H. Charles Fishman

Disability and the Family:

The Search for Competence

Treating Troubled Adolescents

Disability and the Family:

The Search for Competence

H. Charles Fishman

e-Book 2016 International Psychotherapy Institute

From *Treating Troubled Adolescents* by H. Charles Fishman

Created in the United States of America

Table of Contents

Disability and the Family: The Search for Competence

> The mirror sees the man as beautiful, the mirror loves the man; another mirror sees the man as frightful and hates him; and it is always the same being who produces the impressions.
>
> —MARQUIS DE SADE

DISABILITY IN ADOLESCENTS may be defined as any condition that potentially impairs functioning. The condition may be chronic, such as retardation, or temporary, such as the compound fracture of the leg. Certain disabled children are at risk of being developmentally and psychologically impaired for the rest of their lives. Yet a close examination of the literature on children at risk demonstrates that only a minority of disabled children and adolescents experience serious difficulties in personality development. In fact, the vast majority who are exposed to various forms of adversity develop normally and enjoy productive lives (Hauser et al. 1985). Our concern here, however, is the small number of children who do have severe difficulties.

One way of approaching this minority is to study the majority of disabled children who seem to handle their adversities well. In doing so we can discover the qualities of disabled children and their families that encourage successful coping. There is a rapidly expanding literature on these successful children who become invulnerable or resistant to the risks of their disabilities. These studies reveal a vast number of causes for resiliency, including high self-esteem, capacity to control environment, social and scholastic competence, maternal warmth, and a balanced family interaction. In a study of diabetic children Maija-Liisa Koski (1969, 1976) identifies the children who coped best as those having come from families with clear, distinct boundaries between members, realistic and cooperative attitudes toward disability treatment, low marital conflict, and stable composition with the presence of two parents or a competent single parent. Other studies have found that the parents of children exhibiting optimal control consistently value independence, self-sufficiency, and open expression of feelings (Anderson et al. 1981). And researchers such as Michael Rutter (1979) and Norman Garmezy (1983) emphasize the ameliorative role of social support systems and community institutions such as schools.

Recently I saw a comedian who asked the audience, "How many thought there was something very wrong with you when you were an adolescent?" Virtually everyone in the audience raised their hands. If this is the experience of normal adolescents, think what it must be like for youngsters who do in fact vary from the norm. The presence of a disability can profoundly affect the major developmental tasks of adolescence, such as separation from the family, the establishment of a separate identity, the acquisition of social competence, and the abandonment of childish narcissism. How the family and the larger social context treat the disabled adolescent profoundly affects how the youngster navigates these developmental passages.

My focus here is to build on this research and uncover principles of treatment that will show us how the disabled adolescent's social context—family, school, medical personnel, and social agencies—can become a resource for healing and growth. I believe these principles are important for disabled individuals and their families generally, but even more so for disabled *adolescents.* In the adolescent the psychological processes are inextricably influenced by on-going physical changes. How the social context and, especially, the family treat the adolescent has a profound affect. The disabled child is more vulnerable during adolescence than at any other period in childhood. For the disabled adolescent the difficult problems are more difficult. Their disabilities may render their bodies or their minds less reliable than those of their peers, thus compounding the experience for the ever self-conscious adolescent.

General Principles

When dealing with families with disabled children, often the therapist can change the system simply by using the technique of *adding information* (a technique described more fully in another work, *Family Therapy Techniques* [Minuchin and Fishman 1981]). Briefly, what this involves is gently nudging the system toward change by providing information on other options or ways of coping.

This technique is not always successful, however, especially if one is dealing with a psychosomatic family. In treating these families the therapist must be attuned to the presence of characteristics such as enmeshment, overprotectiveness, rigidity, triangulation, and diffusion of conflict. Such situations require a therapy of transformation in which intensity and enactment are used to alter the prevailing patterns right there in the therapy room, and a careful follow-up to ensure that the changes have transferred to home and school. The case study presented later in this chapter includes a therapeutic consultation with one such family.

WORKING RAPIDLY TO COUNTER PRESSURES THAT REINFORCE THE DISABILITY

With disabled adolescents the therapist must work rapidly toward assessment and intervention to counter any pressures from the family system to see the adolescent *only* as disabled and thus to constantly reinforce the disability. The immediate therapeutic goals might vary depending on the age of the child. With younger adolescents the family system might be encouraged to help the child negotiate capabilities; with teenagers the issue may be to provide challenge in the absence of a close connection to peer groups or a strenuous effort to connect the youngster with a peer group. With older adolescents the focus might be on preparation for leaving home. Whatever the primary issue, the therapist must work to enhance functioning as much as possible in the face of the systemic forces that act to stress the disability.

TRANSFORMING THE CYCLE OF LIMITED EXPECTATIONS

Many families with disabled children fall into an insidious trap. The family expects diminished functioning of the disabled youngster and therefore does not challenge the adolescent to stretch and grow. The adolescent, accepting the family's views, does not strive and so languishes in the disability. I call this trap the "hall of mirrors" phenomenon (Fishman, Scott, and Betof 1977). When someone is diagnosed as disabled the label can create special relationships with other people that result in lower expectations and diminished skills. The way the individual is treated affects his self-concept. If the image reflects only the limitations of the disability, then the person's self-image and potential are diminished because he sees himself as impaired. His response to these reflections in a "hall of mirrors" serves to substantiate the image. The result is a self-fulfilling prophecy.

In order to disrupt this cycle the therapist must establish a context in which the possibility of competence and challenge replaces the self-fulfilling expectation of diminished capacity. To do so the therapist must first determine the extent to which the limited capacity is a function of being treated as a limited person. Conversely, one must also ask how much the deficit of the individual serves to organize people in the social context to treat him as disabled.

The goal of therapy, then, must be to change the dysfunctional patterns of interaction between individual and context. The therapist must work with family members, school and medical personnel, and social agencies to increase not only the expectations but the actual functioning level of the disabled child. Too often the disability in question is seen as a permanent, immutable state, losing sight of the fact that there is always a margin within which the adolescent can improve. Moreover, if the parents or others surrounding the disabled individual communicate a feeling of fixed or insurmountable limitation, then that feeling will become reality: the development will freeze and the likelihood increases that the adolescent will remain dysfunctionally impaired.

RECOGNIZING HEIGHTENED VULNERABILITY

The therapist must be able to dissect how the family's needs are played out in the process of caring for the handicapped individual. There is always the danger that relatives will find too much meaning and purpose in the role of helper. Family members experiencing periods of heightened vulnerability in their own lives—when their own needs are not being met and their frustrations are exacerbated—sometimes find it essential to maintain the disabled child as a patient. They may even begin to enjoy the caretaker role and become extremely reluctant to allow the child to emerge as someone other than a helpless individual. It is clear that for many of these family members focusing on a disabled child is easier than dealing with their own issues. In these cases developmental stagnation sets in and the process of helping the disabled adolescent overrides all other processes. The needs of the disabled member tend to run the family, and the family becomes paralyzed.

As therapists we can direct family members to work on their own issues and to foster their own autonomy. The family therapist can help parents and others to step back and ask, "Am I getting too much out of helping?" By encouraging such reflection and offering alternative behaviors and scenarios, we work to prevent the development of overprotective, psychologically crippling relationships in the family. Our goal is to help parents better provide the energizing free space in which the disabled adolescent can grow, without allowing themselves to be recruited as overly assiduous helpers.

One step toward reaching this goal is to ask ourselves the question, "When is a family most likely to organize itself around the limitations of the disabled member?" It is my experience that these periods of heightened vulnerability occur at life-stage transition points: a job change, a mid-life crisis, a death in the family, or problems in the marital relationship. Exacerbations of the adolescent's illness can also mobilize the focus and heighten the psychological vulnerability of the family.

The therapist must be sensitive to these transition points that affect the family's vulnerability. Often they can help explain cessation of a disabled adolescent's progress. For example, a clinician may be faced with an adolescent whose illness has a self-limited course but who has given up trying just as recovery was in sight. Too late, it is discovered that the father saved himself from depression surrounding a ruptured relationship with his spouse by actively maintaining his child's disability. In other words, he "married" his child to save himself at a difficult time of transition.

The therapist must also recognize that the amplification or maintenance of the handicapped state is extremely easy for families to fall subject to. In fact, it is so easy because it is the handicapped child's prerogative to try to elicit such a reaction from them. The family must understand when this pull on them is occurring and must be helped as quickly as possible to become adept at avoiding it. The therapist's goal is to help the family foster whatever independence the disabled person and the system are capable of attaining.

SEARCHING FOR COMPETENCE

One of the key principles in dealing with disabled adolescents and their families is searching for areas of the child's mastery and competence. By highlighting these areas the therapist can help challenge the developmental expectations of both parents and child. This issue will be discussed in greater detail later, in the clinical example. But it is essential for the therapy to be structured so that the parents and the child are given an opportunity to see the child as competent. By employing a therapy of experience in the treatment room, an area of true competence can be demonstrated and seized upon. Stressing its significance can be critical in breaking down whatever walls of limitation the family and the adolescent may have constructed.

ORGANIZING A NETWORK OF CARE

A family is not solely a help-giving support system; it can also serve the important function of problem resolution. Effective problem resolution, however, frequently involves distinguishing what is best done within the family and what is best done outside it. It is a misconception that when one is part of a family, other family members can always offer the best support. In fact, sometimes a therapist can be most helpful merely by informing family members when they *cannot* support one another—for example, when support would place unrealistic demands on individuals or would overstress the system. At such times the therapist should lead the family to look for extrafamilial resources and to create a support system without undue pressure on any one individual.

In creating this support system the definition of the family can be enlarged, even to include more than just relatives. Some years ago, for example, I worked with a family that included a mother who was a single parent, a sixteen-year-old asthmatic girl, and her eight-year-old brother, who had a severe neurological disorder. The mother was obviously overwhelmed by the enormity of her responsibilities. Our first step was to work within the nuclear family. I taught the teenager a relaxation technique so that, at the earliest possible perception of chest tightening, she could try to prevent an attack. This could only be done in the context of family work, for we first had to decrease the extreme enmeshment of mother and daughter, who were so close that the girl actually expected her mother to know when her asthmatic attacks would come on. Only when the girl "owned" her body and felt the early tightening could she head off the attacks and exercise her competence and mastery. Concurrent with this family work we created an organized context of outside helpers to take some of the pressure off the overburdened mother. This enlarged family network allowed the mother to realize that she could in fact be a good mother without having to do everything for her children. Indeed, she could become a better mother if she let others help and did more for herself, thereby freeing herself to be more productive and allowing her children to grow in competence and independence.

ADDRESSING THE FALLOUT: HOW ARE THE SIBLINGS?

In families where one of the siblings is disabled the clinician needs to ask how the disability has affected the development of the other children. Frequently these siblings are depressed, unattended children who have to spend too much time taking care of an ill brother or sister. The disabled adolescent may take all of the parents' attention, leaving siblings to deal with feelings of neglect, hostility, or jealousy. Even in cases where the illness is of a limited duration or where the disabled child miraculously recovers, the siblings may still suffer. Though they may hope or expect that their parents will now attend to them in a more balanced way, this does not usually happen. Frequently such problems of neglected siblings cannot be solved strictly through intrafamilial work. The parents are simply overloaded and can only give so much. The siblings need and must be provided another, outside support system. One oncology unit I know of has instituted sibling groups. These do not replace the parents, who must still be encouraged to deal with and support the siblings, but the groups do offer some relief. The members of the group are able to support one another and share experiences, providing a sense of independence and independent problem solving not contingent on the attention of the parents.

Clinical Example:
Ingrid, A Case of Too Many Helpers

The following consultation occurred in Sweden with a nineteen-year-old girl and her parents. Ingrid had been diagnosed as mentally retarded. She lived at home, unemployed, with no pressure to move on either from her parents or the family's helpers. When I saw the family Ingrid was in a psychiatric hospital because of a suicide attempt. This was her first attempt, although she was described as having been depressed for many years.

ASSESSMENT USING THE FOUR-DIMENSIONAL MODEL

History

Ingrid had the classic history of a disabled adolescent. She had been associated with institutions for essentially her whole life. The "hall of mirrors" phenomenon was very much in evidence. The specific event that precipitated the consultation was extreme depression and desperation about her life and future, brought on by a breakup with a boyfriend, which had led to the attempted suicide.

Development

Both parents were in their early sixties and were clearly engaged in a developmental passage, retirement, in a context of socialism, where retirement is rigidly adhered to. Ingrid was the last of four children; when she left home the parents would enter into a new developmental stage—that of having no child at home, a situation they had not faced for more than twenty years.

Structure

The family's relationships, especially when seen in the developmental context, revealed a situation in which both parents were extremely over-involved with Ingrid. Their over-involvement was of a flip-flop nature: one would distance and the other would grab onto the girl, and then they would reverse roles.

The other relationships involved were in some ways due to characteristics of socialized Scandinavian societies. Unlike the United States and other countries, Sweden has an abundance of social services, providing helpers at all levels. In this case there was a woman in her mid-fifties whose job was to help Ingrid's day flow more smoothly. The unintended result was that another barrier to Ingrid's possible autonomy was created. Not only did the family have difficulty creating a context for Ingrid to test her wings, but the social system compounded the problem by providing at least one person, and at times several, whose sole job was to do for this girl all those things she was supposedly incapable of doing on her own.

Process

The observed process was that of a psychosomatic family. Both her parents and the involved social agencies were overprotective of Ingrid. Other specific process parameters demonstrated were triangulation, diffusion of conflict, and rigidity.

I was moved by this warm and vulnerable young woman. She was extremely compelling. As a therapist I felt pulled to be drafted as yet one more helper, one more too-helpful professional to be recruited into the service of this appealing adolescent, taking over for her and making it difficult for her to develop her own competence through trial and error. The very urge to do something for this girl helped me to generate intensity while being wary not to be too helpful. Ingrid had to be her own advocate.

THE HOMEOSTATIC MAINTAINER

In this family the homeostatic maintainer appeared to be both parents, who persisted in seeing their daughter as so impaired that she could not work and live independently. To the extent that they had this view, they protected and supported their child's incapacity. Rather than challenge their daughter to grow and expand her possibilities, they maintained the homeostasis. Also maintaining the dysfunctional homeostasis were the social-service helpers, such as the woman who was assigned solely to Ingrid.

THE THERAPY

In the room are Ingrid, a plain and young looking girl, her middle-age mother and father dressed in work clothes, and the therapist. Unfortunately absent were siblings and Ingrid's professional helper. Since I do not speak Swedish, the therapist acts as translator. As the session begins, however, it becomes apparent that Ingrid understands my English.

> DR. FISHMAN: Do you know English?
>
> INGRID: Some …
>
> DR. FISHMAN: Where did you learn some English?
>
> INGRID: From the TV.
>
> DR. FISHMAN: So you know English but your parents don't. *(To the parents:)* It's great, she really knows English.
>
> *(The mother turns to her husband in absolute disbelief.)*
>
> MOTHER: It seems she knows more English than we know—than we are aware of.
>
> THERAPIST: I think I will translate for the parents. Okay?

DR. FISHMAN: What do you want as parents for your daughter?

MOTHER: We're not sure what it is.

DR. FISHMAN *(to Ingrid)*: Will you tell me what your mother said?

An area has been established in which the girl is competent—in fact, even more competent than her parents. In addition, as the session develops everyone can laugh at my incompetence with Swedish, and Ingrid, in a very nice way, becomes my guide.

FATHER: Well, we don't exactly know what she is capable of doing and we're not aware of what her ideas are.

DR. FISHMAN: Are you, Ingrid, also confused? You don't know how independent you can be?

INGRID: I don't know.

DR. FISHMAN: So everybody is confused, you're confused too.

MOTHER: The only time she worked before was after school. And she never has worked for a long period. Never. One or two weeks.

THERAPIST: As part of the school system, you work for a couple of weeks to see what working is like.

DR. FISHMAN: What kind of work do you like to do? What do you want to do?

INGRID: Flowers. I love flowers.

DR. FISHMAN: What is your favorite flower?

INGRID: Cactus. *(Everyone laughs.)*

I was impressed that this girl who likes flowers would choose cactus as her favorite. I surmise that people who choose cactus as their favorite flower are individuals who have been forced to rely on a very dry and barren emotional environment. They are people who are struggling to learn to live on few supplies, just as a cactus makes do with only a little water. Moreover, they are people who become economic; they know they cannot count much on their environment, so they learn to conserve what they have. One might also conclude that Ingrid was trying to ward off intrusiveness. Perhaps, like the cactus, she maintains a rough, thorny exterior, while on the inside there is real nurturance.

DR. FISHMAN: You know, some cactus are very very big.

INGRID: Ya, those are my favorite cactus. They're a little like people. *(laughter)*

DR. FISHMAN: Do you want to get a job?

INGRID: Yes.

DR. FISHMAN: You know English. Do you want a job working with flowers?

INGRID: Yes.

DR. FISHMAN *(pointing to a plant on the windowsill):* Can you help that one?

Ingrid laughed because the plant was in very poor shape. The therapist whose office we were in was also the venerated director of the clinic, but he knew nothing about plants. Obviously, Ingrid did have some knowledge of plants. This represented another possible area of competence. The psychiatrist took the plant off the windowsill and held it for the girl's inspection.

INGRID: It's got small animals [mites].

(She continued in Swedish to instruct the psychiatrist on what to do with his plant.)

My work here was centered on searching for discovery of the competent self. This search was organized by my knowledge that both the family and the therapist of this retarded girl had been unsuccessful at connecting with that part of Ingrid's multifaceted self that wanted to grow. All of my interactions, therefore, were focused on reinforcing in the girl that aspect of self that was competent and caretaking and could have ascendancy over the others in the room. This required being alert to the available cues (such as her mother saying, "She knows more English than we know"), then capitalizing on and amplifying such cues. In part I was able to do this by emphasizing both my own newness in the situation and my difficulty with the language, placing myself in the position of a beginner who needed to be instructed in all of the details.

Highlighting for this retarded girl a little corner in which she was competent would open up a new reality for the whole family. However, this was not a therapy in which I could just give the family a new reality and wait for new patterns to emerge. It had to be a therapy of active intervention. When Ingrid instructed the prestigious psychiatrist in how to handle his plant, she set the stage for being treated as an adult. This event, then, became not an isolated interaction but part of a central strategy for change. This kind of therapy is unusual in that it acknowledges the ultimate significance of these small events in reinforcing the positive self, the identity that so far has not been attended to.

Countering Induction with a Fast Assessment

In families of the disabled, especially those with retarded children, the adults tend to organize themselves to confirm the incompetence of the youngster, taking over for these children and patronizing them. For therapy to be effective fast diagnosis and correct intervention is essential. The therapist must quickly counter the induction of the adults by finding instances of the adolescent's mastery and competence in dealing with his environment and resist the tendency to focus only on the limited mental capacities of the young person.

In therapy with Ingrid and her family I quickly established areas of Ingrid's competence, challenging the prevailing notions of the adults in the room and dramatically changing their estimation of her potential. It was no accident that at the end of the session the parents had the sudden thought that perhaps their daughter was ready for an attempt to live on her own. Clearly, this radical change was a result of the fast intervention to counteract the induction of the parents and the presiding therapist.

Before we continue, I must emphasize that an important part of working successfully with retarded adolescents is the avoidance of traps that may be set up very quickly in the first interchanges—traps that can lead the therapist to negate the abilities of the adolescent. If the therapist can avoid such pitfalls and find ways to highlight competence and mastery, he or she can produce dramatic and rapid change in the family system. But the starting place is almost always that inevitable hall of mirrors experienced by the family. To move forward, the therapist must quickly break through those mirrors which imprison both the adults and the disabled child.

Ballooning Small but Valid Moments

My work with this family illustrates another important technique, that of ballooning small but valid moments to unbalance the homeostatic mechanism. In this case the small moment turned out to be the key to therapeutic entry. My discovery of the girl's interest in flowers came in response to the simple question, "What do you like to do?" From this beginning I was able to build for the family a whole structure of competence that surprised them. The previous emphasis, on discovering what the girl could not do, simply disappeared.

It was Salvador Minuchin and H. Charles Fishman (1981) who introduced the metaphor "ballooning the small moment." They cautioned, however, that the art of therapy is in knowing what to balloon. In working with a disabled adolescent the art is in picking up on an incident that will reveal true competence. Ballooning can then prove decisive when it provides evidence to challenge the families' reality.

Of course, there are some caveats in using this technique. The therapist must be careful not to provoke false optimism. The proper use of ballooning hinges on clinical accuracy in determining areas of actual competence—areas that will evoke a reciprocal response from the parents and siblings. To choose an inappropriate area would lead instead to a therapy of condescension and would eventually set the family up for defeat and despair. With Ingrid's family we knew we had hit a true chord when the adults responded with laughter and pleasure when the psychiatrist's decrepit plant was introduced. It was obvious to all that in this area the young girl was far more competent than the eminent doctor.

A Therapy of Experience

According to Jerome Kagan in *The Nature of the Child* (1981), "The structure of beliefs about the self and the world that are most resistant to change is called a frame." (p. 9) This family's "frame"—their belief that their daughter was incompetent, helpless, and hopelessly dependent—was changed *in the session.* Moreover, it was changed in a way that was a consequence of structural family therapy. New experiences do produce a change in frame in most circumstances (Kagan 1984). And this tenet, of course, is an important characteristic of this therapy. It is the family's new experience of seeing their daughter as competent that changes the cognitive frame.

The therapist cannot assume that a new experience will occur outside the context of the session. The therapy must *provide* the experience right then and there. In the case of Ingrid's family the experience provided in the session was one of a radical inconsistency. This was one time that the parents were asked to see their daughter not as a disabled child but as a capable young woman. The therapy put forth a view of Ingrid that was totally inconsistent with the parents' usual way of regarding her. An inconsistency like this is not likely to surface spontaneously; the therapist must work with the system to uncover it in the treatment room.

In Ingrid's case the new experience was provided and an initial frame was set for the therapy. Sessions such as these do not, of course, entail the whole of the treatment. The continuing therapy involves amplifying the frame and making sure it is not inhibited. The therapist works with both the family as a whole and in subsystems to stabilize new structures and thereby maintain change. During this second stage of the therapy the therapist concentrates on not allowing the system to revert back to its denial of the adolescent's strengths.

Ingrid had been in the hospital for two months. In the next sequence I bring up the specter of what will happen when she leaves the hospital.

DR. FISHMAN: How long are you going to be here?

(There is no response.)

DR. FISHMAN: The rest of your life?

(Ingrid shakes her head vigorously in the negative.)

DR. FISHMAN: Two years?

INGRID *(loudly and emphatically):* No!

DR. FISHMAN: One year?

INGRID: No!

Before we could get Ingrid out of the hospital we first had to reinforce her self-confidence. One way to do this was to reemphasize her areas of competence and then challenge her to take on the unknown future. Once her competence was recognized, I could move on. I began by utilizing the old ploy of exaggeration, asking her if she planned to remain in the hospital for the rest of her life. She was immediately motivated to say no, which is what I wanted. Through further questioning I got her to negotiate down the time she would remain in the hospital. The therapeutic art here involved seizing the moment and building on realized competence, so that Ingrid could feel, "I can change things. I am competent. I can make decisions about my life."

Frequently the most difficult part of therapy with disabled adolescents is to get all of the principal helpers pulling in the same direction. In this adolescent's world the sources of feedback are many. The adolescent hears from family, physician, teachers, and other helpers. These divergent sources of response can make it difficult to maintain a positive progressive atmosphere. It may take only one negative source to set back the course of treatment. The therapist must therefore work to include as many of the helpers as possible in reinforcing the adolescent's new identity of self.

A fable comes to mind that I think may help illustrate the reinforcing powers of the outside context. A man coming out of the woods is very, very hungry. He goes into the camp and puts a little stone in a pot. Somebody approaches and asks, "What are you making?" He answers, "Stone soup." The second man tastes it and says, "Well, it's tasting good but it would be better with onion." So he goes and gets an onion. Eventually, each member of the community supplies another ingredient—celery, tomatoes, carrots, and so on—until in the end the first man just removes the stone. Ingrid's "stone" was the plant. The object of the therapy was to get people to rally around her emerging competence. We began with her mastery of plants, and around this fact the family progressively organized and reinforced the idea that the girl was capable in some areas. In the end it did not matter that her capability in handling plants might be a minor issue: the point was that the family had accepted this small capability as a new reality and had begun dealing with her in a variety of other ways as competent and worthwhile.

DR. FISHMAN: Where will you go when you leave the hospital?

(The mother points to herself.)

DR. FISHMAN: Congratulations—do you want her at home? Do you want your lovely, grown-up daughter to be at home?

MOTHER: She can't leave. She can't do important things.

INGRID: She's right.

DR. FISHMAN: I don't understand. You know a foreign language but you can't boil an egg—you can't cook at all?

INGRID: I can but only a little. Really.

This sequence represents the second stage of the therapy, where the emphasis is on stabilizing change and preventing a reversion to old patterns. When the therapy is going well it begins with an honest challenge to provoke a new response, one that is inconsistent with the parents' (as well as the adolescent's) belief that the adolescent is incompetent. By amplifying this inconsistency I managed to get

Ingrid to say "I can" and her parents to acknowledge, with some reluctance, this new fact regarding their daughter's competence. Now came the ultimate test: stabilizing the change. The goal was for Ingrid to free herself from an institutional dependency. I asked Ingrid, "Where can you go where you will be more autonomous and competent?" At that point it was clear that Ingrid could go anywhere she wished. (I should note that leaving home for a disabled child is a different proposition in Sweden than it is in the United States. In Sweden there are many state-sponsored group homes that can serve as midway places for stabilization prior to the final launch from the family.)

In this family we saw a rising resistance to Ingrid's leaving. The mother's overprotective assumption was that her daughter must return home. I chose to act perplexed, as if I could not understand the mother's assumption. I did this in order to evade resistance. The mother did not mention a place for Ingrid; rather, she pointed to her own body as the girl's destination. I interpreted this as a real sign of pathology, but instead of giving the mother a strange look I congratulated her on the fact that the girl was coming home to her. It was then that I professed my bewilderment about the mother's claim that the girl was incapable and so could not go anywhere else but home.

I believe at that point that the therapy was progressing well. The therapists were meeting the specific obstacles—the specific resistances to the release of the young woman. This was the family's way of keeping the daughter in check. We could now work to change this pattern and help to free the girl. Of course, the parental response with a retarded adolescent in this situation is understandable; the mother and father, with mother as spokesman, were afraid that their daughter would fail—that she would not be able to live on her own. It was almost habitual for this mother to rush forth to protect her daughter by holding her in place. But while the motive itself may have been benign, the practical result would have been anything but: the girl would have been prevented from taking her first steps toward autonomy.

Of course, what was at work in this family system was a kind of inertia. We were less concerned with the dark undercurrents in the mother's behavior, her unconscious attempts to curtail her daughter. As therapists we were more concerned with the surfacing of a system, the homeostatic sequences that emerged when the system was perturbed and that acted to return things to the status quo. The parents and Ingrid had both been challenged to behave differently, yet they had no experience in carrying out the new behavior. The developing patterns allowing change and growth had not stabilized, so the parents were unaccustomed to dealing with any possibility of independence. Their most available response was to jump into action to stop their daughter's flight. The system's inertia stood in the way of the therapist's goal of emancipating the young woman. The challenge, then, was to find ways both to amplify the moves toward autonomy and, at the same time, to defuse resistance.

INGRID: I'm not interested in moving out.

DR. FISHMAN *(looking at the mother*):You know why your daughter is not interested in moving out—because you are such a good cook.

The task here was to signal the parents that they are blocking autonomy and independence, and to do so without offending them. My way of accomplishing this was to find an innocuous way to suggest that they are hindering their daughter's growth through their benevolence. I gave many such messages to get my point across. This approach worked better than simply declaring the mother an intrusive, overprotective force, because it kept the parents on my side as well as on the side of their daughter. In addition, I knew that any attack on the parents would have made it more difficult for Ingrid to leave. (It is hard, after all, to leave someone who is hurting.) The chosen technique then, was meant to maintain a light tone and to give the mother the message that she is so good to her daughter that she is holding her back.

DR. FISHMAN (*to the mother*): Are your other children married?

MOTHER: Two of them are married.

DR. FISHMAN: Do you hope she gets married one day?

MOTHER: There's always a hope, but I'm skeptical.

DR. FISHMAN: Why? *(To Ingrid:)* The boys don't like you?

INGRID: I don't like them.

DR. FISHMAN: Oh, that's different. You know what I think interferes with you getting married?

INGRID: What?

DR. FISHMAN: Because your parents make it so comfortable for you at home. Because your parents are confused; they don't know what you can do, that you can be more independent.

MOTHER: There is a problem that she doesn't know how to spell and how to write. There is also the economics—she can't manage economics. We keep her money; we give her some every week.

DR. FISHMAN: Do you like that?

INGRID: What?

DR. FISHMAN: That your mother and father have all your money.

INGRID: It's best.

DR. FISHMAN: Why?

INGRID: I don't know enough about it.

MOTHER (*to the father, in an apparent revelation):* It might be interesting to give her her money to see how she could do.

FATHER: Maybe.

DR. FISHMAN: I think that's a good idea. See, maybe she's smarter than you think.

FATHER: Yes, I don't think there's much to be lost. It's worth a try.

MOTHER: It's a good situation, because if she can handle her money, she can also blow what she wants. It would be interesting to see.

(While the parents are discussing the possibility of her managing her money, I get up and walk over to Ingrid. I kneel next to her and touch her arm.)

DR. FISHMAN: Your mother and father think that you're younger than your age and that you can't handle money. Is that true, or do you want to try? You know English, and you know about plants—why can't you handle money?

INGRID: No, I don't know English.

DR. FISHMAN: But you understand me.

INGRID: Yes.

DR. FISHMAN: Your mother says you will just spend all your money, but I'll bet you can *not* spend all your money and can prove them wrong.

(*Ingrid looks at me and smiles.*)

DR. FISHMAN: If you can handle money you can live on your own. Because we know you can cook some things, and we know you know English, and we know there is an area where you can get a job. Then you can live on your own. *(Looking at the mother:)* Would you let her move out?

FATHER (*shaking his head*): No.

DR. FISHMAN (*to the Mother*): Would you?

MOTHER: Yes. If she can manage her finances.

DR. FISHMAN: Maybe she should stay with you for many, many years.

MOTHER: That's her problem, we can't live her whole life for her. When she moved out, she tried living with people her own age and it didn't work *(shaking her head vigorously).* But then again, it was very close to home and it was easy to go home.

DR. FISHMAN: Maybe it shouldn't be so easy to go home.

MOTHER (*nodding her head vigorously in agreement*): We discussed that it was too easy for her to go home and also [that] she was the only girl there. Now there are three more girls there.

The parents turned to one another and discussed the options raised. They agreed that they would first give Ingrid the chance to manage her money and then, if that were successful, allow her to move out into a sheltered situation.

THE FOLLOW-UP

Two weeks after the last session Ingrid was discharged from the hospital and the parents took responsibility for her charge. Ingrid really wanted to go to school, and shortly thereafter she did start going to a school away from home, an intern school where she stayed overnight. In addition, she started taking care of her own money and managed very well, without any failure. During Ingrid's absence the therapists received several telephone calls from the mother, who was frightened about the girl being given too much freedom. She was reassured that Ingrid was doing well and that the course of action taken was absolutely necessary.

The following summer Ingrid got a summer job as a gardener's assistant. For the first time in her life she received an actual salary, not a pension. Later, she went on a vacation with her parents for two weeks. This turned out to be a "disaster," according to her parents. Ingrid kept testing the parents' limits and went out with boys. When the family came back, the mother phoned the therapists again to talk about this new behavior. Again she was reassured that these actions were developmentally in order, and the therapists further complimented her on giving her daughter freedom.

Eventually Ingrid enrolled in an art school, where she also was able to improve her reading and writing skills. She hoped to secure a job as a gardener or as a gardener's assistant. She had a boyfriend, who she met in the new school, and she was very fond of him. Ingrid had not been at home in the last two months and had had no psychiatric breakdown; nor had she required any medication.

Summary

For three years after this consultation I felt very good about the outcome of this therapy. Any time I spoke with Olaf Ulwan, the psychiatrist who headed the clinic in Sweden where the therapy took place, he had regards to me from Ingrid—things like, "Tell Dr. F. that I am doing well and I am very much enjoying my work."

Last year Dr. Ulwan left the clinic and a non-systemic model of therapy was adopted there. Thus, when Ingrid experienced a new crisis (she broke up with her boyfriend and became very depressed) she was hospitalized for an extended period and then sent home to her parents. Apparently, she was neither working nor seeing her friends.

Hearing this news reminded me of some sobering realities about families and family therapy. We must have respect for the chronicity of the previous homeostasis as well as for the nature of the presenting disability. Ingrid and her family were a very stable system with much chronicity in the dysfunctional organization. Her particular disability, retardation, tends to have the power to organize people to be overly helpful. I believe that family therapists should be cognizant of the fact that systems not only transform but they also *transform backward.* Therapists should, with very chronic cases, make provision for this fact, such as asking families to return for regular follow-up interviews. This would help to maintain the new organization of the family system as well as to let the family know that in this "General Practitioner approach," if a new problem emerges, there is someone available to help. If such an arrangement had been in place in Ingrid's family system, chances are that the original therapeutic team would have been able to head off the new crisis.