduced defensiveness and consequent openness to focus on the self in relationship with others, rather than on the child. The concepts of the family projection process that influences a heightened child focus in some families, alongside an understanding of how children are often triangled into the parent's relationship, provide useful theoretical guides to the conduct of family therapy when a "fix the child" focus is presented. While these systems concepts provide some guidelines for the conduct of therapy, the therapist can subtly be drawn into trying to prematurely impose these ideas on the parents in an attempt to shift a family member's view of the problem. As Family Systems Theory proposes:

"If a therapist reacts to a family's anxiety by telling people what to do, the resources of the family will quickly become submerged. If a therapist does not react, but just helps a family define the nature of the problem with which it is confronted (especially the relationship process that create and reinforce it), the resources of the family will resurface"(Kerr & Bowen, 1988: 283).

Parents will undoubtedly continue to present in therapy saying that "We don't need your help but will you please fix our child?" This expectation is reinforced in the current climate of mental health where individual diagnoses and treatment are privileged. A Family Systems' approach assists in a response to the "fix our child" request with the view that parents are not the cause of their children's symptoms, but they have the ability to provide some leadership and can therefore initiate change in their own behaviour that has a ripple effect through the family. A less anxious parent who is willing to take responsibility for their own difficulties may not automatically lead to a resolution of problems for a child but may set the tone for a child's behaviour to be less of an automatic reaction to their parents and more an expression of their individuality.

Post Script: *3 years after completing therapy with the Peters family, Gary (father) has initiated his own therapy to deal with the cut offs in his extended family and to learn how to relate to Tricia in the face of her continuing anorexic symptoms*.

4 years after the finish of therapy with the Larson family, the eldest daughter Sarah (aged 23) has asked started individual therapy to assist with dealing with the diagnosis of a serious illness of one of her parents.

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