Family Scripts: A Concept which can Bridge Child Psychotherapy and Family Therapy Thinking

John Byng-Hall

Introduction

Child psychotherapists and family therapists need to collaborate. Family therapy is now the major therapeutic approach in many child guidance clinics. Interventions are usually briefer and one therapist, if suitably supported, can treat the whole family. The economics of that are powerful and will not go away. Some children, however, do not respond to family therapy but do dramatically well in child psychotherapy. I refer a number of children for child psychotherapy for that reason. My own view is that family work provides a good launching pad for child psychotherapy. The child when released from scapegoating processes is freer to explore and develop in psychotherapy.

Family therapy is not a separate discipline in the UK. It is a skill added to other professional qualifications such as child psychiatry, social work, psychology or child psychology, etc. In my experience child psychotherapists also make excellent family therapists. The other disciplines using family therapy skills have a lot to learn from child psychotherapists about understanding children. Without this ability seeing families can become work with parents in front of the children. Each approach then needs the other.

In this paper I will present the concept of family scripts (Byng-Hall, 1985) which links intrapsychic and interpersonal phenomena and I will show how it was used with a family. Various family therapy interventions will be illustrated in this way.

Family Scripts; their nature

Each member of the family has an “inner family” which helps to determine what goes on in the outer family; just as each member of the cast has a script for a play. Sitting with families one becomes aware of the same basic pattern of interaction, with minor variations, repeated over and over again like the rerun of one scene in a play. The advantage of the concept of script over object relations theory is that it addresses more readily the fact that everyone not only casts every member of the family in their inner world but is simultaneously playing roles in everyone else's scripts. Not surprisingly, however, object relations theory can be readily translated into script terms. Casting of roles, for instance, involves projective identifications, splitting, etc., etc. Understudying is through identification and introjection, and so on.

The past is made present by bringing scripts for family life from the family of origin. There are several points to be made about that. First, the past is likely to be repeated; what I call a replicative script. Second, there will also

be attempts to alter that experience, a corrective script. Second, there will also be attempts to alter that experience; a corrective script. Most parents will readily recognise the phenomenon of being determined not to make the mistakes they felt their parents made with them, but then, to their horror, find that at times they are doing to their children those very same things that they swore they would never do. Some of the corrective script is likely to remain outside awareness. Repression, denial, reaction formation are some of the mechanisms involved.

Marital choice is a process in which these two elements are both active. Correction is often attempted by choosing someone apparently very different from the parent of the opposite sex. But the chosen partner is often struggling to free him or herself of an identity with the parent of the same sex by being as different as possible, so when the facade breaks down — horror of horrors — she has married her father; he his mother. We are all familiar with this phenomenon.

In both the corrective and replicative scripts the past is programming the present and hence can be restrictive. How can growth occur?

Repetition is unavoidable. We cannot live without repeating; in a sense, our repetitions are what we are. But growth implies not repeating exactly what went before. So one is, and yet is not, who one was. Freud (1909) describes one reason for repeating apparently self defeating acts through the concept of repetition compulsion: “a thing which has not been understood inevitably reappears; like an unlaid ghost, it cannot rest until the mystery has been solved and the spell broken”.

I see repeating the family scripts in the same light. The memory of the family is partly carried, as with individuals, in repeated action — in this case in family scenarios. Each redramatisation carries with it the potential for resolving old problems; for finding a new solution. I see redramatisations as an important opportunity for therapeutic change, not just as resistance.

Another mode of change, however, comes through exploration. From play. In this case the behaviour is not scripted but the setting in which the play can take place is scripted. Here one can turn to attachment theory. Exploration takes place in the setting of secure attachment. The mutual scripting of care-giving is very clear. Mothers have an image of their child's whereabouts and of his current state of mind and body; while the child grows to anticipate that when he needs it she will be there and be able to support him through any upsetting situations. This gives him the sense of security to explore, amongst other things to explore relationships with his family. Being “held” or “contained” are ideas illustrating the same phenomenon.

Implications for therapy

I perceive the therapist as providing a relationship equivalent to the secure attachment in which new relationships can be explored; both via play and through the urgency of redramatisations. These can be anticipated as soon

as the therapist has been tested and found to be strong enough. Family scripts can then be re-edited.

Interactional awareness versus “outsight”

I aim to help families develop the capacity for interactional awareness. This is to be found in families with secure attachments and includes all members of the family. It involves each being aware of the nature of the interaction and how it is affecting everyone. It includes insight into one's own contribution to the interaction. In this way it is possible to modify the family pattern without infringing anyone's defences or leaving anyone unsupported. This is to be contrasted with “outsight” — which is a perversion of insight — into other members of the family's motives. As we know families and marriages provide excellent opportunities for mutual projections. Dicks (1967) argues that this has advantages because at least the disowned parts of oneself are kept at home not spread far and wide and hence unavailable for reality testing. But the use of very precise “inside” knowledge about those disowned aspects of oneself lodged with others can be used as a powerful avenue for projection. I call this “outsight” to differentiate it from proper insight. In practice it can be observed as a subtle, or blatant, denigration of the other person. All those in the field of therapy are at risk of “outsight”. Family therapists who work with families in which members are either in therapy or who are therapists can vouch for that. It is unfortunately not possible to be certain how people use, or misuse, their developing psychological insights unless family interaction is witnessed. No doubt individual psychotherapists can tell family therapists in which way they use or misuse their skills. We need a dialogue about this.

Forgiveness and reparation

Family members often do very nasty things to each other as well as being extraordinarily self sacrificing. Boszormenyi-Nagy & Spark (1973) describe the Family Legacy in which debits and credits are built up, leaving scores to be settled, often many years later. These may be extracted from people other than the original perpetrators. Deprived parents may, for instance, try to extract parenting from their children, thus depriving them and hence maintaining the cycle of deprivation. Withdrawing projections still leaves the legacy. Arguably the two vital steps in all forms of therapy are forgiveness for neglect or for attacks made on oneself, and reparation made for injustice done to others. Readers of this journal will recognise the shift from a sense of blame to a sense of pain inherent in the move from the paranoid-schizoid position to the depressive position. From a family script perspective this is a reciprocal event. It is easier to make reparation if the other person has stopped blaming you and vice versa. The extraordinary energy of the vendetta is laid to rest. In family therapy there is a unique opportunity for forgiveness. The unfolding of the family story can be done in a way which puts everyone in touch with each other's predicaments. This is especially powerful in three generational

patterns. For a child to appreciate that his parent's current behaviour is an attempt to correct their own hurt experience paves the way to forgiveness. One generation further back family trees can show how the grand-parent's treatment of the parents was also a product of their upbringing. It can then be appreciated that the way children are treated is not just a personal assault, but is rooted in an understandable historical context, and often represents the best the parent could do at the time.

Therapists' role in the Script: transference/countertransference

Forgiveness has to start with the therapist. This may be difficult as families are extremely powerful at recruiting into their script roles. If blame is the family dynamic the countertransference of angry blaming (or self blame) will soon emerge. The family leaves a vacuum into which the therapist is sucked. That vacuum may be one of affect or action, but usually both. For instance if the family presents a drama with an inevitable catastrophe just around the corner and no-one in the family is doing anything to avert it, the therapist will feel intense anxiety together with an impulse to put a halt to the escalation. The countertransference is the anxiety; the role he feels pushed towards is the transference.

Usually the vacuum contains the family dilemma; their unresolved conflict. After all if someone firmly telling them to stop was enough a member of the family would have done it already. If the family then make it impossible to be effective, frustration, impotence, or self blame may follow. Equally, depending on the family and the therapist, the person most obviously thwarting the therapist may suddenly draw all his anger. “My God, that mother is resistant!” The general principles apply to other dynamics as well. A family which tells its awful tragedies with fixed smiles leaves the therapist full of their tears. The therapist has to use his understanding of the family dilemma and his response to them as a way of defusing the impulse to blame (or whatever their particular dynamic may be). He acts as a “container”, to use Bion's term.

The ‘X’ Family Referral

The G.P.'s letter was soon followed up by urgent phone calls from Mr. X. He was desperate because his problems with Jeremy, his thirteen year old son, were so bad that he was afraid it would kill him. He explained that he had had open heart surgery a year before.

First Session

I saw the family urgently. Mr. X was a thin, tall man from Kuwait aged 50, who spoke as if he expected to be obeyed, but always disqualified himself by overstating his case. Mrs. X was a red haired Welsh woman with a broad accent who looked down in a demure way, and came to sit next to me. The

two sons sat between their parents. Jeremy, awkward and gangling, sat next to her. He looked shiftily around and would not meet anyone's eye. He grimaced in an odd way. Simon, aged eight, delightful, outgoing, sat next to his father and smiled at me.

Mr. X, taking charge, explained that Jeremy got to school late in the morning and refused to go to bed at night. He said he blamed his wife for this because she gave in to Jeremy which so infuriated him that he was violent to his son, but then, after a few minutes regretted it. This was the bare bones of the family script. Later in first session other information was added.

The function of the symptom

Jeremy was, it emerged, in a serious obsessional crisis. He had several rituals. One involved repeatedly stepping right and left while standing still, a sort of ritualised walking on the spot; another involved running up stairs a particular number of steps and then down again. The third was pressing the buttons on the video recorder in a particular sequence. The consequences of these symptoms were interesting. Much of the family therapy is unravelling the effect of the symptom because these become important to the family; or to put it another way, if the child gives up the symptom what effect will it have on everyone else?

Jeremy's symptom meant that he stayed at home with his mother, often never getting to school. She was thus not left on her own. At night it meant that his mother spent up to 3 a.m. with him trying to get him to bed. She sometimes slept in Jeremy's room. This, of course, prevented his parents sleeping together. In a session with his parents on their own it was clear that this protected them from anxiety about sexual intercourse killing Mr. X. The other effect was to make Mrs. X ring her husband up repeatedly during the day about her difficulties with him. Thus Jeremy's symptom regulated his parents marital distance. I have discussed (Byng-Hall, 1980) how a child's ambivalence about her difficulties with him. Thus Jeremy's symptom regulated his parents' conflict in a marriage which is simultaneously both too close and too distant. This is quite a common phenomenon. Anxieties about intimacy make closeness dangerous but the distance required to feel safe about that makes the relationship feel so tenuous that it feels insecure. Mr. X's heart heightened this dilemma but was resolved by Jeremy who also gave his mother company so that she did not feel abandoned. By tracing the consequences of the interaction set up around the symptom it is possible to start the process of developing interactional awareness and understanding the dilemma facing everyone. It also starts to point towards what needs to change before the symptom will be allowed to disappear.

Anxieties in the family

It is important to discover what catastrophes the script is preventing. Much of the overt behaviour is in the service of preventing more frightening events.

After Mr. X had told me about losing his temper with Jeremy I asked what catastrophes were feared, explaining that families often got used to people losing their temper so that it was not so frightening as other things. They shared the following series of worries. Firstly, Mr. X said he might die, but quickly went on to say that he was prepared for that and had been preparing Jeremy for that since he was eight. Recently he had made his will out to him so that he would become the head of the family. Mrs. X said that she wondered whether this was frightening Jeremy.

Other fears came from the threats that Mr. X had used when he became agitated. He threatened to leave home; to throw Jeremy out; to throw both boys out; to kill his wife with a hatchet or kill Jeremy. Mrs. X was heard to mutter that she felt like doing that herself sometimes. She was quick to point out that she did not think he would ever do any of these things. We had a discussion about how frightening these threats were nevertheless.

Historical context

The reason for, and the impact of these threats could only make sense in their historical context. Father had been eight years old when his father had a severe stroke and nearly died, although he lived on in a vegetable state for many years. His elder brother became the head of the family at that point. This now made sense of warning Jeremy, the eldest son, about being the head of the family, since he was eight.

When Mr. X was thirteen his elder brother, who was then 35 years old, died suddenly of a heart attack, and Mr. X had suddenly found himself having to support his large family. Mr. X's panic now made complete sense.

Age specificity is an important feature of family scripts. It is natural that the age of one's child resonates with experiences at the same age, and the tension between replication and correction reaches its height at points of unresolved events at specific ages of one's own childhood. It should have been possible to predict a crisis for Mr. X and his family when his two boys reached 8 and 13. Add to this his own heart attack and the panic was complete.

Mrs. X told me that she did not have a “family.” She had a twin brother. Her father deserted her mother. She and her brother went into a Welsh orphanage at the age of three. The twins were then adopted by a family who already had a girl of their own. She considered that they were only adopted to give this girl some company. She became rebellious and was thrown out in her teens while her brother stayed with her adoptive parents.

With this background it is possible to see that Mr. X unerringly put into his threat all the traumas of her childhood. No doubt she contributed to this verbal repetition compulsion. It was also possible to understand her wish to keep her children very young to keep them from facing all the traumas she underwent. She was treating Jeremy as a three year old.

Towards the end of the session I was able to point out that each was trying to correct something from his or her past. He was trying to make Jeremy grow

up so that losing his father and becoming head of the family would not be such a shock as it had been to him. She was wanting to give her children all the love and security she had longed for herself. In the meantime Jeremy was receiving conflicting messages about growing up.

Positive labelling in family therapy

I spent a lot of time establishing a respectful relationship with both parents. I related to the strengths of each and labelled them positively. Family therapists need to do that, whereas it is often unfruitful with individual patients who may see it as a sign that the therapist cannot stand bad things about them. Family therapists must never undermine the competence of individuals in the presence of other members of the family. If they do the family will quite correctly leave therapy. Interpreting unconscious phantasy in the transference is often experienced as publicly exposing. This overrides the relief of being understood, which is often experienced in individual work or in stronger groups whose members do not have to relate together afterwards. Once family members have discovered that they are not going to be undermined they are then more likely to feel safe enough to share the bad things that are going on. The X family was able to share their murderous feelings with me.

Interpreting mutual defences is, on the other hand, entirely appropriate and is called “positive connotation” by family therapists. For instance, I said that Mr. X was doing a service to his wife by expressing all the angry emotions thus enabling her to remain calm. Her unemotional calm was enabling him to express his agitation openly. Jeremy was helping both his parents by getting them together, but in a safe way; and so on. This approach opens up the possibility of everyone saying, “We don't need that, thank you,” or keeping the defence going if change is still far too frightening.

These good reasons for the differnces in approach between child and family therapists needs to be understood, otherwise a lot of mistrust between the two sets of workers can develop. Disagreement also makes it more difficult for one person to encompass both approaches. Family therapists see individual therapists as committing the cardinal sin of “negative connotation”; individual therapists see family therapists as giving positives and hence remaining superficial, by not touching the unconscious phantasy troubling the family.

Mr. X was highly ambivalent about coming. On the one hand he demanded immediate urgent help, on the other he threatened not to come back at the end of each session. He told me that he sacked the previous therapist after the first session. I was left in no doubt that I was under the same threat. I knew, however, that he was expressing the ambivalence for everyone. That was his role in the script.

I also knew that if I reciprocated the ambivalence the therapy would be in jeopardy. He behaved in what seemed an abominable manner towards his wife. It was difficult to forgive him sometimes. Hearing about his enormously painful childhood helped me. But I had to understand his often repeated statement that his wife was entirely responsible for all the problems. I came to

understand that in his culture the women was entirely responsible for the children — the men for earning money. He was earning good money. I could at last hear his plea to be respected for having done a good job in his own cultural terms. My understanding this helped me to forgive him and Mrs. X was able to relax too. I was then also able to hear his statement that despite all his bluster he had no power over his children except to frighten them. She held the real power. For instance often she did not tell him about Jeremy not getting to school which left him in an impotent rage when he found out. It was beginning to become clearer how he was inducted into expressing all her suppressed fury while she remained calm and unemotional. One assumption I made was that she had been at the receiving end of a lot of violence as well as rejection as a child. For her, her own behaviour was corrective, while her husband was doing her replication for her.

Her relationship to me was covert and close. She sat next to me. Somehow I felt I was expected to take her side against this tyrannical husband. It would have been an easy trap to fall into. I would have stepped right into Jeremy's shoes.

The other assumption I make is that as a therapist I will be inducted into the same role as the symptomatic member. Robin Skynner (1979) describes how the therapist becomes the family scapegoat. I felt filled with anxiety by this family, feeling I had to do something, but worried about taking sides. This sense of having to do something effective drew me into the family script and into the redramatisation which came at the fifth session.

Active interventions: task setting and prescribing the symptom

I routinely ask what has been happening between the sessions. If there is some important event then I explore what each person did and then ask what were the old ways of doing things and what was new. This focusses attention on the possibility of doing something differently. Some families start using the metaphor of script, and talk about old and new scripts. The X's did not do this. They were too much inside their own drama.

At the beginning of the fifth session Mr. X announced angrily that he had had enough, either something changed or … I asked what had happened and they recounted an even more intense redramatisation of their script which started the previous evening and was obviously still in progress.

They described how Mr. X tried to bully Jeremy into going to bed while Mrs. X spent hours persuading him, It ended in an enormous row. Mr. X said, “The trouble is, Jeremy speaks two languages.” I used this metaphor and expanded it, putting it to them that they were also using two languages, those of control and persuasion. I then spent time clarifying the symbolism of Jeremy's symptom. Clearly the ritual with the different video channels was to do with the two languages, Arabic and English. Running up and down stairs represented the dilemma about

whether to grow up or not. Stepping right and left represented the choice between his mother and his father. If he chose one then he felt torn away from the other. Stepping from one to the other was

his way of avoiding the painful choice. While making these comments to Jeremy I used my hands to illustrate what his feet were doing, and also demonstrated being torn down the middle of the body if he were to choose either parent which would tear him away from the other parent. This nonverbal elaboration of the interpretation seemed to reach Jeremy.

It seemed to me to be important that he should experience me as understanding his dilemma as well as for the family to see his strange behaviour as having a reason. They had viewed it hitherto as either obstructive or evidence of madness.

At the end of the session I made a lengthy intervention. I said that I thought both parents were right. Jeremy needed some pressure but he was also very frightened and needed support. I said I thought that his rituals were important to him as they made him feel safer so he should continue with them but should start them earlier and pack them all into one hour. I spent some more time negotiating when he should start. I accommodated to the parent's worries and objection to aspects of this. We agree that he should start at 9.15 and finish at 10.15 p.m.

I then said that I thought he would need some comforting from his mother and also some good time with his father. We again negotiated an arrangement for father to play darts for ten minutes and then mother to read him a story for half an hour. At the end of this time I suggested that his parents should both go to bed. But because previously Jeremy had screamed his head off when they tried this they should do two things.

Firstly, they should be prepared to lock their door if necessary, and secondly, they needed to tell the paternal grandmother what they were doing and why, so that she would not come out of her room and accuse them of trying to kill Jeremy as she had done when Jeremy had screamed in the past.

Mr. X promptly said that he would send his mother away to stay with his sister (something Mrs. X had been asksing him to do for years).

Following this intervention Jeremy largely stopped his rituals, except for a few minutes before going to school which kept the anxiety going sufficiently for the family to continue for another seven sessions spread over a period of a year. Father was delighted with him. A further year after discharge mother rang to thank me. Things were going well.

The function of tasks is threefold. Firstly, if they are carried out a new pattern if interaction is experienced. Secondly, symptomatic behaviour may be reduced, as in this case. It had become clear to me that the more his father told him to stop his rituals the more Jeremy did them. Perhaps the converse would be true. I will never prescribe the symptom (which is what this is called in family therapy) unless I consider that the new way of performing the symptom would

be to everyone's advantage. Thirdly, they increase awareness of the meaning of interaction and point to potentially new ways of going about things. This I consider to be the most important function.

The X family virtually did none of the tasks as prescribed, but the scenario sketched out for them was very real. We were planning in the session what

do to in a few hours time. There was real negotiation as each person pictured themselves in a new situation within the family. Bodies were going to be related to differently in space and time. The concrete quality of the task enables family members to become aware of things which, if presented in words, might be rejected.

The basic message here was that mothers do need to have a caring relationship with their sons but if that takes precedence over the marriage the son is married to his mother. This choice is too frightening for any son to make and so the parents must themselves take that choice by jointly closing the door to their bedroom.

It is interesting to speculate that it was this idea that enabled Mr. X to put a boundary between himself and his mother for the first time in fifty years. He described his relationship to her as having been very close from the beginning. He was the much favoured youngest son. Sometimes corrective moves can start in one generation and initiate changes in the previous one.

Change through the therapist/family relationship

Change in individual therapy comes through the transference/counter transference relationship. In family therapy the past relationships have been “transferred” to current relationships between the family members in the room. The relationship to the therapist then is not the only avenue available for change. This is not to say that transference phenomena do not occur. Far from it. As we have seen they are very powerful. The therapist has to find a way of not being bound into fulfilling certain family roles in the family script.

In family therapy there is not the same need to avoid personal intrusions into the material as there is in individual work. Family dynamics are so powerful that it is difficult to make any impact, let alone to swamp the family with intrusions. Most family therapists are more active. This gives them more autonomy in the face of the recruiting process. The ways in which the therapist maintains his professional stance requires another paper. In the X family, for instance, I had a group observing through a one way screen. I consulted them before making the intervention I described. I had been partially recruited to the role of paternal grandfather who had a stroke (and my own polio disability added to this) and also the many ineffectual parental figures on mother's side. The family was furious with that and demanded a different and effective parent. A mix of replicative and corrective features could be seen in the transference.

This manifested itself in the enormous pressure to be effective at the same time as being made to feel impotent, which formed a very anxiety provoking mixture.

It was important then that when I was recruited into the redramatisation I did not merely replicate the ineffective role. The whole family needed an experience of a purposeful father who could act when necessary with authority while taking everyone's needs into account. (The work with Simon has been ommitted in this account for brevity's sake). The group behind the screen helped me to recapture that authority.

Conclusions

Many of the core ideas in child psychotherapy and family therapy are remarkably similar and can be put into a similar language. There are, however, some important differences. It is vital to understand and hence respect those difference. A dialogue can then take place. The two approaches might then be able to learn from each other.

It is, unfortunately, easy to use each other for self definition. “We would never be directive, set tasks, prescribe symptoms, reassure, etc., etc.” or “We would never confirm scapegoating by seeing the child, only deal with negatives, go on forever, etc., etc.” This attitude is a disaster; especially if it divides members of the same clinic, or excludes one approach entirely.

Fortunately the dialogue has already started, as the two approaches depend on each other for survival. A family approach has limited validity unless children without families or those who do not respond to a family approach can be helped as well. Child psychotherapy can only survive, in my view, alongside family therapy. Either child psychotherapy resources must be increased enormously, which will not happen in the foreseeable future, or sufficient family work has to be done to deal with service demands leaving space for that precious commodity — long term individual work with some of the children. This is vital not only for those particular children but also to keep us all in touch with what goes on in children's minds.

A dilemma remains for us all. In theory each of us can do both. But each approach requires a training. That is the question which now needs to be addressed.

References

Boszormenyi-Nagy, I. and Spark, G.M. (1973). “Invisible Loyalties”, Harper & Row, London.

Byng-Hall, J. (1980). “Symptom Bearer as Marital Distance Regulator: Clinical Implications”, *Family Process*, 19: pp. 355-365.

Byng-Hall, J. (1985). “The Family Script: a useful bridge between theory and practice”, *Journal of Family Therapy*, 7: pp. 301-305.

Dicks, H.V. (1967) “Marital Tensions: Clinical studies towards a psychological theory of Interaction”, London, Routledge & Kegan Paul.

Freud, S. (1909) “Analysis of a phobia in a five year old boy”, Standard Edition, X, p. 122.

Skynner, A.C.R. (1979) “Reflections on the family therapist as a Family Scapegoat“, *Journal of Family Therapy*, 1: pp. 7-22.