

The pre-school child in difficulty: a systems viewpoint*

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From the early 1950s there has been a steady expansion of family oriented interest into many of the areas of clinical concern to psychiatry, in an attempt to understand psychiatric events as an expression of family process (Bloch, 1973). While the schizophrenias, for example, have attracted considerable attention, behaviour difficulties in pre-school children, in spite of their clinical frequency, have received much less attention. Indeed this state of affairs was borne out quite recently by the Court Report (Court, 1976). In this it was stated, 'child psychiatric services have been planned largely in relation to school age children so that pre-school children have received relatively little attention. This must now be corrected as epidemiological studies have shown the frequency of psychiatric problems in this age group and other investigations have indicated that problems of later childhood often have their origins in early life'.

In 1975 Mia Kellmer Pringle was calling for a similar increase in resources (Kellmer Pringle, 1975). She wrote, 'the most basic difficulty, I believe, is that we have never had a policy for children. They do not suddenly become vandals, runaway from home, commit suicide or murder. There are always early warning signals that all is not well, and these usually show at quite a young age. Yet look at our priorities. We spend vast sums on sixth formers and students while we scrimp on the under fives, especially those who are neglected, rejected or otherwise at risk. Giving top priority to the youngest age group is an investment in the future: they are the seed corn of the future and their development will determine the fabric of tomorrows society.'

Part of the problem in dealing with behaviour difficulties in the pre-school child has been the doubt as to the nature of the difficulties—how they are caused, their prognosis and their prevalence in the population as

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a whole. The survey by Richman, Stevenson and Graham (1975) addressed itself to this last question and their findings suggested that the rate of behaviour and emotional disorders in the pre-school period is very similar to that in later childhood and early adolescence. This study demonstrated that it is possible to identify as moderately or severely disturbed 6-7% of an urban population of three-year-olds. They comment, 'an impression of the disorders we have identified in these children in the community is that they have a serious and significant impact on family life and relationships, and that their existence implies a problem in society towards which professional interest should be directed. There is no reason to think that our findings in this population cannot be generalized to other similar populations.' In this study the authors remind us that pre-school children are highly reactive to their environment and that it is somewhat artificial to regard them in apparent isolation, especially from their parents. They also comment that the presence of a problem within a child should not be equated with the presence of a mental disorder or illness and they suggest that social and family factors may be the most important influences bearing on the behaviour of young children. My own experience at the Parent and Child Centre bears out this point of view and it is interesting to look at some of the remarks made by my predecessors in their annual reports about the work of the centre. For example, in 1953, Millar stated that 'the difficulties which manifest themselves as behaviour disorders in the child can in this particular age group readily be linked by the parents with their own experience in childhood.'

The 1955 report (Millar, 1955) emphasized the importance of the family context for an understanding of behavioural difficulties in pre-school children. It recorded, 'since the work of the Parents Guidance Clinic (as it was then called) is designed to help the parents of children under the school age, it follows that many parents referred are within the young married group where the relationships between husband and wife are still being worked out and where there is still a danger of breakdown in marriage. Such young couples taking neurotic difficulties into marriage often feel these difficulties as an inability to manage their children and so they arrive at the Parents Guidance Clinic via the Infant Welfare Centres for marriage guidance. Here the basic problem is one of marital adjustment rather than child management.'

In dealing with the problems of the pre-school child we are also dealing with families in formation and with the difficulties posed by parenthood.

As an aid to understanding some of the complexities of family life I have found Minuchin's ideas about subsystems within the whole family system invaluable (Minuchin, 1974). For Minuchin the foundation of the

family is provided by the spouse subsystem (see Appendix B). This is formed when two adults of the opposite sex join with the expressed purpose of forming a family. This subsystem of the family has specific tasks vital to the family's functioning. The spouses' need to develop a mutual accommodation in a large number of small routines for example getting up in the morning, having meals, having sex etc. In order to obtain its identity the spouse subsystem needs to achieve a boundary that protects it from interference. In the early stages of family life this boundary represents the separation of the couple from their families of origin and the negotiation of different relationships with their parents, siblings and in-laws. Later on it is important for a boundary to exist between the spouse subsystem and the parent and child subsystem so that the needs of each subsystem can be fulfilled.

In this process of mutual accommodation the couple develops a set of patterned transactions. These represent the ways in which each spouse triggers and monitors the behaviour of the other and is in turn influenced by the previous behavioural sequence. This is to say that marital interaction cannot be fully understood by charting the psychopathology of each partner as an individual. The interaction is a much more dynamic process. Lily Pincus (1971) sees marriage as offering to most people, for the first time since early childhood, 'the opportunity for an exclusive two person relationship; for close physical intimacy and the experience of giving and receiving direct bodily satisfaction. It is not coincidence that lovers sometimes use 'baby talk' or, that we refer to 'love play'! Lily Pincus goes on to remind us that, 'this makes the marriage relationship especially open to a richness of emotional experience and, by the same token, renders it particularly vulnerable to emotional disturbances. Thus the nature of the marital relationship is of fundamental importance for the total situation in the family.

The birth of a child marks a radical change in the family life. It marks a change from the familiar two person to a three person relationship which constitutes a new situation for the marital couple. Immediately the previously established transactional patterns between the couple are challenged.

At this stage in the life of the family Minuchin identifies a new subsystem which has specific functions and which co-exists with the previous spouse subsystem. In the parent and child subsystem the spouses' functions must differentiate to meet the infants demands for care and nurturance. The physical and emotional commitment to the child also requires a change in the spouses transactional patterns.

Isca Salzberger-Wittenberg (1970) has pointed to an ideal arrangement for this new three person configuration. She writes, 'the father's most

important rôle at the beginning of the child's life would seem to be that of a supporter to mother and baby. In a good relationship the father is someone in whom mother can confide her anxieties about her maternal rôle. Mothers are usually very vulnerable after the birth of a baby, and as well as being proud and excited, tend easily to get depressed and anxious. The father infuses hope and steadiness into the mother during the hurly burly of the first few weeks. The experience of a mutually satisfying feeding relationship, achieved by adjustment, and the secure framework given by parents who complement each other becomes the basis of the child's experience of a creative relationship. This will eventually become linked in his mind with the sexual union and creativity of the parents. The introduction of such a good relationship will become the foundation of his stability.'

While it is easy to visualize and appreciate the satisfying aspects of good relationships between parents and their children, these are not always so easily obtained. It must be said at this point that it is not always for want of trying on the part of the parents. Sometimes we as professionals miss vital clues that have been presented to us over and over again (Davies, 1979).

To a large extent the response of husband and wife to the first baby, for instance, would depend largely on their own experiences. Thus for example the husband who is seeking in his wife an ideal, all loving, never rejecting mother may find it difficult to tolerate a 'rival'. His need for this special relationship may have led him to choose a girl who herself had difficulties in sharing. Thus when the baby arrives she may withdraw from her husband and relate exclusively to the baby.

Almost inevitably married couples find the transition to parenthood painful as the arrival of the first child destroys the two person or pair pattern of interaction and forces a rapid reorganization of their life into a three person or triangle group system. Living as a trio is more complicated than living as a pair. The husband may feel that he is the semi-isolate, the third party in the trio, or it may be that the wife feels that her husband is more interested in the baby than in her. Changes have to take place since if the couple preserve their pair relationship and continue their previous way of life, relatives and friends may regard them as poor parents.

Both Le Masters (1957) and Dyer (1963) have studied parenthood from the point of view of crisis phenomena. They both found that a majority of couples experienced extensive or severe crisis following the addition of the first child. Dyer in his conclusion comments, 'the degree to which the advent of the first child represents a crisis event appears to be related to:

- (a) the state of the marriage and family organization at the birth of the child;

- (b) the couples' preparation for marriage and parenthood;
- (c) the couples' marital adjustment after the birth of the child;
- (d) certain social background and situational variables such as the number of years married, planned parenthood, and the age of the child.

The large majority of the couples in both surveys appeared to have made quite a satisfactory recovery from the crisis although this often followed a difficult period of several months. In Dyer's report 81% made 'fair to good' or 'excellent' on their recovery scores. This left 15.5% with poor recovery and reorganization. It is interesting to note that even 12 months after birth of the child a large majority (80%) of both husbands and wives admitted that things were not as they had expected them to be after the child was born. Twelve months after the birth of the child, 40% of the couples indicated that they were still experiencing problems.

In Dyer's report the marital relationship was an important factor in determining the level of crisis experienced at the time of parenthood. Dyer found some support for the hypothesis that the child's claim of priority on the mother makes the husband feel he is the third party in the trio, a semi-isolate. In fact 50% of the husbands felt that their wives sometimes neglected them while another 12% said they were often neglected. Twelve per cent of the wives felt their husbands sometimes neglected them for the child. Problems more frequently recalled by the wives were such items as 'my husband grew tired of being second', and 'less time to give to my husband'. Such findings emphasize the emotional investment in the previous two person relationship and reflect feelings of loss, anger, jealousy, envy. Previous emotional satisfactions may have been lost or may have been switched. Such reactions may be particularly severe where the partners were previously held in a relationship which perpetuates rather than resolves their conflicts and intensifies fantasies which they dare not risk putting to the test of reality. Thus partners may, before the birth of a child, be held in a pattern of mutual inhibition or in a mutually punishing and self depriving interaction, or a pattern of dependence, or dominance. Such patterns inhibit the growth of mutually satisfying relationships and pose problems for the position of the child in the family. Times of family evolution, for example the birth of a child, or children going to school, the onset of adolescence, etc. provide families with a chance to grow. Each family member has his own problems wishes goals etc. that must be understood but they can only be understood and fulfilled in the context of the family (Davies, awaiting publication). Thus, each family member is a producer of, a participant and collaborator in the family system network for good or ill. Each family member has a stake in

stability and in change. Families, like other systems develop practices of their own to retain cohesion as a group. Each newly formed family develops a unique set of rules that are based on the meshing of the individual members needs. The sorts of behaviours that are acceptable to the family, the sorts of behaviours that are complained about will be significant to that particular family. The behaviour will fit the language of the family, it will be something that is familiar, something that is related to the information system that all the family members are immersed in.

Example

The family of Jane, Jack, Mark and Martin were referred because of their difficulty in controlling Mark's behaviour. Jane is thirty years old, Jack is thirty-seven years old and Mark is five. He is described as quick tempered and strong willed.

Jane also describes herself as a strong willed and volatile person and sees herself as constantly doing things for other people in order to gain their approval. She saw her mother's behaviour as having been unpredictable and recalls having had frequent ferocious battles with her. She comes from a female dominated family and her early unsettling experiences in her relationship with her mother have caused her in adult life to find ways of seeking the approval of others.

Jack who is handicapped with arthritis sees himself as a quieter, more easy going character. Jack described, with some feeling of admiration, his father's independent pursuit of 'women and booze'. Jack's father had had little contact with Jack as a child and Jack in his family of procreation seems equally uncertain of his rôle in relation to his own children. His own mother was the dominant member of his family and had virtually ruled Jack in her care of him.

In marriage Jack and Jane had found partners in which they could continue their previous emotional positions. Jane could be a dominant maternal figure in relation to a more passive male. She gained approval from her invalid husband by her care of him. Jack in turn could be cared for and also take less responsibility. But there was also an underlying conflict in this relationship. Jack's anger towards dominating women gained expression in his passive resistance to demands from his wife. While this reaction frustrated Jane, she found it difficult to retaliate because she needed her husband as an invalid. Jack was also discomforted because his passive hostility brought on threats of desertion from Jane which he did not want.

Mark's birth enabled a new balance to be achieved within this system. Mark, physically fit, became the man that Jane could battle with. In this

relationship Jane could repeat patterns from her own family of origin. At the same time when she is hurt by her husband she can express this hurt in her relationship with Mark. Mark in turn can retaliate against his father. At first this would pose no threat but as he has become physically stronger so he becomes more threatening. The answer is to make him ill so that he can still satisfy his mother's needs but not physically threaten his father.

Family members often find themselves programmed into specific rôles and then labelled, for example, the black sheep, the joker, the agreeer, the baby. Labelling does serve a need in the family since each individual gains some identification from it. Each person then plays his part in assuming his label and continuing it. However, most labels prove to be stultifying and have little to do with a person's true nature. If family members can be released from their labels they are then able to fulfil more of their individual potential.

The extent of distress among young families is probably under recognized because it is invariably difficult to measure. But as Christopher Clulow (1979) points out, 'there is some agreement among researchers that new parents can, by and large, expect marital satisfaction to diminish with the birth of a baby, that often they will experience somatic symptoms which can be related to levels of marital tension (and vice-versa), that there is an increased tendency for husbands to have an affair around the period of confinement, that sexual problems following birth are common and that a mother's post puerperal reactions are significantly affected by the current state of her marriage'. Thus, in dealing with young families, regardless which of its members presents as needing help, it is the family as an indivisible unit which demands attention. Problems may be presented in either or both parents or in concern about the behaviour of a young child. The child may be described as unmanageable, or exhibiting sleep or eating disturbances.

When help is sought the immediate response of the professional helper is of particular importance: an immediate felt response to parents complaining about the behaviour of their young child might be to 'reassure'. Yet when we give reassurance it is often to lessen our own anxiety rather than to help the other person. Indeed, reassurance can only confirm how little we have understood of the other person's situation and the feelings associated with it. Indeed, in giving reassurance we are either denying the existence of a problem or attempting to deal with our own anxieties by dismissing it.

Another tendency may be that of trying to push people towards help by trying to recommend solutions or give particular pieces of advice. It is

important to avoid saying how it should be because any teaching or information giving is a health prediction and this may be frightening to the family because they may not be ready to change and move to a more healthy state of functioning. Indeed, usually any predictions that we do make do not come true.

The most important first step is to recognize that the *family* has a problem. The second point to be borne in mind is that the family needs to find its own solution. This is important because it frees the family to make changes when they want to and does not challenge the established homeostasis and so cause resistance in the therapeutic process.

Even if we can recognize the importance of the family context in problem formation and recognize that problems arise from the way people relate and not from the behaviour of any one person, each family will have its own linear story about the origins of the problem. The almost universal desire of families is to take the problem member somewhere and leave him or her for treatment. When professionals go along with the family's story of the problem, its epistemology, they are already part of the family's homeostatic mechanism, and used by the family to maintain their balance. Families will tend to continue their linear communications unless the therapist takes *control*.

In order to take control the therapist must know where he is going. Thus at the outset the therapist requires an hypothesis—'a supposition made as a basis for reasoning, without reference to its truth; as a starting point for an investigation'. In experimental science an hypothesis is an unproved supposition tentatively accepted to provide a basis for further investigation. The value of the hypothesis in the family interview is that it guarantees the activity of the therapist. The hypothesis is a supposition which needs to be tested, and as such it acts as a guide to new information by which it will be confirmed, refuted or modified. A fundamental point is that every hypothesis must be systematic and must, therefore, include all components of the family. It must also furnish us with a supposition concerning the total relational function. As the therapist actively tracks these relational patterns so he takes control. If the therapist were to remain passive, as an observer, then it would be the family that, conforming to its own linear hypothesis would impose its own rules 'dedicated to the designation of who is "crazy" and who is "guilty", with the resulting zero information for the therapist. The hypothesis of the therapist, however, introduces the powerful input of the "unexpected" and the "improbable" into the family system'. Because the therapist is constantly testing out systematic hypotheses the rules of the family system are being challenged, e.g. such rules as 'who can do what' or 'what can be talked about'. The therapist is obviously

operating at a higher logical level—i.e. a view of the whole. The family have a linear approach to their problem and will maintain this view unless encouraged to behave differently. The aim of the therapist is to establish circular interviewing by making connections between pieces of behaviour and obtaining comparisons, e.g. 'Is another family member more or less like I.P.'. 'Were you surprised that this person behaves in this manner rather than anyone else'. It is easier for family members to compare than to talk about differences. By such a systematic approach change is taking place and new information is being introduced. The newness of the information is often borne out by remarks such as 'I never thought about that'. The Milan group have written recently about 'information' (Selvini *et al.*, awaiting publication). They believe that authentic information can be obtained from a family *only* by working with the following fundamentals.

(a) Information is a difference.

(b) Difference is a relationship (or a change in the relationship).

To follow such fundamentals they emphasize that the therapist needs to free himself 'from the linguistic and cultural conditioning that makes us believe we are capable of thinking in terms of "things"' in order to rediscover 'the deeper truth that we still think only in terms of relationships'. Bateson has already explained this point further (Bateson and Ruesh, 1968). 'The same general truth—that all knowledge of external events is derived from the relationships between them—is recognizable in the fact that to achieve more accurate perception, a human being will always resort to change in the relationship between himself and the external object. If he is inspecting a rough spot on some surface by means of touch he moves his fingers over the spot, thus creating a shower of neutral impulses with definite sequential structure, from which he can derive the static shape and other characteristics of the thing investigated . . . In this sense, our initial sensory data are always 'first derivative', statements about DIFFERENCES which exist among external objects or statements about CHANGES which occur either in them or in our relationship to them . . . What we perceive easily is difference and change—and difference is a relationship'.

Thus in working with families our most basic aim is to shift from pathology to the systematic interview. We do not know what people think, we can only see their behaviour. They, themselves, will decide what to think as our interviewing style, our linking of behaviours, our questioning introduces new information.

Therapists should not try and change the system. They should not try and restructure it in their way, it has to be the family's idea. A system is a

system. It is not to be judged good or bad. It exists. If someone in the family begins to change, this change feeds itself back into the family system and maybe a new homeostasis is developed. This is a change, a change in calibration within the system. The family must decide the nature of the change that provides them with a solution. It is the pathological nature of the system that has to be changed.

The therapist acts as a catalyst and should aim at being as neutral as possible. He should avoid taking sides and avoid negative connotations to behaviour. Obviously to be completely neutral is impossible, but the emphasis should be on seeking information and encouraging one member to talk about another pair.

In fact as long as the therapist invites one member to comment on the relationship of two other members, he appears at that time to be allied to that person. However, that alliance shifts the moment he asks another family member and yet another to do the same. The end result of the successive alliances is that the therapist is allied with everyone and no-one at the same time.

Part of the neutral stance is allying with the homeostatic mechanisms in a family. The aim is to give the system a positive connotation e.g. 'the child's behaviour is functional to the marriage since the child is working at holding you together'. The therapist should not push for change because this is a push against the homeostatic tendency and may create further resistance. It is not helpful to be made conscious of what you are doing in a pathological system. There is no need to teach people. People can change, they can do things differently, they can think more clearly if they are permitted to by the system.

Conclusion

I began this paper by pointing out the imbalance between the prevalence of behaviour difficulties in pre-school children and the knowledge and services available to deal with them. I have suggested that such difficulties can be more readily understood if they are viewed in the context of the family. I have stressed that young children are particularly vulnerable because they have interrupted the exclusive relationship that previously existed between their parents. While the birth of a child presents a crisis to most couples, it is usually those couples whose relationship perpetuates earlier emotional conflicts or fantasies who experience the most difficulty. The case of Mark was cited as an example. Other cases spring to mind. There is the pawn game. The situation where a couple unable to voice their disagreements openly will issue their child with conflicting instructions, simply to annoy the marriage partner. Parents will so often use their

children, e.g. those mothers who complain they cannot get quite small babies off to sleep at night. A little questioning may reveal that the child's father is out at night and the mother simply wants her child as company.

I have emphasized the importance of examining the family context and of guarding against following the family's linear story. I have warned against 'reassurance' and 'giving advice' and I have commented on aspects of the therapeutic process.

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Appendix A

The Parent and Child Centre

The Parent and Child Centre (previously known as the Parents Guidance Clinic) is a unique agency, opened in January 1934 by Birmingham Public Health Department 'to assist parents in the management of difficult children', as a component part of the Child Welfare Scheme. Children were referred to it initially by the medical officers at child welfare centres throughout the city although very shortly this service was extended to general practitioners, and to the child guidance clinics which focused on children of above five years of age. The Centre has been situated in its present address, since 1937. Initially the Centre was operated by two 'medical psychologists' (i.e. psychiatrists), aided from 1938 by a special health visitor. Home visiting soon became an important and routine part of its operation. Despite temporary difficulties during the war and the immediate post-war period it adapted to meet the problems of the time (evacuation, absent fathers, then the return of fathers, and overcrowding). Even in those far-off days the focus of the Centre was as much upon the adults who bring up children as on the children themselves. Mothers and fathers, as well as professional staff from the infant welfare service who were having problems with children under their care, were also seen as clients in their own right.

The annual report of 1949 provided a reflection of the way in which the difficulties of the children being referred to the Centre were understood and treated. It commented that the children were seen as 'passing through normal phases and their troubles were corrected by relieving the mother's anxiety'. This view was repeated in the 1952 report, 'many of the maladjustments arise from the emotional difficulties of the parents'. Much the same explanation of the Centre's work was given in 1953. 'The difficulties which manifest themselves either as anxiety, or lack of confidence in the parent, or as behaviour disorders in the child can in this particular age group readily be linked by the parents with their own experience in childhood. In recognising her own pattern of behaviour she learns to modify it and break the chain of neurotic reaction'.

By the beginning of the 1950s home visiting was a dominant aspect of the Centre's work, only a third of the cases being seen actually at the Centre. The source of referral also extended during the 1950s to include the whole range of voluntary and statutory agencies likely to have contact with pre-school children, their families and also to the parents themselves. The importance of this last group of referrals was emphasized in the report of 1955, 'Since the work of the Parents Guidance Clinic is designed to help the parents of children under school age, it follows that many parents, referred are within the "young married group" where the relationships between husband and wife are still being worked out and where there is still a danger of breakdown in marriage. Such young couples taking neurotic difficulties into marriage often feel these difficulties as inability to manage their children and so they arrive at the Parents Guidance Clinic via Infant Welfare Centres or Marriage Guidance. Here the basic problem is one of marital adjustment rather than child management.'

However, the predominant sources of referrals continued to be the Infant Welfare Clinics principally by way of their health visitors. An important consideration with all referrals has always been that only those parents actively wanting help could be referred.

The name of the clinic was changed to the Parent and Child Centre in 1964. In the same year the staffing of the Centre was increased by the beginning of the sessional attendances of a psychologist from the Public Health Department.

In the mid sixties there was also evidence of the beginnings of a further conceptual shift towards family psychotherapy. The annual report for 1965 records, 'it is significant that in a number of instances client's bring up problems of family relationships which are not confined to the behaviour of the pre-school child which originally precipitated the referral—marital relationship, anxiety over another child. The behaviour of this latter child is often a reflection of a disturbed family situation and improves as family tension as a whole diminishes without any direct contact with the child concerned.'

Bloch in *Techniques of Family Psychotherapy*, sees this to have been a general trend. 'From the early 1950s there has been a steady expansion of family oriented interest into all areas of clinical concern to psychiatry, in an attempt to understand psychiatric events as an expression of family process, and secondly to develop techniques for intervention based on modification of interactive patterns of the entire family.'

By the early 1970s the social work staff had increased to seven, and the Centre received regular sessions from a consultant psychiatrist and psychologist.

An increasing feature of the work in the 1970s has been the extension of the service out into the community and out into the health centres. Health centres are now served throughout the city, social workers doing regular sessions there for the reception of on-the-spot referrals. These are then followed-up either, in the Health Centre or in the client's home as is appropriate. This approach reflects the emphasis of the Centre upon immediate response to requests to help, there being no 'waiting list' for attention.

Generally, the work of the Centre remains analogous to that of 'well baby clinics', directed not towards the few handicapped children and their long-term problems but towards the general problems met by the many ordinary families who have potentially short-term problems in bringing up their children. It is believed that intervention at this stage prevents such problems becoming more chronic in nature and when family patterns may have become more entrenched and so more difficult to change.

Such problems now, as they have done throughout the time of the Centre's operation include difficulties of control and management, anxieties about unusual behaviour, problems of eating, sleeping, toilet training etc. and worry about the child's growing personality.

Appendix B

A diagrammatic representation of subsystems within the family system. As families grow with the addition of new members, so new subsystems appear, each with specific functions. Thus initially there is only the spouse subsystem. A new level of family life appears with the birth of the first child. At this time two subsystems can be identified within the family. The final subsystem—the sibling subsystem—is a step away from the parent-child subsystem towards the outside world. Here children, independent of their parents, begin to learn from each other.

This scheme demonstrates a pattern of family development and shows some of the maturational crises with which families have to cope.

SPOUSE SUBSYSTEM

Must achieve a boundary that protects it from interference from either children or in-laws. The main skills required are complementarity and mutual accommodation. Both husband and wife must yield part of their separateness to gain in belonging. At the beginning of marriage, the spouses begin to work out their mutual accommodation, developing a routine for meals, sex, getting up in the morning, dealing with work etc. They may also face the task of separating from their families of origin, or from life as an independent single person. Loyalties must shift and mutual friends be selected.

PARENT+CHILD SUBSYSTEM

This system must perform the task of loving and socializing the child without losing the mutual support that should characterize the spouse sub-system. A boundary must be created that allows the child access to both parents while excluding him from spouse functions. When the children are young nurturing functions predominate and these can represent a considerable stress. As the child matures especially during adolescence, the demands made by the parents begin to conflict with the child's demands for age appropriate autonomy. It is essential to understand its problems. Parents cannot protect and guide without at the same time controlling and restricting. Children cannot grow and become individuals without rejecting and attacking. The process of socialization is inherently conflictual.

SIBLING SUBSYSTEM

In the sibling subsystem children learn to support, isolate and make scapegoats. They learn how to negotiate to share and to compete. They learn how to make friends, enemies and allies. Its members experience the world outside and bring back this experience for the benefit of other members of the subsystem. Each child gains an individual sense of identity from belonging and adapting to the family group and being separate by participating in the different subsystems and in relationships outside the family.