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Case Study of a Psychosomatic Family

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Abstract. Even if nowadays bronchial asthma is no longer considered a psychosomatic disease, there is evidence that stress and other psychological factors can trigger or accentuate the symptoms of the disease. Children's bronchial asthma is one of the most frequent diseases seriously enabled by these factors. The article is based on empirical data and its aim is to investigate from the viewpoint of systemic social therapy the functioning of the families in the case of children with asthma. The interview with the family conducted according to the family-model dimensions of McMaster (problem solving, communication, roles, affective responsiveness, affective involvement, behavior control and general functioning), psychological questionnaires and a case study completed from the point of view of systemic family therapy approach (structural methods). The family-systems of children with asthma show atypical signs in terms of family interactions and organization, which most commonly take the form of fusion, overprotection, rigidity and conflict avoidance. Family members appeared to be over-involved in the lives of each other and tended to show protective behaviors towards the children. At the same time, such families seemed to be resistant in front of change and had low levels of conflict-resistance. All in all, we can conclude that in the case of children with asthma, asthma as a psychosomatic symptom takes a range of metaphoric meanings, i.e. the sickness has a symbolic meaning which must be communicated in the form of somatic rather than discursive repertoires.

Keywords: family therapy, systemic approach, psychosomatic family

INTRODUCTION

In the last three decades, the research concerning family functioning has been targeting two branches within the medical sciences: firstly, it intended the families of schizophrenic patients, then later those families of children afflicted with psychosomatic illnesses (Bateson *et al.*, 1969; Groen, 1974; Hermann, 1981; Lidz *et al*, 1979; Stierlin *et al.*, 1985; Watzlawick, 1969, 1974). Important in this sense is the research carried out by Minuchin *et al.*, 1978 who, with the aid of systemic family therapy, produces good results regarding families with children suffering from psychosomatic afflictions (Minuchin *et al.*, 1978, 1995, Minuchin, 1979).

The systematic model contends that there are certain types of family organization which can be connected to the occurrence and perseverance of the psychosomatic syndrome in children; likewise, this model brings forth the fact that the psychosomatic symptoms of the child play an essential role in maintaining the family homeostasis (Ibidem, 1995).

In order to argue as suggestively as possible in favour of the paper's hypothesis, according to which "the familial organization might be linked to the occurrence and perseverance of the psychosomatic syndrome in children, and their psychosomatic symptoms constitute a key factor in maintaining familial homeostasis", we will present a case study conducted on a psychosomatic family. It is important to accentuate that, taken singularly, the case study is not representative from the viewpoint of our research. Instead, the case study has two aims: firstly, it constitutes a pioneer approach for the Romanian family psychotherapeutic

practice and, secondly, it serves as a grounding for our empirical research based on a relatively large sample, i.e. 79 children (38 with bronchitic asthma and 41 from the control group) and 79 adults (38 with bronchitic asthma and 41 from the control group) and in this way illustrates the need for holistic approaches in family therapy, i.e. the need for recognizing not only the symptoms but also those problems which are signalled by the symptoms.

MATERIALS AND METHODS

For the purpose of the present paper, we used qualitative, as well as quantitative methods of research. The instruments employed were the following: interview with the family based on the family-model dimensions of McMaster (based on Epstein *et al.*, 1983): McMaster Family Assessment Device, FAD), questionnaires: Spielberger, C.D. (1970): State Trait Anxiety Inventory, STAI Form X-1, STAI Form X-2; Folkman, S., Lazarus, R.S. (1980): Ways of Coping (Kopp and Skrabski, 1992). And For children (with asthma): Spielberger, C.D. (1973): State Trait Anxiety Inventory for Children, STAIC; Rosenberg, M. (1965): Self-Esteem Scale – RSES, Kovacs, M. (1981): Child Depression Inventory, CDI (Kovacs, 1992).

For a better comprehension of the case study, we used the following structural methods: genogram and the design of emotional attitudes within the family. Genogram is a structural diagram which displays the family relations spread across multiple generations. The design of emotional attitudes is also a diagram, but used in signifying the emotional relationship established between family members.

RESULTS AND DISCUSSIONS

The S. family comprises four members: parents with two children. The parents graduated from a university, and the mother is aged 39 (Eva S.), whereas the father (Adrian S.) is 42 years old. The oldest boy (David) is 13 years old in the 6th grade, and the girl (Ana), the patient diagnosed with bronchial asthma is 9 years old in 2nd grade.

Ana was diagnose with bronchial asthma when aged 4. At the beginning of the illness, the asthma crises had been frequent and intense, and her parents called for the doctor many times. In time, Ana was subjected to diverse medicament treatments, but her state did not significantly improve. Consequently, her sickness was labelled as chronic, "untreatable" and a last-resort recommendation to see a psychiatrist was made.

Hence, we notice that the patient's family exhibits a deficient functioning (General functioning: 90), that Ana's mother uses emotion-based coping (31) and that she reached high values on the anxiety scale (as state: 39, as trait: 43). These results are similar to the results of our empirical research realised on 79 adults (38 with children with bronchitic asthma and 41 from the control group), because this results show that there are significant differences between the general functioning of the children families with bronchitic asthma and the functioning of those families which compose the control group (the arithmetic mean being 16.88 for the control group and 19.47 for the experimental group). Regarding the type of coping, the parents of bronchitic asthma children use emotion-centered coping (the arithmetic mean being 24.66 in comparison with 19.98 for the children's parents from the control group), whereas those of the children from the control group employ problem-based coping (the arithmetic mean being 13.05 in comparision with 10.95 for the children's parents from the experimental group).

Tab. 1

Results of the questionnaires addressed to Ana's mother

MOTHER	FAD (Family Assessment Device)								
	Problems results	Communica-tion	Roles	Emotional response	Emotional involvement	Behavioural control	General functioning		
	6	9	12	13	12	19	90		
	Ways of Coping								
	Problems analysis	Comparison with the goal (decided)	Emotion-based comparison	Adaptability	Help request	Search for the emotional equilibrium	Withdrawal	Problem-centered coping	Emotioncentered coping
	4	5	4	8	5	6	8	9	31
	STATE TRAIT ANXIETY INVENTORY, S.T.A.I								
	S.T.A.I Forma X1 (the anxiety state as state)				S.T.A.I Forma X2 (the anxiety as trait)				
	39				43				

The significant statistical differences ensued from our research (the arithmetic mean for S.T.A.I. FORM –X1: 34.71 for the control group, 41.08 for the experimental group; the arithmetic mean for S.T.A.I. FORM –X2: 33.27 for the control group, 41.76 for the experimental group) indicate that the parents of the children afflicted with bronchitic asthma are confronted with a higher degree of anxiety than those of the children from the control group.

Tab. 2

Results of the questionnaires addressed to Ana

ANA	SELF-ESTEEM SCALE, RSES	
	12	
	STATE TRAIT ANXIETY INVENTORY FOR CHILDREN, S.T.A.I- C	
	S.T.A.I Forma C1 (the anxiety state as state)	S.T.A.I Forma C2 (the anxiety as trait)
	32	39
	DEPRESION INVENTORY IN CHILDREN, CDI	
	13	
	SYMPTOMATOLOGY OF BRONCHIAL ASTHMA	
	Nightly symptomatology	Daily symptomatology
	3	2

As the second table shows, Ana has low self-esteem (12), high anxiety (as state: 32, as trait: 39) and manifests signs of depression (value: 13, albeit it is not a very high one). These results are similar to the results of our empirical research realised on 79 children (38 with bronchitic asthma and 41 from the control group). Children with bronchitic asthma had lower self-esteem than the children from the control group (the arithmetic mean for RSES: 20.49 for the control group, 16.34 for the experimental group), had a higher degree of anxiety than the children from the control group (the arithmetic mean for S.T.A.I. FORMA –C1: 29.59 for the control group, 34.39 for the experimental group; the arithmetic mean for S.T.A.I. FORMA –C2: 34.27 for the control group, 38.82 for the experimental group) and

manifests signs of depression (the arithmetic mean being 13.21 in comparison with 8.93 for the control group).

The following description is built on the stock of information that ensued in the three familial therapy sessions with the S. family. All family was present during the first session. Together, we did the family's genogram (Fig. 1).

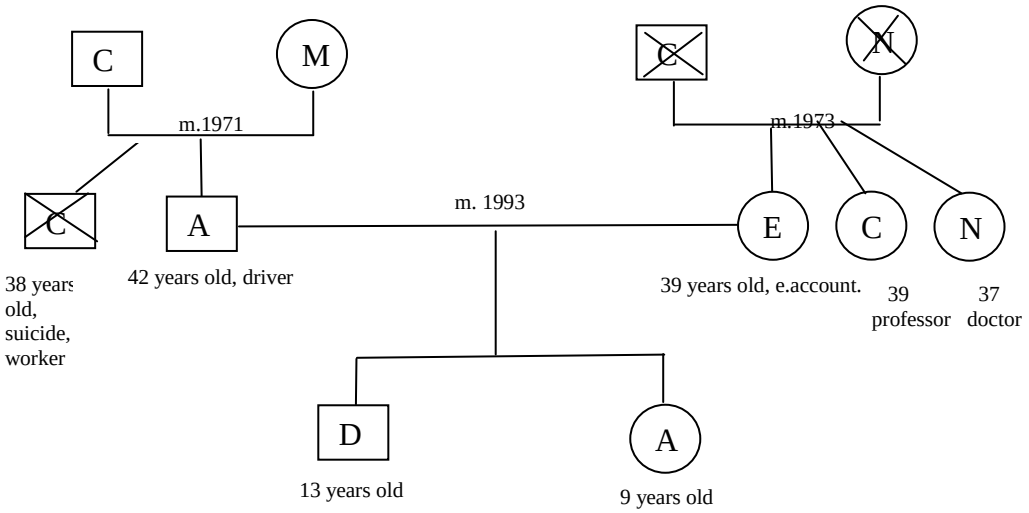

Fig. 1. The S. family's genogram

By drawing their genogram, we found out that the members of the S. family live in a private house, away from the father's parents ("and it is healthier this way" – the mother said) and from the mother's little brothers. Three year ago, an "accident" occurred that affected the extended family: the father's brother killed himself (since then they did not talk about this traumatic event). The mother has two younger sisters who live with their own families. The mother's parents died 4, respectively 6, years ago from illness (lung cancer, cardio-vascular diseases).

During every session, the family presented itself as a united one, within which there are no problems to tackle, and behaved according to the slogan mentioned by the father: "all for one, and one for all". They all claimed that "we have no problems except for Ana's illness", issue that disappoints them "immensely".

Both the parents and Ana's brother conduct themselves in an extremely protective way towards Ana. Her brother, David, said that even if he would have liked to go fishing with his dad, he understands the situation that his family has to deal with on a daily basis and agrees with his mother that Ana can't be left alone. Therefore, he gives up his desire to spend time alone with his father. Following this idea through, the overall picture rendered by all family members painted them doing everything together: they all go shopping together, on trips together, to the cinema, etc. The father said that "since Ana's illness", he and his wife have never been anywhere alone, without the children, for recreation. Even before finishing his talk, the father was interrupted by the mother who wanted to intervene in order to clarify things: "you know very well that we can't be relaxed without having Ana with us, without having both of our children with us".

According to the parents' characterization, Ana is a very good, hard-working girl, who never made them any problems. She is doing well in school, and even if she would have liked to go to popular dance, she was not allowed to because she's ill. The father seems to be more inclined to give Ana a little "freedom" (to go to the school dance), but the mother contradicts him immediately, reminding him that "her health state" is not conducive to such

pastimes.

David is apparently a quiet boy (we learned that at school he is used to beating his colleagues; we will assign a session in order to approach these episodes), who takes refuge in the computer games played together with his school friends. He never contradicts his parents and confirms that his family acts like "the fours musketeers". It is important to observe that he adds to this comparison the assertion: "maybe it is time to go to fight separately as well". Nevertheless, he finishes quickly his train of thought with "eh, I'm just kidding, musketeers fight together".

Although the father graduated from the Faculty of engineering, he never worked in this capacity. At present, he works momentarily as a driver. He doesn't earn well, but as his wife says "he makes enough for cigarettes" while of everything else "thank God, I'm in charge". She thinks that her husband "did not choose wisely his profession", that "he had no luck". It is interesting that although the non-verbal communication suggests that he disagrees with his wife, the husband does not refute her opinions. Eventually, he says: "ok mother, everything is as you say it is". We notice that he addresses her as "mother" and not "wife" or by her name.

From the point of view of the family therapy, a further exploration should entail tackling questions like: how the family members function when taking on different roles (for example, the role of partner, gender, etc.), if they are capable of doing altogether, etc.

The mother is an expert accountant. She stresses a few times that she is an "expert"; she is very proud of her academic accomplishments because she attended college during her having her second child, and the expert exam was successfully passed while nurturing a "sick child". She says that "it was not easy for me, but I had to do it" because they needed money for purchasing a house.

Although it was obvious from the start that there was tension simmering between the family members, between the parents, during the first two sessions they spoke calmly and relaxed. They wanted to convey the "myth of unity". There were likewise signs that they wanted little changes to take place – for example, the children to live for a weekend, or to go with the father fishing -, but after expressing hopes in this sense, they quickly contradicted themselves within the same sentence, going back to emphasizing the importance of being together, doing everything together. And all of this with Ana's condition in mind.

During the third session we drew the diagram of emotional attitudes. The emotions specified by the family members were: love, dedication, solidarity, beauty, unity, happiness, goodness, respect. It is important to take into account and valorise how this picture looks, to see where the place of every family member within the drawing is: Ana is very close of her parents (the triad Ana-parents evokes the idea of "a by-passing road" corresponding to Ana's role in her relationships with her parents); David is further away, as if he were not properly part of the family. Although, in David's case, there is a form of distance from the other family members, their mutual, close relationships is still a strong given even for David.

During the completion of the drawing, while every family member verbally encouraged and supported the others, nonverbally there was little contact: eye-contact was very rarely made, David, albeit very quiet, conveyed uneasiness and Ana waited for the others to answer in her place, giving her verbal approval to whatever they said. It was very interesting to see that at a certain moment when the husband said about his wife that she is "his dear captain", and when she, in her turn, strongly retorted denying it in a higher voice, Ana succumbed to an asthma crisis. In the next second, all family members leaped to her side. The mother said: "you see, we can't have a moment's piece because of our daughter's illness". This very suggestive episode leaks the basic rule for this family's general behaviour: "In our family fighting is forbidden".

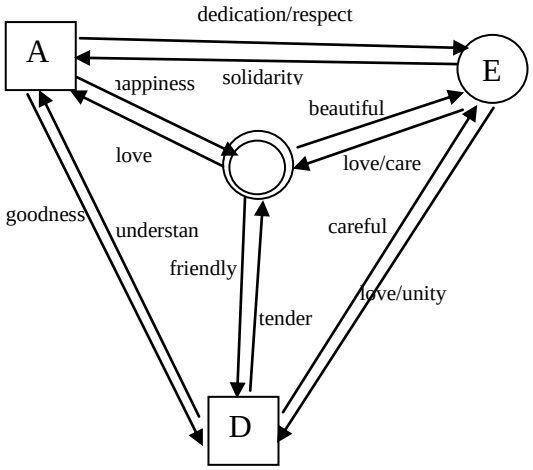

Fig. 2. The diagram of emotional attitudes

CONCLUSION

In the wake of the three sessions, our general conclusion is the following: Ana's family is characterized by enmeshment, hyper-protective behaviour, rigidity and lack of conflicts solving. The boundaries between the family members are weak, blurred, while their individual autonomy is low; at the same time, the boundary between the family and the outside world is very clear and firm. Family members exhibit hyper-protective behaviour, striving to influence the other's conduct and feelings.

Ana's symptomatology has a regulative role in conflicts solving. Her family contribute to her symptoms' endurance, but she herself, through her asthmatic crises, lends a hand in maintaining the family equilibrium. Through her illness, she "keeps her parents close together", while her brother enjoys more freedom. For this family, conflicts do not show themselves, their solving means hiding them under the carpet. Fights are forbidden within the family because they are considered extremely dangerous for the integrity of the family. Nevertheless, the tension does not go away; it only gets displaced on another person from the family (Ana) who reacts by having asthma crises.

Therefore, Ana's condition helps in maintain the familial homeostasis, and this entails equally that the illness perpetuates itself. There is, hence, a "diabolic", vicious circle at work which maintains and amplifies the sickness and which confirms our research hypothesis.

Analytically grasping the results from the point of view of the systemic model, it results that: 1) there are certain types of family organization which can be linked with the occurrence, development and persistence of the psychosomatic syndrome in children; 2) psychosomatic symptoms play an essential part in maintaining the family homeostasis.

Consequently, for asthmatic children the psychosomatic symptom is metaphoric (symbolic), connected with something which can't be verbally communicated and, therefore, it manifests itself through "bodily communication".

REFERENCES

1. Bateson, G., D.D. Jackson, R. Laing, Th. Lidz and L.C. Wynne (1969). Schizophrenie und Familie. Frankfurt, Suhrkamp.

2. Epstein, N.B., L.M. Baldwinand, D.S.Bishop (1983). The McMaster Family Assessment Device. in Journal of Marital and Family Therapy. 9:171-180.

3. Folkman, S. and RS. Lazarus (1988). Manual for the Ways of Coping Questionnaire. Palo Alto, Consulting Psychologists Press

4. Groen, J.J. (1974). The Challenge of the Future: the Prevention of Psychosomatic Disorders. Mechanism in Sympton Formation. 283-303

5. Hermann, E. and I. Berlin (1981). Család és betegség. in Valóság. 1981/9:95-108

6. Kopp, M. and Á. Skrabski (1992). Megküzdési Módok Kérdõív. in Papir-ceruza teszt. ac. 2013, Budapest, Animula

7. Kovacs, M. (1992). Children's Depression Inventory (Manual). New York, Multi-Health Systems

8. Lidz, Th. and S. Fleck (1979). Die Familienwelt des Schizophrenen. Klett-Cotta

9. Minuchin, S., B.L. Rosman and L. Baker (1995). Pszichoszomatikus családok, Budapest, Animula

10. Minuchin, S., B.L. Rosman and L. Baker (1978). Psychsomatic Families. Harvard University Press

11. Minuchin, S. (1979). Familie und Familientherapie, Freiburg, Lambertus

12. Spielberger, C.D., R.L. Gorsuch and R.E. Lushene (1970). Manual for the State-Trait Anxiety Inventory. Palo Alto, Consulting Psychologists Press

13. Spielberger, C.D. (1973). State-Trait Anxiety Inventory for Children. Palo Alto, Consulting Psychologist Press

14. Stierlin, H., I. Rücker-Embden, N. Wetzel and M. Wirsching (1985). Das erste Familiegespräch, Stuttgart, Klett-Cotta

15. Watzlawick, P., J.H. Beavin, D.D. Jackson (1969). Menschliche Kommunikation. Formen, Störungen, Paradoxien, Bern, Huber Verlag

16. Watzlawick, P., J. H. Weakland and R. Fisch (1974). Lösungen: Zur Theorie und Praxis menschlichen Handelns. Bern, Huber Verlag