THE ADOPTED SISTER

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Case Presentation

Ginny, a beautiful Vietnamese child of nine, was adopted by the Banners when she was three months old. The Banners have one daughter, Molly, who is five years older. Ginny can be socially charming. She likes to engage her older sister's friends and hang out with them, but, sometimes, having insinuated herself into the teenager's circle, she will wreck everyone's good feelings by "clowning" (Molly's word), talking baby talk, or speaking in nonsense syllables. This behavior embarrasses Molly when she is unable to get Ginny to stop or to go away. The scene rapidly becomes an angry shouting match between the sisters, who are unable to resolve their differences or separate without adult intervention. In these circumstances, Mrs. Banner tends to become hysterically angry, mostly at Ginny, and her anger unnerves Molly, who "goes to pieces."

The therapist has known the Banner family for three years, but they have met with her regularly only during the past four months. Mr. and Mrs. Banner are bright, attractive, and successful. He is an engineer. She was formerly a busy interior designer. Since giving birth to their older daughter, Mrs. Banner takes occasional jobs but prefers to devote her energies to home and church activities. After several miscarriages, the Banners adopted Ginny.

Ginny's parents are concerned that she might be hyperactive. She can be extremely difficult to deal with at home, refusing to obey, challenging requests, blaming her mother, thwarting family routines (by not going to bed on time, for example), staying in bed instead of dressing to go to school, and generally alternating between misbehaving and clinging. Mrs. Banner nearly always has to deal with Ginny's tantrums and immaturities alone, since her husband works long days at the office and is often out of town on business trips. When Mr. Banner happens to be home and is drawn into the family disputes, he also tends to become angry at Ginny for acting out.

Molly is a sensitive child. She is plainer than her sister, who has flashing black eyes and black hair. Aside from reacting to Ginny's provocations, Molly frequently expresses considerable unhappiness. Her parents do not understand her and feel a lack of closeness with her. When the family is at its most disrupted and angry, Molly expresses hatred toward Ginny, tells her she wishes she were dead, and strikes at her physically. At other times, the sisters

enjoy being with one another. Both have mercurial changes of mood.

Ginny was disruptive in kindergarten and first grade. She would not wait her turn and sometimes would intrude on another's artwork or block construction. She was often the center of commotion in class. When she tipped her chair over backwards, flinging her coloring book and crayons in all directions, it appeared to be part of a pattern of drawing attention to herself. Although she followed her teacher around, evidently wanting her affection, Ginny would often ignore directions. Even when given ample notice, she would dig her heels in and refuse to leave an activity she was engrossed in to go to the next one.

During the therapist's classroom observations and in testing, Ginny did exhibit moderate hyperactivity. Intrapsychic conflicts involving fears of being abandoned, guilt, and fantasies about her real family appeared to underlie her disruptive behavior and rejection of limits. Despite her problems, she was liked by her peers. By contrast, Molly worried about being accepted. At her saddest, she withdrew and her parents did not know how to communicate with her.

Mr. and Mrs. Banner maintain that they have a good marriage, and they decline to talk about problems they may have in relating to each other. The therapist has the impression that Mrs. Banner may wish to say more but that

she is inhibited by her husband. Mr. Banner is not especially intimidating, but his wife appears to feel she must respect his reserve. The Banners are somewhat ashamed of being involved with a therapist at all.

During the first year following their referral, the Banners wanted nothing more than help in understanding the test data on Ginny and guidance in terms of her school placement. The therapist encouraged them to keep her in the same school setting, and at the therapist's suggestion, school personnel kept Ginny in a mainstream class. During the second year, the Banners wanted behavioral recommendations from the therapist. They came sporadically to therapy and resisted becoming involved in an ongoing therapeutic relationship, hoping their problems would simply disappear. At the suggestion of the school psychologist, they took Molly to a different therapist in the Banner's community. Molly did not object but also did not open up; in fact, she became increasingly constricted.

Up to this point, the approach of the therapist submitting the case was to encourage whatever efforts the Banners made toward engaging in a therapeutic relationship. She openly shared her assessment of Ginny with them and recommended family therapy, but she felt they could not accept confrontation at that point. The family hoped that summer would bring respite, which indeed it did. Molly went away to camp and did well socially. Ginny went to day camp and also adjusted well. Soon after the start of school,

however, matters deteriorated. In January, the Banners accepted the therapist's suggestion of a short series of family sessions to evaluate family needs and to consider how to proceed. During these sessions, Molly opened up to a degree that shocked her parents, saying that no one saw or cared how taking Ginny into the family had messed up her life. Ginny was far less expressive but responded well to behavioral contracts worked out by the family in the sessions. A token economy, instituted at the therapist's suggestion, worked well in getting Ginny to conform to family schedules.

Over the past four months, the Banners have become more aware that they need to commit themselves to family therapy. Mr. Banner's absences disrupt the process somewhat, and the specific approach has yet to be determined.

Formulations and Treatments

Bernard, G. Guerney, Jr. (Systems and Integrative)

I read the case description to mean that an organic basis for Ginny's hyperactive behavior and the need for medication have been ruled out. If there still are serious problems in school, I would want to confer with school personnel to gain a better understanding of these problems. I also would want to get the perspective of all family members, especially Ginny, about

such problems and to work with them toward their solution.

If family members have not already had brief, confidential individual interviews, I would do this in order to elicit problems they may be reluctant to discuss in the presence of other family members. This approach seems particularly important for Mrs. Banner, because it was noted that she appeared inhibited in Mr. Banner's presence. I also would conduct such interviews to discover or rule out sexual or physical abuse, alcoholism, serious depression, or other problems that might call for interventions adjunctive to family therapy—which is, I agree, the most appropriate treatment choice.

I gather that nothing was found requiring treatments other than family therapy. No mention was made of a requirement to supply diagnoses to a third-party payer, and I feel no need to apply even informal systemic diagnostic labels, such as *enmeshed or disengaged,* to the family.

As I practice family therapy, I do not rule out separate sessions with individuals or subgroups within the family. For example, if the wife called me for a confidential interview, I might agree. Issues discussed in such an interview would be brought up with other family members, if and when appropriate, and I would not be concerned about creating problems by sharing a so-called family secret. Rather, I would be concerned about a

problem remaining unknown to me and having one or more family members know that I do not know it.

All members of this family would benefit greatly from learning to express their emotions and viewpoints to one another and to help one another resolve interpersonal and intrapsychic problems and conflicts. Hence, I would conduct *relationship enhancement* (RE) family therapy with all of them. A key question, however, is whether to use one or two types of RE therapy.

That decision depends on characteristics of Ginny's that are not entirely clear in the description. If Ginny is an articulate child with a reasonably long attention span for discussion of family issues, then the only type of family therapy needed would be family relationship enhancement (RE) therapy. If not, another type of RE therapy would also be introduced— *child RE family therapy* (CRE), also called *filial therapy.*

In CRE, parents of children (generally up to age ten) are taught the theory and methods of client-centered play therapy. The parents then conduct therapeutic play sessions with their children to help the children express themselves emotionally and to overcome traumas and intrapsychic and interpersonal conflicts. Ginny's feelings about her adoption could be worked through in play sessions. Parents also are taught certain behavior

modification principles to help them socialize their children appropriately (Guerney & Guerney, 1985). If Mr. and Mrs. Banner were to engage in CRE with Ginny, they would offer Molly equivalent "special times" with them to avoid exacerbating rivalry (L. F. Guerney, 1985). Even if

CRE were used, we would want Ginny present in the RE family sessions when rivalry issues were discussed. Because her age limits her articulateness, a therapist would use a great deal of *doubling* (B. G. Guerney, 1977). That is, in discussing issues with other family members, the therapist often would speak as if he or she were Ginny, with Ginny confirming or denying what the therapist said on her behalf. Molly and the other family members are entitled, should the need or wish arise, to the same service from the therapist.

The processes of RE therapies are designed to resolve intrapsychic and interpersonal problems and conflicts of family members by transforming the family system from one that is neutral or pathogenic to one that is therapeutic. RE integrates psychodynamic, humanistic, behavioral, and interpersonal theories and methods of psychotherapy; it rejects some aspects of each of these schools and blends other aspects of each into a coherent therapeutic system (Guerney, Brock, & Coufal, 1986).

RE procedures have been explained in detail elsewhere (e.g., B. G. Guerney, 1977, 1984, 1987; Guerney & Guerney, 1985) and demonstrated on

videotape (e.g., Figley & Guerney, 1976; Vogelsong & Guerney, 1977). By means of in-session training and home assignments—some of which make use of audiotapes (Guerney & Vogelsong, 1981), readings, questionnaires, and logs (B. G. Guerney, 1987)—the clients are systematically taught nine skills: empathy, expression, discussion/negotiation, problem/conflict resolution, facilitation, self-change, other change, generalization, and maintenance. The therapist provides direct, intensive, live supervision in the sessions and selective after-the-fact supervision (through audiotape or self-report) of the play or family sessions conducted at home. In both types of interaction, the family members use the skills they learn to achieve catharsis and insight—relevant both to intrapsychic and interpersonal problems— and to initiate and maintain behavioral changes.

If there were a crisis situation that required immediate resolution before the family had acquired sufficient skills to follow the usual procedures for resolving it, special RE procedures would be brought into play. Crises do not seem particularly likely in the Banner family, and the ordinary sequence of procedures of RE and CRE would be expected to suffice. These ordinary procedures would include troubleshooting, social reinforcement, and vicarious reinforcement to improve the regularity of Mr. Banner's attendance (B. G. Guerney, 1977). As the family developed proficiency in RE skills, the therapist would guide their selection of issues toward ones progressively

more difficult, more emotion arousing, and more fundamental.

To give the reader a flavor of RE, a brief imaginary segment of the Banner's therapy will be presented. The annotated hypothetical transcript is from the tenth hour of RE family therapy. By then, the Banners would have enough skill to tackle highly emotional issues.

The family member initially adopting the expressive mode chooses by eye contact a particular family member to respond empathically. Discussion/negotiation skills allow the empathic responder to become the expresser if he or she so desires, after having given a response deemed empathic by the expresser. (Others in the family may interject comments into the dialogue under conditions not explained here.) The family member to the left of the expresser (exempting the empathic responder) acts as the facilitator (coach) for all the other family members. The children have the same privileges and responsibilities as the adults. At this stage of therapy, with exceptions as necessary, the therapist facilitates through the facilitator.

Let us assume that Ginny has chosen Molly to talk to and that she has expressed the view that Molly treats her unfairly, makes fun of her, and says mean things to her, especially in front of Molly's friends. Molly has already responded empathically to a series of such expressive statements from Ginny over a span of five minutes. Ginny's expressive performance and Molly's

empathic performance have been assisted and socially reinforced by the facilitator, who happens to be Mr. Banner, and indirectly by the therapist, who also facilitates through Mr. Banner.

Our transcript begins with an empathic statement from Molly to Ginny.

Molly: It really bothers you a lot when I say something like "Beat it, creep" or "Get lost!" or "I hate you!" It makes you feel like I don't care about you at all. In fact, it makes you think I really do hate you.

[The therapist wants Molly to be further reinforced for her empathic responses and seeing that Mr. Banner has not spontaneously done so on this last occasion, sends a nonverbal signal to Mr. Banner, who understands the signal.]

Mr. Banner: Very good, Molly. [The therapist reinforces Mr. Banner's appropriate facilitation.]

Therapist: [to Mr. Banner] Good.

At the same time, Ginny, who is tearful, has nodded her head and shows no indication of wanting to continue talking. Molly correctly takes Ginny's head nod as meaning that her empathic response has been perceived by Ginny as being on target. Ginny's nonverbal acknowledgment of the appropriateness of Molly's empathic response means that it is all right for Molly to switch to an expressive stance now if she wishes to do so. She does switch, choosing Ginny by eye contact as her empathic responder. Molly makes the following unskilled statement.

Molly: Ginny, I just do that when you're being a baby. When you . . .

Therapist: [interrupting Molly] Molly, hold it, please, [turning to Mr. Banner] Mr. Banner, I'd like you to take over as facilitator on this one. You could help her correct the "baby" business, but I think it is important that we try to bring in some of the underlying positive feelings, and you have not had any experience in coaching that. So this time just watch me, and try to remember the way I go about trying to help so that you can do it in the future, OK?

Mr. Banner. Sure.

[The therapist turns to Molly to troubleshoot, structure, and model.]

Therapist: Molly, you're frustrated and annoyed right now because it seems to you that Ginny is putting all the responsibility on you and not seeing her role in the problem. I'm sure that would make it hard for you to bring in some of your underlying positive feelings at this point, before you get into some of the negatives. But if you can do that, I think that it would really help you to get your own views across to Ginny. So, if it is true, and if it can fit in well enough with your overall feelings right now, I'd like you to say something like this to Ginny: "I feel really bad that you feel so hurt when I say things to you like 'creep' and all. I may want to hurt you at the moment, but overall I don't want to make you feel bad about yourself. But some of the things you do, especially when I am with my friends, make me furious." And go on from there, Molly. Tell Ginny some of the specific things she does that make you so mad. Following the specificity guideline will also help you follow the guidelines for avoiding generalizations and get you out of the "baby" comment. First, is what I said about your underlying positive feelings toward Ginny true?

Molly: [nodding her head vigorously] Yes.

Therapist: Do you feel you could say that to her now, in your own way, of course, and also tell her what, specifically, she does that makes you so very mad?

Molly: OK. [and she does.]

This gives some idea of the structure of the session and a few of the types of responses RE therapists make. It is important to note that the purpose of the intervention was as stated—to implement a guideline for expressive skill that calls for stating underlying positives (as well as to correct the "baby" generalization). The intervention very definitely was not intended to cut off the expression by Molly of angry feelings or simply to help relieve Ginny's depressed or hurt feelings.

In a prior hypothetical sequence, the therapist helped Mr. Banner to help Ginny go as deeply as possible in expressing negative feelings of anger, pain, and hopelessness over Molly's treatment of her; and, a few minutes after the transcript ended, the therapist helped Mr. Banner to help Molly freely express her strong anger and her momentary desire to hurt Ginny when Ginny behaved in certain ways. The therapist tried to deepen and facilitate the expression of such negative feelings as well as positive feelings. The RE therapist did so because he or she viewed the full expression of negative feelings (catharsis) when done in appropriate ways and contexts (and only then) as highly conducive to the expresser's insight, as freeing the expresser to make therapeutic changes, and as permitting other family members fully to appreciate the expresser's predicament and to show complete acceptance to the expresser. When the expresser harbors strongly negative feelings, he or

she cannot feel fully accepted as a person by the object of those feelings if the latter does not even know about them.

Where would this dialogue likely go after Molly described what Ginny did that infuriated her? At the least, we would apply problem/conflict-resolution skills based on new perceptions, emerging feelings, and attitudes acquired during the dialogue. Specific agreements between Ginny and Molly about how each is to behave when Molly is with her friends would commit each to use self-change skills. Possibly, each family member would undertake to use other-change skills to help Ginny and Molly make the changes they agreed to make. Efforts toward such change would be regularly monitored and adjusted by the family, with the therapist supervising this application of their skills. Probably not immediately, but springing from this dialogue or another, issues of perceived parental favoritism and Ginny's feelings about her adoption would be discussed. We would expect such a discussion, with facilitation, to lead to highly emotional expressions of love and caring from both parents toward both children. The outpouring of love and affection would have a dramatic effect on the self-esteem of the children, would sharply reduce their rivalry, and would result in a general improvement in family functioning.

I assume, especially in light of Mrs. Banner's reticence in Mr. Banner's presence, that problems additional to those already visible will need attention

in the course of the therapy. However, I see nothing in this case to warrant unusual wariness—no anticipations of psychotic breakdowns, suicide, homicide, or child or spouse abuse. I expect that Ginny's school difficulties, her adoption problem, the excessive sibling rivalry, the mood swings of the children, Molly's distress, Mrs. Banner's lack of assertiveness regarding Mr. Banner, and structural defects in the family will be resolved without more than the usual therapeutic interventions.

Janus M. G. Fraillon (Existential)

The Banner family is presented as living in a state of hostile dependency that is being addressed by family therapy. This may be a useful way to proceed, but it is important to know as much as possible about the family and its individual members, about their past and present, and about the existential problems they face, not only with the family, but also in the society in which they live. Specifically, I would like answers to the following questions.

How old are Mr. and Mrs. Banner? Is the age difference between them significant? Is religion a source of conflict, perhaps even inside a shared religious structure? Do Mr. Banner and Mrs. Banner share or integrate into each other's interests?: Is there conflict in their social consciousness?

What medical examinations of Ginny have been made, and what were the results? What could be learned of the Banners' psychological functioning by means of IQ testing, MMPI, Logo Test, and results of other psychometric instruments? Do the Banners form a hierarchy based on sex, color, body size, or whatever? Is Mr. Banner a rigid or flexible type, and so forth?

Are Mr. Banner's hours of work and traveling related to a precarious position? If so, who has put him there—himself, his wife, his parents or siblings, or economic forces affecting his work? Why is Mrs. Banner devoted to church work? Who blames whom for the miscarriages, and what share of the blame does Molly have to bear, if any? Why should Molly accept Ginny? What is the parent's attitude toward Molly?

What were the Banners' reasons for marrying? Have attitudes and values that originally attracted the Banners to each other become grounds for the present evident isolation? Are Ginny's problems a projection of an already failing marriage?

Did Mr. Banner sire Ginny while on a tour of duty in Vietnam? Even if not, does Mrs. Banner think he is her natural father? How did Mrs. Banner feel about an adopted child—a Vietnamese adopted child? Did she love this baby at the time of adoption? Did Mr. Banner? Does she now? Does he?

How do Mr. and Mrs. Banners' parents, siblings, and friends react to the children and to the present situation? How does the community accept a Vietnamese child? Is she called names, attacked, or made to feel different in school?

Has Mr. Banner been involved sexually with either or both daughters? Is his wife frigid? Does Mr. Banner have extramarital relations? If so, does Mrs. Banner condone them because she cannot cope with him sexually? Or is she having an affair with another man or woman—perhaps one in her church or PTA group? Are they hostile to therapy and therefore keeping these matters secret?

Does any of the family have an accessible sense of humor? Could any of them be trained to use *paradoxical intention* or *de-reflection* to look at what can be done to cope with each person's reactions while pursuing a constructive goal?

This is an ideal situation for existential analysis and a logotherapeutic intervention once all these variables are assessed for presence and importance. I would explore with each family member the present choices available and the implications for him or her and for others in the family. The factors in such choices can be explored by the techniques of paradoxical intention and logical extension into absurdity. When counseling techniques

falter, even at Ginny's age, this exploration is possible using stories, poems, role playing and drama, discussion of films, television dramas, and class events.

What harvests do the Banners reap? It could well be that the Banners' marriage is no longer of value to either of them and should be dissolved. If so, then both Molly and Ginny will need a great deal of support over a period of years, including allowing them to express anger and receive love and to express fear and find acceptance.

Diana A. Kirschner and Samuel Kirschner (Systems)

We can only admire the therapist's persistence with an obviously resistant couple. The therapist observed the identified patient in the classroom, saw the parents together, spoke to the older sister, and interviewed the family together. This flexibility may have ultimately paid off in her being viewed as a resource when the parents finally "gave up" in the second year and came in for treatment. In our view, the therapist's movement toward a stronger therapeutic contract that includes family therapy is entirely appropriate for this case. Adopted children and their families often have intrapsychic and interpersonal issues that can be dealt with effectively in a treatment integrating individual and family sessions. Here is a brief description of an integrative therapy model, followed by our assessment of

this case and a possible treatment plan.

Comprehensive family therapy (CFT) (Kirschner & Kirschner, 1986) provides a theoretical framework that targets both psychodynamic and transactional processes in the family. The intrapsychic model is derived from psychoanalytic and object-relations theories. In this model, CFT postulates a three-level self-system. At the core of the self is the foundation of the ego (Guntrip, 1969), which is formed initially through the relationship with the mothering one. Basic and primitive issues of trust are generated in the mother-child dyad.

At the next level of the self-system, the child develops an even more separate sense of self—a sexual identity (Freud, 1975) based on identification with parental figures. Sexual identity is usually congruent with that of the parent of the same sex.

The third level of the self-system is the triangulation level, an internal model created by the child's experience of relating in a triad. The triad's features may include oedipal wins and losses, homo-affiliative coalitions against the opposite-sex parent, and scapegoating the child to avoid the issues in marital conflict.

Ginny manifests separation anxiety and abandonment terrors at the

foundation level (following the teacher around, staying in bed, and refusing to go to school). At the level of sexual identification, Ginny manifests an infantile sense of self (talking baby talk, using nonsense syllables). She does not appear to be deeply identified with her adoptive mother, and she fantasizes about her biological family. This is quite common among adopted children in adolescence, although in our experience, children in the latency period do not usually do so.

We would hypothesize that Ginny is experiencing a reverse oedipal win. Mrs. Banner's energies go to her, albeit in a negative way, rather than to Mr. Banner. A reverse oedipal win typically engenders much guilt and self-hatred (as manifested in Ginny's protocol). Along with primitive fears of abandonment, Ginny suffers from an inadequate sexual identification and from being caught in an illicit coalition with her adoptive mother.

The self-systems of each family member are in dynamic exchange with the transactional components of the family. In CFT, we typically assess three systemic variables: the *rearing, marital,* and *vocational transactions.* In the Banners' rearing transaction, the mother seems to play an ineffectual role leading to conflict with Ginny, while the father plays a distant role. At times, Ginny sets herself up to be mother's companion by refusing to go to school and remaining at home. Both parents seem more distant from Molly, who is neglected. Parental teamwork seems weak or nonexistent. Neither girl is

receiving adequate nurturing, discipline, or guidance. As a result, both girls are in distress. Ginny acts out more overtly, while Molly complains of "going to pieces."

The difficulties in the rearing transaction can be linked to signs of severe marital dysfunction. Mrs. Banner's signals about possible marital problems, followed by her subsequent reluctance to discuss them in front of her husband, suggest a lack of openness between the spouses. What other secrets are being covered up in the marriage? Is Mr. Banner, who is away much of the time, having an affair? Molly's complaints about being alienated and displaced can be heard as metaphors for the alienation in the marriage. And the siblings' conflict may be a manifestation of the latent marital conflict.

Systemically, Ginny's role as the identified patient keeps attention focused on her and away from the marriage. At times, Mrs. Banner can draw her disengaged husband back into the family through her helplessness in coping with Ginny. She can also vent her marital frustration through Ginny, thus maintaining the stability of the marriage.

In CFT, the marital transaction is viewed as the most powerful determinant of the emotional life in the family. The marriage shapes, and in turn is shaped by, the self-systems of the spouses. This dialectical exchange tends to control the other familial transactions. Because the spouses' self-

systems are formed in their families of origin, information about their backgrounds is critical for the success of treatment. Data about the Banners' families are lacking in the write-up. We would certainly pursue this information in clinical interviews with each spouse individually.

In the area of vocational transactions, we also require more information. Why did Mrs. Banner not return to work after Molly was of school age? Did Mr. Banner feel threatened by her competency outside the home? These questions would be addressed both in individual and conjoint sessions.

The therapist would work with all members of the family using both individual and conjoint sessions. Initially, the therapist would focus on the presenting problems while bonding with the family and seeding for later marital work. In family sessions, Ginny's behavior would be reframed as bringing the family closer together. Ginny's fears of abandonment and Molly's despair as metaphors of family alienation would be communicated to the spouses. The therapist might remark that in this family, no one has a sense of belonging. The parents would then be joined together with the therapist to provide a greater feeling of community for the parents and the girls. It would be suggested to the parents that, with the therapist, they could straighten out their daughters' problems as well as their own.

Following the CFT model of healthy family functioning (Kirschner &

Kirschner, 1986), the therapist would place Mrs. Banner in charge of the girls. She would be the primary disciplinarian and programmer, while Mr. Banner would function more as the facilitator and nurturer. This triangulation model serves to promote same-sex identification while promoting a positive view of the opposite sex.

In individual sessions with each spouse, the therapist would elicit material about his or her family of origin and explain how such an upbringing contained the seeds of the marital conflict and alienation. We have found that clients are open to this interpretation because it seems to shift blame from them to the preceding generation. As the therapist is perceived as more understanding and empathic, each spouse becomes more open to a reparative relationship. The therapist can then tailor a more nurturant or confrontational stance with each spouse—a stance designed to fill gaps and heal wounds from childhood.

This type of reparative relationship is the cornerstone of CFT, supporting all the individual-behavioral and structural- strategic family techniques. As the work continues, both spouses will regress in relation to the therapist while progressing in their marital and parental roles.

Marital intimacy would be encouraged through initiating dating and other courtship activities. Communication skills to enhance self-disclosure

and active listening would be taught to the spouses in conjoint sessions. As the spouses grew together, their parental teamwork would become stronger and the children healthier. Occasional individual sessions with both Ginny and Molly would assist the parents to monitor their progress. In particular, Ginny would need to be able to discuss her longing for and fantasies about her biological family.

In the final phase of therapy, the spouses would learn to become therapeutic agents for each other (Kirschner and Kirschner, 1989a, 1989b). By then, better acquainted with each other's needs, they would be asked to be more active in fulfilling them. For example, Mrs. Banner might have a fantasy about a career that Mr. Banner could help her make a reality. The couple's teamwork would be promoted in all areas of their lives—as parents, as lovers, and as promoters of each other's independent careers.

Points of Contention and Convergence

Bernard. G. Guerney, Jr.

The major point of convergence is our agreement with the Banners' psychotherapist that family therapy is the treatment of choice here; at least none of us objected to it. A couple of decades ago, this agreement almost certainly would not have occurred. Of equal interest, in terms of agreement, is

that none of us objected, as some family therapists might, to the idea that some separate interviews would be permissible, and perhaps desirable.

A convergence between the Kirschners' approach and mine can be found in their last paragraph. They say there that in the final phases of therapy, the spouses would learn to become therapeutic agents for one another. I was very excited and joyful about this, because promoting the use of family members as psychotherapeutic agents in family therapy has been my major "cause" for some thirty years (e.g., B. G. Guerney, 1964, 1969).

Upon calmer reflection, it seemed to me that although there doubtless is overlap, the Kirschners and I probably do not think of the term *therapeutic agents* entirely in the same way. In considering the Kirschners' use of the term, I wondered, "If family members are to act as therapeutic agents, why wait until the final phase of therapy to teach them how to do it?" I would think that by the final phase, by definition, there would be little therapy left to do. I infer from this statement about timing, and also from the statements and examples that followed it, that the Kirschners mean they encourage family members to be helpful to one another in meeting clearly expressed, already known, and nonconflicting wishes. Such a role is important, but to my way of thinking, it represents only the happily wagging tail of the therapeutic dog. We view the rest of the dog—the hardworking parts—as being represented by family members directly helping one another in the tough work of digging

out the family's deepest fears, desires, and feelings and helping one another to resolve the often-conflicting intrapsychic and interpersonal expectations, desires, and goals that cause individual and systemic distress. To accomplish this digging out, the RE therapist generally starts training family members to be psychotherapeutic agents during the very first hour of therapy. In short, we expect mutual therapeutic assistance to become an integral part of the new "family rules" that we install to displace the old nontherapeutic or pathogenic family rules. (Of course, we encourage this type of hardworking therapeutic dog also to wag its tail when that is appropriate.)

Although it is not explicit in the responses, I believe there may be another related point of convergence among the three of us—one that distinguishes us as a group from many family therapists. I refer to our view that family therapy provides not only an acceptable but also a highly effective setting in which to help individual family members to work on personal problems in an intrapsychic fashion. By *intrapsychic fashion,* I mean exploration of such things as self-concept issues, feelings, and relationships—including those that may go back to childhood experiences and conflicts. These explorations can lead to the cathartic expression of deep emotion to help individuals achieve psychological insight.

Fraillon and I agree in our lingering concern about the possibility of an organic factor contributing to Ginny's hyperactivity. We also share a concern

about the necessity to rule out the possibility of severe disorders and dangers such as suicide and abuse. However, Fraillon and the Kirschners seem to share the desire to pursue at once a great many diagnostic questions and decisions having to do with individual and family dynamics. And that brings me to a major area of divergence: the others have a diagnostic orientation; I do not.

As implied in my comments above about the need to discover organicity, suicidal tendencies, and the like, I am acutely aware of the need to make broad-gauged action-oriented diagnostic judgments that might immediately call for treatment strategies different from or in addition to family therapy. And, of course, diagnoses may be made for administrative purposes such as insurance requirements or for clinical research. For convenience, let us call all such diagnostic efforts *Type I diagnosis.* Let us call all other quests, not only for the best *DSM-III* label, but also attempts to determine the genesis, nature, causes, prognoses, and dynamics of an individual's or a family's problems, *Type II diagnosis.*

An RE therapist is as much concerned with Type I diagnosis as is anyone else. However, following an educational model as opposed to a medical one (B. G. Guerney, 1982; Guerney, Stollak, & Guerney, 1971), RE therapists do not concern themselves very much with Type II diagnosis.

Instead of trying to figure out what is wrong—so it can be eliminated with the expectation that family members will then know how to do what is right without having to be taught what is right (medical model)—RE therapists try to teach what is right with the expectation that doing so will eliminate all that is wrong (educational model). Reflecting this difference in orientation, by count of paragraphs, the Kirschners devote about 50 percent of their original response to Type I and II diagnoses combined, Fraillon about 80 percent, and I about 5 percent. These percentages may provide a measure of how much time and energy we each think worthwhile to devote to the diagnostic quest of figuring out what is wrong and why.

Even though not explicit in the three responses, it seems fairly safe to conclude that RE differs from the other two therapeutic methods under discussion in the following respects: (1) RE working more directly and systematically with the family toward specified positive goals, (2) the method of determining the duration of therapy and structuring its phases, (5) termination procedures, (4) home assignments, and (5) topic selection and control. Space does not permit an elaboration of such differences here, and the reader can find elucidation elsewhere (e.g., B. G. Guerney, 1977; Guerney & Guerney, 1985).

Comparing therapeutic strategies and methods with esteemed colleagues in this manner has been an extremely stimulating and valuable

experience. I much appreciate having had the opportunity to participate.

Janus M. G. Fraillon

What can we do to unfurl the Banners? It seems that a whole panoply of different therapies is open to us, and yet are they not perhaps cut from the same cloth?

Guerney's RE approach is obtainable, it would seem, from any reputable bookseller. However, the psychotherapist uses a form of social or behavior training to lead the family members into the light by means of audiotaping or even videotaping of family interactions. Who would actually operate the various recording devices—while Mrs. Banner refuses her tired husband's advances once more in the intimacy of the bedroom—is not actually stated.

The Kirschners' approach, CFT, is strongly based on the driven nature of the Freudian mechanistic model. Oedipus blindly drives the children even more dangerously in reverse. CFT, too, would seem to involve the therapist in social manipulative games with the parents trying, as in RE, to play roles with which they could become eventually at ease and so lighten the burden on the children. The problems that arise as a result of shifting the blame onto the preceding generations are not as bad, it seems, as those current ones with which the therapist is trying to deal.

Both RE and CFT lead invariably to the present and to the hopes of the individual family members for the future. They want freedom—freedom from the demons that have been driving them—and social-behavioral manipulations provide means to that end. But each silver lining has a cloud. In these situations, each family member must take responsibility for his or her own actions, despite the blameworthiness or not of the generations of the past. Almost as in the old Alcoholics Anonymous (AA) mode, each member of the family must make restitution for any costs incurred as a result of his or her behavior. Also, as in AA, an individual must acknowledge that he or she needs help to find the way to deal with the problems with which each day confronts him or her.

Many psychotherapists rely on typical Freudian transference to become this external source of power for the clients. Some of us try to tap the power inherent in the conscience of the clients themselves through seeking with them the meaning of the moment in any situation—any warm interaction as well as any disaster. Through the cumulation of these meanings, we hope to find the real purpose that keeps the individual alive, against all reason at times.

Ginny may have no real reason to wish to live with her adoptive parents. Indeed, the burden of being indebted to her supposed benefactors, who also expect her to like their older daughter, may be the last straw. The primal

pains of her experiences in Vietnam, which led her to being adopted into an alien culture, may never be resolvable by the Banners under any flag. Ginny must eventually take the responsibility for resolving the mess herself, at her age in her way, in order to get on with her own life as a contributor to the society in which she now lives and from which she benefits.

Molly must also come to terms with her hostile dependency on her unlovable mother and absentee landlord of a father. It is awful to hate a do-gooder, especially an artistic one, particularly if that do-gooder is your mother. So Molly must resolve her anger in constructive ways that her conscience will allow.

The questions raised about the family and the possible complications of their situation described in my original contribution were meant to inspire therapists to seek the broadest canvas for the protagonists to paint their life pictures upon and to integrate with one another's vision. The psychotherapist then may become not only the art historian for that family but also somewhat of an entrepreneur recognizing the particular genius of each of them and encouraging them, individually and as a family, to realize their special potentials.

Diana A. Kirschner and Samuel Kirschner

There appears to be a consensus among the authors that intrapsychic and interpersonal issues need to be resolved in the Banner family. In this respect, we all agree that Ginny, the symptomatic child, can best be helped by broadening the treatment focus to include other members and other aspects of family life. For example, Guerney suggests that enhancing the communication skills of the girls will reduce conflict between them, and Fraillon believes that Ginny's problems may reflect other, more serious issues, including a failing marriage. In sum, then, all the authors agree that a unidimensional treatment approach to the Banners cannot adequately deal with the individual and family problems they present.

However, the authors clearly diverge in implementing a treatment plan. These divergences take several forms: framework for sessions, focus of treatment; and treatment goals.

Guerney advocates conjoint sessions for the therapy while using individual sessions "if necessary," and Fraillon recommends individual existential analysis for each family member. We suggest using a combination of individual sessions with each spouse as well as conjoint family or couple sessions. The differing frameworks arise out of the second divergence—the focus of treatment.

While stating that intrapsychic issues are important in this case,

nowhere does Guerney really address them. Both our response and Fraillon's delineate specific hypotheses and concerns that we have about the spouses and their history—concerns we could address in individual sessions. For example, we would deal with Mrs. Banner's poor self-esteem and lack of assertiveness in the family and in the world.

In addition, like Fraillon, we have serious concerns about the marriage. Unlike Guerney, who ignores the issue, Fraillon would deal with the marital rift on an individual basis. We would take Fraillon's view one step further. As we have indicated in our response, we consider the marriage and the intrapsychic functioning of the spouses to be the most powerful dynamic in shaping all of family life. The spouses are, after all, the models and executives for the children. Thus, after restructuring the parenting relationships (especially reengaging Mr. Banner), we would concentrate on individual and marital work conducted in concurrent and conjoint sessions with the spouses.

The differences concerning frameworks and foci for treatment appear to grow out of differing goals for therapy. In comprehensive family therapy, our goals include a clear parent-child hierarchy and a marriage in which the spouses serve as growth agents for each other and for the children. As such, the therapy with the Banners requires restructuring the parent-child relationships through conjoint family sessions; building self-esteem, assertiveness, and self-awareness through individual sessions; and promoting

sexuality, intimacy, and a “win-win” mutuality through conjoint couples work.

In contradistinction, Guerney’s goals appear to involve a more diffused parent-child hierarchy in which each family member develops communication and facilitative skills so that there is clear empathic communication and negotiation in the family. As Guerney writes, “The children have the same privileges and responsibilities as the adults.”

We disagree with Guerney that the hierarchy of parents and children is somehow not important in family life. Indeed, we view the Banner family as a dysfunctional one in part because the hierarchy between parents and children is unclear and because the boundaries between the marital couple and the children are diffuse. Mrs. Banner often plays the role of the hysterical child and is much more in the children’s camp than she is a partner with her husband at the spousal or parental level. Without a strong parental coalition to guide and structure the daughters and to help them resolve conflict, the girls are left to flounder on their own. Reestablishing the proper hierarchy and boundaries in this family would be our first task. As a consequence, good communication between parents and children and between siblings would then be possible, and the symptomatic behaviors would tend to abate.

Fraillon’s approach, on the other hand, seems to emanate from yet another set of treatment goals that include the individual family member’s

understanding and accepting his or her choices and realizing the implications of these choices for the family. We agree with Fraillon that insight into and acceptance of oneself is an important goal of therapy. We believe, however, that promoting behavioral change in the rearing, marital, and vocational transactions is also needed. In fact, it is our contention that in many instances, insight follows rather than precedes behavioral change.

Authors

Bernard G. Guerney, Jr., Ph.D., is a diplomate in clinical psychology (ABPP), behavioral medicine (AABM), and marital and family therapy (ABFam. P). He is professor of human development and head of the Individual and Family Consultation Center, Pennsylvania State University. He has practiced and taught family therapy for over thirty years and has been corecipient, with his wife Louise, of several national awards for developing the Relationship Enhancement Approach.

Janus M. G. Fraillon, M.B.B.S., FRACGP, is a general practitioner who has worked in Melbourne, Australia, since 1956. He has held various clinical and academic posts during that time and was cofounder of the Logotherapy Society in Australia. He also represents the International Academy of Eclectic Psychotherapy in Melbourne and lectures on both logotherapy and counseling in general practice to various professional groups.

Diana A. Kirschner, Ph.D., maintains an independent private practice. Together, the Kirschners have coauthored Comprehensive family therapy: An integration of system and psychodynamic treatment models (1986), as well as numerous papers on integrative theory and practice.

Samuel Kirschner, Ph.D., serves as an adjunct faculty member at the Wharton School of Family Business and is in independent private practice.