

1-1-1977

# The significance and purpose of family organization in families whose children have inflammatory bowel disease.

Edward G. Corrigan  
*University of Massachusetts Amherst*

Follow this and additional works at: [https://scholarworks.umass.edu/dissertations\\_1](https://scholarworks.umass.edu/dissertations_1)

---

## Recommended Citation

Corrigan, Edward G., "The significance and purpose of family organization in families whose children have inflammatory bowel disease." (1977). *Doctoral Dissertations 1896 - February 2014*. 3130.  
[https://scholarworks.umass.edu/dissertations\\_1/3130](https://scholarworks.umass.edu/dissertations_1/3130)

This Open Access Dissertation is brought to you for free and open access by ScholarWorks@UMass Amherst. It has been accepted for inclusion in Doctoral Dissertations 1896 - February 2014 by an authorized administrator of ScholarWorks@UMass Amherst. For more information, please contact [scholarworks@library.umass.edu](mailto:scholarworks@library.umass.edu).

UMASS/AMHERST



312066013585266

THE SIGNIFICANCE AND PURPOSE OF  
FAMILY ORGANIZATION IN FAMILIES WHOSE  
CHILDREN HAVE INFLAMMATORY BOWEL DISEASE

A Dissertation Presented

By

EDWARD GEORGE CORRIGAN

Submitted to the Graduate School of the  
University of Massachusetts in partial fulfillment  
of the requirements for the degree

DOCTOR OF EDUCATION

May 1977

EDUCATION

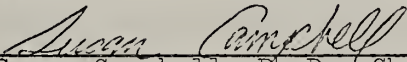
THE SIGNIFICANCE AND PURPOSE OF  
FAMILY ORGANIZATION IN FAMILIES WHOSE  
CHILDREN HAVE INFLAMMATORY BOWEL DISEASE

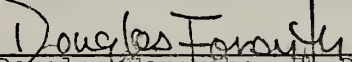
A Dissertation Presented


By

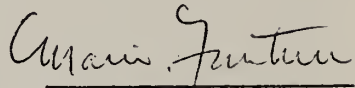
EDWARD GEORGE CORRIGAN

Approved as to style and content by:

  
\_\_\_\_\_  
Susan Campbell, Ph.D., Chairperson

  
\_\_\_\_\_  
Douglas Forsythe, Ph.D., Member

  
\_\_\_\_\_  
Ernie Drucker, Ph.D., Member

  
\_\_\_\_\_  
Mario Fantini, Dean  
School of Education

## ABSTRACT

### The Significance and Purpose of Family Organization in Families Whose Children Have Inflammatory Bowel Disease

August 1977

Edward G. Corrigan, B.A., Drew Uni-  
versity, M.Ed., University of Massa-  
chusetts, Ed.D., University of  
Massachusetts

Directed by: Professor Susan Campbell

Inflammatory bowel disease (IBD) in childhood seriously impairs the emotional and physiological development of the affected child. Psychologic factors are recognized as relating to the onset and development of the disease, however, the families of these children have not been extensively examined.

Minuchin et al. (1975) developed a highly successful technique for working with families of children with other severe psychosomatic symptoms based on their understanding of these families' organization. They were able to isolate and restructure family interactional patterns which reinforce the child's symptoms. The characteristics of families whose children are suffering with IBD have not been examined in terms of those family interactions which may play a major role in the onset and maintenance of the disease. Accordingly, one factor of the model proposed by Minuchin et al. was examined in this project,

i.e., the family's interactional characteristics. Specifically, this research hypothesized that the families of children with IBD would reveal a distinctive organization which could be described as enmeshed, overprotective, and lacking conflict resolution skills.

Twelve families of children with IBD were compared to seven families of children with non-psychosomatic illness (diabetes) along eleven variables which measure these interactional patterns. Using a sign test, a P value of .000448 was obtained, clearly demonstrating the difference between the families and in the direction hypothesized. A second related hypothesis concerned the relation between the severity of the symptoms and the degree of enmeshment, overprotection, etc., in the family. This hypothesis was tested by comparing six families whose children's disease was more advanced with six families whose children's disease was less serious and/or in remission, with the prediction that the former group should be more enmeshed, etc., than the latter group. This hypothesis was not confirmed. Using a sign test a p value of .886719 was obtained.

Based on the findings and the logic of Minuchin's work, a convincing hypothesis could be recommended that the families of children with IBD could be involved in the onset and maintenance of the symptoms of IBD. However, the fact that all of the families revealed these interactional patterns,

regardless of the state of the disease indicated to the author that there was a more complex relationship between the families organization and the child's symptoms than Minuchin had hypothesized for the subjects in his study.

The author speculated that based on the defenses repeatedly observed of these patients in the literature and the nature of the mother child interaction as observed in the literature, as well as the nature of the interactional patterns which stress closeness and deny and suppress conflict, that the underlying condition in the family was a schizoid state and that the symptoms relate to this state. This interpersonal situation is the environment (breeding grounds) that provides the necessary conditions for the development of the symptoms through a conversion process as described by Sperling (1946, 1967).

Finally it was concluded that the disease is a "problem solving" technique which works on several levels. Intrapsychically, the symptoms serve as a defense against depersonalization (Winnicott, 1966). Interpersonally, the sick child meets certain needs of the mother (Engle, 1955, Gerard, 1953 and Sperling, 1955). On the level of the family system the sick child may be used as a focus - a homeostatic technique - whose exacerbations may be timed to "save" the system from amplifying beyond the range of its equilibration - that is, as a deviation - counteracting technique. These operations are

encased within the family system - its "unpregnable compromise" (Finch and Hess, 1962), which in a sense frees the somatic components to amplify. The gastroenterologist is handicapped in that he is working outside the compromise with the somatic elaboration of a complex psychological situation.



## CONTENTS

ABSTRACT.....		iv
TABLES.....		viii
CHAPTER ONE	Inflammatory Bowel Disease.....	1
CHAPTER TWO	Psychosomatic Literature on Inflammatory Bowel Disease.....	8
	Personality Traits and Family.....	9
	Alexander.....	13
	Prugh.....	15
	Gerard.....	17
	Mohr, Josselyn, Sprulock and Barron....	18
	Engle.....	21
	Sperling.....	24
	Winnicott.....	31
	Jackson and Yalom.....	33
	Finch and Hess.....	35
	A Systems Perspective.....	37
CHAPTER THREE	Family Organization and Psychosomatic Illness in Children: Minuchin's Model....	42
CHAPTER FOUR	Method.....	49
	Hypotheses of the Present Study.....	49
	Subjects: Experimental Group.....	50
	Subjects: The Comparison Group.....	52
	The Family Task.....	52
	Rating the Tapes.....	55
	Rating Scales.....	57
CHAPTER FIVE	Results.....	65
CHAPTER SIX	Discussion: Part One.....	71
	Enmeshment.....	73
	Overprotection.....	84
	Lack of Conflict Resolution.....	88
CHAPTER SEVEN	Discussion: Part Two.....	101
	An Hypothesis.....	107
CHAPTER EIGHT	Conclusion.....	117
	The Need Not To Know.....	120
	Limitations of the Present Study.....	126
	Summary.....	127
APPENDIX -SCORING MANUAL.....		130
REFERENCES.....		158

## TABLES

1	EXPERIMENTAL GROUP DATA.....	53
2	MEDIANS AND RANGES OF THE EXPERIMENTAL AND COMPARISON FAMILIES ON FAMILY TASK VARIABLES.....	67
3	MEDIAN AND RANGES ON ACTIVE AND INACTIVE FAMILIES ON FAMILY TASK VARIABLES.....	68
4	EXPERIMENTAL FAMILY SCORES ON FAMILY TASK VARIABLES....	69

## Chapter 1

### INFLAMMATORY BOWEL DISEASE

Inflammatory bowel disease in children seriously impairs the affected child's emotional and physical development. The etiology of the disease is unknown and its natural course is exacerbation and remission. The disease can be modified and controlled by aggressive medical management, but never cured. Often surgery, with all of its complications, has to be performed. However, even medical treatment, especially through steroid therapy, can lead to such chronic complications as a high frequency of retarded growth and development. And cancer risk increases after each year of continuous involvement.

Psychological factors have long been thought to play a role in the onset and course of the disease and there is a voluminous discussion in the literature as to the role emotional factors might play. However, relatively little attention has been paid to the sick child in the context of his family. In this area, Minuchin, Baker, Rosman, Liebman, Milman and Todd (1975) have had great success in moderating the emotional factors affecting the physiology of children with brittle asthma, superlibile diabetes and anorexia nervosa. In family therapy they have been able to isolate and restructure path-

ological interactions within these families which affect the symptomatic child. Although Minuchin et al. postulate a general type of family interaction that encourages somatization, the characteristics of families with inflammatory bowel disease have not been examined in terms of those family interactions which may play a major role in the onset and maintenance of the disease. Consequently, promising therapeutic opportunities for these children remain unexplored. Accordingly, the present study will examine the structure of the families of children with inflammatory bowel disease, hoping to discover factors in their structure which might provide new therapeutic options in the treatment of this disease.

### Inflammatory Bowel Disease

Inflammatory bowel disease is a syndrome which includes both ulcerative colitis and granulomatous disease of the bowel, also known as Crohn's disease. Although these diseases are independent entities and there are many points of differential diagnosis, many gastroenterologists now feel that the two syndromes are end-organ variants of the same basic pathophysiological processes (Golograber and Kirshner, 1958; Silverman, Roy and Cozzetto, 1971). Often cases of lower bowel inflammatory disease are not clearly classified as being either Crohn's disease or ulcerative colitis on pathological, clinical or radiologic grounds (Hawk, Turnbull and Farmer, 1967; and McKegney, Gordon and Levine, 1970). Further, McKegney's

et al. (1970) study indicates that the two syndromes have many "host-environmental" disease factors in common. Their study of 123 patients with either Crohn's disease or ulcerative colitis indicates a similarly "high incidence of emotional disturbances and life crises prior to the illness onset in both somatic diseases" (p. 153).

There are no significant differences between patients with the two diseases in a large number of demographic, psychosocial, personality, behavioral, psychiatric and physical disease characteristics. In both syndromes, more severe emotional disturbances is associated with more severe demonstrable physical disease. The findings support the theory that these two somatic processes represent ends of a spectrum of biological responses to similar psychosocial and personality factors.  
(p. 153)

Thus, in this study, the literature on both syndromes will be reviewed and distinguished and families with children suffering with each disease will be evaluated, with the expectation that the different syndromes will not be an important variable.

The classic presentation of inflammatory bowel disease is a symptom complex which may range from mild abdominal cramps, diarrhea with blood in the stools to severe cramps, vomiting, nausea, and stools consisting almost entirely of blood and mucous. Frequently, there are associated systemic manifestations which may include recurrent febrile episodes, growth retardation, weight loss, lethargy, anorexia, skin

rashes, arthritis and uveitis (Daum, Boley and Cohen, 1973). It can be an acute fulminating process, but more often than not, it is insidious and slow. The natural course of this disease is variable, marked by remission and exacerbation.

In ulcerative colitis many children (from 30%-40%) respond to medical therapy and do well. They may have mild or moderate relapses but on the whole are able to lead fruitful lives. Other patients (from 20% to 45%) with chronic, continuous type of ulcerative colitis fail to respond to medical management. The risk of cancer in these children is great. The mean mortality is about 20% after 15 years of disease. (Silverman et al. 1971)

In the pre-steroid era, a follow-up study on eighty-four children with ulcerative colitis revealed a high mortality rate, 33 percent, and a high incidence of major surgery, also 33 percent, and 33 percent were alive without surgery but with chronic recurrent ulcerative colitis (Korelitz and Gribetz, 1962). The introduction of steroid therapy has resulted in more dramatic remissions. However, their influence of the later course of the illness has been less satisfactory. This therapy has undesirable side effects, especially when given over a long period of time, and contributes to complications. (Sperling, 1967) A follow-up study of thirty-seven children aged two and a half to eleven and a half years, treated with steroids during the first three years of the disease, later revealed an even higher incidence of chronic



complications compared with the results in the pre-steroid era, and a higher frequency of retarded growth and development (Korelitz, 1964).

With Crohn's disease, mortality is low, morbidity is high. The disease process is progressive in most cases and its course interspersed with both acute and chronic complications leading to variable degrees of invalidism. In Crohn's disease there are several alterations in structure and function of the small bowel, which results in a malabsorption syndrome that can be very severe and life threatening (Silverman et al. 1971).

According to Kirshner (1971), inflammatory bowel disease is most prevalent among young people--children, teenagers, and young adults--although no age is exempt. In the University of Chicago series, the most frequent age of onset is between 10 and 19 (Kirshner, 1971). Other statistics vary considerably. One study indicates that only 10% of all reported cases of ulcerative colitis have onset before 15, the commonest age being 8 1/2 (O'Connor, Daniels, Flood, Karush, Moses and Stern, 1966). Another study indicates that the pediatric population may account for 20% of the total number of cases (Daum et al. 1973). But no matter what the incidence of inflammatory bowel disease is among the young, it is, when it strikes, a devastating disease. Cohen (1976) estimates that over the last ten years, 50% of the children and adolescents he is familiar with, either with ulcerative colitis or

Crohn's disease have undergone major surgery. Daum (1973) has stressed the relative virulence and debilitating effects of Crohn's disease in adolescence. In an actuarial analysis of the long-term prognosis of 346 children with ulcerative colitis, Devroide, Taylor, Sauer, Jackman and Stickler (1971) noted a 22% fatality after 10 years.

As to what causes inflammatory bowel disease, "many etiologic factors have been proposed but no one conclusive agent has been demonstrated" (Daum et al. 1973, p. 934). Kirshner posits an "individual tissue vulnerability--a state of disease readiness with external (environmental) triggers (e.g., emotional disturbances, enteric infections, oral antibiotic, etc.) which precipitate the clinical expression of the disease." (Kirshner, 1971, p. 681-82) The role of psychological influences in the pathogenesis of inflammatory bowel disease remains unsettled. Many writers believe that the psychiatric disorders observed in their patients are the result of a chronic debilitating disease rather than being evidence of an etiologic factor. (Crohn, Ginzburg and Oppenheimer, 1932; Rosner, Daum and Cohen, 1974) Thus, Kirshner (1971) noting that emotional disturbances are common in patients with ulcerative colitis, and believing they undoubtedly contribute to the exacerbations, chronicity, and to the severity of the disease process, believes that they are not specific for ulcerative colitis, and reflect, in part secondary emotional responses of the chronically ill patient.



Daum et al. (1973) support this position. "Despite the large volume of material, no conclusions can be drawn regarding the relationship of the patient's personality structure to this disease. There is no proof of a primary psychiatric role but personality structure appears to play an important role in the response to management." (Daum, et al. 1973, p. 937) On the other hand, several writers (Sperling, 1946, 1967 and Gerard, 1953) believe that the psychological processes cause the disease, while others (Engle, 1955, Finch and Hess, 1962, and Lepore, 1965) believe that psychological factors play an important role. This body of data and theory will be reviewed in the following chapter. Following that Minuchin's et al. model will be examined in detail.

## Chapter 2

### PSYCHOSOMATIC LITERATURE ON INFLAMMATORY BOWEL DISEASE

There is an extensive literature investigating the relationship between psychological factors and ulcerative colitis, and that which was written before 1954 was reviewed by Engle in his "Studies on Ulcerative Colitis," published from 1954 through 1958. Interest in the relationship between emotional factors and Crohn's disease has been not only much less extensive, but less developed. These studies have been reviewed by Whybrow, Kane and Lipton (1968). However, as mentioned above, ulcerative colitis and Crohn's disease are probably different end-organ variants of the same basic pathophysiological processes, and as McKegney's et al. study (1970) has ascertained, there is no significant differences between psychological, behavioral and psychiatric characteristics. So there is an excellent possibility that the discussion on ulcerative colitis applies to Crohn's disease.

Most of the published material on either disease is on adults. There has been less written on children and only a few papers which deal specifically with these diseases in adolescence. In this review I will concentrate on the major theories which try to relate psychological processes to the etiology of the disease, and the literature on children.

Before proceeding, however, I would like to summarize the various descriptions of the personality traits and families of patients suffering with ulcerative colitis.

### Personality Traits and the Family

Karush, Daniels, O'Connor and Stern (1968), Sperling (1967) and Engle (1955) have shown that there may be a wide range in severity of psychopathology for those suffering with inflammatory bowel disease. Generally, however, most observers agree that individuals with inflammatory bowel disease suffer serious psychological illness. There are certain personality characteristics which are repeatedly observed of both adults and children suffering with this disease. A high percentage of these patients are described as manifesting obsessive-compulsive character traits with guarded affectivity and rigidity. They have a difficulty in expressing anger openly and appropriately which is often attributed to the conflict between their need to express it and their need for a close dependent relationship. These patients are hypersensitive, easily hurt and on the alert for signs of hostility and rejection. There is a marked use of denial in some, others are placating, conforming, submissive and seductive. They usually have a hostile-dependent relationship with one or two important persons, and have difficulty in establishing warm and spontaneous relationships with others. Their sexual identification is seen as very disturbed.

Engle (1955) notes that a good number of men and women remain with little or no heterosexual experience even when married. Prugh (1951) has described children along similar lines as:

passive, rigid, dependent on parental figures, socially inhibited, narcissistic, emotionally immature with compulsive needs to conform exaggeratedly to social dictates. They are relatively unable to express effectively strong feelings of anger or resentment, especially in relation to parents or authority. (p. 341)

McDermott and Finch (1967) evaluated 48 children psychiatrically and saw them as either expressing infantile pregenital strivings or as establishing compulsive defenses in reaction to these strivings.

The compulsive defenses often seemed to be nothing more than a translucent varnish through which one could see the inner layer of underlying immaturities, heavily defended against, but manifested by episodic eruptions of temper outbursts and obstinate, clinging, whining behavior bursting through the pseudo-mature outer shell. (p. 514)

These authors conclude that the innermost part of this pregenital core is a tendency towards depression.

Characteristically the families of children with inflammatory bowel disease present themselves as normal and healthy and rarely speculate on a possible connection between their child's illness and any emotional disturbances in the family or in their child's history, which is usually presented as insignificant. Yet, in most cases there is evi-

dence of a premorbid personality and problems include feeding difficulties, difficulty in toilet training, temper tantrums, enuresis, extreme shyness, school maladjustment and poor peer relationships. (See Finch and Hess, 1962.) Parents are depicted as emotionally immature, inhibited, lacking energy and socially inactive. Fathers are seen as passive, ineffective and unimportant in the family, and mothers as aggressive, controlling and dominating. (See Engle, 1955.) Most writers stress the symbiotic nature of the relationship between the mother and the patient. Lidz and Rubenstein feel that characteristically the mother conveys to the child "the feeling that they will always take care of him in every way, that they will always assume all responsibilities for him and that they will always be able to direct him" (Lidz and Rubenstein, 1959, p. 684). The mother's controlling techniques are often disguised by her role as martyr. Engle describes the "mother who devotes herself selflessly to everyone, sacrifices herself, suffers humiliation and hardships, all for the health and welfare of the patient" (Engle, 1955, p. 235). Yet, the child is often seen as the object of the mother's unconscious hostility and rejection. Finch and Hess (1962) believe that this is shown in her need for illness in the child, this providing an opportunity for her to demonstrate her concern. Sperling (1946, 1949, 1952, 1963) has described this phenomena. She has described the mother as unconsciously seeking the maintenance of a lifelong depen-



dence on her for the gratification of her own needs, and at the same time, having strong unconscious destructive impulses towards the child.

Engle (1955) has emphasized the consequences and interactional aspect of this kind of frightened and mutually controlling relationship:

One gains the impression that the patient lives through the key figure (i.e., the mother) and the key figure lives through the patient. Seen from the side of the patient, the patient appears to depend on the key figure as part of his equipment for dealing with the external world. This is revealed by their leaning on the key figure for guidance, advice and direction; by their reluctance to take initiative or to plan independent action; by their tendency to act out wishes, conscious and unconscious, of the key figure, or to live vicariously through the key figure; by their use of this individual as a barrier against or protection from threats from other sources; and by their need to please and placate this figure and to protect her from anxiety or other unpleasant effects, whether provoked by the patient or by others. At the same time the patient's attitude is a highly ambivalent one. The patient is extremely sensitive to, but often frustrated by, the demands of the key figure, but finds it impossible to relinquish his own parasitic relationship. Similarly, the demands and requirements of the patient at times are unmet, or only conditionally met, with consequent intensification of the conflict. (p. 234)

Keeping these brief summaries in mind, I will turn now to review the observations and formulations of some of the important researchers who have studied ulcerative colitis.

Alexander

Alexander's (1950) formulations, based on a Freudian psychodynamic model, emphasize the patient's prevailing anal characteristics. Thus, the fact that the first symptom of ulcerative colitis "frequently appears when the patient is facing a life situation which requires some outstanding accomplishment for which he feels unprepared" can be grasped on the basis of the psychodynamics of the anal stage. Alexander observes that two emotional factors of this stage are conspicuous in patients with ulcerative colitis:

First is the frustrated tendency to carry out an obligation, and second, a frustrated ambition to accomplish something which requires the concentrated expenditure of energy. (p. 124)

Thus, in persons with this kind of anal fixation, whenever the urge or necessity to "give" arises in later life or the realization of an ambition on some adult level is blocked by "neurotic inhibitions," a regression takes place. Alexander notes that in this respect, ulcerative colitis patients closely resemble patients suffering from other forms of diarrhea. But he adds that anal regression is extremely common in all kinds of diarrhea and in psychoneurosis, in general. Thus, he notes that there may be some local factor or peculiar physiological mechanism which is initiated by emotional stimuli and leads to ulcerative colitis.

A common criticism of Alexander's thesis is that the somatic processes in ulcerative colitis are not related to the

or thoughts which were associated with the emotions of anger, resentment, fear and guilt were frequently evocative of a hyper-motile response on the part of the large bowel, as indicated by symptomatology of mild to severe bouts of tenesmus and the appearance of loose or watery stools containing, at various times, mucous, pus and blood. Prugh's observation can be demonstrated by drawing upon an example from one of his case studies:

A nine-year old boy being interviewed by Prugh suddenly caught sight of a small boy, standing unconcernedly with obviously soiled diapers in the adjacent bed. This sight caused the patient visible concern, and he turned away, saying, "That's messy, that's bad." Complaining of abdominal cramps, he asked for the bed pan and subsequently passed a small amount of blood and mucus. At no time could he verbalize why this sight so disturbed him.

In this case it was apparent to Prugh that this boy's mother had emphasized scrupulous cleanliness as a standard of behavior ever since early infancy, a standard at first reluctantly and later anxiously and even compulsively accepted by this boy in most of his spheres of behavior. Because of this mother's intense need for absolute cleanliness, arising from the dictates of her own rigid, overly conscientious personality structure, toilet training had been a major point of difficulty for mother and child. Early and quite rigid training had stemmed from mother's disgust at the messiness of the child's stools and their disposal. Prugh concludes that the boy's anger, rebellion and anxiety, his emotional responses to his mother's inexorable standards had been repressed but they retained, however, their "pathogenic" quality, in spite of repression.



somatic processes of diarrhea. (See O'Connor, 1964.) Thus, the severity of the bowel symptoms and the easily analogized relation to the analytic theory of the anal period has led Alexander along the wrong path. Engle (1955) believes ulcerative colitis is a systemic disease, and that there is no evidence to link the mucosal-submucosal reactions of ulcerative colitis to the psychophysiological relationships of the toilet training period of childhood. On the other hand, Alexander's basic observation that the first symptoms of ulcerative colitis appears when the individual is facing a demanding life situation which requires a response for which he feels unprepared is thought of as an accurate observation.

#### Prugh

Prugh (1951), a psychiatrically trained pediatrician, investigated twelve cases of ulcerative colitis in children ranging in age from 4 to 19 to determine the frequency of occurrence, degree of intensity and nature of operation of an emotional component in ulcerative colitis as it is seen in childhood, and to assess the effectiveness and mode of action of psychotherapeutic methods. These children were seen for varying periods in consultation, play therapy and observed interacting with mother. Extensive social work data was available on the child's adjustment at home and school.

In each child studied, Prugh was able to establish a correlation between varying types of emotional stress and exacerbation of gastrointestinal symptomatology. Thus, topics

This reasoning leads Prugh to cite the correlation between the emotional stress, unconscious in this instance, and gastrointestinal symptomatology--namely a hyper-motile colonic response. Prugh does not understand the mechanics of this response.

As with the exacerbations of symptoms, Prugh was able to make correlations between the original onset of symptoms and emotional stress. However, in most instances, this relationship had to be established retrospectively by historical methods. In this discussion, Prugh notes that the differences in integrative capacity or ego strength seemed to bear a definite relation to the character, severity and rapidity of the onset of symptoms. Thus, in the "fulminating" group, the children were intensely dependent, markedly immature and reacted to any anger or resentful feelings with widespread guilt. In analyzing the precipitating event, Prugh notes that in these cases the stress is often less clear and objective, often possessing a special unconscious meaning to the child. In the group of children whose onset of symptoms is more gradual and milder, the precipitating event is more apparent, less devastating. These children possess less dependent and rigid personalities and occasionally act out angry feelings, however immature these expressions are.

In conclusion then, Prugh is anticipating the observations of Spierling and Gerard. He emphasizes the reservoir of repressed and unacceptable anger, and indicates its origin lies in the family constellation:

Evidence indicates that the origins of the unacceptability of negative emotions, leading to the development of the characteristic system of psychological defenses, appears to lie in the family constellation. Rigid, at times over-indulgent and often inconsistent handling of the child by one parent, most commonly the mother, had been present in each instance, leading to overwhelming domination motivated by the parent's unconscious emotional needs. In nine of twelve cases, such domination was demonstrably most intense at the time of toilet training. The child's inevitable reaction to such pressure was thus activated at an early age, bringing about an association both between desire to conform and "produce" results, either gastrointestinally or behaviorally, and wishes to rebel in both these spheres of activity. Behavioral rebellion seemed to pose the greatest difficulty for these children, who later internalized parental pressures in the form of an uncompromising, guilt-ridden conscience, at the same time clinging to parental figures in a dependent and immature fashion. (p. 352)

### Gerard

Gerard (1953), impressed by the influence of pre-genital phases of development on symptom and character formation, examined the mother-child relationship in 38 cases of varying psychosomatic diseases, eight of which were ulcerative colitis. Her premise was that:

Since early adaptation is mainly that of adjustment of the various body organs to their various functions in extrauterine conditions, it is reasonable to suspect that later maladaptation of the organ due to emotional causes may arise from emotional difficulties experienced in the first months of life when patterns of response are initiated. (p. 83)

Gerard was interested in the details of "mothering," of supporting, of talking, of bathing, etc., in an effort to answer the questions of symptom choice which have evaded ex-

planation and as she notes, too often answered by "constitutional causality or causal nihilism." Thus, in the eight cases of ulcerative colitis, she notes the mothers "complained of disgust and dislike of stools and diaper changes and were particularly irritated with the child's diarrhea. Bowel training in all cases had been early and punitive" (p. 91). And when the child's symptoms appear, mother appears to be rejecting and especially irritated, unlike the normal mother who responds to the child's distress by trying to relieve it.

An important general finding which applies to all of the mothers in the cases studied was that:

With no exception, all these mothers were narcissistic and uninterested in the child except as a self-enhancing asset. They resented the exertion involved in child care and rarely gained pleasure from the mother-child relationship. In other words, they all lacked mature motherliness. In addition, most were rejecting and physically cruel in various ways and resented the added care of the infant during physical illness. Therefore, each child presenting a psychosomatic disorder had experienced frustrated dependence at a stage when needs are dependent upon the mother for satisfaction. (p. 88)

Thus, according to Gerard, it may be that the physiological vulnerability which many authors posit, may really be an historical consequence which reveals itself later when the child's adaptation to his inadequate maternal experience breaks down.

Mohr, Josselyn, Spurlock and Barron

Mohr et al. (1958) studied the parents, parent-child relationships, and conflict situations of six cases of ulcerative

colitis in children seven to eleven years of age. This study was guided by the work of Gerard (above).

The authors interviewed the mothers of their six patients in an effort to determine their emotional orientation to pregnancy and the initial care of their ill children as well as their relationships with their own mothers. Their findings reveal that the mothers of their patients felt they had experienced "a lack of maternal warmth and care from their own mothers" who they described as "cold, severe, domineering, controlling and unaffectionate." And although these mothers made strenuous efforts to win the love and approval of their own mother, they consistently failed, and as the authors note, maintain a "hostile-dependent relationship" with them disguised by compensatory efforts towards self-control and independence. These women "see the world as a dangerous place in which one survives only as a result of one's own efforts; yet their efforts are experienced as potentially ineffective because of fantasized self-deficiency" (p. 1069).

With this emotional history these women are unprepared for a non-anxious relationship with their child. Domineering and controlling patterns emerge toward their children motivated by "deep fear that failure will have disastrous consequences." These compensatory and anxious patterns are further stressed by their lack of support in the family's current living situation--none of the fathers are seen as offering emotional support for their wives. The authors thus suggest



that the illness of the child finally serves the mother as a "confirmation of her inadequacy and of the undependability of the environment."

Mohr's paper concludes with a description of the characteristic situation of stress for a child with ulcerative colitis. The description follows Alexander's hypothesis discussed above. Given the inability of the parents of a child with ulcerative colitis to respond to his needs, the child attempts to meet his own needs by becoming self-sufficient, but this is a precarious situation in which he is easily threatened by demands which tax his limited integration.

In the basic relationship with his mother, his "biological security" is threatened by his mother's inability to respond with "comfort, acceptance and security." "Both mother and child are anxious about his survival, and the reactions of both to the basic threat are characterized by intensity and a sense of urgency" (p. 1074). Eventually he tries to protect and provide for himself, but becomes pre-occupied with the problems of his day-to-day living. This is an anxious and suspicious performance and failures reinforce his basic anxiety and hostility. The onset and exacerbation of his symptoms are seen as related to the state of stress provoked by his inability to maintain his defensive, compensatory efforts to manage his own life.

Engle

Engle has done the most extensive work on ulcerative colitis. He has written five important papers in a series entitled "Studies in Ulcerative Colitis." The paper which I will concentrate on is his third--"The Nature of the Psychologic Processes," (1955) which attempts to establish, in Engle's terms, "the existence and nature of conditions which may be contributory or even necessary, yet may be not sufficient for the development of ulcerative colitis." (p. 315) Engle's formulations are based on his experience working with 39 of his own patients and an intensive review of 44 published papers on psychological data on more than 700 patients with ulcerative colitis. He concludes that the major psychological determinates which lead to the onset of ulcerative colitis are (1) some disturbance in the key relationship, which (2) leads to an affective state of helplessness or despair. To Engle, the helplessness following a disturbance in the key relationship, in adults often in a transference relationship,

may be regarded as evidence of a traumatic separation process, which cannot be managed by psychological defense mechanisms, and that such a state may be accompanied by a biochemical or physiologic derangement which permits initiation of a variety of pathologic processes in tissues, including those characteristics of ulcerative colitis. The nature of these processes remain unknown. (p. 249)

The key relationship has at its roots the mother-child symbiosis which Engle notes is distinctive in ulcerative colitis. He believes it contributes to the specific psychological vulnerability of the patient and may contribute to the predilection for bowel trouble.

For example, the child in Engle's description quoted at the end of the introduction summary above faces extraordinary problems of adaptation. A bad mother is better than no mother and survival depends on staying close and adapting to the "bad mother." Separation from this kind of mother is traumatic because the symbiotic connection holds the key to survival. In order to reduce the danger of separations, the child often identifies with the mother's conflicts, thereby adapting to mother's conflictual behavior, but at considerable cost to his ego development:

He remains permanently dependent on mother without whom he is literally helpless, since he cannot function in certain ways, having never successfully achieved independent means to do so. (p. 248)

In this way, the individual with this kind of psychological inheritance remains extraordinarily vulnerable to fluctuations in his important relationships.

Engle lists some of the essential qualities of the mother-child transactions which lead to this symbiotic and mutually controlling relationship:



- (1) The mother has an unresolved involvement with her own mother which is often transferred to this one child.
- (2) For a variety of reasons the mother's relationship to the child is a "conditional" one, meaning that it may be relatively warm and succoring only when the child's behavior does not mobilize anxiety or guilt in mother. Transactionally, some of the child's intrinsic behavioral patterns, such as feeding, bowel activity, motor activity--over which the baby has limited or no control--may be among the behavioral processes which evoke maternal anxiety, guilt or shame. (See Gerard)
- (3) These mothers acquire a striking measure of control over the motility of their children or the children require control and succeed in enlisting it. Here again, one sees mutual provocation, gratifications and resultant guilt.
- (4) The psychosexual development of these individuals is arrested by virtue of the persistence of the symbiotic relationship, the need for "external" ego support. (pp. 252-253)

Engle believes that there may be some defect, biological or acquired early in infancy, which then may contribute to the localization of the disorder in the bowel. Thus, Engle postulates that three conditions operating together may lead to the onset of ulcerative colitis: (1) a pre-existing biological determinate, (2) a developmental psychological determinate (the mother-child relationship) and (3) a current external situation, (i.e., threatened or real separation from the key figure). However, the question of some defect, biological or acquired early in infancy is left open by Engle, and now, twenty years later, it is still an open question.

## Sperling

Now, we turn to Sperling whose work demands close study because of the success she has had in treating these children. Sperling elaborates a psychologic concept to account for the pathophysiologic developments of colitis but to explain it, first I will have to review her developmental formulations and her work with colitic children and their mothers.

In Freudian psychology, the period between one and a half and two and a half to three years, the child's developmental task is to progress from the passive, dependent, oral stage into the active, aggressive anal stage. This is a vulnerable period for the child and

certain attitudes of the parents, especially the mother, may interfere with a satisfactory development of the anal-erotic and anal-sadistic drives and provides the basis not only for bowel disturbance but also for a disturbance in the child's ability to handle and to express adequately aggression and sexuality later in life. The fixation to the anal-erotic and anal-sadistic phases of development and the regression to these fixations under traumatic circumstances in later life are of particular importance in ulcerative colitis. (1967, p. 339)

This is because the mother cannot support the child's maturational processes. The mother is troubled and needs to have the child dependent upon her.

Sperling believes that some of the mothers "behave as if the physiologic act of having given birth to the child (separation) had not been accepted as a fact in the uncon-

scious" (1949, p. 385). Sperling describes the mother's difficulty as an unresolved emotional conflict from her own childhood which she acts out with the child. The child may represent an unconsciously hated sibling or parent which the mother projects onto the child, but then because she is so identified with her own projections, she must control it (the child). Sperling then notes that the "use of projection and the need for control, in which the child's individuality is completely disregarded, leads to a certain impairment of reality testing with reference to the child. However, because this specific relationship is limited to one of the children in the family, the behavior of the mother may not appear to be particularly disturbed, especially since her reactions can easily be rationalized in the case of a sick child" (1949, p. 384).

From this frame of reference, the mother's extremely ambivalent attitude towards the child makes sense. She feels strong unconscious destructive impulses toward the child, but she needs the child:

The outstanding feature of this relationship the mother rewards in actuality the dependence of the child and although she may complain overtly about the burdens imposed upon her by the illness of the child, she can give love and care only to the sick child. The child's dependence on the mother, cemented by the illness, creates a sort of magical relationship (a mutual magical life insurance) between them, with reassurance to the child that he will not suffer a loss of his mother as long as he remains dependent upon her. When the child complies with these unconscious needs

of his mother, namely to be sick, and thus remain the helpless infant, the unconscious gratification in the mother leads her to a guilty preoccupation with the child's care. She may consciously resent the child's illness and give the impression of rejecting the child.

I have found that the mother in the case of psychosomatic illness of the child rejects the child only when he is healthy and evi- dences strivings towards independence, but encourages his illness and rewards him when he is sick. (1955, p. 320-21)

How does the child react? According to Spierling, with hostile attachment and an intense need to hold on to the position of a baby, and, of course, this is a precarious situation. What happens when separation from the mother happens or is threatened? This is a fate which must be avoided since it would mean psychological death, i.e., depersonalization or personal annihilation, but this kind of fear must be a constant experience for the child because of the mother's ambivalent and contradictory behavior. This situation sets in motion, according to Spierling, "the archaic mechanism of oral-sadistic incorporation of the needed object with all the destructive somatic consequences of the defense mechanism" (1946, p. 325).

These children are in a state of permanent frustration that results in a state of unconscious rage with an irresistible urge for immediate discharge. The slightest additional frustration...provokes exaggerated reactions. The destruction and elimination of the object through the mucosa of the colon (bleeding) would seem to be the specific mechanism in ulcerative colitis. As the object is incorporated sadistically, it is a hostile inner danger and has to be eliminated immedi-

ately. The feces and blood (in severe attacks, only blood and mucous) represent the devaluated and dangerous objects. In all cases with much bleeding observed and analyzed, it appeared as if the quantity of blood was directly proportional to the intensity of unconscious rage present at the time. (1946, p. 326)

Sperling believes that it is "essentially the degree of regression that differentiates ulcerative colitis from conversion hysteria and mucous colitis," but it is the quantity of sadism that perhaps determines the depths of the regression itself.

Psychodynamically, ulcerative colitis is an organ neurosis with pregenital conversion symptoms. The choice of the organ is determined by oral and anal fixations, the colon being the eliminatory organ. The anorexia, vomiting, abdominal pain, diarrhea and bleeding represent expressions of and defenses against aggressive incorporation of the frustrating object. (1946, p. 327)

This formulation has been criticized by Engle (1955) because he feels that it "remains to be seen" whether a psychological construction (destructive impulses turned inward toward the introjected object) can account for the breakdown of the mucosal surface of the colon. (1955, p. 248) However, this is a concept which organizes Sperling's treatment approach. It is a radical theory but one which gains support from patients' material in psychoanalytic treatment. Let me provide a few clinical anecdotes.

An analyst working with an adult patient with ulcerative colitis felt that he was not making progress because he was



being constantly attacked by his patient. He told the patient that he had to stop his complaining and soiling. The patient did not show up for his next session, but was admitted to the hospital with a severe exacerbation of colitis. Had this patient projected his introjected object (his mother) onto the analyst and relieved his internal situation by attacking it (projected onto the analyst), and then did he turn his attack upon himself again and did this exacerbate his colitis? Here is another clinical anecdote from Sperling:

Previously she would have had cramps and bloody diarrhea in such a situation. The fact that she could now, in a conscious phantasy, gratify her impulse to attack the irritating person made the somatic symptoms unnecessary, although she could not yet tolerate consciously the affect accompanying the phantasy. Instead of feeling angry, she felt amused. She still did not trust her ability to control destructive impulses in reality. She had a dream which she could not remember, but she recalled the feeling of the dream when she awoke. She summarized her feelings: "These impulses are too strong, too overwhelming. I had better have colitis; I need a safety valve." (1960, p. 453)

The consistent observation that patients with inflammatory bowel disease have great difficulty in expressing anger lends support to Sperling's theory. And recall Prugh's (1951) observations on the reciprocal relationship between the therapeutic release of "pathogenic" angry or hostile emotions and the intensity of the colonic hypermotile response.

While these anecdotes and observations are not conclusive, they are suggestive and gain greater support from the success which Spierling has had in treating these children. Spierling tells her patients that their symptoms are meaningful and their way of expressing and discharging feelings and conflicts of which they are not aware consciously. She works psychoanalytically.

With children of prelatency age, she works first with the mother and in many cases finds this is sufficient so that no direct work with the child is necessary. "The mother has to be helped to modify her unconscious needs and to achieve sufficient security so that she can relinquish this relationship with her child" (1967, p. 350). With children of latency age, she works with the mother preceding or concomitant with the treatment of the child. With children of puberty age and adolescents, she works directly with the child, except in severe cases where the underlying psychiatric disorder is of a schizophrenic or borderline nature, in which case it is preferable to divide the treatment of mother and child between two therapists.

It is essential to understand that ulcerative colitis for which no known external or internal etiological cause can be established medically, indicates the presence of a psychiatric disorder and that the symptoms of ulcerative colitis are the somatic manifestations and expressions of the specific unconscious fantasies and conflicts; furthermore, that we treat not the

symptom or the diseased organ(s) but the patient who produces and who needs and maintains these symptoms. The clinical manifestations and course of ulcerative colitis in a child reflect the severity of the underlying psychopathology not only of the patient, but also of his family, especially the mother. (1967, p. 349)

As I stated at the start of this review of Sperling's work, she has had impressive success in her work with ulcerative colitis patients. She was successful in "thirty out of thirty-three cases" (1967, p. 348). Of the unsuccessful cases, one patient was withdrawn by his mother and two adolescent girls were subjected to colectomy when they were hospitalized for reasons other than ulcerative colitis itself.

I will conclude this review of Sperling's work with a dramatic clinical anecdote. The patient, a nine-year old girl, was acutely ill with ulcerative colitis. Surgery had been advised but she was so ill that the surgeon feared she would expire on the operating table. Sperling had some information about the case prior to this interview and had interviewed the mother.

In this first meeting with the child I told her that I knew how she felt and what she was doing, namely, destroying herself. I also told her that I did not think that this was the only way out of her situation and that I could assist her in finding a better solution. From the way she responded, I recognized that I had hit it off right and that she felt I understood. After I reassured her that I could and would help her and would speak to her mother about taking her out of the hospital, we made an agreement.



I explained that in order to help me to help her, she would have to stop this suicidal undertaking and start eating. She knew and I explained to her that her mother was using the fact that she was not eating as the most valid reason for having her in the hospital because she needed frequent transfusions. The change in the child's condition after I left her was short of miraculous. What is amazing in such cases is the speed with which the most severe clinical symptoms can develop and subside.  
(1967, p. 347)

### Winnicott

Next, I turn to Winnicott, among whose many distinctions was that at different times in his career he was President of both the British Pediatric Society and British Psychoanalytic Society. In his paper "Psychosomatic Illness in its Positive and Negative Aspects," (1966) he states that the illness in a psychosomatic disorder is not the somatic pathology, but a split or multiple dissociation in the patient's ego organization and it is this split or dissociation which keep separate the somatic dysfunction and the conflict in the psyche. In order to establish the full meaning of this idea I will need to briefly review Winnicott's theory of psychological development.

Health in the infant's early development implies for Winnicott "continuity-of-being." The early "psyche-soma" proceeds along a certain line of development providing its "continuity-of-being is not disturbed." This depends on "good-enough mothering" which in the early stages must actively

adapt to the needs of the newly formed psyche-soma (infant). "Not good-enough mothering" is bad because the mother fails to adapt herself to the needs of the infant. Her failure is experienced by the infant as an "impingement" to which the infant (the developing psyche-soma) must react. (1975, p. 245) This reacting disturbs the continuity-in-being and upsets the early developmental processes, in particular "personalization" which is the development of the feeling that one's person is in one's body. "It is the instinctual experience and the repeated quiet experiences of body care that gradually build up what may be called satisfactory personalization" (1975, p. 151).

Psycho-somatic illness is the negative of a positive; the positive being the tendency towards integration in several of its meanings and including what I have referred to as personalization. The positive is the inherited tendency of each individual to achieve a unity of psyche and the soma, an experiential identity of the spirit or psyche and the totality of physical functioning. A tendency takes the infant and child towards a functioning body on which and out of which there develops a functioning personality, complete with defenses against anxiety of all kinds.

This stage in the integrating process is one that might be called the "I AM" stage...It is the meaning of "I" and "I AM" that is altered by the psychosomatic dissociation. (1966, p. 514)

Thus, a psychosomatic disorder is a form of ego weakness which is a result of not good-enough mothering. However, there remains in the individual a "tendency towards integration"

and the somatic illness is maintained so as not to lose this potential. But the illness is also a defense against "unintegration," or the "threat of annihilation at the moment of integration" (1966, p. 515). One is now in a position to appreciate Winnicott's statement:

I have a need to make it plain that the forces at work in the patient are tremendously strong. (1966, p. 510)

In summary, maternal failure inhibits "personalization," a primitive developmental process which normally leads to the feeling "I AM"--an ego based on a body ego. The opposite of personalization is depersonalization, a primitive anxiety which the psycho-somatic patient prevents on the basis of his illness. "Psycho-somatic illness...has this hopeful aspect, that the patient is in touch with the possibility of psycho-somatic unity" (or personalization), but the "psycho-somatic illness implies a split or dissociation in the individual's personality, with weakness of the linkage between psyche and soma" (1966, p. 515).

#### Jackson and Yalom

Jackson and Yalom (1966) studied and treated eight families whose children ranged in age from seven to seventeen, and who had ulcerative colitis. They were impressed by the high degree of similarity in interactional patterns in the families.

The authors use the terms "restricted family" and "restrictiveness" to convey their dominate impression of the families' style:

Family members seem to hold each other in check by placating, nullifying and subduing each other. Voice tone is often quiet and expressionless. Arguments and emotional comments, anger and affective responses are, in most instances, avoided. There appears to be a conscious awareness of pain, disharmony and unhappiness in the family and yet an agreement that this will not be mentioned in front of other members. (p. 415)

They feel that a "restricted family" has rules which confine who can say what to whom, with sanctions against anyone who says more than he should. They report an incident from a family session in which the interviewer is trying to get the family to discuss their reticence and hesitation in the session:

Finally we advanced the question of whether they had really had nothing to say or whether they felt they were not permitted to say things within the family. At this, Anita blurted out a memory: she was younger, she would come into the room, but everyone would tell her to be quiet because they were watching television. The mother and father quickly denied this had happened; a few minutes later the girl herself denied she had ever mentioned such a thing. (p. 415)

They also note that the communication style in the family supports this restriction: "Data would be given in a rather loose, tentative fashion so that it could easily be altered if another family member complained or questioned it or disagreed" (p. 417).

What is important about this study is that it has been a deliberate effort to examine the family of children with ulcerative colitis. The authors believe it unlikely that the interactional characteristics they have observed are specifically etiological for ulcerative colitis; they agree with most other observers that it is most likely a disease produced under stress where certain genetic factors already exist. They also note their findings are tentative, incomplete and lacking in scientific vigor. Their sample was white middle class and had no control for the effect of a chronically ill child on family interaction. However, their findings -- "the striking similarity" in the families' interactional patterns -- influenced and suggested my interest in the families of children of inflammatory bowel disease.

#### Finch and Hess

Finch and Hess (1962) studied 17 children suffering from ulcerative colitis ranging in age from four to fourteen years. Their investigation included a detailed case history and family evaluation, psychological testing and psychiatric evaluation of each child. Their data repeat and confirm many of the observations on the personality structure and dynamics of the ulcerative colitis patient, his relationship with his parents, and the etiology of the disease as described above. They conclude that:



No clues could be found to indicate why, from the psychological point of view, these children developed ulcerative colitis. No primary relationship could be established between the nature or extent of the psychological disturbance and the gastrointestinal symptomology. No specific or unique factors could be found in the psychological development of the children. No specific family patterns existed to account for the child developing ulcerative colitis. (p. 823)

Yet they conclude that a non-organic factor must be present in order that the disease becomes manifest and/or perpetuated. Based on psychological test data, certain observations were made repeatedly about the children:

The most important finding is the hypercathexis of the mother-child relationship, with profound and intense interactions resulting in conditional ego functions and inadequate relationships aside from that with the mother.

...All view the mothers as dominating and inconsistent, varying between a hostile and/or overprotective figure. All children view their mother as basically rejecting and insensitive to the child's needs, due to her own narcissism. The mothers are seen as prohibiting direct expressions of both sexual and aggressive impulses and requiring conformance to strict standards...Sadomasochism is found in every child. (p. 822)

It is this consistent psychological profile which suggests to Finch and Hess that a definite non-organic factor must be present in order for the disease to manifest and perpetuate itself. Their position is that the disease has a genetic, constitutional or congenital base, which is then



triggered by emotional factors. They then hypothecate a "typical" case in which these factors may combine to produce ulcerative colitis. They conclude their hypotehsis with the following statement:

The development of an objective physical disease would then represent a rather successful and impregnable compromise for the child, the mother, and the family. Following this, further elaboration and distortion of both the physic and somatic components of the pathological state could take place. With such an "excellent" solution to mutual psychopathology of mother and child and family, the pathologic process need not progress to more florid stages of mental illness, such as specific neurosis or psychosis., (p. 824)

Thus, Finch and Hess point out the importance of thinking about ulcerative colitis in system terms as a homeostatic regulator.

### Systems Perspective

Building on Finch and Hess' idea, it may be that these families are troubled to begin with and they take advantage of or use the onset of a serious illness as an opportunity to stabilize the family system. Meissner (1966), a family therapist and researcher, implies that a disease can serve a homeostatic function in that it helps the family restabilize their emotional system after some event has disrupted it. It stabilizes the family in that the family becomes organized around it. Thus, it halts the historical momentum

of a family, or to put it another way, it prevents the amplification of an historical trend of ego vulnerability from more profound decompensation, at least temporarily.

Meissner's work is based upon Bowen's familiar concept of the "undifferentiated family ego mass," in which an individual's functioning and stability depends to a greater or lesser degree on the emotional forces within the family. In the family system as Bowen conceptualizes it, a basic deficiency in one person's personality is stabilized through his emotional interactions with other family members. Persons less differentiated or possessing less ego strength depend more on others for their "sense of self." This is a precarious emotional system in which the less differentiated member will experience an emotional crisis if there is a shift in the emotional organization of the family. "With the emotional props pulled out, the individual lacks the sufficient ego-resources to maintain adequate functioning on all levels. Consequently, the individual responds with a form of decompensation" (p. 153). Decompensation can take many forms, of course,. Meissner suggests that members who respond with physical symptoms may manifest a tendency to express emotional conflicts in somatic terms. Meissner's thesis is supported by the fact that in a high percentage of cases, the onset of symptoms is related to a period of emotional disruption within the family. (See McKegney et al. 1970, for example.)

These ideas would have implications for treatment because the treatment of the disease must include treatment of the family's "impregnable compromise." Medical treatment alone simply treats the "further elaboration" of the disease. From this point of view, individual psychotherapy, especially of children and adolescents, does not make sense, at least initially, since the child and his disease are so involved in the family's processes.

Winnicott (1966) recognized this:

Unfortunately I was unable to see early enough that the ill person in this case was the mother who had the essential split, and the child who had the colitis. But it was the child who was brought to me for treatment. (p. 513)

Indeed, Finch and Hess (1962) in suggesting treatment procedures state the psychotherapy can rarely follow psychoanalytical principles:

The intense involvement between parent and child and the function of the illness as a problem-solving device for intraphysic, intrafamilial, and social conflicts, often dictates the necessity for a therapist to assume a strong and active treatment role both with parents and the child. He must, in a sense, intervene emotionally and be prepared to remain a strong force in the intrafamily dynamics for a long time. (p. 875)

Thus, it may be that a diagnosis which only sees the thus treats the physiological process may inadvertently rein-

force the family's compromise or the homeostatic function of the illness. This kind of thinking would parallel the important work on schizophrenia in which a psychiatric diagnosis and subsequent hospitalization is seen as confirming and reinforcing a family process which was, in fact, driving one of its members crazy. In the case of a psychosomatic disease process in children, regardless of the psychological processes involved in the etiology of the disease, the troubled family may take advantage of the disease to help solve its psychological problems as a family and inadvertently reinforce the child's symptoms. Not to treat the family's dubious problem-solving techniques while at the same time treating the physical disease process would be inadequate.

The present study bears on this problem in that it seeks to examine the family structure of children suffering with inflammatory bowel disease. The study cannot determine the extent to which the disease serves as an "impregnable compromise," but as it will investigate the family as a system and as it is prepared to study whether these families pattern themselves as a system of enmeshed, overprotective and conflict avoiding structures, it will have reference to this issue.

What exists is a situation of great detail and complexity. It may be that all the investigators reviewed

see something which is correct. The disease may serve many systems all at once. It may be the child's alternative to a terrifying loss of self-feeling (depersonalization), as well as an opportunity for the family to stabilize an emotional system at the point of break-up (i.e., divorce).

## Chapter 3

### FAMILY ORGANIZATION AND PSYCHOSOMATIC ILLNESS IN CHILDREN: MINUCHIN'S MODEL

Minuchin and his colleagues at the Philadelphia Child Guidance Clinic (Minuchin et al. 1975) have studied the interactional characteristics of families with other severe psychosomatic symptoms and found that they were meaningfully related to the child's symptoms. Minuchin et al. (1975) postulate that:

- (1) certain types of family organization are closely related to the development and maintenance of psychosomatic symptoms in children and that
- (2) children's psychosomatic symptoms play a major role in maintaining family homeostasis. (p. 1032)

The model does not relate specific symptoms to a given family structure, but describes a general type of family interaction that encourages somatization. The model describes three factors that are necessary for the development of severe psychosomatic illness in children:

First, the child is physiologically vulnerable, i.e., a specific organ dysfunction is present. Second, the child's family has



the following four transactional characteristics: enmeshment, overprotection, rigidity, and lack of conflict resolution. Third, the sick child plays an important role in the family's patterns of conflict avoidance, and this role is an important source of reinforcement for his symptoms. (p. 1032)

Minuchin et al. have developed therapeutic strategies that successfully restructure family interactions that reinforce psychosomatic symptoms and thereby have treated labile diabetes, anorexia nervosa and brittle asthma in children with high levels of success. In their discussion of the first factor--the physiological vulnerability--Minuchin et al. (1975) differentiate between "primary" and "secondary" psychosomatic symptomology:

In primary psychosomatic symptomology, a physiological disorder is already present. These include metabolic disorders like diabetes, allergic diathesis such as that found in asthma, and so forth. The psychosomatic element lies in the emotional exacerbation of the already available symptom. In the "secondary" psychosomatic disorder, no such predisposing physical disorder can be demonstrated. The psychosomatic element is apparent in the transformation of emotional conflicts into somatic symptoms. These symptoms crystallize into severe and debilitating illnesses such as anorexia nervosa.

Symptom choice may be differentially determined in these two instances. However, our work indicates that the "psychosomatic" family organization described here is applicable across these varieties of psychosomatic illnesses. (p. 1032-33)

To Minuchin et al. in the brittle asthmatics and super-labile diabetics they treated, the psychosomatic element lay in the emotional exacerbation of the already available symptom. They do not question the child's physiological vulnerability. This is a given. They can then go on to discuss a "psychosomatic episode" or "crisis" in the context of the family. They posit that a family conflict may trigger emotional arousal in the child. This is the "turn on" phase. The "turn off" phase or the return to base line levels may be handicapped by the nature of the family members' involvement with each other around the conflict.

Thus, a primary physiological disorder becomes complicated by emotional factors, primarily unresolved conflicts in the family, which are perpetuated and manifest themselves through the family's interactional characteristics of rigidity, enmeshment, overprotection and lack of conflict resolution and these interactional patterns "may trigger the onset or hamper the subsidence of psychophysiological processes, or both," (p. 1032) or as in a "secondary" psychosomatic disorder, such as anorexia, emotional conflicts are transformed into somatic symptoms through the family's interactional characteristics.

The third factor in Minuchin's model is that the sick child plays an important role in the family's patterns of conflict avoidance, and this role is an important source of reinforcement for his symptoms. This factor is not something

which can be tested with inflammatory bowel disease as Minuchin was able to test with his diabetic and asthmatic subjects. For example, in the diabetic group, based on the relationship of free fatty acid levels to emotional stress on the one hand and diabetic ketoacidosis on the other, they were able to structure a family interview, a "stress" interview, in which they could correlate family interaction with rising levels of free fatty acids in the sick child. Based on the following pathway:

emotional arousal → autonomic nervous system activation → excessive and prolonged lipolysis → increased free fatty acid concentration → excessive production of ketone bodies by the liver → diabetic ketoacidosis. (Baker, Minuchin and Rosman, 1967, p. 71)

they were able to establish a significantly greater "turn on" and "turn off" in their experimental group than in their contrasts groups. They were able to establish that "the impairment in 'turn off' can be correlated with the role of the child in family conflict, that is, whether or not the child experiences difficulty in 'turn off' is directly related to his role in family conflict" (Baker et al. 1967, p. 75). However, with inflammatory bowel disease, it is not possible to find a measure which has a relation to inflammatory bowel disease as free fatty acid levels do to diabetes. So that this factor cannot be proved in the same way as it was in Minuchin's work, however, it is difficult to imagine that in an enmeshed, overprotective, conflict avoiding family,

that the symptomatic child is not involved in the family's conflict avoidance. But these observations would not prove, as Minuchin et al., in an ingenious and concrete way, were able to prove, that the child through his symptoms, is involved in conflict avoidance, and that he "appears to be important in maintaining the family homeostasis, which may account for the continuation of the symptom" (Baker et al., 1967, p. 72).

We turn now to the first factor in Minuchin's model -- that the child is physiologically vulnerable, i.e., a specific organ dysfunction is present. One cannot simply apply this concept to inflammatory bowel disease. While it may be that in inflammatory bowel disease, a specific organ dysfunction is present, this is not a statement which can be made with any scientific proof. The etiology of inflammatory bowel disease is unknown, and what exists are many different hypotheses as to its cause.

It is a fact, however, that some children with inflammatory bowel disease manage their disease better than others. (Silverman et al. 1971) Among the latter group are children whose disease cannot be managed medically and surgical intervention is required. It would make sense that these two groups of children could be seen as corresponding to Minuchin's two groups of diabetics: those who are defined as normal and who manage their disease well, and those who are superlabile and whose disease presents difficult and complex medical man-

agement problems. These latter children are, in a sense, out of control and their families are highly enmeshed, overprotective, etc., compared to the families of normals.

(Unpublished data available through the Philadelphia Child Guidance Clinic) In regard to the subjects in my experimental group, there are those whose disease is mild and intermittent or in remission. In reference to these two groups, it may be that we will find that the families of the former group will be highly enmeshed, overprotective, etc., and the families of the latter group will resemble the normal control group.

### The Present Study

Thus, encouraged by Jackson and Yalom's (1967) findings and based on my familiarity with Minuchin's model of psychosomatic illness in children, I decided to study in more detail the interactional characteristics of families with children suffering with inflammatory bowel disease. In doing so I would be doing the preliminary research which could establish whether Minuchin's model of psychosomatic illness in children could be applied to children with inflammatory bowel disease.

In this project I will examine one factor of the model proposed by Minuchin and his colleagues -- the family's interactional characteristics. Specifically, this research will study whether the families of children with inflammatory bowel disease will reveal a distinctive organization which

can be described as enmeshed, overprotective, and lacking conflict resolution skills, and whether these families, on variables which measure enmeshment, overprotection, etc., will be consistently more enmeshed, overprotective, etc., than families whose children have a chronic, but non-psychosomatic illness.



## Chapter 4

### METHOD

Twelve families of children with inflammatory bowel disease were compared to seven families of children with a chronic, but non-psychosomatic illness along variables which measure enmeshment, overprotection and lack of conflict resolution skills as described by Minuchin and his co-workers at the Philadelphia Child Guidance Clinic; and among the twelve families of children with inflammatory bowel disease those whose disease process has been more severe and chronic will be compared to the other six whose children's disease has followed a milder course and/or is in remission.

#### Hypothesis of the Present Study

The principal hypothesis of this study is that the families of children with inflammatory bowel disease will reveal a distinctive family organization which can be described as enmeshed, overprotective and lacking in conflict resolution skills. This hypothesis will be tested by comparing the families of children with I.B.D. to families whose children have a chronic, but non-psychosomatic illness.

A second related hypothesis deals with severity and duration of IBD in relation to family structure. Specifically, it may be that the families of children whose inflammatory bowel disease is more advanced will be more enmeshed, overprotective, etc. This hypothesis will be tested by studying the correlation between the severity of IBD and measures of enmeshment, overprotection and conflict resolution skills.

Subjects: Experimental Group

The experimental group is made up of twelve intact families of children, age  $8\frac{1}{2}$  to 19, with either Crohn's disease or colitis. These children are being followed by the gastrointestinal program at the Children's Hospital of Philadelphia. Approximately twenty-five families were contacted and asked to volunteer for the study and twelve families did volunteer. They were told a study was being conducted to investigate the relationship between inflammatory bowel disease and family interaction, and each family understood that the study would not benefit their child. Most of the families who participated were white, middle-class families. This sample includes one black family. The ages and sex of the children, the number of siblings, their disease and its course and treatment is represented below on Table 1. One child has had a colostomy and surgery has been recommended for one other. Six children are on various dosages of steroids.

Two children are being treated with azulfidine, a milder medication. Three children are not on medication and their disease is in remission. Three children have ulcerative colitis which is limited to the rectum (ulcerative proctitis). The prognosis is more favorable for ulcerative proctitis compared to ulcerative colitis in that there are minimal repercussions on the patient's general state of health.

Those children whose disease is considered more serious and chronic (at this time), and whose families are expected to be more enmeshed, overprotective, etc., (in terms of hypothesis two) are families A, B, C, D, E and F. This group includes one child (A) for whom surgery has been recommended, (ulcerative colitis) and one child (F) who has had surgery, but whose wound has not healed for  $1\frac{1}{2}$  years (ulcerative colitis). This child was included in this group (based on the rationale of this study) because it was felt that the family interactional patterns which had contributed to the extreme exacerbation of the child's symptoms would still be operating. Three other children have ulcerative colitis (B, C, and D) and are being treated with various dosages of steroid therapy. One child in this group has Crohn's disease.

Those children whose disease has had a milder course and are in remission (at this time) include the three children with ulcerative colitis limited to the rectum (proctitis). This disease is active in these children, but because the prognosis is much more favorable with less complications,

they were included in this group. (G, H and K) Three other children (I, J and L) with Crohn's disease are in remission.

All of this information is summarized on Table 1.

### Subjects: The Comparison Group

The comparison group is made up of seven families with diabetes. The families are volunteers from the Juvenile Diabetes Foundation in Philadelphia. They are intact white middle-class families whose children range in age from ten to seventeen. The average family size is the same as in the experimental group, although the range in the experimental group is wider.

### The Family Task

All families were asked to perform a series of tasks which were pre-recorded and ready for playback on a tape recorder. When the tape recorder was turned on the family heard the following instructions:

#### Recorded Family Task Items

1. Suppose all of you had to work out a menu for dinner tonight. You would all like to have your favorite foods for dinner, but in putting this menu together you can only have one meat, two vegetables, one drink and one dessert. We'd like you to talk together about it now and decide on this one meal that you would all enjoy. Remember, it can only have one meat, two vegetables, one drink and one dessert. You must end up agreeing on this one meal that everyone will enjoy. All right now, turn off the machine and go ahead with your discussion. When you're ready to go on to the next question turn on the machine once again please.

TABLE 1  
EXPERIMENTAL GROUP DATA

<u>Age/Sex Siblings</u>	<u>Age of Onset</u>	<u>Disease</u>	<u>Course/Treatment</u>
17/M/1	11	Colitis	Continuous chronic activity. Colostomy recommended.
9/F/0	6	Colitis	Continuous chronic activity. Treatment: High dosage of steroids
11½/F/4	8	Colitis	Intermittent activity. Treatment: Low dosage of steroids.
12/F/2	8½	Colitis	Intermittent activity. Treatment: Azulfidine.
15/M/3	14	Crohn's	Severe weight loss and growth retardation. Treatment: Steroids.
17/M/2	14	Colitis	Colostomy during first admission. Open perineum wound.
*****			
10/M/1	6	Colitis (Proctitis)	Intermittent activity. Treatment: Steroids.
12/F/4	9	Colitis (Proctitis)	Original chronic course. Milder recently. Re-Diagnosed as ulcerative proctitis 1/75. Treatment: Steroids.
15½/M/8	9	Crohn's	Intermittent activity. Not on medication for 1½ years.
16/M/3	13	Crohn's	Mild course. Occasional abdominal pain and diarrhea. Not on medication.
8½/M/2	2½	Colitis (Proctitis)	Mild course. Occasional bloody stools. Treatment: Azulfidine.
19/M/3	18	Crohn's	After diagnosis and initial treatment, remission and presently not on medication.

2. All right now, we're ready for the next question. In every family things happen that cause a fuss now and then. We'd like you to discuss and talk together about an argument you've had, a fight or argument at home that you can remember. We'd like you to talk together about it. You can cover what started it, who was in on it, what went on and how it turned out. See if you can remember what it was all about. We'd like you to take your time and discuss it at length. You can turn off the machine and go ahead.
3. We're ready now for the last question. For this one, we'd like each of you to tell about the things everyone does in the family: the things that please you the most and make you feel good but also the things each one does that makes you unhappy or mad. Everyone try to give his own ideas about this. You can go ahead and turn off the machine now.

The families were told that there were no right or wrong answers and that they should all participate.

The interview was videotaped and a verbatim transcript was made of the family's response to the first two questions. A list of the responses made to the third task was made, but not all the interaction in this task was analyzed, just the responses.

The first two tasks were used to analyze family interaction. Each speech was analyzed as to who was making it, to whom it was being made, (who-to-who speaking patterns), and its interactional value, i.e., as an executive transaction, a task opinion, request for leadership, an agreement or disagreement, a refusal to answer, etc. (See Transactional scoring for details.) In addition if a speech indicated pro-



tectiveness, conflict avoidance, mind reading, etc., it was scored as such. In addition, task two, the family argument, was used to measure certain conflict avoidance scores and task three, the like-and-don't-like question was used to measure interpersonal perception. Overall, the data from the three tasks is rich in clinical detail and implication.

The data was analyzed on the basis of a scoring manual which was developed at the Philadelphia Child Guidance Clinic. The manual is enclosed as Appendix A. Essentially, what it does is to break down the interactional characteristics into units of behavior which can then be measured. This will be discussed in the next section.

The assessment of a family's structure through the family tasks was first developed by Minuchin and his colleagues in an effort to discern the structure of delinquent producing families compared to families that had not produced delinquent children. It provides an opportunity to observe and analyze the overt behavior of the participants in a relatively "natural" yet structured situation which does not include authority figures such as therapists or physicians. The family responds to these tasks through their inherent structural organization. (Minuchin et al. 1967)

Rating the tapes. The control group was rated by two independent raters who scored this material as well as the families of children with anorexia, brittle asthma and superlabile diabetes. Their ratings were made without knowledge

of the different categories, and on the basis of procedures established in the scoring manual. An 85% reliability was established between the raters.

The experimental group was rated by a different set of raters. These raters, the author and one other person, were trained by one of the raters who worked on the comparison group, and the material we trained on was the protocols of the anorectic, asthmatic and superlabile diabetic families. We trained until we had learned to "think" as the other raters had and felt confident we could approach our material from the same point of view as they had. We established a reliability of 86% on the last training tape.

The first two tapes of the experimental group were rated independently and a high reliability was established -- 89%. Disagreements were often minor, for example, as to the different technique of conflict avoidance. Since the final scoring does not differentiate the style of conflict avoidance, it mattered little whether we scored A, B or C. (See conflict scoring) It was rare that we did not recognize jointly an instance in which what the family was doing was avoiding or surpressing conflict. Once reliability was established, the tapes were rated jointly or independently. The protocols were compared and disagreements were talked out.

The experimental group included families of children with ulcerative colitis and Crohn's disease, with different degrees of severity. We did not know which diagnosis had been made until after all the ratings had been completed.

Rating scales. Each interactional characteristic or pattern is made up of a complex of behaviors which can be operationalized into specific behaviors for the purpose of research. In most instances behaviors were counted. Exceptions will be noted.

In this section Minuchin's et al. descriptions of enmeshment, rigidity, etc., will be quoted and followed by the specific behaviors or categories which were rated to indicate the incidence of the different patterns in each family.

Enmeshment. Minuchin, et al. have defined enmeshment in the following terms:

A pathologically enmeshed family system is characterized by a high degree of responsiveness and involvement. This can be seen in the interdependence of relationships, intrusions on personal boundaries, poorly differentiated perception of self and of other family members, and weak family subsystem boundaries.

In a highly enmeshed family, changes in one family member or in the relationship between two reverberate throughout the family system. Dialogues are rapidly diffused by the entrance of other family members. A dyadic conflict may set off a chain of shifting alliances within the whole family as other members get involved.

Internal structures within a highly enmeshed family system are characteristically fluid. The boundaries that define individual autonomy are so weak that an individual's life space is impinged on. This may be reflected in lack of privacy, excessive "togetherness," and sharing. ("Why do you change the furniture around in my room all the time when I'm not there?" a 15-year-old complains to his mother.) Family members also intrude on each other's thoughts, feelings, and communications. One family member may relay messages from another family member to a third, blocking direct communication. Often there are many interruptions; family members may finish each other's sentences.

Problems of enmeshment are also reflected in family member's poorly differentiated perceptions of each other. Parents asked to tell what they like about each of their children often speak of them as a group.

In enmeshed families, subsystem boundaries are weak and easily crossed. As a result, executive hierarchies are confused. Children may join one parent in criticizing the other. Often the children take inappropriately parental roles toward each other. In the absence of a clearly defined and effective parental subsystem, it is common for the parents to work at cross purposes in relation to the children. Often a parent enlists a child's support in struggles with the other parent. (p. 1033)

#### Scoring for Enmeshment:

1. Executive hierarchies. One dimension of enmeshment is a confusion and weakness in sub-system boundaries. The following variables each measure an aspect of these boundary problems. Taken together they indicate the presence or absence of boundary problems between the sibling sub-system and the parent's executive subsystem:

a. Speech skew. Overinvolved dyads and triads are indicated by the skew in the "who-to-who" speaking patterns

which can be determined by establishing the average percentage of speeches that each person should make and then subtracting or adding to that figure the percentage that each person does speak. A greater skew indicates overinvolvement by some members and underinvolvement by others. (See transactional scoring)

b. Leadership patterns:

(1) The effectiveness of parent's executive functioning can be assessed on the basis of the percentage of executive failures as compared to the parent's total executive transactions. Examples of unsuccessful leadership include behavior such as other(s) laughing at a leadership comment; other(s) not responding in any way to a leadership comment or refusing to answer when directed to do so, etc. (see transactional scoring)

(2) Executive skew. The executive skew is determined by figuring each parent's percentage of total parent's executive transactions and subtracting this figure from 50%. A lower executive skew indicates a more equal involvement of parents in executive activity and a higher skew indicates domination or overinvolvement by one parent.

2. Mind reading. Mind reading occurs when one person suggests a response to another with the implication "I know what you want, think, feel," or A tells B what C wants, thinks or feels when C has not so indicated. (see enmeshment scoring)



3. Interpersonal differentiation. The quality of interpersonal perception can be judged on the like-and-don't-like task. In this task the family members are asked to tell each other what they like and don't like about each other. Each response is scored as to its quality of differentiation. Thus responses can be scored as differentiated or semi differentiated on one hand, or undifferentiated or global on the other. (see scoring for task 3)

Overprotectiveness:

In families with a psychosomatically ill child, family members show a high degree of concern for each other's welfare. This concern is not limited to the identified patient or to the area of illness. Nurturing and protective responses are constantly elicited and supplied as family members interact. A sneeze sets off a flurry of handkerchief offers; complaints and queries about fatigue or discomfort punctuate the flow of communications. Critical remarks and demands are often accompanied by pacifying behaviors. Signs of distress frequently cue family members to the approach of dangerous levels of tensions or conflicts. For example, a mother's weeping as she anticipates father's criticism may galvanize the children into distracting behavior. A symptomatic child's emotional outburst may elicit comforting and help to avert exploration of family conflicts.

Family member's perceptions of each other are structured around protective concerns, particularly where there is a sick child. When family members are asked to tell what pleases them and displeases them the most about each other, they may for example reply, "I like it when you rub my chest" "I like it when he gets sick all the time." In such families, the parents' overprotectiveness retards the children's development of autonomy and competence. (A father tells his two adolescent diabetic daughters,



"If Mommy and I could only take the needles for you, everything would be alright.")

In turn the children, particularly the psychosomatically ill child, feel great responsibility for protecting the family. For the sick child, the experience of being able to protect the family by using his symptoms may be a major reinforcement for the illness. (1975, p.1033)

Scoring for overprotection is based on the total count of the following behaviors: (See Protectiveness Scoring)

1. Concerns with hunger.
2. Concern with or easily affected by signs of stress or distress, physical well-being of others.
3. Comforting behaviors.
4. Excessive or inappropriate unwillingness or reluctance to "disturb."
5. Pacifying or conciliating behavior.
6. Eliciting protectiveness through complaints of hunger, fear, crying, etc.
7. On task #2 shifting discussion of conflicts from issues to concerns about feelings, worries, illness, etc.

Lack of conflict resolution:

The rigidity and overprotectiveness of the family system, combined with the constant mutual impingements characteristic of pathologically enmeshed transactional patterns, make such families' thresholds for conflict very low. Often a strong religious or ethical code buttresses and provides a rationale for avoiding conflict. As a result, there can be no explicit negotiation of differences. Problems are left unresolved, to threaten again and again, and continually activate the system's avoidance circuits.

Each family's idiosyncratic structure and functioning dictate their ways of avoiding conflict resolution. Often one spouse is an avoider. The nonavoider brings up areas of difficulty, but the avoider always manages to detour confrontation that would lead to the acknowledgement of conflict and, perhaps, its negotiation. A man may simply leave the house when his wife tries to discuss a problem.

Other families bicker continuously, but the constant interruptions and subject changes typical of an enmeshed system obfuscate any conflictual issue before it is brought to salience. Other families simply deny the existence of any problems whatsoever. (1975, p. 1033)

The lack of conflict resolution is based on four categories:

1. In the transactional scoring on the first two tasks conflict behavior can be scored in the following instances: (See Conflict Scoring for details) Each behavior counts as one.

a. When no conflict emerges. For example, when a family structures a situation to avoid different opinions or critical opinions.

b. When hints of conflict emerge but are kept in check. For example, after an appropriate or minor disagreement is expressed, pressure is applied: "Remember, we must all agree," or "Don't let's have a fight now."

c. When conflicts, disagreements, complaints are expressed by one or more family members but no resolution can be achieved due to one or more other family member's behavior.

For example, when one family member evades or changes the subject to avoid confrontation.

2. In task two the family is asked to talk about a disagreement or argument they have had. The number of arguments they feel free to discuss indicates the degree of openness towards and ability to discuss conflict.

3. Disagreements. The total number of disagreements indicates the family's ability to initiate and manage conflict. In conflict avoiding families, we would expect this figure to be low. A disagreement is scored when one person directly (disagrees) responds to another person.

4. Aggression. Aggression is scored for personal attacks, derogations and sarcasm. As with disagreements, its presence indicates the family's ability to at least initiate conflict.

Rigidity. Minuchin et al. define rigidity in the following way:

The pathologically enmeshed families are heavily committed to maintaining the status quo. In periods when change and growth are necessary, they experience great difficulty. For example, when a child in an effectively functioning family reaches adolescence, his family will be able to change its rules and transactional patterns in ways that allow for age-appropriate increased autonomy while still preserving family continuity. But the family of a psychosomatically ill child operates like a closed system. When events that require change occur, family members insist on retaining accustomed methods of interaction. Consequently, avoidance circuits must be developed, and a "symptom bearer" is a particularly useful detouring route. When the family's low threshold of toler-

ance for conflict is approached, the sick child becomes ill, allowing family members to detour their conflict via concern for him. The family reinforces his development of deviance and rewards its continuance because of its usefulness in maintaining the pathogenic system's precarious equilibrium.

As a result of their inappropriately summoned homeostatic mechanisms, these families live in a chronic state of submerged stress. Issues that threaten change, such as negotiations of individual autonomy, are not allowed to surface to the point where they could be explored. Typically, these families represent themselves as normal and untroubled except for the one child's medical problem. They deny any need for change in the family. (p. 1033)

#### Scoring for rigidity:

Rigidity cannot be measured directly through the tasks. Some aspects of rigidity, for example, a family's inability to adapt to the adolescent need for greater autonomy, can only be measured over time and through clinical interviewing. Other aspects of rigidity, the use of the sick child's symptoms to detour conflict, for example, can only truly be measured by the kind of research technology Minuchin et al. were able to apply to diabetes, as described in chapter one.

## Chapter 5

### RESULTS<sup>1</sup>

#### Hypothesis I

The findings on Hypothesis I are recorded on Table 2. Using the sign test to compare medians for the experimental and comparison groups a p value of .000448 was obtained. On each measure used to assess the families' interactional characteristics, the hypothesis was confirmed in the direction predicted.

#### Hypothesis II

The findings in Hypothesis II are recorded on Tables 3 and 4. Using the sign test to compare medians for the active

---

1 Inasmuch as the size of the two groups is small, thereby rendering the mean somewhat unstable because of the presence of outliers, conventional statistics, (i.e., parametric statistics) were not used. Moreover, because for two of the categories (speech skew and executive skew) a mean would have been inappropriate, medians were calculated and a sign test performed to compare differences (1) between the comparison group and the experimental group and (2) between the active families and the inactive families with the experimental group. Pluses and minuses were assigned as follows: If the difference between the medians, (e.g.,  $Md_{exp} > Md_{comp}$ ) was as hypothesized, a plus was assigned. If the difference was not as hypothesized, a minus was assigned.

and inactive groups, a p value of .886719 was obtained. The hypothesis was not corroborated. - This can be simply observed by scanning Table 4. Family L, for example, whose adolescent son has Crohn's disease which is in remission, scores very high on speech skew (58) and conflict avoidance (35). Similarly, family G scores high on mind reading (8) and conflict avoidance (26).



TABLE 2

MEDIANS AND RANGES OF THE EXPERIMENTAL AND COMPARISON FAMILIES ON FAMILY TASK VARIABLES

Variable	Comparison Median	(N-7) Range	Experimental Median	(N-12) Range	Hypothesis	True	Sign
<u>Ermeshment</u>							
Speech Skew	21.8	14-31	40	20-66	Md <sub>exp</sub> > Md <sub>comp</sub>	yes	+
Executive Skew	10	6-42	26	4-54	Md <sub>exp</sub> > Md <sub>comp</sub>	yes	+
Leadership failures	.4	0-5	3	0-20	Md <sub>exp</sub> > Md <sub>comp</sub>	yes	+
Mind reading	1	0-12	4.5	0-10	Md <sub>exp</sub> > Md <sub>comp</sub>	yes	+
% diff. & semi diff.	.95	.34-100	.76	.10-.92	Md <sub>exp</sub> < Md <sub>comp</sub>	yes	+
% undiff. & global	.05	.00-.19	.24	.08-.60	Md <sub>exp</sub> > Md <sub>comp</sub>	yes	+
<u>Overprotection</u>	.5	0-1	4	0-6	Md <sub>exp</sub> > Md <sub>comp</sub>	yes	+
<u>Lack of Conflict Resolution</u>							
Total A's, B's & C's	3	0-13	19	1-23	Md <sub>exp</sub> > Md <sub>comp</sub>	yes	+
Disagreements	8.1	1-12	3	0-13	Md <sub>exp</sub> < Md <sub>comp</sub>	yes	+
Task #2 - No. of arguments	5	2-9	2.5	1-4	Md <sub>exp</sub> < Md <sub>comp</sub>	yes	+
Aggression	8	0-21	.5	0-7	Md <sub>exp</sub> < Md <sub>comp</sub>	yes	+

Probability of getting 11 plusses in 11 categories where P = .50 is .000448.

TABLE 3

MEDIAN AND RANGES ON ACTIVE AND INACTIVE FAMILIES  
ON FAMILY TASK VARIABLES

Variable	Active Medians + Ranges (N-6)	Inactive Medians + Ranges (N-6)	Hypothesis	True	Sign
<u>Emmeshment</u>					
Speech Skew	51 20-66	28 22-58	Md <sub>act</sub> >Md <sub>inact</sub>	yes	+
Executive Skew	20 14-54	30 4-44	Md <sub>act</sub> >Md <sub>inact</sub>	no	-
Leadership Failures	3 1-20	2.5 0-7	Md <sub>act</sub> >Md <sub>inact</sub>	yes	+
Mind Reading	4 0-9	4.5 1-8	Md <sub>act</sub> >Md <sub>inact</sub>	no	-
% diff. & semi diff.	.73 50-92	.78 10-91	Md <sub>act</sub> <Md <sub>inact</sub>	yes	+
% undiff. & Global	.27 .08-50	.22 .00-60	Md <sub>act</sub> >Md <sub>inact</sub>	yes	+
<u>Overprotection</u>	5 3-6	3 0-5	Md <sub>act</sub> >Md <sub>inact</sub>	yes	+
<u>Lack of Conflict Resolution</u>					
Total A's, B's & C's	17.5 5-24	18 16-35	Md <sub>act</sub> >Md <sub>inact</sub>	no	-
Disagreements	1 0-3	4 3-7	Md <sub>act</sub> <Md <sub>inact</sub>	yes	+
Task #2-NO. of arguments	2.5 1-3	2.5 2-4	Md <sub>act</sub> <Md <sub>inact</sub>	no	-
Aggression	0 0-4	1 0-7	Md <sub>act</sub> <Md <sub>inact</sub>	yes	+

Probability of getting 7 plusses in eleven categories where P = .50 is .886719.

TABLE 4

## EXPERIMENTAL FAMILY SCORES ON FAMILY TASK VARIABLES

Variable	A	B	C	D	E	F	G	H	I	J	K	L	Comparison Median
<u>Parental Punishment</u>													
Speech Skew	66	66	65	20	30	37	22	43	51	34	26	58	21.8
Executive Skew	14	54	16	54	16	24	36	4	26	44	34	26	10
Leadership Failures	3	3	20	1	3	1	7	1	0	0	5	4	.4
Kind Reading	3	5	9	0	10	2	8	2	5	8	1	4	1
diff.	.60	.56	.92	.86	.92	.50	.91	.77	.75	.90	.80	.40	.95
undiff. Global	.40	.44	.08	.14	.08	.50	.09	.23	.25	.10	.20	.60	.05
<u>Overprotection</u>	6	5	6	3	5	4	4	2	1	0	5	4	.5
<u>Lack of Conflict Resolution</u>													
Total A's, B's C's	16	20	27	5	5	24	26	16	18	18	22	35	3
Disagreements	3	0	1	2	1	1	7	4	3	4	7	5	8.1
Task #2-No. Arguments	1	1	3	2	3	3	3	3	2	2	2	4	5
Aggression	2	0	0	0	4	0	1	3	1	7	0	0	8

## Chapter 6

### DISCUSSION: PART ONE

The findings of this study corroborate the first hypothesis - the families of children with inflammatory bowel disease are more enmeshed, overprotective and conflict avoiding than the families of children with a non-psychosomatic, but chronic disease (diabetes). This finding demonstrates not only that these families are enmeshed, overprotective, etc., but that these patterns are not necessarily related to the chronicity of the disease, but are related to symptoms in some other way.

The second hypothesis was not corroborated. This finding demonstrates that this group of families is relatively homogenous and that the degree of enmeshment, overprotection, etc., does not necessarily relate to the degree of severity or status (remission) of the illness. This is an important, but complex result.

Minuchin et al. (1975) have demonstrated that the interactional characteristics of enmeshment, overprotection, rigidity and lack of conflict resolution are related to symptom maintenance in children suffering with superlabile diabetes, brittle asthma and anorexia nervosa. The findings of the present study would support an hypothesis (based on the

logic of Minuchin's work) that the interactional characteristics of families with children suffering with inflammatory bowel disease are related to symptom maintenance. But the findings in regard to the second hypothesis complicate this picture because there is no direct correlation between the status of the disease and the degree of enmeshment, overprotection, etc., in these families. It may be that the families interactional patterns are still intimately related to the exacerbation of the disease in the way Minuchin et al. described in regard to the subjects of their study. Inflammatory bowel disease is a process of exacerbation and remission, and children who are doing well one day may exacerbate the next. And concerning Crohn's disease, although there are periods of exacerbation and remission they are sometimes difficult to define. (Silverman et al 1971)

However, the consistency with which these characteristics pervade the experimental families suggests that these patterns not only relate to symptom maintenance, that is they do not only reinforce the symptoms, but are related to the disease in a more complex way. For example, this finding suggests that inflammatory bowel disease cannot be differentiated into "normal" inflammatory bowel disease and "psychosomatic" bowel disease, in the the same way Minuchin differentiated between normal and superlabile diabetes. Minuchin and his colleagues described "primary psychosomatic symptom formation" as the emotional exacerbation of an already given

symptom - i.e., diabetes and asthma are exacerbated into superlabile and brittle syndromes. In the latter syndromes, they identified family patterns which maintained the symptoms in their exacerbated state. However, in the experimental group of the present study, all the families exhibit these characteristics, and while some families impressed me as less disturbed than others, what I want to emphasize is the degree of pathology which exists in all these families.

There are no "normal" families in the present sample. It is this fact which leads me to think that the interactional patterns are related to the child's symptoms in a more complex way than could be attributed to them if one were to simply apply Minuchin's model to these families. What I have in mind is that these patterns, which suppress conflict and stress closeness, reveal an underlying schizoid condition and the child's symptoms are related to this condition. In order to develop this point I plan to discuss the results as clinical phenomena using the transcripts and statistical data to study each interactional pattern as it reveals itself in different sequences of the families' responses to the tasks.

### Enmeshment

Minuchin views the family as a system of sub-systems, i.e., the spouse sub-system, parental sub-system and the sibling sub-system, and each sub-system is divided by more or



less clearly defined boundaries. In a pathologically enmeshed family, these boundaries are weak and sometimes nonexistent. This encourages a high degree of responsiveness and overinvolvement. Dyads do not exist in an enmeshed family - hence the husband and wife unconsciously invite one of the children "into" their marriage. Or the husband-wife executive dyad becomes a triad with one of the children crossing a boundary and establishing a coalition with one parent against the other parent. Members of an enmeshed system know each other's thoughts and intrude into each other's personal space. Separateness and individuality are blurred. Ultimately, enmeshment is a symbiosis: "I cannot live without you." In this section, I will discuss the measures of enmeshment and compare these patterns to a family from the comparison group.

Speech skew and executive skew. Speech skew was used to measure overinvolved dyads and triads. It is scored by determining the number of speeches each family member might ideally make if there was an equal involvement and participation of everyone in the family. The actual percentage of each member's participation is then subtracted from or added to this figure. For example, in an ideal situation, each member of the L family of six should speak 17% of the time. The percentage they actually speak is recorded below:

M =	29%	+	12	
F =	33%	+	16	
D1 =	16%	-	1	
D2 =	10%	-	7	
S1 =	9%	-	8	
S2 =	3%	-	14	
			<u>54</u>	= Total speech skew

In this family mother and father dominate the interaction, while three of the four children hardly participate. S2 is the patient and he participates the least. In the B family mother speaks 45% of the time and correspondingly the speech skew is quite high - 66. Executive skew is another reliable indicator of overinvolvement. Each parent's percentage of the parent's total executive is subtracted from or added to 50% - the ideal figure. In the B family, mother makes 77% of the leadership moves, correspondingly the executive skew is quite high - 54. These measures do not locate clinical dimensions and style but they are useful indicators of overinvolvement, or in the case of the comparison group, of more equal participation.

Sometimes speech skew is deceiving. With some families it is most meaningful when it is considered in relation to executive skew. For example in the K family, the speech skew is 26, not a high figure compared to the others. But the executive skew is relatively high (34). This is because the father is so much more active in the family. This is a family of five. The father speaks 26% of the time, mother only 12%. Between the mother and father's total leadership, father makes 80% of the executive moves. Father is spoken to 41 times,

mother only 6. This is a joyless family in which father tries to obsessively and monotonously control the children around logical issues - "majority rule," while mother sits back passively, with her arms crossed.

In the B family cited below, mother speaks 46% of the time and makes 73% of the leadership gestures. And in this family the daughter is spoken to 50% of the time. This is a family in which everyone is wearing the same sweater and mother and daughter sit, are actually almost nestled next to each other. They both laugh and giggle together and mother does not seem much more mature than the daughter. The speech skew in this family is quite high (66) and so is the executive skew (54). All these figures indicate what is quite obvious in the dialogues below, mother and daughter are keenly involved with each other.

Leadership failures. Leadership failures was used as an indication of breakdown in the executive hierarchy. This figure was much higher than in the control group. In the E family to be cited below, in which the father is isolated while mother controls the family, the father had seven leadership failures. It will be recalled that leadership failures are scored when family members do not respond or ignore the leadership statement. In the C family there are 20 leadership failures, 14 by father. His efforts are continually ignored

or tangentially responded to. Here he admonishes his son and his son magically slips away: (1)

F-S2: Haven't I always told you that it isn't right to be fighting one another.

S2-F: Hey, come on Dad. Don't say that on TV.

Mind reading. The scores on mind reading assess enmeshment in terms of intrusion into personal space, and as predicted the families of children with inflammatory bowel disease score higher. However, clinically the gap is not as wide as I would have predicted. I think this can be explained by the fact that the families of children with inflammatory bowel disease use other conflict avoiding techniques which structure and organize the family members so effectively that no conflict even emerges. While mind reading is an indication of enmeshment, it is also a conflict suppression technique. That is, someone who says to another person - "I know what you're thinking" - before the other person has made his statement is not only not allowing this person to speak for himself, he is eliminating the chance that he might say something conflictual. Some families, for instance the E family, rely on mind reading while other families (L and F), rely on conflict avoidance techniques. In general, the families of the

(1) Code for Transcripts: M=Mother, F=Father, A=All, S=Son, and D=Daughter. Siblings are numbered consecutively from left to right as they face the camera.

experimental group use conflict avoidance techniques more than mind reading as a way of controlling family members.

One of the points I want to make as I go along is that enmeshment, overprotection and lack of conflict resolution skills are inextricably related to each other, and as a group they describe a family process which is a defense against high levels of anxiety. The relationship between mind reading and conflict avoidance is one indication of this inter-relationship.

In the data, there are many examples of mind reading. The E family has just heard the instructions for the menu:

S2-A: What are we having for dinner?  
F-A: Well, we all have to agree on one meal.  
You know what we can't eat.  
M-F: Well, George can't have, won't eat.....  
M-S3: Oh, but George will eat chicken, right?

A great deal happens within these few exchanges. Father immediately signals that everyone must agree. It is as if he is sending out the call to rally around. It is a sign of anxiety and it alerts the family not to disagree. He also says, "You know what we can't eat," as if to say don't bring up any of those items which might cause conflict. But this statement intrudes on the family member's autonomy. We don't know what he is referring to, perhaps S2's dietary restrictions or the fact (it comes up later) that George, the "Number One Son," is a vegetarian. This statement also works to suppress conflict before it has emerged. In a less enmeshed family, it is simply the kind of information which would be taken for



granted with the knowledge that family members can speak for themselves. Mother is immediately keyed to George and what she says to Father is an example of mind reading and a mediating speech, and as she redirects her statement to her son it is simply mind reading. Again, in a less enmeshed family, each person would be allowed to make their own statement because their individuality could be accepted.

Here is another example of mind reading and conflict avoidance. (the J family)

- F-A: Well, everybody likes steak so lets have steak.  
D1-A: I hate steak. I'll eat fish.  
S1-A: Don't start trouble.  
M-A: We'll all have fish.  
S1-A: No, we'll all have steak.  
D2-A: She's (M) the only one who doesn't eat steak.  
M-A: I'm sure it would have to be french fries for everybody, do you agree.  
F-A: French fries for one of the vegetables.

Why is it that mother and father cannot allow everyone to make their own decision? - "Everybody likes steak," "I'm sure it would have to be french fries." And why does S1, the symptomatic child, admonish his sister not to start trouble? This family is constantly quarreling (they were discussed above) and perhaps it could be argued that they are trying to avoid another quarrel, especially on camera. But there is a deeper reason, I believe, and it has to do with the meaning of enmeshment as a process, the psychological function it serves. What is so impressive is how little the members of these families can tolerate waiting and allowing others to make their own de-



cision. It seems they have to intrude, and this has to do with their own lack of individuation as persons. Compare and contrast these examples with the process below. This is a family from the control group:

F-A: Okay.  
F-S1: What would you like for meat?  
S1-F: Me?  
F-S1: Yeah.  
S1-F: Prust.  
F-S1: Prust. I guess we have to describe it.  
That's what?  
M-A: Pot roast.  
F-A: Pot roast of beef.  
F-S2: Do you want that? Would you like that?  
S2-M: Not in particular.  
M-S2: What is your favorite?  
F-S2: Well, you gotta talk up. They can't hear.  
S2-M: Lamb chops.  
M-A: Lamb chops.  
F-A: Lamb chops.  
M-A: I like chicken.  
F-A: Chicken.  
M-F: How about you?  
F-A: How about steak?  
F-S1: That's kind of acceptable to you?  
S1-F: Shakes his head no.  
M-S1: No?  
M-A: Good. Y'know, we can't make up our minds...  
laughter.  
M-S1: How about turkey?  
F-S1: Fish. Fish.  
S2-A: What kind?  
M-A: Absolutely not. No fish.  
S2-S1: Tuna fish?  
S1-S2: Shakes his head no.  
M-A: We have to have something we all eat.  
M-S1: Right? We all eat chicken. You eat fried  
chicken.  
S1-M: Shakes his head no.  
M-A: Bob doesn't eat...  
F-A: How about, let's get to the vegetables.  
We'll come back to the meat.  
S1-A: Potatoes....  
M-F: Okay, potatoes.  
F-S1: Okay, potatoes.  
S2-F: It's bread.

M-S2: Yeah...  
F-S2: Well that's ...they don't...theyre not  
concerned with if it's bread thing for you.  
M-S2: It's a vegetable.  
F-S2: Two vegetables.  
M-S2: All right.  
M-A: Potatoes and carrot sticks.  
S2-S1: I like carrot sticks.  
S1-S2: Naw.  
S2-S1: I want carrot sticks.  
S1-S2: Alright, carrot sticks.  
F-A: Carrot sticks, bread 'n potatoes...  
M-A: We all like carrot sticks?  
M-F: You like that, too?  
F-S2: Fit in with everybody's diet.  
M-F: You like that, too?  
S2-M: What?  
F-M: Yeah that's all right.  
M-S2: Carrots and potatoes.  
F-A: That's two vegetables.  
S2-M: Yeah.  
M-S2: Okay. A drink.  
F-S1: A drink.  
S1-F: Fruit punch.  
M-S2: Fruit punch?  
S2-M: Hawaiian Punch.  
M-S2: Hawaiian Punch...same thing.  
F-S2: Hawaiian Punch...  
S1-S2: I want fruit punch. Like the...  
S2-S1: Hawaiian Punch.  
M-F: All right, let's pick the same. What do  
you like?  
F-M: Is that sweet or sour?  
M-F: Very sweet.  
F-M: Hmm.  
M-F: Very sweet.  
F-A: How about...let's go to an acceptable soda  
since we have diet problems?  
M-F: I don't drink soda.  
F-A: All right. I'll give in if you give in a  
little bit. I'll have fruit punch with  
you.  
S1-F: Okay.  
F-A: Cause I lost some weight...  
M-S2: You too?  
S2-M: Yeah.  
M-S2: You can have High C diet, right?  
F-A: Okay...all right. Let's go back to the meat.  
S1-F: Dessert.  
M-F: Dessert

F-A: Oh...you want to get dessert first before  
meat?  
S1-F: Yes.  
F-S1: Okay...

And so it goes for another hundred exchanges. This is a family in which the parents are in control and they easily monitor their children's behavior. Many suggestions are made, and all family members participate and talk with each other. They can disagree and in tone there is a directness and spontaneity which does not exist in the experimental families. Interestingly, it is almost impossible to figure out who is the symptomatic child. It is S2. Compare this process with the F family below.

F-M: All right.  
M-A: A roast beef. Just a...  
S-A: Yeah.  
F-S: All right. Roast beef.  
S-A: All right.  
M-A: Baked potatoe...I would say.  
F-M: And what we all enjoy...  
S-A: Corn.  
M-F: Oh, corn...yeah.  
M-S: How about dessert, Bob?  
S-M: Ice cream. That'd be it.  
F-A: Ice cream.  
M-A: And a drink.  
F-A: Well, tea for me.  
S-A: Milk.  
F-A: Milk...is is just one?  
M-A: Just one.  
F-M: One?  
S-A: Definitely milk for me. We don't have  
to have...  
M-F: Let's don't bother. Roast beef....  
F-A: Milk.  
M-F: Milk...The usual, in other words. Okay?  
F-A: Okay.  
S-A: Right.

The contrast between these two families is striking and meaningful. One of the questions which concerns this research is the question of how a chronic disease affects a family. And the challenge is to determine whether or not the family reacts to a chronic disease by becoming enmeshed, overprotective and conflict avoiding. This is a question which I will deal with in more detail later, but from these examples, it must be clear by now that the families in the experimental group, through their enmeshment, overprotection and conflict avoidance are up to something quite different than simply reacting to one of their children's chronic disease.

Interpersonal perception. In terms of interpersonal perception, the control families see each other in differentiated and semi-differentiated terms more often and rarely in global or undifferentiated terms. The experimental families' responses are often meager, global and moralistic. Quite often they do not finish the task, and frequently the parents avoid the task altogether. The mother in the C family gives an example of a global response when she says she likes it "when there's peace in the house." The father of this family says he "loves" it when they (his five children) do the things "we stress, like respecting others, living up to responsibilities, doing their chores, doing their homework, and when there's 'togetherness.'" These responses relate to the children as a group. Mother in the L family likes it "when we go away and they're nice and they leave her alone a little," and "when

nobody fights." Rarely does anyone say anything as distinct as this father talking about his children in the I family: "I enjoy her sense of humor, she's a happy-go-lucky kid and pleasant to be around." He says about one of his sons: "I enjoy his quick mind, and his humor. He'll do anything you ask and he handles responsibility well." The children mostly relate to their siblings around what they do for them - like giving candy or doing favors. Much of this is age appropriate as liking one for how they help him or for sharing something. But what is so impressive is how organized the responses to these tasks are around "neatness," and "cleaning up." The literature points to difficulties in the developmental history in children with inflammatory bowel disease as occurring during the anal period, and, of course, in the classical psychoanalytical literature, the anal period is the source of obsessive defense formation - these children's basic defense. Well, these families are preoccupied with neatness. The families with diabetic children often focus on chores in task three, but not to the extent that these families do. They always seem afflicted with cleaning up and being neat.

### Overprotection

The control families do not get involved with their sick children around overprotective themes. In fact, it is quite difficult to determine who he or she is in viewing the tapes, but it is almost always apparent who the symptomatic child is in the experimental families. The experimental families seem

to organize around the child's sickness. It seems that in these families the child's sickness becomes a personal event in the lives of the parents, particularly the mother. It's not that that should not happen, but the emphasis seems neurotic. Thus one mother says she "hopes, prays and wishes that things can be cleared up for Robert."

As we study each of these interactional characteristics, it becomes clear how each pattern is merged with the others - all combining to create a process which seems to foster closeness and prevents conflict from emerging. There are numerous overprotection themes that run through the data. In the B family cited above, the emphasis in task three is on nurturing and feeling themes: Daughter likes it when "we do nice things together," "having a Daddy, loving," and does not like it when her parents yell at her and make her "feel bad." The parents like her because she is "so loving," "a gentle being." A nine year old boy (the E family) who has had his symptoms since two likes his mother when she "lets him sit on her lap and go to sleep." In the following dialogue (the F family), deeply anxious themes emerge around the daughter's late hours:

F-M: It'll be something that....let's see.  
How about the daughter and her hours?  
You want to do that?  
M-F: Yes, but that don't have anything to  
do with Robert.  
F-M: Well, we're all there.  
M-A: Oh, worrying about her coming in right?  
F-A: Yes.  
S-A: And when you wake me up...  
M-A: Yeah.  
F-M: Yes, we worry about our daughter, Susan...



M-F: Staying out late...  
F-A: Staying out late...  
M-A: And that causes some....  
F-A: With her girlfriends, not alone and...  
M-A: Well...  
F-A: It just is a concern for all of us who stay home more often than not.  
M-A: Worrying about her.  
F-A: Worrying about her...right...and we all get in on the act.  
S-A: Yeah, you wake me up, "Go and see if she's...."  
M-A: Well, I thought, you know, we were going to go.  
(At this point the family is briefly diverted, but come back to this theme.)  
F-M: Well, the one that really gets us upset is Susan, right?  
S-M: When she's out.  
F-M: When she's out.  
S-A: We sit and wait for her.  
F-A: We worry about her...  
M-A: The whole house is in an uproar about...  
F-A: We have a reason for it, though. She was in a very, very serious accident in 1972.  
M-A: Uh huh.  
F-M: And we're concerned that someday we're going to get that phone call again.  
M-F: That's right. But I don't think Robert worries about her too much do you Robert?  
S-A: Uh uh. I could care less when she comes in or not, you know.  
M-A: Robert don't worry about her.  
F-A: I'll bet.  
S-M: How old is she?  
M-S: She's too old to be...  
S-A: She can come in by herself...I don't care.  
M-S: That's right.  
F-A: That's right. You shouldn't worry about it, and we do, and it sort of rubs off we realize...  
M-A: I know.  
S-A: Yeah, but you're going through the house, "She ain't here, she ain't here."  
M-A: She's not home.  
F-M: Well, we can't sleep 'till she does get home.

quite appropriately the son recognizes how overly concerned the parents are. This sequence which demonstrates a protective theme is also an example of enmeshment and conflict avoidance. Notice how the parents anticipate and complete each other's thoughts. There is something almost dreadfully symbiotic in how they operate. And of course, picking an argument which involves an absent member is scored as a conflict avoidance. Interestingly, Robert has had a colostomy. His wound has not completely healed yet though after almost two years. Mother, of course worries about him - "some days he's not as well as he should be;" and she "hopes, prays and wishes that things can be cleared up for Robert."

Of course, these families inevitably like it when their sick child is "feeling better." It may seem that this is to be expected - and it is. But by contrast, families from the comparison group who have a sick child are not preoccupied with their children in the same way. Their children have diet restrictions, for example but they do not come up in the menu task and when they do it is handled matter of factly. The experimental families frequently make it an event:

M-S: Well, I can't agree to the corn for you because it is not good for you, but it would be OK if you could eat it.

This is a protective theme as well as a sign of enmeshment. The physician who is treating this severely ill boy (the A family) told me this is the mother's refrain: "I know its not good for you."

## Lack of Conflict Resolution

All the scores under this category indicate the degree to which the families in the experimental group not only lack conflict resolution skills, but the extent to which they avoid conflict. For example, in the scoring for aggression and disagreements, the families in the comparison group score higher because they are able to initiate conflict, whereas the families in the experimental group suppress disagreement and aggression. Under the scoring for conflict (See Conflict Scoring), the families in the experimental group score much higher. In most cases these scores represent not the lack of conflict resolution skills, but the complete denial of conflict or its immediate suppression if it does arise. The control families are more able to allow conflict to develop and to discuss it. Hence, the number of arguments that families feel free to discuss on task two, the comparison families bring up twice as many as the experimental group.

The families in the experimental group certainly lack conflict resolution skills. In some of the examples below we can see that there are certain repetitive conflicts which are never resolved. In other examples, conflict never emerges, and in others there are hints of conflict but it is quickly suppressed or minimized.

In the D family mother brings up the morning as the time of their biggest fights.

- M-A: Tell me what happens when I wake you up in the morning?
- D2-M: We don't get up.
- D1-M: We don't get up, we lay in the bed and start screaming and hollering and then we get to get up and we take out time combing our hair, we take out time putting on our clothes and then you tell us to get out of the room. And then we get in the car, then we say....
- D3-M: We're always late.
- F-A: That's an easy one. You all should have got something a little harder because this is a continuous thing.

Both mother and father are aware that the morning ritual is a time of confusion and probably, nagging, petty quarrels. But the parents lack the ability to manage this scene. Perhaps this is because the father dominates the family's leadership, making 75% of the leadership statements. This kind of skew may be an indication that the parents do not work together, and do not support one another's leadership. Mother and father address each other only three times during the entire session, and they don't say anything to each other in the like-and-don't like task. But among these three statements is the following:

F-M: "But we probably will never agree on that, right. Because you know you won't be in on it anyhow." They are talking about ice cream, but this may be father's complaint with his wife. This information indicates that it is very likely that the family's lack of conflict resolution - "this is a continuous thing" - is due to the parents submerged marital conflict which expresses itself through the children's quarreling.

There are other examples of conflict which has a quality about it of being a "continuous thing." In the J family,

mother and her two daughters are involved in an acrimonious, attacking quarrel which father observes from some distant, almost serene point, sitting back smoking his cigar. He does not support his wife, but sees her as one of the children - "all five of you constantly bicker and argue about childish, inconsequential things." Mother is the bad one in this family - "hypochondriac," "too sensitive," "overly pushy," "starts fights." Father is a "cool person." The argument is about the daughter's appearance, which mother finds offensive. Father says to his wife: "Well, I didn't see the shirt so I can't enter into the argument." Mother responds to father: "As far as I'm concerned it wasn't presentable and she doesn't have to wear something like that. She has other things." At this point, the symptomatic child intervenes: "OK, next question," and father never responds to his wife's plea. It appears that a submerged marital quarrel expresses itself through the daughter's hateful, continuous quarrel with mother, while father tacitly allies with the daughter. It is also quite interesting to see the symptomatic child intervening when he does - at a point when a conflict might emerge more clearly between the parents. This is an indication that the sick child is involved in the parents' conflict avoidance.

These examples above are obvious examples of what Minuchin means by lack of conflict resolution skills. In most of



the families in this group, conflict does not even emerge. This is because they are so adept in structuring their responses. Sometimes their operations are quite subtle as in the following example. This is the B family, whose only child has chronic ulcerative colitis and is on a high dosage of steroids:

They have just turned off the tape recorder after listening to the menu task. Mother is sitting in the middle with her daughter close to her side. She turns to her husband and asks, "It has to be meat? It can't be fish?" Father responds, "It has to be meat. It can't be any chicken or fish, so it's steak." The entire family laughs uncomfortably. Mother responds, "Okay," and turns to her daughter. "What kind of meat do you like? Roast beef better?" Her daughter hesitates, then chooses roast beef. Mother repeats, "Roast beef," and turns to her husband, "Okay. That sounds good to me." Father agrees, "Roast beef, sounds all right."

Apparently, mother preferred roast beef, but she did not say this directly to her husband, she suggested it to her daughter, who was put in the position of having to make the decision. Father then acquiesces. This example may seem benign, but this is the pattern in this family - the daughter is repeatedly asked to make decisions which obviate potential disagreement in the family. She is spoken to, in fact, 50% of the time.

This example comes as close to a conflict as the family expresses during the tasks. With the other suggestions of menu items, each suggestions is instantly agreed to, with hardly any hesitations. Their response to the argument task unfolds quickly:



M-D: I don't remember having any fighting.  
D-A: Or an argument.  
F-A: Yeah. We're going to punt on this one. We've got a problem. This may be the biggest problem we've had - answering this question.  
M-D: The biggest problem is what we've ever fought over... I can't think of any disagreement. Can you think of any?

This is an astonishing sequence, and again note how mother turns to her daughter. The role she is playing must be completely undermining her autonomy. The psychologist who instructed the family in the tasks, and observed it behind the one-way mirror told me that he felt she did not have any of her own feelings and that she was extraordinarily anxious. One further note on this family's enmeshment - they were all wearing the same shirts!

It is not unusual at all that the sick child seems to be the person the parents talk to instead of each other. In the G family of four the sick child is addressed 43% of the time. In the interview, the family had completed task 3, the like-and-don't-like question, without the parents exchanging their views to each other. I intervened at this point and asked them to do that. They did, but they addressed all their statements to the sick child, not only speaking directly to each other. And this ten year-old boy listened to what they said - a little gentleman! But the confusion in this family is revealed by the following sequence:

Mother had just finished telling her son what she did not like about her husband. (After I had intervened) He does the wrong things for her...can't help her with her problems...gets on her nerves. Father then decides to tell his daughter what he doesn't like about her. He had already done this! What he tells her is that she cries for no reason at all and tells tall stories. At this point, the flustered daughter turns to me behind the one way mirror and points to her mother, as if to tell me that her father was really talking about her mother.

Thus it appears that potential conflict is detoured through the children. Father tells his daughter that she cries too much, but certainly this is what he is feeling about his wife as he is reacting to what she had just said about him. This is a clear example of the blurring of boundaries between the marital sub-system and the sibling sub-system. It demonstrates the interrelationship between the processes of conflict avoidance and enmeshment also. After the interview the parents told me they had learned something quite important - how petty the children were!

There are many styles in which conflict is avoided. The task two's instructions are to talk about a "disagreement or argument," "an argument or fight." Mother reinterprets them as "hand to hand combat," or a "four-rounder" so as not to respond to the task. Also in this family hints of conflict emerge, but they are quickly suppressed. This is another style of conflict avoidance.

S-F: Let's see, an argument that we have all had...

F-S: No.

S-F: You mean just me and Linda and then you and Mommy?

M-S: Well, usually when something does go on between you and your sister, we all sort of get into it.

F-S: Eventually.

M-S: Eventually, yeah.

D-A: You just tell us to knock it off all the time.

M-S: Yeah, knock it off. (Mother is mimicking daughter)

S-M: You mean if me or Linda is gay or something?

F-S: No I don't think that. That's not important.

M-S: We really don't have any hand-to-hand combat...you know...like punch, shove and poke around.

M-A: Let's see...

F-A: Let's see... How about something about Christmas. Any arguments around Christmas time about who plays with what and whose toys?

Notice how the son brings up potential arguments which could be discussed, i.e., "you mean just me and Linda and then you and mommy" - and how these are all swept away until father arrives at a safe one. Of course father's question is a set-up and the sick child dutifully complies. What develops is a long tedious "petty" discussion of a running quarrel between son and daughter, which father conducts by asking questions and moralizing.

So what we see in many of these families are situations structured so that no conflict emerges or conflict emerging but quickly suppressed. Let's look at another dialogue in which the family (L) is at pains to avoid any hint of conflict:

M-F: Wait a minute. Is this a fight involving all six of us?  
 F-M: It doesn't sound like that.  
 D2-A: Or are they trying to get us to fight again?  
 F-M: We never fight with all six of us.  
 M-F: We never fight without six.  
 Laughter - everyone talking at once.  
 M-F: Two at a time.  
 S1-A: Ah... the cleaning of the new room.  
 M-S1: No, that isn't a fight.  
 M-A: A real battle!  
 F-A: Was that lately? Lately we've been very good.  
 F-S2: When was the last fight?  
 S2-F: S2 shrugs.  
 F-M: We always fight because of the closing of the doors on the closet in the kitchen.  
 M-F: Right. Stop making such a....  
 F-A: We haven't.....  
 D1-M: No. Close the doors...  
 M-A: We haven't had any bad arguments.  
 D1-M: No, close the doors.  
 S1-A: The dog used to be our fight, but we haven't had any....  
 F-A: Barb is even being good. I haven't yelled at her that much.  
 M-A: Everybody's been very good.  
 F-D2: It's true.  
 D1-A: When you put some things in the closet...  
 M-F: Do they mean a fight with us against them or us against each other?  
 F-M: That's bickering. That's not fighting.

.....

M-A: We haven't...  
 F-A: had a good fight in a while.  
 M-A: We just bicker a little.  
 F-A: They might not enjoy it but we didn't have one.  
 M-A: Yessssss. Nothing.

This anxious sequence is typical of how many of these families operate. Someone is confused by the instructions. There is much laughter, joking. "Cleaning the new room" is not a real fight. They're looking for a "real battle." Something about

closing the kitchen doors is consistently ignored even though D1 brings it up several times. A fight of "us against each other" is "just bickering." The family, particularly the parents, seem to want the interviewer to believe they are in earnest - "they might not enjoy it but we didn't have one." And notice how father and mother complete each other's thoughts. Interestingly enough, S2, the symptomatic adolescent boy, does not once contribute to the task, except as he shrugs to answer his father's question: "When was the last fight?"

In the next case example (E), the last we will look at in terms of conflict avoidance, S2 has Crohn's disease which is causing severe weight loss and fatigue. This once active boy has become quite passive and apparently quite depressed. It is easy to appreciate the argument that a debilitating disease affects a person's psychology. It does. But there is something very wrong in this family. The dialogue begins after the family has listened to the instructions for task two:

M-S2:	A family feud.	M	defines the task as a feud.
S2-A:	Oh.	My	impression, based on
M-S3:	And George grins.	a	discussion with the fam-
M-A:	I can't think of any argu- ment or discussion we have had recently that didn't center around anyone but...	ily	afterwards, was that
S2-A:	Cutie...	mother	and her oldest son
S3-A:	Cutie pie.	have	been "feuding" since
M-A:	Number one son.	his	birth.
F-A:	Well, was there anything that involved the whole fam- ily other than this thing with George.	S2,	the sick child, and
		S3	complete mother's sen-
		tence.	Apparently every-
		one	in the family knows
		about	the feud.
		Father	tries to switch
		the	discussion away from
		the	"feud."



M-F: Well, if you're fighting with one, I think, it involves the whole family.

F-A: About the only thing I think of is watching the TV program. He (S2) wanted to watch his game... Mother ignores father and turns away from him.

S2-F: When was that?

M-S2: That's...

S1-M: That's all the time.

F-S2: Three months ago.

F-A: No? Is there anything more profound than that? Than the TV set? Mother laughs at father.

M-F: Yes. I can't think of anything else but the most recent occurrence which you don't want to discuss.

M-S3: Do you want to discuss your most recent difference with the family?

S3-M: It's too involved.

M-S3: This is not going to help.

S2-A: Eddie. S2 volunteers a mild and confusing disagreement between himself and his younger absent brother who is not present. A potential disagreement between the parents is diverted.

After the interview I sat and talked with the family. The mother told me that she was surprised her oldest son, George, whom she admits she has been "feuding" with since birth, is not the sick child. He has had abdominal pain continuously through adolescence.<sup>(2)</sup> But this feud seems a love-hate affair, hence S2 and S3 complete mother's thoughts above - "cutie pie."

(2) It turns out that everyone in the family has some kind of bowel trouble. Besides S2's Crohn's disease two others have diarrhea, and the remaining three are constipated.



Father also seems to want to avoid a discussion about "Number One Son." But the action is between mother and her oldest son, who impressed me as being quite depressed and confused. (The latest difference is about George moving out and living with a younger girl.) Might it not be that mother, disappointed that her husband has not fulfilled her expectations (on an unconscious level) has turned to her oldest son (unconsciously). Again marital conflict is suppressed and expressed through an overinvolvement between mother (in this case) and her children. The only disagreement between father and mother is over religion. At least this is what they admit. In the like-and-don't-like task she criticizes him for being too serious and obsessive. But in the dialogue she continually ignores father, turns away from him when he is talking and occasionally laughs at him. Others in the family also ignore him, especially S2.

S2's involvement in the family is confusing. When father expresses an interest in him, he ignores father. He even criticizes father for father's fumbling with the tape recorder - "Now you've messed it up." When S2 volunteers to start the fire for barbeque chicken, he's ignored. People pay attention to him around his special diet requirements - that is, because he is sick. And as we have seen above, he distracts a potential argument from his parents to an incident involving himself and his younger brother. He seems disoriented and confused and is criticized by others for not being

"disciplined in getting over his sickness," for lacking a "driving force," and "not fighting his illness." There is a lot of non-verbal communication between this child and mother, mostly of an approving and comforting nature. Mother said that she did not feel overprotective until he got sick, that she has never treated him this way. It is hard to know what this might mean. It could be appropriate or serving her needs in some neurotic way.

This is a sophisticated and well-educated family. There is an emphasis on achievement, no doubt, two of the children are in college, and both parents are professionals. It may be that this fifteen year-old boy, who has been sick for one year, is not related to for the demands of his present developmental task, but is pressed to succeed and develop a pseudo-maturity.

It appears then that the father is isolated and continually undermined by mother who has a special relationship to her oldest son and although I have not discussed it, a similar close relationship to S1, the next oldest. Father tries to relate to S2, but his son seems to reject him. The youngest son did not participate in the interview. Everyone remarks about his energy and creativity, though, and perhaps he is related to as an eleven year old boy. All of this is very subtle, and somewhat speculative, although within the realm of the clinical material. These would all be signs of severe anxiety which would be hardly noticeable as this family

presents itself as normal and dealing well with its life together, except for their son's disease. The family's conflict avoidance techniques are subtle and shifting. The parent's marital conflict, which would embrace each person's individual psychopathology, is suffused into alliances in the family which mask the pathology, but I believe these people are in great pain, as is the sick child.

## Chapter 7

### DISCUSSION: PART TWO

I have a desire to make it plain that the forces at work in the patient are tremendously strong. (Winnicott, 1966, p. 510)

Minuchin and his colleagues have emphasized the interrelationships of these family patterns which I have been discussing. For example, in describing lack of conflict resolution, they state that the "rigidity and overprotectiveness of the family system, combined with the constant mutual impingements characteristic of pathologically enmeshed transactional patterns, make such families thresholds for conflict very low." (1975, p. 1033) They also state that these characteristics appear to be representative of a general type of family organization and functioning. What I want to discuss now is what I believe is a deeper, pervasive condition which is at the heart of this family organization, and which helps explain the tenacity of the symptoms and the difficulty which faces all involved with treatment of these children. In developing this hypothesis I will be bringing in several concepts from the literature as well as my own experience with this project.

In the literature there are several qualities about children with inflammatory bowel disease, particularly ulcerative colitis, which have been repeatedly emphasized. Almost every observer writes about their obsessive-compulsive traits and their difficulty in expressing anger. Behind a placating and conforming pseudo maturity, they see an obstinate, whinning, clinging infant whose innermost tendency is towards depression. Sperling writes about the primitive organization and defenses, which these patients use to manage their precarious and anxious relationship with their rejecting and ambivalent mothers. Winnicott says that the real illness is not the physical illness, but a split in their personality which keeps a conflict in the psyche separate from the somatic dysfunction. He feels they suffer a form of ego-weakness which is a result of "not-good enough mothering," and the illness is a defense against depersonalization. He means, literally, that the physical illness is better than nothing.

Following the current developmental psychology in psychoanalysis, particularly the British school as represented by Fairbairn, Winnicott and Guntrip, the obsessive qualities and pseudo-mature veneer of these children indicates a primitive defense against, and the presence of a schizoid state. The schizoid condition conveys a history in which the child had to mentally withdraw from a situation in which his mother did not directly and sensitively respond to his emerging needs, (not good-enough mothering). But not all of him withdraws,

just his needy, love-hungry true self. Part of him must stay in some contact with mother because he has to psychically survive. He must adapt to his mother's tangential, impinging behavior. Children adapt in many ways. Many become good boys and girls, mediating and splitting off their real needs, while quietly relating to as good and idealized a version of mother as they can create and as actually exists. Meanwhile, the internal world is alive with need and rage, no matter how deeply buried. They use their obsessive, "good" defenses to manage and contain their inner predicament.

Besides feeling basically unrelated and cut-off, people with a schizoid orientation cannot treat other people as people with an inherent value of their own. This can be seen as regressive phenomenon determined

by an unsatisfactory emotional relationship with their parents, and particularly with their mothers...the type of mother who is specially prone to provoke such a regression is the mother who fails to convince her child by spontaneous and genuine expression of affection that she herself loves him as a person. (Fairbairn, 1952, p. 39)

Recall now Mohr et al., Gerard, Prugh and Sperling's observations about the mother's of children suffering with ulcerative colitis. Gerard (1953), for example, said of these mothers that "with no exception, all (of them) were narcissistic and uninterested in the child except as a self-enhancing asset" (p. 88). Sperling (1955) observed that the outstanding feature



of the relationship between the mother and sick child is her "need to keep the child in a lifelong dependence for the gratification of (her) vitally important bodily and emotional needs" (p. 320). Sperling has found

that the mother in the case of psychosomatic illness of the child rejects the child only when he is healthy and evidences strivings towards independence, but encourages his illness and rewards him when he is sick. (p. 321)

The connection which I am trying to establish now is that both the early life experience of children suffering with inflammatory bowel disease, as noted by Gerard, Sperling and others, as well as the defenses of children with this disease, indicate the presence of a schizoid condition. I also believe that the family patterns indicate the presence of a schizoid condition. I can best convey what I mean by introducing an idea which at first may seem unrelated, but which will take me further in the direction I am headed.

One way of thinking about schizophrenia is that it represents, developmentally, a "con-fusion" between mother and child. (Bush, 1975) That is, mother and child are symbiotically fused or "con-fused." Anyone who has worked with schizophrenics and their families knows how "confusing" they are. One way of understanding the confusion is that it is related to the schizophrenic's early developmental "con-fusion" with his mother. It is as if the family perpetuates "contains" and "holds" the early developmental fault. The "con-fusion" be-

tween a mother and a future schizophrenic baby may not look pathogenic, in fact, it may seem appropriate. In an older child, adolescent or chronological adult in his family, it is clearly crazy, but it is almost as if what is being perpetuated is that early scene.

I believe there is a similar relationship between the early developmental pathology of these children and the family characteristics of enmeshment, overprotection and lack of conflict resolution. These family patterns perpetuate, contain and hold a schizoid condition. They embody this state. As such they are a sign of a failure of individuation - that developmental sequence in which the child sees others (his mother) and is seen by the other as a distinct individual. Because this is what enmeshment as a family process is about. These people are up to much more than avoiding conflict. They have not developed a capacity to be alone and the emphasis is on closeness. They cannot allow others to speak for themselves - hence the mind reading and personal control, and they do not see each other as distinct, separate individuals - hence the high scores on semi-differentiated, undifferentiated and global perceptions.

Another way of viewing the schizoid fault is to think of it as pre-depressive phenomena. Pre-depressive because to reach the depressive position "a baby must have become established as a whole person, and to be related to whole persons as a whole person." (Winnicott, 1975, p. 264) Engle, Mohr et al.,

and Sperling have documented and discussed how this has not been the case of children suffering with ulcerative colitis.

The essence of the depressive position in analytic developmental psychology is that the infant-child masters his natural splitting processes. That is, he recognizes his "good" and "bad" mother as being the same person, who heretofore has been split into the "good and bad breast," and manages to repair, through love and creativity, the hatred and guilt he feels for his newly discovered, whole mother, (both good and bad). A clinical experience may enrich the meaning of this sequence. An analyst working with an adult patient suffering with ulcerative colitis told me that his patient could not be angry and hold object constancy. That is, everytime his patient got angry at him (the analyst), the analyst ceased to be a real object for the patient. She could not be angry and "hold" him as an object at the same time. What is repeatedly observed, of course, is that patients suffering with inflammatory bowel disease cannot express anger appropriately or effectively. This is because the ability to be angry indicates a developmental achievement of "being" in the world as a whole person living among other whole, separate persons. Anger implies separation and people who have trouble with expressing anger effectively are people who have not individuated. Conflict with such people is a threatening psychological phenomena. They can quarrel and bicker and some families may have "their continuous thing,"

but resolving that would imply taking some kind of position which might imply standing alone.

Mahler (1972) writes how the biological birth of the human infant and the psychological birth of the individual "are not coincident in time -- the latter is a slowly unfolding intraphysic process." (p. 333) I believe that the consistent presence of enmeshment, conflict avoidance and overprotection is an indication that the individuals in these families have not achieved "psychological birth." I am not only talking about the patient, but the parents as well.

### An Hypothesis

It is this interpersonal situation which is the environment (breeding grounds) that provides the necessary conditions for the development of the symptoms of inflammatory bowel disease. I believe the process is as Sperling has described it in her paper in 1946 -- it is essentially a process of conversion. The child reacts to his precarious intraphysic situation (he has very little to live by in terms of ego development) with "hostile attachment (to his mother) and an intense need to hold onto the position of a baby." But because his real object (his mother) is inconsistent and basically unrelated to him, he must "swallow" it in order to establish some kind of inner security: the situation sets in motion "the archaic mechanism of oral-sadistic incorporation of the needed object with all the destructive somatic consequences of the defense mechanism."

These children are in a state of permanent frustration that results in a state of unconscious rage with an irresistible urge for immediate discharge. The slightest additional frustration...provokes exaggerated reactions. The destruction and elimination of the object through the mucosa of the colon (bleeding) would seem to be the specific mechanism in ulcerative colitis. As the object is incorporated sadistically, it is a hostile inner danger and has to be eliminated immediately. (1946, p. 326)

What Sperling is describing here are essentially the mechanics of hysterical conversion. Fairbairn (1954) describes hysterical conversion as a defensive technique which is designed to prevent conscious emergence of emotional conflicts involving (inner) object relationships. "Its essential and distinctive feature is the substitution of a bodily state for a personal problem, and the substitution enables the personal problem as such to be ignored." (p. 117) Fairbairn also emphasizes that the colon is a vulnerable organ for conversion processes.

Thus the symptoms resolve a number of dilemmas. Intraphysically, it is a defense against depersonalization. It is also an expression of rage turned in and an attempt to resolve (intraphysically) the precarious emotional relationship with an ambivalent, narcissistic mother. Sperling also points out how the disease can serve as a problem solving technique for a developmental crisis. In one case study she discusses a child's illness as a solution to the conflict of whether to remain a baby and cling to her mother or to grow up and go to school. (Sperling, 1946) The disease can also function as a



problem solving technique for the mother. Titchner et al. (1966) discuss the mother in a family with a very sick child suffering with ulcerative colitis in these terms:

Anger, her disappointment regarding the lack of financial and social success, and depression were diverted into maternal care, pity and worry over the adversities of another. (p. 137)

On another level the disease serves a homeostatic function and although I am not able to demonstrate this in a technical way, (i.e., Minuchin and Baker's experiments with free fatty acid level and superlabile diabetes), it is apparent that in these families the sick child plays a significant role, often intervening as the parents might start an argument (C and K), or by being the person they talk to instead of each other (G and B), or by being conspicuously inactive (L). In another family (I), as soon as it has heard the instructions to the argument question, the children, all eight of them, turn to the symptomatic child, and in unison, point their fingers at him and call out his name. This does not develop further, but one has to wonder what role he plays in their lives.

Not all the symptomatic children are involved in submerging conflict between the parents. In one family (A), the patient actively provokes or tries to provoke a conflict between the parents. The family has just heard the instructions for the family argument task:



F-M: That's a tough one. That's a tough one.  
S-M: Who does the work.  
M-S: Huh, who does the work?  
S-M: You are always telling him why doesn't he do any work.  
M-A: Oh yeah.  
F-M: You mean in the house.  
M-F: Yeah help in the house. I wouldn't call it a real argument.  
F-M: No.  
S-A: It's an argument.  
M-A: Yeah, I guess it is, OK....  
F-S: Is it, do we argue, do we fight about it?  
M-A: Yeah, sort of...  
S-F: Yeah, she...  
M-F: I complain and you yell.  
S-A: Well, what started it is because the house is dirty, right?  
M-F: Yeah, because it is messy and you don't like it and you don't want to help...  
F-M: I help...  
M-F: And then what happened? M-S: What do we have to discuss the argument and what happened?  
F-M: No, because the house never gets clean.  
M-F: Because you don't help... So we are back to the same thing.  
S-M: But you mess it up and leave all the junk around.  
M-A: Yeah and everybody messes it and nobody wants to help.  
S-A: All right.  
M-A: That's it.  
F-A: That's it.

The son plays a central role here and brings up a conflict which the parents try to close down: "I wouldn't call it a real argument." "No." "Do we argue, do we fight?" But he insists, "It's an argument." The family does not make any real effort to solve the problem, or to discuss it for that matter. It is almost as if they have an investment in not getting things straight. This is a disturbed family. Surgery has been recommended for this 17 year-old who has had chronic, con-

tinuous ulcerative colitis since age eleven. He has been in individual therapy and the family has been briefly seen in family therapy. The mother has had schizophrenic episodes. The boy has had hallucinations which may have been a side effect of steroid treatment, but he is clearly a troubled young person. Certainly the role he plays in the family - joining with mother and attacking father, "You are always telling him why doesn't he do any work," then attacking mother, "But you mess it up and leave all the junk around," must relate to his symptom maintenance in that he is involved in creating conflict as well as diverting his parents from any resolution they might achieve as a dyad. He is continually involved in this process -- but why? Winnicott (1966) suggests an answer:

Naturally, when the personality is dissociated, dissociations in the environment are exploited by the individual. An example would be the use made of a tendency in the mother towards disintegration or depersonalization, of parental discord or of the breakup of the family unit... (p. 515)

Winnicott is pointing out that children with a psychosomatic illness will take advantage of marital discord, they will use it so they can maintain their own dissociation and prevent a premature integration which would, in Winnicott's terms, lead to "annihilation" or depersonalization. Family therapists are well aware of the child's active involvement in the family system. But here is another explanation of the patient's involvement in his family system: the patient's loy-

alty is to his own potential integration and his own fear of unintegration or depersonalization and he will exploit any opportunity to keep his dissociation.

Most families in the present study attempt to create outer harmony and peace and conflict is attenuated. Jackson and Yalom (1966) observed the same in their families:

We were struck by the similarity of behavior among these families when interacting in conjoint family therapy. All the families appeared to be severely socially restricted and actively restricting each other in the range of permissible behaviors. Data collected on individual family members as to their "outside the family" behavior corroborated the impression that they existed in a narrow band of social participation when compared to the group of "ordinary" families under study at the Mental Research Institute. The limitation in the range of interaction, the careful dealing with each other, the handling of a variety of situations in a similar fashion, suggest at one and the same time a feeling of despair and yet a feeling of family sameness that almost seemed like solidarity. Wynne's term "pseudomutuality" best describes the apparently false solidarity of these families. (p. 418)

We are using a different terminology but it is apparent from their summary that we are both describing the same phenomena. Thus it appears that the child's loyalty is to solidarity and harmony. But more disturbed families like the A family reveal what may be going on beneath the "calm." In treatment or if some external stress generated a regression, I would predict some of these families would start to look like the A family and the child's real loyalty would be exposed - he

would protect his own dissociation by supporting discord in the family. Sperling (1946) provides an extreme example:

In this connection it transpired that Robert had been sleeping in his parent's bed since he was an infant... On many occasions, especially during the night, he would soil himself... In this manner he managed to keep his parents awake, to separate them, and so prevent intimacy between them. He would either take his mother's place with his father or preferably keep his father busy emptying the bedpan. (p. 306)

In this example, Winnicott would stress how the child keeps the parents separate, in fact exploits the discord so as to protect his dissociation.

In the B family, the child is not provocative because she is quietly involved in keeping the parents separate, as she is in a symbiosis with her mother with father agreeably on the outside. (See pages 91-92) The child may then quietly maintain a dissociation because she is not threatened by the parents being together.

### Summary

The consistency with which enmeshment, lack of conflict resolution and overprotection has been scored in the families in the present study indicates to me that not only do these patterns relate to symptom maintenance (based on the logic of Minuchin's et al. work), but to a pervasive, underlying schizoid state -- a basic and deep condition of unrelatedness - which accounts for the tenacity of the symptoms as well as the anxious cohesion, the hovering quality and immaturity which

characterize these families. The disease, once it becomes a fact, "solves" a number of problems. First, it works for the child as a defense against depersonalization. In this sense it solves a problem created by not good-enough mothering. Personalization, a feeling that one is in one's body, is a developmental sequence which is naturally achieved if the child experiences continuity-in-being, based on and created through good-enough mothering. Not good-enough mothering leads to a "feeble establishment of indwelling in personal development." (Winnicott, 1966, p. 515) In Winnicott's terms a child with a psychosomatic disorder is in touch with potential personalization through his psychosomatic disorder - and this is its positive value -- "the individual values potential psycho-somatic linkage." But it is also a defense in that it protects the individual against depersonalization. The quality of this anxiety Winnicott stresses when he alternatively refers to it as "annihilation."

The disease is the consequence of a psychological process (introjection), a defensive process which attempts to solve an outer problem (an ambivalent and rejecting mother) by making it an inner problem ("oral-sadistic incorporation of the needed object with all destructive somatic consequences"). That is, the child tries to deal with an insecure outer situation by internalizing it. This creates more trouble than he intended. The disease, however, once it is established, creates a link with mother and a bad mother is better than no



mother. Bad mothers become overprominent, however. Recall these observations from psychological data as recorded by Finch and Hess (1962):

The most important finding is the hypercathexis of the mother-child relationship, with profound and intense interactions resulting in conditional ego functions and inadequate relationships aside from that with the mother.

All view the mothers as dominating and inconsistent, varying between a hostile and/or overprotective figure. All children view their mother as basically rejecting and insensitive to the child's needs, due to her narcissism. (p. 822)

The disease not only serves the child but the mother also.

Engle supplies an anecdote which supports this fact. This is a statement of a twenty-two year old patient:

She (my mother) always had to inspect and regulate, so that when I became sick it was very gratifying to her. She took pleasure in the diet and was completely preoccupied with doing the right thing. She penetrated into all levels of control, even to regulating my bowel movements. Her health was never better than at that time. (Engle, 1955, p. 235)

There is an emotional symbiosis created around illness.

On the level of the family system the sick child may be used as a focus - a homeostatic technique - whose exacerbations may be timed to "save" the system from amplifying beyond the range of its equilibration - that is, as a deviation-counteracting technique. Spurling feels that the child can control the amount of blood and it may be that in the total



system, an exacerbation could be used to control too great a deviation in the system, (i.e., divorce). In Meissner's frame of thought, it may help the family stabilize their system - halting an historical momentum towards decompensation and greater vulnerability.

Many observers have noted the range of psychopathology of individuals suffering with inflammatory bowel disease. In the sickest cases, I believe, all the operations I have described would be at work, incited by the family's "impregnable compromise," (that is the family's use of the disease to solve its psychological problems), which in a sense, frees the somatic components to amplify towards greater physical involvement, surgery or death. (See Pages 35-41) The gastroenterologist is handicapped in that he is working outside the compromise with the somatic elaboration of a complex psychological situation.

## Chapter 8

### CONCLUSION

It makes no difference if it was something in the parents that caused the child's illness. Often this is the case. But the damage was done neither willfully or wantonly. It just happened. (Winnicott, 1968, p. 64)

It may be that we ourselves would rather not be forced to see it too clearly lest we should find a text book in our hearts. (Guntrip, 1969, p. 178)

I believe my last statement in the preceding chapter is a key towards the more successful treatment for children suffering with inflammatory bowel disease. The gastroenterologist is handicapped in that he is working outside the compromise with the somatic elaboration of a complex psychological situation. He is treating the physical consequence of a psychological process and he may be able to moderate this consequence, but he cannot cure it. Sperling's (1967) statement stands out:

It is essential to understand that ulcerative colitis for which no known external or internal etiological cause can be established medically indicates the presence of a psychiatric disorder...

Furthermore, that we not treat the symptom or the diseased organ, but the patient who produces and who needs and maintains these symptoms. (p. 349)

But the psychotherapist is confronted with an intricate and extremely difficult case for all the reasons outlined in the last chapter and especially because the child is enmeshed in his or her family. Winnicott (1966) underscores the possible consequence of individual treatment in a case he failed with:

A child was having an analysis with me because of colitis, certainly a good example of the type of disorder that appears along with the split I am trying to describe. Unfortunately, I was unable to see early enough that the ill person in the case was the mother. It was the mother who had the essential split, and the child who had the colitis. But it was the child who was brought to me for treatment. (p. 513)

Yet family treatment can fail. An experienced family therapist working with a family with a child with ulcerative colitis felt that she had worked well with the family, had successfully restructured the symptom maintaining interactional patterns, yet the child eventually had to have a colectomy.

I believe the only way of succeeding with these patients is to believe that their disorder represents a psychological developmental fault, and to communicate this to the child in terms which Sperling outlines throughout her work. She tells her patients that their symptoms are meaningful and their way of expressing and discharging feelings and conflicts they are not aware of consciously. Within this framework, various approaches could be successful. Sperling works with the child and the mother from the point of view that for the child,

only the mother counts. This is because these children are so primitively organized.

But family therapy might be successful and I believe this problem presents it with a significant challenge. Could it be that the early developmental pathology is so fused into the family system that reworking the system could rework the pathology? One must keep in mind Winnicott's (1966) contribution on the positive aspects of a psychosomatic illness and that the child is not likely to give it up until something has cohered in him which makes it unnecessary.

Given time and favorable circumstances the patient will tend to recover from the dissociation. Integration forces in the patient tend to make the patient abandon the defense.  
(p. 515)

The goal of family therapy would thus be to work with a family with one member who has a disease in a way that makes it unnecessary for the individual to have the disease. The goal should not be to moderate "psychosomatic" inflammatory bowel disease so that it can be considered "normal" inflammatory bowel disease, which would be the goal in the Minuchin frame of thought as expressed in his concept of "primary psychosomatic symptom formation."

There are many details to be considered in treatment, but the next step in research should be a treatment-research project. This would require the cooperation of a gastroenterologist who could believe in psychology-psychiatry and who

would understand their patients need to split the care-taking (medical-psychiatric) provision. That is, these patients and their families will exploit splits in the medical care. (Winnicott, 1966; and Sperling, 1967) This is a process which must be understood. Countertransference phenomena would be critical as these families and patients provoke strong responses in the therapist and physician. These details would depend on the researcher-therapist's orientation. Sperling has had the most success with these patients and her technique is psycho analytic, but in that she works both with the child and mother she is affecting the system.

#### The Need To Know

When a family has a child with a chronic disease, the family has to be affected as is the child. There is no question about this. And it may seem reasonable to think that the family might respond by avoiding conflict, becoming overprotective and enmeshed. This has been the reason to compare the families of children with inflammatory bowel disease to the families of children with a chronic, non-psychosomatic illness. But when one looks very closely a contrast group would not even be required because it does not make sense that a family would react to a chronic illness in the way these families operate. A family would not necessarily react along lines of interpersonal perception as these families react with such global and undifferentiated views of each other. Nor would they



react as the B and G families have where so much of the communication is directed towards the symptomatic child. Or why as in the K family would the father make 80 percent of leadership statements between he and his wife? It does not make sense to consider this kind of activity as a reaction to chronic illness. And it does not make sense because these patterns are signs of deep psychopathology.

In the E family, for example, the young boy is described by his parents as a once active and trouble free youngster. There is one peculiar story about his never finishing a meal, but the parents offered no other information that indicated a pre-morbid history. This youngster is suffering with Crohn's disease and Crohn (1932) argued that the psychopathology of children suffering with Crohn's disease was the result of having a debilitating illness which so dramatically and virulently strikes adolescents. Rossner (1973) and his colleagues also argue this point of view:

Thus, it can be noted that the usual retrospective studies of patients with inflammatory bowel disease often do not take into consideration that a chronic debilitating illness characterized by diarrhea and medical preoccupation with diet may produce many of the characteristics described, such as orderliness, denial and withdrawal. (Rossner, Daum and Cohen, p. 3)

These are reasonable arguments and in the case under discussion, they appear to make sense. But when one looks at this boy in the context of his family, this point of view loses its sub-



stance. One would have to wonder why it is that the family reacts in the way that it does. Would the onset of this disease cause the mother to be so heavily overinvolved with her oldest son, and the father to be as isolated and undermined as he is? (See pages 96-100) And of course the obsessiveness noted by so many authors is a psychological defense related to intraphysic phenomena. It has very little to do with "orderliness," except that the individual is trying to control the inside by controlling the outside.

One has to expect that family members, especially mother, would become overprotective and more nutrient to a child with a chronic illness. Minuchin et al. (1975) understand that a chronic disease can powerfully affect a family. They write:

Once it has appeared, the psychosomatic symptom becomes embedded in but also changes the family organization. Challenged by the chronicity, the unpredictability, and the life threatening quality of the illness, the family members respond by increasing their protective control of the sick child. (p. 1036)

A life threatening illness does create a degree of anxiety in a family which it is likely to respond to with nurturance and overprotection. But why would the family react to disease by avoiding and suppressing conflict as consistently as these families do. And the families in our study group are overprotective, enmeshed, etc., regardless of how sick the child is. The J and L families, for example, have children whose

disease is in remission and they are not on medication, yet statistically and clinically they reveal family patterns which are decidedly enmeshed, conflict avoiding, etc.(1)

Sperling wrote her paper in 1967 because she was alarmed by the increasing incidence of surgery being performed on children suffering with ulcerative colitis. She writes that "the purely medical approach to the treatment of this disease has proven so unsatisfactory that surgery has become a rather frequent procedure" (p. 336). Winnicott, himself a distinguished pediatrician as well as psychoanalyst, pointed out in his 1966 paper, "Psycho-Somatic Illness in its Positive and Negative Aspects," how it is very common for the "well-informed, well-trained and even exceptionally well-equipped" physician to fail in the case of psycho-somatic illness." This is because the "illness state in the patient is itself a defense organization with very powerful determinants." "The psycho-somatist (physician-therapist) prides himself on his capacity to ride two horses one foot in each of the two saddles, with both reins in his left hands," but Winnicott points out that

some practicing doctors are not really able to ride the two horses. They sit in one saddle and lead the other horse by the bridle or lose touch with it.

(1) If the medians of the inactive group were compared to the medians of the comparison group using the sign test, a p value of .000448 would be obtained -- all the hypotheses would be confirmed in the direction predicted.

After all, why should doctors be more healthy in a psychiatric sense than their patients? They have not been selected on a psychiatric basis. The doctor's own dissociations need to be considered along with the dissociations in the personalities of the patients. (p. 510)

Winnicott and Sperling's work in particular have been around for some time. Sperling published her first paper on children with ulcerative colitis in 1946. But this work has not affected the treatment of these children and I believe this is for the reasons Winnicott states above. What exists on the part of the physician is a need not to know about their patients deep psychopathology. And what compounds this problem is these patients' ability to present themselves as normal. This is the patient's inevitable defense which fools the physician. He would probably not be fooled if he were trained or alert to his own feeling responses (countertransference) to his patients and their families. At best, he usually notices a kind of impatience, annoyance or uncomfortableness in his feelings.

What is so oppressively documented in the literature is how troubled both children and adult's suffering with inflammatory bowel disease are, but the medical literature deals with the problem in a cursory, unthoughtful manner. This is from a standard medical text.

Psychologic factors. There has been speculation that psychologic influences mediated through the autonomic nervous system are responsible

for the disease. However, prevailing opinions have diminished support for that hypothesis, and the precise role of psychogenic factors in the pathogenesis of ulcerative colitis remains unclear despite considerable clinical interest in the problem.

The frequency of emotional disturbances in patients with ulcerative colitis and their important relationship to the exacerbations are accepted. Families of children with ulcerative colitis are described as severely restrictive socially. Mothers are commonly dominating, overprotective, and self-centered. Children with this disease are described as emotionally fragile and have increased dependency needs. They are thought to have considerable more disturbance of personality functioning than children suffering from other chronic diseases.

Much more needs to be known about the biologic effects of emotional disturbances on the colon. Ulcerative colitis is more likely an organic disease with psychogenic influences contributing significantly to its activity and chronicity. (Silverman et al. 1971, p. 201)

Many medical texts conclude their discussion of the psychological factors with a statement about needing to know more about the influence of psychological processes on the colon. Engle concluded the same in 1955. It seems as if researchers are always waiting to see that before they would be willing to look at the psychological factors involved in the disease process. If this were an easy experiment it would have been settled, but the technology has not been developed. The medical profession does not want to acknowledge a psychological theory, but Spiering has advanced a theory and has had great

success in treating children. It is as if the medical practitioner cannot imagine what he cannot see. This may be based on his lack of psychological training.

### Limitations of the Present Study

While a more traditional research design might have used raters who were unaware whether they were rating experimental or control subjects, the fact that this study deviated from standard practice does not seem to be too serious a limit. This is indicated because the raters expectation (the second hypothesis) was not confirmed, thus any bias was not actualized.

Certainly the sample could be extended and it would be more persuasive, but if one includes Jackson and Yalom's observations, a picture of family pathology gets established which is impressive. And it should be noted that my sample is not weighted towards the most difficult cases. One child has had surgery, it has been recommended for another, and one child is on high dosages of steroids. All the other children have "milder" cases. Even three cases of ulcerative colitis limited to the rectum have been included. And the sample includes only one case of Crohn's that approaches as severe and virule a case as this syndrome can develop. An extended sample should include more severe cases as well as children who have had surgery.



## Summary

I started this project with some relatively simple and straightforward ideas. I wanted to see if I could extend Minuchin's work with the families of children with anorexia, etc., to the families of children with inflammatory bowel disease. In thinking this out it made sense to me that there should be some correlation between the families of children whose disease process was exacerbating in critical ways -- leading to aggressive medical intervention (steroids) or surgical intervention (colostomy) and the degree of enmeshment, overprotection, etc., in these families. Obversly, those children whose disease course was relatively mild would have families who were less enmeshed, overprotective, etc. This finding would have supported an hypothesis about the families interactional patterns being related to symptom maintenance and would have provided "evidence" to initiate a therapy research project based on strategies designed to restructure the symptom reinforcing and pathological interactions.

The nature of the findings, however complicated this picture and I recognized that Minuchin's theory could not account for the data. What continually impressed me about these families was the degree to which they denied or minimized any indication of conflict and it was this phenomena which I felt had a "deeper" meaning in their lives than only being an indication of their lack of conflict resolution skills. That is,



in Minuchin's theory an emotional conflict in the family may trigger (exacerbate) a psychophysiologic process. The subsidence of the process may be hampered by the family's interactional patterns - i.e., its lack of conflict resolution - hence the child remains "turned on." In families of children with inflammatory bowel disease the same thing may happen, and treatment designed to restructure the family's transactional patterns may moderate the degree of exacerbation. But these families "lack of conflict resolution" which in so many instances is conflict denial and suppression relates to a deeper level of pathology - a schizoid condition of basic unrelatedness and I believe the symptoms are most meaningfully understood in this context.

Paraphrasing Guntrip (1969), it may be that we ourselves -- physician, psychologist and psychiatrist -- would rather not be forced to see it too clearly lest we should find a text book in our hearts. But what choice have we? Psychological treatment of these children and their families will be difficult. Occasionally, it could be dangerous. For all we know now about the inner difficulties that people live with, we know that some children and their parents will not be able to succeed. The skill of the therapist will have to be expert and he should expect failures and confusion, but I feel strongly that research should be organized around a treatment program. And that program should be based on a radical psychological theory.

Sperling's success must be taken into account. Therapy which is not based on the recognition that the disease is a consequence of a psychological process is bound to fail -- as the symptoms then cannot be brought under the ego's omnipotence.

APPENDIX

Scoring Manual

Philadelphia Child Guidance Clinic

# TRANSACTIONAL SCORING

1. Executive
  - 1-1 Leadership
  - 1-2 Control
  - 1-3 Guidance
2. Request for Executive Activity (2-1, 2-2, 2-3 as above)
3. Task Opinion
4. Agree
5. Disagree
6. Affectionate
7. Aggressive
8. Refusal to answer
9. Unscorable - if disruptive, rude, etc. \*
0. Inaudible - if disruptive \*

Note: Circle number of the statement if response is nonverbal or primarily nonverbal. If 2 transactional scores for one communication, put on separate lines (no new number) in order to confusion.

## Who to Who

Label family members in order in which they sit around table from the left (viewer's point of view) to right. Mo = Mother, Fa = Father, So = Son (So1, So2, etc. from left to right, Da = Daughter (Da1, Da2, etc.). After scoring, child labels may be changed or re-identified as index child, control child, etc.

Each speech is coded who speaks to who (Mo-Da1, Da1-Da2, etc.). If the target of speech is unknown or speech is addressed to whole group, leave blank (mo- =Mother addresses whole family) or (Mo-A = Mother speaks to all).

The who to who scoring should reflect the literal speaking pattern. If mother asks a question and son replies with an agreement for Da Task Suggestion, the who for speech should be scored Mo-So, So-Mo.

## 1-1 LEADERSHIP

Calls on people to answer, directs people to answer, or calls for opinion, suggestions or answers. Makes summaries of the answers, asks people if they agree to a certain answer, takes a consensus, etc. Questions whether one or all individuals have finished or have answered.

Directing: Telling someone to turn on the tape recorder if the purpose is to proceed to the next question or to indicate that everyone is finished with a question. Stating what a final decision is. Notate this type of leadership with the abbreviation Dir.; (If person has given opinion before & then gives opinion i.e., Mo-Fa 1-1 Dir. (at end of decision making which leads into discussion of next topic, that person receives 1-1 dir. score)

Task Orientation: Defining the task, explaining what the question is, what the people are supposed to do, whether they are or are not fulfilling the task requirements, what the "examiner" said or wants, and giving information about the content of the task. Notate this type of leadership with the abbreviation T.O.; i.e., Mo-Fa 1-1 T.O.

When leadership is unsuccessful score with a minus sign; i.e., Mo-Fa 1-1<sup>-</sup>. Examples of unsuccessful leadership include behavior such as other(s) laughing at a leadership comment; other(s) not responding in any way to a leadership comment or refusing to answer when directed to do so; other(s) vying for the first speaker's leadership and achieving it around the time the first speaker made leadership comment (Example:

Fa-So2 "Scott doesn't like carrots" 1-1<sup>-</sup> (So1)  
So2-Fa "I know, but he won't have to eat them" 1-1).

Occasionally a leadership statement is incomplete, incorrect, or misleading in some way. For example, Task 2 is often misinterpreted as meaning "a fight that we were all in", or "it means a big fight".

(or two)

The first time that this is misinterpreted, it can also be scored with a minus sign.

Questions can often be scored as leadership especially when asked by parent(s) in order to elicit a particular response. This can be detected by the general conversation.

Special Cases:

- a) A asks B his opinion and makes a suggestion to or for B.

Score 1-1,3 (T.O.)

- b) A asks B his opinion of C's suggestion just given; or tells B what B's opinion should be of C's suggestion.

Score 1-1 (C 3)

"Just given" means the next 2 statements after C gives his or her suggestion. After this time it is often unclear if A's statement questions/clarifies C's suggestion or if it is just A's own task opinion, agreement, disagreement, etc. of C's suggestion.

- c) A gives a general definition or direction about suitable answers or makes a normative statement implying a rule.

Score 1-1 T.O. Statement must provide some clue about appropriate answers.

This may be on the initiative of the speaker A or in response to a request for help or information. However, if the statement is made in response to a leadership question implying "what do you think about ..." the statement should be scored 3 (task opinion) instead. If the statement is just part of a specific objection to a task suggestion (that isn't a meat, that wasn't an argument) score as 5 (disagreement), not as leadership.

- d) A makes an authoritative statement to B about C's behavior implying special knowledge or control of C.

Score A-B 1-1 (C)



- e) Giving information (reminding) about what people have already said or what has transpired in previous transactions.

#### 1-2 BEHAVIOR CONTROL

Control of ongoing behavior during the task. Do not score if control is expressed about some outside situation under discussion (as for example some event that is described in the story of the family argument) or if the beh. relates to the task per se (these would receive task opinion or leadership (T.O.) scores)

Be aware of non-verbal behavior control. For example, parent (s) take child's hand away from tape recorder, remove child's hand from his/her mouth, place a hand on child to keep him/her from moving around or being disruptive, etc. without verbalizing these commands. (discipline issues)

Examples of the responses to be scored here are "sit down", "stop that". Also, "you turn on the tape recorder" if meant to tell the children whose turn it is to avoid conflicts, rather than to suggest going from one question to another, regulating behavior in sense of giving permission or not giving permission.

Indicate when this is unsuccessful by a minus sign. This is apparent when child does not stop the objected behavior. Also note by a minus sign whether control is morally wrong, challenges the test situation, etc. (this is rarely the case).

#### 1-3 GUIDANCE

Similar to Control except that Guidance Behavior:

- a) Contains an explicit or implicit reference to the future or other occasions than the immediate one.
- b) The statement may take a generalized form, such as stating a principle rather than making a concrete point.

(a) and (b) include pointing out a cause-and-effect relationship between the object's behavior and consequences, or normative statements.

c) Teaching of skills and methods.

Examples: "Don't do that again." "Speak louder so that everyone can hear what you are saying." "It's not polite to interrupt all the time."

Indicate when this is unsuccessful by a minus sign.

### 2-1 REQUEST FOR LEADERSHIP

Examples: "What does the question say or mean?; what are we supposed to do?; Who should speak next?"

Da-Mo "How long is this?" 2-1

Da-Mo "What do we argue about?" 2-1

A request stated in an imperative or demanding form, implying request for permission, even if about the task ("Can I be the one to say the \_\_\_?") rather than for direction or information should be scored 2-2 (Request for Behavior Control) rather than 2-1 (request for leadership).

If A asks B about C, making an authority of B about C

Score A-B 2-1 (C)

### 2-2 REQUEST FOR BEHAVIOR CONTROL

Examples: "Can I sit next to you?" "May I turn on the tape recorder?"

### 2-3 REQUEST FOR GUIDANCE

Example: "Why must we take these tests?"

Beware of confusing Leadership, Control and Guidance responses couched in question form with true requests for help, information. On the other hand, children sometimes state requests in an imperative form but are really asking for permission.

All three kinds of requests for executive activity are likely to be followed by some type of executive response unless the request is not answered, in which case a minus sign would be necessary. It is sometimes difficult to distinguish requests for executive activity from other types of transactional scoring. In this case the statement in question may be some type of leadership or task opinion.

### 3: TASK OPINION

Responses answering the Task question (food items on Task 1, information about the family fight on Task 2) and subsequent opinions on these suggestions. On Task 1, the suggestion score is starred (3\*) when the item mentioned is a new one. Sometimes a general suggestion is offered and someone else chooses something more specific. This can be scored as a new Task Opinion if main intent is to add an important new feature. If intent is to express approval (not necessarily to suggestion given) but adds or modifies the process score 3 but not with an asterisk. If two people express two different conflicting modifications, each would get an asterisk. Also, on Task 1, if two or more suggestions are given in the same speech, this is scored 3\* + 3\* etc. If someone registers approval (may be by repetition of the response) or disapproval of a task opinion, whether original or not, to the suggestion or opinion giver, score as Agreement or Disagreement. Otherwise, score remarks of preference for or against prior task opinions as 3. (The for and against aspect will be picked up in the support-oppose scoring). If a yes or no answer is elicited in response to a leading question ("do you like chicken?" or "do you agree with that?") score as 3 unless it is clear that the yes or no answer is an agreement or disagreement with the questioner's own opinion.

Task 1: Score 3<sup>-</sup> for stating what one doesn't want although one has suggested it. For example, "Not water!" when it had not been mentioned until that statement.

Task 2: Score 3<sup>-</sup> to indicate "we have no fights".

Statements are often interrupted and must be scored unscorable (9).

However, task opinions, when interrupted, can often be recognized and scored.

#### 4: AGREEMENT

A statement of agreement, acceptance or approval of a preceding relevant speech communicated to the person who had made that speech: a simple repetition of what someone has just said if said to that person implying agreement rather than questioning it. An elaboration of the preceding speech in addition to agreement may require an additional score as well. Do not score agreement when the yes is an informational answer to a request for Executive activity.

Examples: Da-A: "How about roast beef?" score 3  
So-Da: "Roast beef." score 4

Fa-Da: " Let's decide on the meat first." score 1-1  
Mo-Fa: " All right. What do you want for meat?" score 4 and 1-1

So-Fa: " Are we supposed to start?" score 2-1  
Fa-So: " Yes." score 1-1

There are some cases of token agreement that have underlying qualities of disagreement. Therefore, do not always take agreements verbatim.

For example, So-Fa: "All right, I'll take milk but I won't drink it."

#### 5: DISAGREEMENT

A statement of disagreement, nonacceptance or of disapproval of a relevant preceding speech communicated to the person who made that speech; just giving an alternative response is not necessarily a disagreement unless the statement clearly implies that it disqualifies the first one.

A further elaboration of the speech giving alternatives or contradictory or other information may require additional scoring. If the primary characteristic of the speech is something else (a leadership which by its import disqualifies the preceding speech may be sufficiently scored leadership, and the oppositional or disagreeing quality will be picked up in the support-oppose scoring). A contradictory or competitive leadership response made after a leadership response is not a disagreement unless expressed to that person and the disagreement aspect is clearly specified.

Examples: Mo-A: "The fight started over Joe." score 3  
 So-Mo: "No, it didn't." score 5  
 Da-A: "I want milk." score 3  
 So-Da: "Ugh, not me." score 5  
 Mo-A: "Let's go on to the next." score 1-1  
 Da-Mo: "No, we haven't finished yet." score 5 and 1-1

[Fa-A: "How about cake?" 3\*cake [Fa-A: "How about cake?" 3\*  
 So-Fa: "I want ice cream." 3\* I.C. [So-Fa: "I want ice cream instead." 3\*  
 Da-A: "That's when it happened." 3  
 So-Da: "No, it didn't." 5  
 Fa-So: "Yes, it did." 5

To distinguish further between disagree & task opinion:  
 If "all" or several people speak to someone & he answers "all" negatively, score as 5.  
 If "all" or several addressing all or others and person responds to "all" with a negative task opinion, score 3. No direct interchange one way or the other.



6. Affection-praise enhancing esteem

May be scored alone or be part of an answer receiving another score as well.

example: "That's terrific suggestion" "You always have good ideas"  
"She's wonderful when it comes to helping"

If the remark pertains to another person than the one addressed, indicate who after the score and circle or write in different color for emphasis.

Mo-Fa 6 Da

7. Aggression

A personal attack or derogation, ad hominem attacks. Global characterizations "you always", "you never", could be sarcastic.

Do not score for non-derogatory criticism of behavior which can be scored Behavior Control or for simple mention of behavior in task question where this may be part of the task answer "Joe and Mary started it".

Score the transactional rather than merely retrospective. However aggressive responses may occur around these task responses - pay attention to blaming, or derogatory elaborations of factual events which currently express hostile attitudes.

Example: "That's a dumb idea"

"She always starts all the fights, she loves fighting"

"You don't know what you want" (said in exasperating tone)

Mo-Fa 7

Mo aggressive to Father

Mo-Fa 7 Da

Mo makes aggressive remark about Da to Father



8: REFUSAL TO ANSWER

Examples:

"I don't know." (sometimes)

"I don't care."

"I don't want to answer."

"I can't think of anything."

Laughter in response to a direct question.

A shrug which carries no answer in response to a question.

Absolutely no response to a direct question.

9: UNSCORABLE

A response which is audible but incomplete or cannot be squeezed into one of the above categories.

Examples: "Oh!"

"Huh?" score 9 (also score 9 if a statement is repeated in response to "Huh?" and it already has a previous score.)

If a statement is partially stated & can be interpreted as 3, etc., give it that score unless the same statement is said later in which case the partial statement would get a 9 score.



ALLIANCE SCORING MANUAL

A. Support: This is scored for a broader category of responses than those included under agree in the transactional scoring. A response scored Leadership could include support for someone's position or as a person etc. For a response to be scored support there should be some indication of an alignment with, agreement with or support for someone else's position.

a) an agreement with or repetition of or expression of preference for someone's Task suggestion (could be one's own, see below)

b) support for or agreement with someone's Leadership, Control, Guidance in relation to others or to all. (not if L,C,G just applies to self) May be said to one person but apply to all or to other individual.

c) A Leadership response which selects one person's alternative Task Suggestion over another, or which reinforces another's Leadership response, (or a Control or Guidance which similarly reinforces another's response).

d) An affection response or responses defending person against attack.

Scoring: with a + indicating who is supporting who, and what is being supported

The who-who is not necessarily the same as the who to who for speech.

examples: So + Da 3 (milk)	So supports Da Task Suggestion
Fa + Mo 1-1 to all, or to C	Fa supports Mo Leadership
Da 6 + Mo	Da is affectionate to Mo or about Mo or defends Mo
Da + own 3 (milk)	Da under attack supports own Task suggestion
Da + self	" " " defends self

FOR TASK QUESTION 1

Next to 3\* score, write in content of the original task suggestion so you know who made it. Later supports, opposes etc. are scored in reference to that original score. (Put in content here too. A+B chicken)

Only exception -- if one person suggests an array of things to pick from and A picks one, B picks another and an argument ensues, score as if suggestion by A + B.

Warning -- if A disagrees with B, not necessarily scored as A opposes B if the disagreement is over C's suggestion (even if C not involved in dispute. ) For example

So 3\* milk

Da 3\* soda

MoDa 5

Mo - Da soda

Fa Da 3

Fa + So milk

Da Fa 5

Da - So milk

TASK 1

expression of preference or rejection of food items scored only as + item or -item in alliance column each time stated (except when repeated on request due to hearing difficulties). This is done whether the transactional score is a 3, 4, 5, 1-1 etc.

Food item written transactional column only when original (first time)

Score alliance scoring only when there is a conflict -- see definitions

If A makes a 1-1 to B supporting a certain suggestion or opposing it and C seems to support A's remarks -- try to judge whether it is the 1-1 part that is being supported (C + A 1-1 B) or whether it is the task suggestion part that is being supported (A 1-1 B A + X's task suggestion)

(C 3 C + X's task suggestion)

## FOR TASK QUESTION 2

Do not have to follow task suggestions through (you haven't marked who was original maker anyway) -- go more by immediate context of give & take in conversation but indicate if it is (3), (1-1), (6), (7) that is being supported etc.

A + B (3)

A + B (-) C

A + B 1-1 All etc.

Note when a new argument suggestion is suggested with an \* as in Task #1. Do not follow through on this as much -- we just want to note who suggests & what happens to these suggestions.

A later repetition of task content alone should not be scored support unless it is clear there is some controversy or support for the person clearly indicated.

### SUPPORT/OPOUSE LEADERSHIP RESPONSES

Do not score acquiescence or acceptance of a leadership, Behavior Control or Guidance response to self alone as support or oppose. Do score support or oppose if the 1-1 etc is made to others or to whole group or about them or having implications for them. Look to see if support/oppose has been picked up in transactional column as agree, disagree -- if not, score in alliance column.

B. Oppose: An opposition to someone or their position

- a) Disagreement with or rejection of someone's Task suggestion, Leadership, etc.
- b) Through a Leadership response actively squelching someone's Task suggestion (not just leaving it out or picking someone else's) or squelching or contradicting another Leadership response.
- c) Aggression response to or about someone

Scored with a minus sign, indicating who is opposing who similar to support scoring above.



examples: So 7- Da So is aggressive to or about Daughter  
 So - Da 3 milk So rejects Da Task suggestion  
 Fa - Mo 1-1 So Father rejects Mo Leadership to So. or offers clearly  
 contrary or contradictory Leadership.

C. Alliance A joins B against C scored as A + B - C Alliance

examples: So + Fa7 - Da So agrees with and repeats Fa aggression to or about  
 Da  
 Mo + So - Fa3 Mo supports Son's rejection of Fa's Task Suggestion  
 Fa + Da3 - So So and Da have been arguing about Da's Task suggestion  
 Fa joins in Da's defense of her Task suggestions  
 against So's criticisms

A hint of where to look for alliances — if one person says a statement & another person immediately states the exact same thing (almost word for word), there is a possible alliance. Especially likely if person says "yeah, \_ \_ \_."

Should be clear that the third party is coming in to support one against the other. Not scored if A is against B's suggestion and later C is against B's suggestion independently. (A's response is scored as A-B3 and C response is scored as C-B3)

D. Recruitment

Positive instance: A tries to persuade or urges B to support C

SCORED A ++ C (B)

Negative instance: A tries to persuade or urges B to oppose C

SCORED A -- C (B)

examples: Mo- "Milk" Da-So "Let's have milk" Da ++ Mo 3 milk (So)

Mo "Milk" So "Yeah" Da-So "You don't like it" Da -- Mo 3 milk (So)

E. Appeal A soliciting support for himself from B "Wasn't that the way it happened"

"Don't you want milk (own suggestion)"

A++ own milk

A ++ self



F. Disaffiliation Doesn't take a position or make a decision - may make reference to a task suggestion but give no indication of own opinion "What do you mean, apples" "I don't care what we have" "Milk? Hmmm"

SCORED ? example Mo ? Da milk

Used only when person is asked to decide between 2 choices, persons, etc. -- used mostly during conflict.

G. Alliance Shift A sudden swing from one position to another:

- a) A has been supporting B, after intervention by C shifts to oppose B or to support C instead of B
- b) A and B both critical of C, B suddenly shifts to defend C against A
- c) A gives up own position to actively support or recruit for another, even contrary, position.

Do not score if for a final consensus, there is simple acquiescence to a final answer which excludes a position one has previously held.

-- alliance shift only if task opinion, etc. has been supported or opposed. If an opinion gives changes opinion, no shift score is necessary.

Examples

1. Da - Task Suggestion	3	2. So - TS	3
Fa - Supports Da TS	Fa + Da 3	Da - Supports So TS	Da+So 3
So - Opposes Da TS	So - Da 3	Mo - Opposes So TS, Offers own TS	Mo-So 3 3
Fa - Supports So	Fa + So - Da 3	Da - Recruits So to Support	
Opposes Da	Alliance Shift	Mo TS	
		Da ++ Mo 3 (So)	
		Alliance Shift	

3. Task 2 - Mo and Fa critical of child in fight story, support each other's criticisms, child may or may not defend self, Mo shifts and disagrees with Fa, supports child and defends his behavior, Fa may or may not shift himself into support for the child.

A. No conflict emerges

1. Structuring situation to avoid different opinions or critical opinions or redefining task to avoid conflict - each one is assigned separate role or portion of task and no alternatives called for; one person might do all the talking, others only have to agree or not disagree. Marital disagreements openly excluded.

2. As soon as one opinion expressed, instant agreement, consensus.

3. Denial of conflict or disagreement even to extent of not doing task; inability to give critical opinion of others even when required. ("I can't think of anything" "There's nothing I don't like")

B. Hints of conflict emerge but kept in check by the following methods:

1. Suppression. After appropriate or minor disagreement expressed or conflict described, pressure is applied. "Remember, we must all agree" after a few or only one alternative task suggestions offered; "Don't let's have a fight now"; trying to get a person to retract critical answers on task 3 by reasoning etc. even though this is task requirement. "You're giving the wrong impression."

2. Minimizing. Reducing something to nothing; "That's not important, that's just a little thing" "Not a fight, just a little disagreement" minimizing differences between two positions or saying two things are the same when they are different.

3. Straw man exaggeration. (Related to fear of small conflict becoming a devastating conflict) "Fight means like you can't stand it any more" "They want to hear about really bad things" "I can't remember any time when we all exploded together."

4. Rhetorical questions. These raise false or exaggerated issues about blame or conflict which obviously pull for a reassuring answer; "Do you think I'm to blame because I ...." In the meantime, the real issues are obscured.

5. Cuing. Hinting or stating that what A is saying or about to say will hurt or anger B - may be in the form of joking - mock threats of reprisal "If you're going

to talk about me, maybe I should leave the room ha ha."

6. Undoing. After critical or conflictful remark (or before it) speaker retracts, minimizes it or praises or says affectionate or nurturant things to moderate the blow.

7. Giving up, at least sign of opposition, or difference of opinion to avoid further conflict or confrontation.

C. Conflicts, disagreements, complaints etc. expressed by one or more family members but no resolution due to one or more other family member's behavior.

1. Evasion-avoidance. No response when it would be appropriate or actual refusal to answer for example on task 3; describing actual escapes, or withdrawal from conflict or potential conflict via recreation, work or other activity; non-remembering of situation or issues involved in dispute; changing subject to avoid confrontation. (especially to non-conflict topics)

2. Reductio ad absurdum. Laughing at complaint or serious disagreement which is not funny to the other; teasing or ridiculing responses about someone's conflict statement; not taking the other seriously; (may be expressed in pseudo affectionate way "You're cute when you're mad").

3. Rationalizing. Diminishing conflict by "objective reasons" "That shouldn't bother you because ...." "You may feel that way but the fact is ...." Attempting to eliminate conflict by logical explanations of facts or reasons.

4. Show stoppers. Strong, inappropriate (may be matter of degree) stress responses to task questions, crying or getting very angry on task 2 or 3 at having to say something bad or hear something bad. It may not stop the show but alter the course of the discussion, inhibit free expression by others or get one off the hook.

5. Global solutions which mask or displace conflict: Self-blame "It's all my fault" Other-blame "If only you didn't ...." "She always gets too excited and that's the only thing." Externalizing - everything would be all right if only the job, extended family, money, doctors, etc. could be taken care of.

6. Personal attacks which are not just part of conflict but distract & lead away.

## ENMESHMENT SCORING

### A. Blurring of separate identities

#### 1. Mind reading - (M.R.)

a) Suggesting one's own response to another if that person response or hasn't expressed an opinion. Should have the implication "I know what you want, think, feel "Not A MEDIATED RESPONSE

b) A tells B what C wants, thinks, feels when C hasn't so indicated - might be telling the whole group - THIS IS ALSO A MEDIATED RESPONSE (See 3 below)

WHETHER A MEDIATED RESPONSE OR NOT, THE NOTATION FOR MIND READING IS TO WRITE THESE WORDS OR JUST M.R. IN THE ENMESHMENT COLUMN

#### 2. Personal control - (PC)

A speaks authoritatively, usually to a third party C, about B - what B may or may not do, etc. have or what B typically does, in such a way as to imply a special kind of ownership, special relationship or exclusive knowledge about others limitations or regulations. This relationship may be indicate also when C asks A what B can have or do. When involving three parties this way WOULD ALSO BE SCORED AS MEDIATED. TO NOTATE THE PERSONAL CONTROL, WRITE THESE WORDS OR P.C. IN THE ENMESHMENT COL.

#### 3. Mediating responses - (Med)

These are responses made by a person acting as a pathway between two other people or to a person which puts him/her in the position of being a pathway between the speaker and a third person. These responses replace direct communication between A and C---A asks or tells B about C or something C has said. To indicate who is the "mediator" or "go-between" circle the person's label in the who-to who scoring. The third party in the mediation (the one being mediated about, so to speak) should be noted in parentheses following transactional score.

Ex. 1. Mo-Fa 3\* (So) M.R. "Peas because he likes them"

Ex. 2. Da-Mo 2-1 (So) P.C. "Will he eat that"



Ex. 2. Mo-Da 1-1 (So) P.C. "Yes, he will"

Ex. 3. Fa-Da 3\*, 1-1 M.R. "Potatoes, you like potatoes" Not a mediated response

A mediating response does not have to be a mind-reading or personal response as well. If A unnecessarily repeats and/or passes on information from B to C this would also be scored as mediating. Don't forget to add the (B) after the transactional score and to circle A in the A-B (who to who) scoring, so we know who is mediating between whoms.

## B. Distance

1. Handling- touching, patting, holding hands, tapping, hitting, poking (non-aggressive), brushing hair, wiping someone's face.
2. Closing the gap- looking close into someone's face, moving one's seat closer to someone else's, whispering into someone's ear, private conversations.
3. Joint affective reactions- crying in unison, laughing in tandem as replacement for communication to indicate closeness - private jokes.

## C. Reactivity

1. Affective tone - Inappropriate tone in response to another's remark or answer - may have a startling quality to the viewer - for example, an unusually vehement "no" or excessively demonstrative agreement, histrionics, sarcasm, noises of delight or disgust, crying, hysterical laughter for minor jokes, etc.
2. Affective engagement (more than one exchange) - a series of teasing, protective, joking, aggressive or argumentative responses and counter-responses, which may spread from one dyad to the group - generally gets the discussion away from the task.
3. Distractive engagement (more than one exchange) - a series of interchanges which get away from the tasks - the family may get involved in some private or family discussion, or involved in circumstantial detail over an issue generated by the task originally but which leads away from main issue.



PROTECTIVENESS SCORING

1. Transactional - On all or any item

- a) concern with hunger (don't score just for references to anorexia unless great concern and worries indicated over the person)
- b) concern with or easily affected by signs of stress or distress, physical well-being of others
- c) "comforting" behavior
- d) excessive or inappropriate unwillingness or reluctance to "disturb"
- e) pacifying or conciliating behavior, accomodating to elicitation behavior

elicitation protectiveness

exhibiting stress - crying, complaints of hunger, fatigue, headache, pain, fear, etc. possibly heat & cold - soliciting sympathy or nurturant care

2. In question 2 argument discussion - shifting in discussion of conflicts from issues to concern about feelings, worries, illness etc. explaining away behavior in terms of worries, illness etc.

3. Preoccupation with these issues in picture stories, (item 4) skewing stories around themes of illness, worries and excessive concern with feelings (not just saying child on card 1 feels bad or that children in card 2 are frightened or worried, that is too common)

"Protecting" themes or danger themes in picture stories. Mother protecting children against father, children protecting parent against parent etc.

## FAMILY ARGUMENT

- A. Complete conflict-behavior scoring and conflict-alliance scoring (especially shifts) for rest of item ( especially covert alliances and recruitments.

Look for scapegoating as well as disagreements, and alliances around leadership (e.g. undermining).

ex. of a shift-- Mo and Fa both criticizing child (Mo may have originally brought up issue) then Mo suddenly reverses and defends or supports child.

In other words, don't only go by literal alliance definitions from transactional scoring around disagreements in telling story etc. but also look into content go back and note any missed in 1st 5 minutes if doesn't show up any place else.

- B. Content scoring

---For each conflict mentioned

1. Number of different arguments, conflicts or disagreements referred to and specificity of each.

specific- particular argument or occasion referred to, details and sequence reasonably clear.

general- something that is "always" or "usually" a problem rather than a specific occasion or instance.

vague - poorly defined issue referred to, hardly explained, unclear as to topic or incident.

2. Content of argument in brief, who involved and course of dispute if possible - use subsystem labels and problem content areas a/la item 3, may be a series of interchanges

particularly note parental involvement, if any, either as participants in disagreement or in reference to resolution of the issue of conflict, whether they support each other, explicitly or implicitly or undermine each other, differentially support or attach child.

if parental dispute (between spouses) look for alliances of child with one parent against other, children's involvement in resolving recruitments, disaffiliations, etc.

if dispute between parent & child or among children, or whole family, look for parental executive behavior (presence or absence) differences of opinion, ineffectiveness in resolving conflict, or parents involved in dispute as peers with children, or children resolve via executive behavior or conflict resolved in some other way (escape avoidance etc.)

C. Overall Rating of treatment of conflict material by the family

denial conflict is bad, we don't have any at all, or settle on excessively trivial one, suppression maneuvers generally successful

avoidance, minimizing may mention several real ones by deny emotional significance, reduce or discard all

diffusion bring up many global, mish-mash ones or one long drawn out story or issue but confusing, side-tracking discussion, irrelevancies, feeling of confusion about who is doing what, blurring content, shiftiness within stories

resolution vs. non-resolution fairly clear discussion, conflict issues emerge even if individual family members obfuscate or distract but distinguish those where there is some feeling of closure, ending, resolution even if not completely satisfactory to all vs. one where you are left hanging or there is a feeling that the conflict is continuing, unresolved or just left to fizzle out

(note if resolved in past or just now in task)

Column 1Who is speakingabout whose behavior

Mo	self
Fa	Mo, Fa
Dal	So 1, Dal, etc.
Da2	Children (as a class)
So1	parents (as a class)
etc.	whole family

In this column, indicate Mo-Fa for Mother speaks about Father etc. If remark is about family as a group or children as a group (unidentified as individuals) write Mo-children for Mother speaks about children, Fa - family for Father speaks of family as a whole ("everyone in the family, the whole family, all of us"). If two or more named or addressed individuals are described in a joint activity (..when A and B fight) score as Mo-A, Mo-B, etc. and bracket. If the speaker thinks the question means what does he or she like or not like to do, score self (even if activity involves others or not) - the emphasis in these cases is not on evaluating others in the family, or their demands on him.

Column 2

Differentiation of Person(s) spoken about.

- a. DIFF(ifferentiated): speaks about particular family member, gives specific labels, describes the person or his or her behavior in different terms from other family members, may elaborate, perception of that person is clear, unambiguous, somewhat unique
- b. SEMI(differentiated): speaks about particular family members but the content is the same or very overlapping, or talks of two or more at a time, also for vague, non-specific content.  
e.g. "A is helpful, B is helpful," etc. or "A and B both fight with each other" -- "A is a good kid", or "B is immature" without specifying what this means.
- c. UNDIFF(ifferentiated): people are described in a class ("I don't like when you kids do" or Da to Fa and Mo ("I wish you two would...") or So says "Don't like when everyone picks on me"
- d. GL(lobal): Whole family referred to in a mass (I like it when we're all getting along) or (I wish we were all more neat)

These ratings should be done separately for like and don't like parts since they may be different- May be global for all on the "like" part and differentiated for only two family members on the don't like part etc.

\*\* The "other" may be implicit -- for example, if the child says to the mother "I don't like to have to take out the garbage" he is really complaining about her so would score Mo in this instance, that is So - Mo

Self is scored for "I like to sew, watch television, etc." or "I like to play with the kids"

SCORING TASK 3 (cont.)

(If one person receives same label from several or all family members - note number of the other response(s) in the Diff. column)

- a) if no answer (bad or good) given about someone - leave blank \*
- b) if refused to answer, write refused \*
- c) if can't think of something, write d.k. \*  
(i.e., "There's nothing I don't like." "I can't think of one." "I like everything." "I don't like anything.")

\* Write this in appropriate content areas column

Column 3 - Subsystem involved

Describes the subsystem involved in the described behavior in relationship terms - that is, the people involved are identified by their relationship to the speaker.

terms: Self, Fam(ily)  
 Par(ent) when remarks made by children  
 Sib(s) " " " " "  
 SP(ouse) " " " " parent  
 CH(ild) (s)" " " " "  
 EX(trafamilial) " " " anybody

examples: Mother is talking about Fa's behavior to child or children  
 score SP---CH(S)  
  
 Mo is talking about one child's behavior to another  
 score CH---CH  
  
 Mo is talking about Fa behavior to herself  
 score SP---Self  
  
 Fa is talking about his own activity with child (I like to play with her)  
 score SELF---CH  
  
 Child is talking about Fa or Mo to self PAR---SELF  
 other child to self SIB---SELF  
 Mo to Fa PAR---PAR

Anybody talking about what they like to do with or to another person, score SELF---That person---example might be SELF---EX(trafamilial)

If preference for solitary activity---score SELF ONLY ("I like to sew")

The sub system may not be explicit - that is the activity or attribute of the person described may not be specified as impinging on anyone in particular. Decide if there is an implicit reference to self or to others and put it in. If unsure, parenthesize.

Ex. Mo "You are not a good father" score as Sp-Ch(s)

So "Don't like it when you scream" score as Par-Self or Par-Fam depending on context.



May be a reference to a persons relation to a bunch of others at a time  
or of the whole family mass together

Mo talks about Fa relation to whole family score SP-Family  
(I like Daddy because he takes care of us all)

Child talks about someone in relation to himself plus to another  
(We (mommy and I implied) don't like it when you scream)  
scored Par---Self + Oth. Par

Child talks about parent in relation to self plus sibs Par-Self + Sibs  
Child talks about parent in relation to sibs only not including self  
score Par-Sib

Mother complains about children and Fa's joint treatment of her  
score SP + Ch(s)---Self



## REFERENCES

- Alexander, F. Psychosomatic Medicine. New York: W.W. Norton and Co., 1950.
- Baker, L., Minuchin, S., and Rosman, B. The use of beta-adrenergic aspects of juvenile diabetes mellitus. In: Diabetes Mellitus: Diagnosis and Treatment, Vol. II. Editors: G.J. Hamwi and T.S. Danowski. American Diabetes Association, New York, N.Y.
- Bush, G. Unpublished Lecture.
- Cohen, M. Personal Communication.
- Crohn, R.W., Ginzberg, L., and Oppenheimer, G.D. Regional ileitis. Journal of the American Medical Association, 1932, 99, 1323.
- Daum, F., Boley, S.J. and Cohen, M.I. Inflammatory bowel disease. Pediatric Clinics of North America, 1973, 20, 933-942.
- Devroede, G.J., Taylor, W.F., Sauer, W.G., Jackman, R.J. and Stickler, G.B. Cancer risk and life expectancy of children with ulcerative colitis. New England Journal of Medicine, 1971, 285, 17-21.
- Engle, G.L. Studies in ulcerative colitis III: the nature of the psychologic processes. American Journal of Medicine, 1955, 19, 231.
- Fairbairn, W.R.D. Psychoanalytic Studies of the Personality. London: Routledge and Kegan Paul Ltd., 1952.
- \_\_\_\_\_. Observations on the nature of hysterical states. The British Journal of Medical Psychology, 1954, 27, 105-125.
- Finch, S.M. and Hess, H.H. Ulcerative colitis in children. American Journal of Psychiatry, 1962, 118, 819-826.
- Fisher, K. and Foge, B. Psychological correlates in children with ulcerative colitis. Proceedings of the 81st Annual Convention of the American Psychological Association, 1973, 8, 517.
- Gerard, M. Genesis of psychosomatic symptoms in infancy. In: Deutsch, F. The Psychosomatic Concept in Psychoanalysis. New York: International Universities Press, 1953.
- Goldgraber, M.B. and Kirshner, J. The histopathology of the experimental hypersensitive state in the gastrointestinal tract. Archives of Internal Medicine, 1958, 102, 13.

Guntrip, H. Schizoid Phenomena, Object Relations and the Self.  
New York: International Universities Press, Inc., 1969.

Hawk, W.A., Turnbull, R.B. and Farmer, R.G. Regional enteritis  
in the colon. Journal of the American Medical Association,  
1967, 201, 738.

Jackson, D. and Yalom, I. Family research on the problem of ul-  
cerative colitis. Archives of General Psychiatry, 1967, 15,  
410-418.

Karosh, A., Daniels, G., O'Connor, J. and Stern, L. The response  
to psychotherapy in chronic ulcerative colitis I: pretreatment  
factors. Psychosomatic Medicine, 1968, 30, 255.

Kirshner, J.B. Ulcerative Colitis = mysterious, multiplex and  
menacing. Journal of Chronic Diseases, 1971, 23, 681-683.

Korelitz, B.I. Ulcerative colitis in children. New York State  
Journal of Medicine, 1964, 64, 1851-1856.

\_\_\_\_\_ and Gribetz. The prognosis of ulcerative colitis  
with onset in childhood: II. The steroid era. Annals of  
Internal Medicine, 1962, 57, 592-597.

Lepore, M.J. The importance of emotional disturbance in chronic  
ulcerative colitis. Journal of American Medical Association,  
1965, 191, 819-823.

Lidz, T. and Rubenstein, R. Psychology of gastrointestinal dis-  
orders. In: Arieti, S., (ed.) American Handbook of Psychiatry,  
Vol I: New York: Basic Books, 1959.

Mahler, M. On the first three subphases of the separation -  
individuation process. International Journal of Psychoanalysis,  
1972, 53, 333-338.

McDermott, J.F. and Finch, S.M. Ulcerative colitis in children:  
reassessment of a dilemma. Journal of the American Academy of  
Child Psychiatry, 1967, 6, 512-525.

McKegney, F., Gordon, R. and Levine, S. A psychosomatic compari-  
son of patients with ulcerative colitis and Crohn's disease.  
Psychosomatic Medicine, 1970, 32, 153-164.

Meissner, W.W. Family dynamics and psychosomatic processes. Fam-  
ily Process, 1966, 5, 142-161.

Minuchin, S., Montalvo, B., Guerney, B.G., Rosman, B. and Schumer, F.  
Families of the Slums. New York: Basic Books, 1967.

- Minuchin, S., Baker, L., Rosman, B., Liebman, R., Milman, L. and Todd, T.C. A conceptual model of psychosomatic illness in children. Archives of General Psychiatry, 1975, 32, 1031-1038.
- Mohr, G.J., Josselyn, I.M., Spurlock, J. and Barron, S.H. Studies in ulcerative colitis. Psychosomatic Medicine, 1958, 1067-1076.
- O'Connor, J., Daniels, G., Karush, A., Flood, C. and Stein. Prognostic implications of psychiatric diagnosis in ulcerative colitis. Psychosomatic Medicine, 1966, 28, 375.
- Patterson, M., Castiglioni, L. and Sampson. Chronic ulcerative colitis beginning in children and teenagers: a review of 43 patients. Digestive Diseases, 1971, 16, 289-297.
- Prugh, D.G. The influence of emotional factors on the clinical course of ulcerative colitis in children. Gastroenterology, 1951, 18, 339-354.
- Rosner, B.L., Daum, F. and Cohen, M. Chronic inflammatory bowel disease: psychological consequences in adolescence. Pediatric Annals, 1973. (available through Adolescent Division, Montefiore Hospital, Bronx, New York)
- Silverman, A., Roy, C.C. and Cozzetto, F.J. Pediatric Clinical Gastroenterology. Saint Louis: C.V. Mosby Company, 1971.
- Sperling, M. Psychoanalytic study of ulcerative colitis in children. Psychoanalytic Quarterly, 1946, 15, 302-329.
- \_\_\_\_\_. The role of the mother in psychosomatic disorders in children. Psychosomatic Medicine, 1949, 11, 377-385.
- \_\_\_\_\_. Psychotherapeutic techniques in psychosomatic medicine. In: Specialized Techniques in Psychotherapy, ed. G. Bychowski and I.L. Desput. New York: Basic Books, 1952.
- \_\_\_\_\_. Psychosis and psychosomatic illness. International Journal of Psychoanalysis, 1955, 36, 320-327.
- \_\_\_\_\_. Unconscious phantasy life and object-relationships in ulcerative colitis. International Journal of Psychoanalysis, 1955, 41, 450-455.
- \_\_\_\_\_. Transference neurosis in patients with psychosomatic disorders. Psychoanalytic Quarterly, 1967a, 36, 342-355.

\_\_\_\_\_. Ulcerative colitis in children: current views and  
therapies. Journal of the American Academy of Child Psychiatry,  
1967b, 5, 336-352.

Winnicott, D.W. Psycho-somatic illness in its positive and nega-  
tive aspects. International Journal of Psychoanalysis, 1966,  
47, 510-516.

\_\_\_\_\_. Through Paediatrics to Psychoanalysis. New York:  
Basic Books, 1975.

