



Some Considerations regarding the Family System of the Children with Bronchial Asthma

Andrea MÜLLER-FÁBIÁN

Babeş-Bolyai University, Cluj-Napoca, Romania
andrea_fabian_ubb@yahoo.com

Abstract. Within psychosomatic families, the person who manifests the symptoms has a regulative role in solving the conflicts. The family contributes to the endurance of the symptom, whereas the ill person contributes to the maintaining of the pathologic equilibrium. We tried in this paper to approach the psychosomatic illness (bronchial asthma) in children according to the systemic theory. The theoretic input was conceived in such a way as to attack the bronchial asthma problematic with regard to children from the point of view of the medical prophylaxis as well as from the perspective of psychological research and systemic family therapy. Our hypothesis claims that, along with genetic factors conducive to bronchial asthma in children, there must be also other kind of factors of psychological and social nature that, in their turn, have a relevant significance in the manifestation and the maintaining of the illness. We drew special attention to the family of the child with bronchial asthma (the psychosomatic family) because we found theories and research that emphasized certain particularities in the functioning of the family within which the child with psychosomatic illness carries out certain vital roles.

Keywords: family system, bronchial asthma, psychosomatic family

Family as a system

According to the systemic approach, the family unit is more than the sum of its members because the interaction between them must also be taken into account. This web of relationships is spun in accordance with certain rules, enwoven in certain functions, and it tends to uphold a certain equilibrium within the family itself. When one of the members undergoes a change, there is an immediate effect upon the other members of the family (Fábián 2007).

Human systems present three defining characteristics: they are non-summative (the whole is more than the sum of its parts (Watzlawick, Beavin, and Jackson 1967); the parts of a system mutually influence themselves in a bidirectional

manner so much that one part's modification leads to the modification of the others (Pinsof 1995); finally, the limits of a human system are unclear and ambiguous (*ibidem*).

The systemic family theory purports that family is a self-regulating system, which functions according to its own rules. It has two basic functions: maintaining the homeostasis (un-change) and, respectively, adjustment to changes (Hermann and Berlin 1981). Both functions hold an important role in the system's survival and only together can they achieve this goal.

The family system is defined by the system of rules needed for its functioning, by structural characteristics, and by communication schemata. The homeostasis provides the stability and continuity of the system and it is ruled by the laws and rules at work in the family. Every human system takes on its own identity as well as limits and develops itself vertically (it contains several subsystems) and horizontally (it is itself part of a more extended system).

Family, as a system, consists of several subsystems which mutually interact with one another. These sub-systems are usually diverse and different from one another, and they function as components of the overall system. But even a particular subsystem may operate as a system with regard to its own components. There are no two identical subsystems and every subsystem has accordingly its own particularities. Family subsystems are: the parental subsystem, the children subsystem, the marital subsystem, the grandparents' subsystem, the siblings' subsystem, the boy-girl subsystem, and the nephew-grandparent subsystem.

The family as a system is in constant interaction with the environment, permanently connecting and communicating with it. Families do not merge and fuse with the environment; they have clear boundaries which are at the same time flexible enough to accommodate changing exigencies and demands. The boundaries' flexibility determines whether a family is open or closed. Completely open or completely closed families do not exist. Within closed families, the family rules are more severe, whereas within open families they are more lenient.

In normal situations, the boundaries change according to the demands of the family life cycle. Blurry (faded) boundaries fortify the feeling of belonging to the same family, but aggravate the development of individual autonomy for family members. Rigid boundaries lead to reducing the exercise of the protective function, to rendering difficult and halting the communication between family members who are, thus, left to fend for themselves. Both the rigid and blurry/faded boundaries indicate a pathological situation.

In families with faded boundaries, each member of the family reacts to everything very quickly, with an out of the ordinary intensity; the doors of these families are always open, and there is no intimacy. Everyone knows what the other is thinking, and this shows up in communication when one speaks ahead of and instead of the person who is asked to speak (Hermann and Berlin 1981).

In families with rigid boundaries, family relationships are loose and relaxed. Oftentimes, family members do not react when they should. 'Dramatic' events are needed in order for them to engage in a reaction and to get the function of family protection going. Such events may be, for example, an attempted suicide, an asthma crisis, an accident etc. (ibidem).

Most of us have experienced for ourselves the power of the family system during our lives. Irrespective of the changes registered at the social level, the family was and still is a 'workshop' of personality development. The two parents are 'the leading masters' of this workshop, and they lack experience, confidence and moan in the face of such a big responsibility (Satir and Baldwin 1984). According to these authors, family problems stem from: low self-esteem; indirect, ambiguous, insincere communication; strict rules that cannot be negotiated; anxious relationship based on the submission to those who control the family (Fábián 2007).

To resume, the family is a unique system with a particular social and relational structure which consists of an array of communitarian situations, constantly pertaining to each other and permanently entangling one another. This situational web of relationships can become, suddenly or gradually, problematic. When a problem appears, family members usually focus upon one person whom they deem problematic, and claim that only this person is the one who created the problem in the first place.

There are families relatively 'without problems,' but this does not mean that they are immune to problems; on the contrary, this problem-free situation entailed solving the problems through their own forces (Fábián 2007).

The functioning of the psychosomatic family

In the last three decades, research regarding family functioning has targeted two facets of medical sciences: first of all, the families of schizophrenics and then the families of children with psychosomatic disease (Hermann and Berlin 1981).

The research of Minuchin and his collaborators is highly noticeable: with the aid of systemic family therapy, they obtained good results in the case of families with children affected by psychosomatic illness (Minuchin, Rosman, and Baker, 1995).

The systemic model claims that there are certain types of family set-ups which can be connected with the occurrence and maintaining of the psychosomatic syndrome in children. This model also sustains that the psychosomatic symptoms of the child play an important role in maintaining the family homeostasis (ibidem).

According to their research, Minuchin and his collaborators established four characteristics of psychosomatic families. Alone, none of these traits seem to be enough to cause the psychosomatic symptom to appear or to endure in time, but

the group of transactional matrices may respond for those family processes that encourage somatization.

These characteristics are the following: enmeshment, hyper-protective behaviour, rigidity, and lack of conflict solving (*ibidem*). Enmeshment appears when the boundaries between family members are vague, faded, and the individual autonomy is lessened. Hyper-protective behaviour manifests itself through highly intense relationships wherein members of the family try to influence the other's behaviour and feelings. In the case of rigidity, the rules and norms which regulate family life are very difficult to modify, and consequently new solutions are hard to accept. The lack of conflict solving pertains to pushing the problems under the rug, which many family members may confront. The family strongly pains in the face of conflict erupting between its members. Fights are forbidden because they are deemed to be entirely destructive phenomena.

Within psychosomatic families, the person who manifests the symptoms has a regulative role in solving the conflicts. The family contributes to the endurance of the symptom, whereas the ill person contributes to the maintaining of the pathologic equilibrium.

In a psychosomatic family with several children, the enmeshment between parents and the diseased child ensures the increased independence of the other children. In this kind of instances, the sick child 'connects' and 'holds the parents closely together'. Many a time, the most sensitive person of the family takes this role (of being sick) upon herself in order to allow the other children to lead a freer life (Hermann and Berlin 1981).

In psychosomatic families, its members are afraid that the family will be dissolving if it gets out that something is not in order with them. Consequently, the cardinal rule in these families states and requires the avoidance of conflicts, exactly because conflict is perceived as something 'dangerous' that needs to be strategically ignored, put out of view. Likewise, the expression of negative feelings is unacceptable in this kind of families. Unfortunately, the tension does not go away, but it only attaches itself to another person of the family (most of the times, the tension between parents is transferred upon children) or it transposes itself upon a person whose symptoms do not go through a psychosomatic conversion. Conflict avoidance technique is not unusual in healthy families, but it does not represent a prevalent behaviour and strategy, such as is the case in psychosomatic families. The most dangerous situation occurs when the parents, as a method of conflict averting, drag the children into their conflict, waiting for them to 'solve' it.

There are three forms of involving the children in their parents' conflict: triangulation; the child-parent coalition; taking the long way round, or 'the roundabout route' (Hermann and Berlin 1981). In the case of triangulation, both parents spur the child to take his/her part in front of the other parent. The child-parent coalition entails the association of a parent with the child against the other

parent. When the child has the role of the 'roundabout route' in a family, it means that in the family in question everything appears to be in order at a superficial level, whereas in reality the child is keeping the family together.

The child's illness may be the best method of discharging the marital conflict. In such cases, the sickness contributes to maintaining the family homeostasis. Thus, a 'diabolical,' vicious cycle can be noticed at work here, which is conducive to the illness and which amplifies it in time.

The desire to avoid conflict represents in fact a social norm. Psychosomatic families comply with this norm. The society we live in appreciates positively and enforces this attitude of conflict avoidance, playing therefore an important role in maintaining, perpetuating, and regulating this vicious circle. Transactional schemata are inherited by generations upon generations. Only by dismantling cognitive schemata can one deter from or block the transfer of problems from generation to generation. The systemic theory allows for the approach of the individual as a member of the family system and is able to capture and analyse the problematic burden of his/her relationships with family members and its generational cross-over.

Conclusions

'The human organism can be conceived as a unitary whole, and this point of view constitutes the basis of the psychosomatic paradigm; or it may be regarded as a co-operation between two components: physical and psychic' (Dumitrascu and Pohribneac 2007, 12). The relevance of psychosomatic medicine consists in 'searching for physical sufferance without evident medical, objective data [...] in taking care of physical affections with psychological or psychosocial etiopathogenesis' (ibidem, 16).

Psychosomatic medicine is based, along with a drug treatment, on specific interventions, such as: psychotherapy techniques, psycho-education, taking an interest in patients' diaries, relaxation therapies, the technique of expressive writing and biofeedback (ibidem, 18).

Ranschburg (1998) claims that bronchial asthma is not a 'chosen' disease, as psychoanalysis has inferred. There is no 'asthmatic personality' hiding behind this illness and there is no particular atmosphere prevalent within the asthmatic child's family, nor do his/her parents present special educational attitudes (ibidem).

Contrary to Ranschburg's scientific results, Nemes thinks that there is, after all, a connection between the child's asthmatic condition and the family dynamic because when the child is ill his/her behaviour is deemed to be 'in order,' but when the child gets healthy his/her behaviour becomes asymptomatic. Ranschburg

states with regard to the latter idea that it represents a kind of 'transposition of the symptom' in the sense that when the behavioural problems of the child become way too risky, he/she transfers the problems in a fully-fledged illness and vice versa. The sickness and the behaviour of the 'good' child as well as the healthiness and the 'badness' of the 'bad' child develop an associative relation, wherein under 'goodness' one must see the need of dependence and the need for parental care, while under 'badness' the child's desire for 'freedom' and his/her aspiration towards autonomy.

Revisiting Nemes' thesis, it is clear that it is not by chance that those children who are suffering from a psychosomatic illness are excessively good but ill, whereas those who are usually healthy are more alert and frisky; they may not take care of themselves, but they are healthier. There is no doubt that a child who lives under the strict control and exacting and exaggerated norms of his/her parents, and whose aspirations towards independence are constantly hindered by them when he/she tries to disengage from their hypercritical demands and claims, takes 'refuge' in the somatic illness. Nevertheless, one cannot speak in this case about a transposition of the symptom because the situation is not about the transference of a permanent behavioural problem but rather about the fact that this 'good' child, who in the majority of time behaves according to the norms, cannot cope with or face up that he/she did not comply with a norm that he/she deems very important. It follows that 'the child gets sick, a somatic symptom occurs (and this is not about the transformation of a behavioural symptom into a somatic one)'; on the other hand, the child 'does this' because he/she knows that the 'being sick status' brings him/her more attention and understanding from his/her parents.

We tried in this paper to approach the psychosomatic illness (bronchial asthma) in children according to the systemic theory. The theoretic input was conceived in such a way as to attack the bronchial asthma problematic with regard to children from the point of view of the medical prophylaxis as well as from the perspective of psychological research and systemic family therapy.

Our hypothesis claims that, along with genetic factors conducive to bronchial asthma in children, there must be other factors of a psychological and social nature that, in their turn, have a relevant significance in the manifestation and the maintaining of the illness. We drew special attention to the family of the child with bronchial asthma (the psychosomatic family) because we found theories and research that emphasized certain particularities in the functioning of the family within which the child with psychosomatic illness carries out certain vital roles.

The systemic approach envisages to discover the relations within and the functioning of a real system – the family system. Its essence consists in the fact that it does not seek for 'scapegoats,' or to assign blame to somebody: nobody is impuissant or helpless. Each member of the family is right because each of their manifestations serves to gain stability, to achieve homeostasis for the family

dynamic. Consequently, everybody strives for something inherently good. In order to deal with the symptom, to drive it into a healthy disappearance, a new stability is needed within the family. And here comes the specialist.

We think that the most efficient systemic approach may be carried out in the case of children with psychosomatic illness, while the illness is not yet chronic, not yet fixed. Moreover, the parents of these children tend to be young, and it is easier in their situation to work on the family structure problematic.

References

- Dumitraşcu, Dan–Pohribneac, Cristina. 2007. *Medicină psihosomatică*. Cluj-Napoca: Medicală Universitară Iuliu Hațieganu.
- Fábián, Andrea. 2007. *A családokkal való szociális munka elméleti és gyakorlati vonatkozásai*. Cluj-Napoca: Echinox.
- Gorell-Barnes, Jill. 2001. *Család, terápia, gondozás*. Budapest: Ed. Animula.
- Hermann, Erzsébet–Berlin, Iván. In: *Család és betegség. Valóság* 9.
- Minuchin, Salvador–Rosman, Bernice–Baker, Lester. 1995. *Pszichoszomatikus családok*. Budapest: Animula.
- Nemes, Lívia. 1974. *Pszichogén tünetkepződés a kisiskolás korban*. Budapest: Akadémiai Kiadó.
- Pinsof, William. 1995. *Integrative-Problem Centered Therapy*. New York: Basic Books.
- Ranschburg, Jenő. 1998. *Pszichológiai rendellenességek gyermekkorban*. Budapest: Nemzeti Kiadó.
- Satir, Virginia–Baldwin, Michelle. 1984. *Satir Step by Step: A Guide to Creating Change in Families*. Palo Alto: Science and Behavior Books.
- Watzlawick, Paul–Beavin, Janet–Jackson, Donald. 1967. *Pragmatics of Human Communication: A Study of Interactional Patterns, Pathologies, and Paradoxes*. New York: Norton and Co.