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School Problems

Martin R. Textor, Dipl.-Paed.

The life of any child or adolescent is intensely influenced by three social units: the family, the school, and the peer group. For young children, the family is the most crucial group, largely determining their development, socialization, and personality growth. Behaviors, communication skills, emotional expression, values, and attitudes are learned in interaction with their parents, siblings, and relatives. But as the children grow older, the influence of the family decreases. Many of the family's tasks and functions are taken over by preschools, kindergartens, and schools. These institutions teach basic skills, pass on the fundamental knowledge of the respective culture, offer social training, and prepare the child for adult life. Children and adolescents spend more than one-quarter of their waking hours in schools which, therefore, have great impact on their cognitive, emotional, and social growth. These institutions must build on what the family has achieved—in their thinking, communication skills, achievement motivation, and

attitude toward authority, though the family continues to influence the children's fate at school. The amount of cognitive stimulation offered, the specific interests supported, the type of life goals encouraged, and the impact on their emotional well-being are of great importance in this respect.

The more that children are permitted to explore their surroundings on their own, the more influential their peers become, and during puberty they become the most influential group. Children acquire social and leadership skills, develop many different interests, and experiment with heterosexual relationships within their peer group. But they will have positive experiences only if they learned the necessary interpersonal skills in their family, and they can become autonomous and independent from their parents only if they are supported by their peers. The school will either promote or hinder the development of long-lasting, informal peer groups, according to the kind of environment it provides (e.g., course or class system, the size of its classes, yard, or playground). And it can create formal peer groups, such as school bands, clubs, or sports teams. The school can also help determine who will have high status in the peer group (e.g., good or bad students). On the other hand, peers largely influence classroom atmosphere, attitudes toward learning, and relationships with teachers.

Thus, family, school, and peer group are three systems that operate in relation to and interact with one another. Each unit influences children and adolescents in positive, neutral, or negative ways, and these influences can be additive (exponential increase) or mutually neutralizing in their effects. If therapists treat children being referred for school problems, they should assess the impact of all three systems, for then they can treat the most destructive group, the unit that is the easiest to change, or all three systems. Professionals trained in family therapy are well qualified to intervene in families, schools, and peer groups, as they have learned how to deal with systems. We shall now discuss the etiology and treatment of learning disorders, school behavior problems, and school phobia.

LEARNING DISORDERS

Learning disorders such as underachievement, reading problems, or communicative disorders (not including learning disabilities that are

caused by physical factors) can affect perceptive, integrative, or expressive processes. Children suffering from learning disorders usually have low self-esteem and a negative self-concept, as they constantly experience failures and punitive consequences from their surroundings. They react to failures by becoming depressed or angry, acting out, lowering their achievement motivation, or avoiding learning situations. This usually leads to even more problems and negative experiences (positive feedback cycle).

In some cases, these children did not adapt to school life, are not accepted by their peers, or compete with more capable (younger) siblings, thus losing their parents' affection and approval, as they are not as successful (cf. Foster and Culp 1973). Adolescents might underachieve in order to reach independence by challenging parental or societal values or by rejecting inappropriate or unrealistic goals. But they may also be afraid of growing up and may fail classes in order to remain dependent on their parents.

Interpersonal causes for learning disorders may also lie in the parents' achievement expectations (Friedman 1973b, Friedman and Meltzer 1973, Philage et al. 1975). Excessive pressure for high marks results in anxiety or rebellion and is detrimental to academic success, whereas indifferent or laissez-faire attitudes toward learning do not motivate children to achieve. Expectations of failure often become self-fulfilling prophecies, and disagreement between parents concerning school work leads to inconsistent rewards which do not motivate these children to give their best. Parents may also present their achievement expectations in an ambiguous or confusing way so that their children do not know what their parents want.

Much research evidence suggests that these parents were unsuccessful at school or suffer from low self-regard (Friedman 1973b, Friedman and Meltzer 1973, Foster and Culp 1973, Pannor 1973, Peck 1971). They may see their children as competing with them and fear that the latter may surpass them. Thus, they often covertly discourage learning, for example, by provoking negativistic behaviors, undermining their children's performance, or using double-bind messages ("I want you to succeed, but then I will become depressed"). These parents, moreover, are bad models, as they do not stress academic achievement, have negativistic attitudes toward schools and universities, or do not offer any cognitive stimulation. Similar problems occur if the other-sex parent stresses learning and the same-sex parent is a bad learner. Then

the child may associate academic success with sex-linked traits that he or she should not acquire.

Friedman and Meltzer (1973) described two patterns in the behavior of fathers with children suffering from learning disorders. In the first, the father had been unsuccessful at school, functioned at an occupational level below his potential, regarded himself as a failure, and often felt helpless. In the second pattern, father is a more successful and aggressive person and is the acknowledged authority figure in the family. "Unfortunately, success and assertiveness only cover over a deep sense of inferiority and frustration stemming from early failures in life" (Friedman and Meltzer 1973, p. 49, cf. Peck 1971). In any case, these fathers may project their weaknesses onto their children, be unable to express satisfaction with their achievement, or refrain from supporting them. Their sons are frequently caught in oedipal conflicts, perceive success as competition with their fathers, exhibit castration anxiety, or identify with their underlying passivity. If the fathers are cold and rejecting, their children may retaliate by not learning.

In regard to mothers of children with learning disorders, Friedman and Meltzer wrote in their review: "Some mothers have extremely close bonds with and an intense fear of losing the special intimate relationship with a particular child. So long as this child does not learn, he will not lose his mother, will remain dependent on her, and be free from the anxieties of growing up" (1973, p. 46). These mothers may overprotect or infantilize their children, induce fears of separation, divert them from their homework, or imprint myths onto them ("My child is disabled"). If the mothers have low self-esteem or feel intellectually stupid, they may feel ambivalent toward their children's academic performance and refrain from encouraging success (cf. Friedman 1973b, Peck 1971).

Families of children with learning disorders are often characterized by power struggles, open fights, or suppressed conflicts. The spouses are angry and hostile, depressed and tired, or fearful and anxious. They may try to keep the system intact by carrying out numerous irrelevant interactions, avoiding sexual and emotional intimacy, or preventing any changes (cf. Peck 1971). Their children may become preoccupied with family problems and, therefore, cannot individuate or concentrate on learning. They may also fail at school in order to distract their parents from their fighting by allowing them to focus on the school problems (and not on their marital conflicts), to

voice their frustrations, and to vent their suppressed tensions. Thus, the children become scapegoats and stabilize the family, while at the same time call for community help. The parents criticize and punish these children but also reward them, either covertly or overtly, for their sacrifice.

Learning disorders may also result from sociocultural factors. For example, the surroundings of many children living in urban Western societies do not allow for much exploration (e.g., small apartments), offer little stimulation (incomprehensible technology, uncreative toys), restrict social relations (isolated nuclear families, anonymity in apartment blocks), offer few opportunities for imitation (washing and preparation of meals done by machines), and rarely make it possible for them to observe and help adults at work. Problems may also be caused by the family's frequent moves, which make it difficult for children to establish stable relationships with peers or to adjust to their teachers. Or these problems may result from social change, as more and more adults are uncertain about what is required from them as spouses and parents or feel insecure in these roles. Many parents may also have problems at work, with institutions, or in their social life, which distract them from supporting their children.

Socioeconomic factors are also important. Children from slums or lower-class areas often come from disorganized or one-parent families or arrive at school malnourished, sleepy, or in poor health. They may be afraid of their teachers, lack achievement motivation, have a limited vocabulary, or use different communicative codes and modes of thinking. Their parents often do not appreciate education or are resentful of the school system. Thus, these children may underachieve or develop learning disorders. Similar problems are encountered by children of minorities, immigrants, exiles, or foreign workers. The educational system may show little respect for their languages, traditions, values, and mores. And so these children feel discriminated against, are suspicious of their teachers, and cannot give their best.

SCHOOL BEHAVIOR DISORDERS

School behavior disorders like disruptiveness, aggression, stealing, lying, truancy, or withdrawal may also be caused by family problems. Conflicts in marital, parent-child, or sibling relationships, live-in grand-

parents, drug abuse, or family crises (death, illness, loss of employment, and so on) result in family stress which might be acted out by children at school. Parents suffering from marital conflict often use their children as scapegoats, go-betweens, allies, or ersatz partners which may lead to inappropriate behaviors at school. If the spouses are separated or divorced, their children frequently act out their parents' bewilderment, sadness, or anger, suffer from separation anxiety, or are burdened by guilt feelings. The divorced parent may neglect or parentify the children or use them as a means of retaliation. Thus, these children may express their troubles by misbehavior at school.

Behavior disorders may also result from problems with authority. If the parents are harsh, punitive, or rejecting, the children may express their hostility toward them by challenging the teacher's authority or by becoming fearful and withdrawn. If the children come from an overly strict home environment, they may try to find behavior release at school. If the parents are overpermissive, the children may not internalize norms or develop inner controls and so are unable to follow the teacher's rules. According to Friedman's (1973a) review, children may also act out a parent's repressed wish to defy authority (and provide him or her with vicarious satisfaction) or to follow a family value of nonconformity. In these cases, the parents often encourage (also by ambiguous messages) or condone the misbehavior. They will also tolerate it if they identify with their children's resentful feelings toward school. Children may also develop behavior disorders if they identify with a misbehaving older sibling or if they fail in competition with more gifted siblings.

Quite often, the relationship between family and school is disturbed. If parents are frequently called to school because of chronic problems with their children, they may see themselves as failures (especially if they see their children as extensions of themselves) and become defensive (cf. Boyd 1974, Moynihan 1978). The communications between teachers and parents may also be disrupted if the parents were unsuccessful in school and, therefore, hold negative attitudes toward it, if they use their children as the only message bearers, or if both sides resort to mutual blaming instead of helping these children.

Certainly, behavior disorders can also be caused by the school system itself. Schools are often too big and anonymous, lack warmth and personal relations, or place unattainable demands on some stu-

dents. Teachers are frequently unable to care for their pupils if they have too many or too large classes, are overburdened by bureaucratic tasks, or concentrate only on teaching (believing that they are not responsible for their students' interpersonal and intrapsychic fate). Many teachers are not trained to deal with the children's problems, do not understand them, and may even aggravate them by the techniques they use (e.g., reinforce them positively). Moreover, many teachers often do not discuss their problems in handling certain students with their colleagues or school psychologists, as they are afraid of being labeled as pedagogical failures. Consequently, they do not learn better methods of teaching and child management by means of supervision. Many teachers are also afraid of using educational situations, modifying the informal class organization, representing values, or speaking privately with their students. Thus, school learning degenerates to purely cognitive learning—and the children's emotional, social, and personality growth is left open to chance. School behavior disorders may also be caused by peers who admire students who are aggressive or challenge the teacher's authority.

SCHOOL PHOBIA

School phobic children exhibit panic attacks, extreme fears, and psychosomatic complaints such as nausea, vomiting, or stomach pains. In rare cases, these symptoms are reinforced by physicians prescribing medication and become chronic, while the family, school, and community adjust to this pathological situation. But most cases are acute, usually occurring after holidays or family crises (hospitalization, death, and the like) but also when children have to attend school for the first time. According to Skynner (1974), school phobic children frequently overvalue themselves, have a very positive self-image, and have unrealistic achievement goals. Therefore, they may avoid school and peers because these threaten their self-esteem and feelings of omnipotence. Their fantasies and goals, however, are not challenged at home, where these children have a strong and magical position, dominate or exploit their parents, and are not restrained in any way. In rare cases, school phobia may result from real or imagined fears of mistreat-

ment by teachers and peers or from dislike of certain aspects of school life.

Most researchers (e.g., Davis 1977, Skynner 1974, Veltkamp 1975) believe that the mothers of school phobic children usually have very close relationships with their own mothers and transfer these to their own children, that they were unable to relinquish the exclusive relationship with their infants and now maintain it through childhood and puberty, or that they were disappointed with their spouses and developed intimate relationships with their children as ersatz partners. Quite often, they value their children more than their husbands. These mothers are overindulging, infantilizing, and overprotecting, but they may also feel slightly ambivalent or hostile toward their offspring. Their children are extremely dependent and suffer from great separation anxiety. They want to stay at home even if this requires that they develop painful symptoms. As their fathers are usually detached, passive, and insecure, cling to their wives, or spend little time at home, they cannot disrupt or weaken these symbiotic relationships and force their children to go to school. In some other cases, one parent may be depressed or sick, fear the spouse, or expect an unwanted separation. Their children may sense these anxieties, be extremely concerned with what might happen to their parents while they are at school, and thus decide to stay at home.

DEALING WITH SCHOOL PROBLEMS IN FAMILY THERAPY

If school problems are caused by family pathology, family therapy is indicated—and this has already become obvious to many parents, teachers, and professionals. Many parents, therefore, who contact family therapists do so because of learning and school behavior disorders. Often they are referred by teachers, principals, or guidance workers. Moreover, many school counselors and school psychologists have been trained in family therapy and offer it to selected clients.

Usually only those families that refer themselves express a need for change and a willingness to collaborate in order to solve their problems. If only one parent contacts the therapist, if the family is referred by the school, or if they are invited by the school psychologist, the family

members may feel threatened or forced and become resistant and defensive. The parents may then try to shift the responsibility for their child's change to the therapist or argue about who will control the sessions. Many fathers resist treatment, as they regard child rearing as their wives' responsibility. Family therapists should overcome these resistances by interpreting them and by being friendly, warm, congruent, and empathic. They should mobilize the family's desire for change, overcome some initial shyness by scheduling a home visit, and insist on always seeing the whole family, thereby taking a position of real authority. If a father really cannot come to sessions during office hours because of work-related problems, the therapist could offer therapy during the evening.

The assessment usually takes place in the therapist's office and should involve the whole family or at least the parent-child triad. Sometimes the spouses and the problem child should be interviewed separately for a while. In many cases it is necessary to invite teachers to the first session or to contact them by phone, to arrange for classroom observation, to plan a home visit, or to refer the child for a medical exam in order to rule out organic causes of the disorder. This way, the therapist obtains much information from different sources and viewpoints as well as from his or her own observation.

At the beginning of the assessment interview the focus should be on the learning or behavior disorder. The family therapist asks for a detailed description of the problems, its onset, antecedents, and consequences, discusses the ideas of each family member concerning the causes of the disorder and inquires about solutions tried before. Afterward the therapist takes a short family history, asking about the parents' school experiences and performance, the child's development and socialization, family crises, and factors related to social class, economic situation, and minority status. With that, the interview acquires a broader focus, and more detailed questions are asked. The therapist explores the child's feelings and attitudes toward school, his or her achievement motivation, school adjustment, and relationship with teachers and peers (classroom status). As well, the therapist assesses the child's maturity, self-concept, and confidence, looking for feelings of inadequacy, inferiority, or separation anxiety. The therapist may also ask about the school, the requirements, the classroom atmosphere, and the remediation services offered.

The family therapist also assesses the mother-child and father-child relationships for symbiosis, dependency, infantilization, overprotection, disengagement, scapegoating, rejection, and the like. The therapist should also inquire about achievement goals, behavior expectations, values, child-rearing techniques, and the family-school relationship. Friedman (1973b) even recommended conducting "a brief homework or tutoring lesson with the parent as supervisor or tutor for the purpose of direct observation of parent-child interaction in an authority-related, task-oriented, and possibly conflict-laden situation" (p. 90). Finally, it is important to look for power struggles and conflicts between the spouses. At the end of the assessment phase, the family therapist should also have an impression of the overall family functioning, quality of communication, role performance, and individual psychodynamics. Then he or she is able to determine the nature and extent of the connection among individual, family, and school problems. The therapist may explain these links in a nonblaming way so that all sides arrive at a common view of the problem, recognize their part in it, and become motivated to solve it together.

Afterward the family and the therapist discuss treatment goals. They should arrive at the same ones and state them in such a way that progress can be measured against them. General goals are the modification of situations that negatively affect learning and school adjustment, the resolution of marital and family conflicts, the facilitation of individual growth, and the promotion of good child-management techniques. Then the family therapist can outline the treatment program, thereby building on individual and family strengths. If deemed necessary, a treatment contract is formulated.

During the treatment phase, the family therapist helps the parents recognize that experiences with their own parents or their own unfulfilled educational goals determine their responses to their children, thereby encouraging them to treat their offspring as individuals with their own rights. If the family has undergone any traumatic events (separation, death, job loss, and the like), the therapist may use crisis intervention, help the parent(s) voice their feelings of loss and disappointment, stimulate the mourning process, and alleviate stress. As well, he or she should facilitate therapeutic interactions among family members and encourage open and honest communication about marital and family conflicts. The family therapist makes the family share their

thoughts and feelings, explore one another's attitudes and life-style, and achieve a greater understanding of one another. He or she uses interpretations to help the family members gain insight into the causes of their conflicts, focuses on nonverbal communication in order to show hidden conflicts, confronts the family with rules and myths, and intercepts manipulative relationship patterns and scapegoating, thereby demonstrating and teaching effective communication.

The family therapist often has to disrupt the symbiotic relationship between mother and child as well as increase the closeness between father and child, for example, by encouraging mutual help and joint activities. The therapist reassures the parents that nothing is physically wrong with their child, emphasizes the results of diagnostic tests, and points out the child's capacities, strengths, and vulnerabilities. The parents are urged to give up unrealistic goals or behavior expectations and help their child to accept himself or herself and to stop competing with more gifted siblings. The therapist informs the parents about the bad effects of an authoritarian, permissive, or overprotective relationship on their children and teaches them better child-rearing techniques and democratic methods (e.g., contracting, family councils). He or she helps them set and enforce rules, structure the child's life at home, and develop trust by listening effectively and looking for the causes of a behavior. The therapist may model missing parental behaviors and teach them by means of shaping and role playing.

Parents should help children with learning problems gain more self-confidence by providing successful learning experiences. If the child is school phobic, the parents should make him or her relinquish omnipotent demands for total control of the mother, alleviate fears of separation, and send him or her back to school. Sometimes the family therapist must make it clear that residential placement will be arranged if a return to school is not enforced. If the problem person is an adolescent, the therapist may use contracting to force him or her to take responsibility for his or her own behavior and performance at school and to gain more autonomy from the parents. In these cases, the therapist may also invite peers to the sessions so that they can support the adolescent, offer clarification, and prevent the parents from blaming them for their child's problems.

Friedman (1973c) developed the Parent-Tutor Therapy: If a parent is an inadequate learning model, unconsciously accepts the bad per-

formance and behavior of the child, or does not support the child's learning, he or she will be trained as a tutor. The family therapist explains or models a constructive tutoring approach and then makes the parent teach his or her child. In this way the parent remains responsible for the child's performance and eventually becomes an effective tutor and role model. The therapist works as a supportive coach, helping the parent choose suitable learning material for the child, suggesting better techniques, and modifying the parent-child interaction. Working separately with the parent or child, the therapist may comment on the tutoring or learning behavior, convey confidence, model fair expectations, or interpret feelings and experiences. Tutoring may also be given as homework after the parent has become a better learning model.

A comparable approach was developed by Patterson and colleagues (1975), who train mothers to work as remedial reading teachers for 30 minutes a day. Each mother receives a manual, data sheets, and a programmed reading text listing the sounds and words to be introduced. They are trained to use this material in one tutoring session, in which they learn reinforcement techniques and teaching methods. Afterward they are contacted by telephone weekly in order to discuss their progress and to help with any problems. Philage and associates (1975) also offer special remedial programs. These therapists work with groups of children, using a token system, discussing feelings, improving social skills, and modifying manipulative devices. The remedial work is gradually taken over by parents who learn to do it by observing, modeling, and role playing.

While these approaches seem to be effective for children with learning problems, Group Filial Therapy was developed by Ginsberg and colleagues (1978) to treat children with school behavior disorders. At first, parents read a training manual on client-centered play therapy, and then they observe the therapists treating groups of children at their school. Later on, the parents become more and more involved in playing with their children until they become the primary therapists. The group leaders meet with the parents at the end of the play session to discuss practiced skills, give feedback, and suggest changes in the home. The treatment principles are to develop a nondirective, accepting, and child-focused atmosphere, to set limits providing a secure and safe environment, to foster communication and trust between parent

and child, to teach reflective listening, and to enhance the children's interpersonal skills. The parents, moreover, can learn from each other and are encouraged to generalize their new behaviors to the home situation, whereas the children are helped to accept themselves, gain more confidence, become responsible for their own behavior, and transfer their new skills to the school environment.

A comparable approach was developed by Williams (1973) who trains parents to use operant conditioning to make their preschool children change their disruptive behaviors. Williams uses videotape feedback to show cueing and bad reinforcement techniques, explains and models better child-rearing methods, and points out bad communication patterns that confuse or overwhelm the child.

Several therapists (e.g., Durell 1969, Hillman and Perry 1975, Skynner 1974) use Multiple Family Therapy (MFT) to alleviate school problems. Though they have comparable goals and use techniques similar to those that therapists use for conjoint family therapy, they believe that MFT has several advantages. For example, families can learn from one another through identification and imitation and can benefit from interventions directed at other families. Fathers can interact with fathers, mothers with mothers, and children with children, empathizing with and supporting one another as representatives of the same role. Members of other families can also be more objective and helpful, offer advice, and help resolve conflicts and problems.

Many therapists like Boyd (1974), Downing (1974), and Philage and associates (1975) use parents' groups to alleviate learning and school behavior disorders. These groups may be available in schools or agencies, and their members may be referred or take part voluntarily after having heard about them by news releases, school reports, or public addresses. They may be therapeutic or discussion groups, training groups (e.g., in behavior modification techniques), enrichment groups (e.g., Parent Effectiveness Training), or lecture groups. The discussions may focus on common problems, parent-child and marital relationships, child-rearing or remediation techniques, communication and problem-solving skills, and feelings of guilt, frustration, or protectiveness. The therapists explore specific problematic situations, increase insight into the causes of conflicts, and try to change parenting behaviors, attitudes, and values.

A few family therapists also work as consultants. They help parents

identify and meet their children's developmental needs, improve marital and parent-child relationships, and develop strategies to reduce inappropriate behaviors and increase appropriate ones. In these cases, the therapists remain outsiders who see their main function as giving advice (as well as clarifying, analyzing, and interpreting) and who let the parents decide how to use this information.

All the family therapy approaches mentioned so far have in common the belief that working on the parent-child and marital relationships and resolving family conflicts will result in changing the children's behavior and performance at school.

SCHOOL INTERVENTIONS

Many schools offer remedial programs, especially for children with learning disorders. Many teachers, however, notice that their efforts are greatly enhanced by the interest, support, and cooperation of the parents—and are minimized by hostility, disinterest, and power struggles. Moreover, if the symptom has a function within the family, the children and parents will want to maintain it (at least as long as no help is provided for the whole family) and collaborate to defeat the remedial teacher (or if they cannot, the child will develop a new problem in an area out of this teacher's reach). Many remedial teachers, therefore, try to involve the parents as part of the helping team. They inform them about the school program and try to persuade them to support it, for example, by motivating their children, helping them accept responsibility for their problems, and supervising their homework. These specialists also discuss the parents' feelings of anger or worry, criticisms, and manipulative devices.

If remedial teachers cannot win the parents' cooperation, if the family suffers from great pathogenic conflicts, if long-term treatment is indicated, or if the school counselor does not feel competent to offer treatment to the family, the school may refer the problem child and his or her family to an agency or private practitioner for family therapy. This makes it necessary for the school staff to be informed about available community resources (including drug abuse centers, vocational rehabilitation offices, public health services, and the like) and also about these services' primary theoretical approaches and waiting

periods. If the family is afraid or resistant, the referral can be facilitated by having the first meetings on the school premises or having the teacher or school counselor invite the family and take part in the first sessions (at the school or agency). However, the referring school staff remains responsible for the family: They should maintain contact with the agency and coordinate the efforts of the school (e.g., continued remedial work), family, and therapist.

Family therapists must also cooperate with the school staff in order to obtain relevant information, influence the child's treatment at school, and improve the parent-teacher relationship—and they often feel as though they have two clients, as the referring agent may seek help, too. Thus, family therapists should offer consultation to remedial teachers and counselors, invite them to strategic sessions and case reviews, and work on problems among them, the problem children, and the parents. This has the advantages that the therapists can help where the problems occur, that the school staff continues to be involved with the children, and that all sides accept part of the responsibility for change. On the other hand, family therapists sometimes have to avoid being identified with school personnel, as the family may perceive them as prejudiced and biased in that they represent the (hated) school system. They must emphasize that they are working for the family.

Cooperation between family therapists and the school staff can be improved if they confer frequently. For example, Moynihan (1978) meets with the problem child's teachers after having dealt with the family's and the child's reluctance, embarrassment, or anxiety and after having gained the permission of all family members and the principal. She often includes the problem children in these conferences but always shows positive regard for them before inquiring about their problems. She makes the children and teachers communicate more directly and openly with one another, encourages them to share feelings, experiences, and disappointments, helps them better understand one another, and motivates them to solve problems together. Thereby, she models a positive relationship between teachers and students. Moynihan also serves as a consultant and teaches child-management techniques. She provides the school staff with a picture of the problem child's home environment and thus helps them empathize with the family and their problems. She also mediates between parents and school, helping the parents take a more positive and cooperative stance

toward the teachers, control their feelings, and communicate more effectively. The children are then no longer surrounded by combating adults and can focus on age-appropriate achievements and competition with peers.

Some family therapists go even further and require that part of the treatment take place at the school. Many of them are behavior therapists who believe that changes in the child's behavior at home will not automatically generalize to the classroom. After the parents have "earned" the additional investment of professional time by effectively applying behavior modification techniques at home, Patterson and colleagues (1975), for example, involve teachers in reducing the rate of disruptive behaviors and ameliorating learning problems. They organize conferences with the parents and teachers in order to improve their communication, create an alliance between staff and family, and explain the treatment program. Then they ask the teachers to list all the problems with the student on a card which is given to him or her. This card has to be presented at the end of each class to the teacher, who marks each problem behavior that has occurred. Then the child has to show this card to his or her parents, who assign a consequence for each positive or negative behavior according to a token program. The parents also maintain contact with the school by telephoning the teachers once a week in order to obtain an overview of the child's behavior.

In more difficult cases, Patterson and associates (1975) teach behavior modification techniques to teachers and even demonstrate them *in situ*. They may also use a work box which signals and counts good behaviors (often operated by the parents). If the problem student scores a certain number, the whole class can leave earlier for recess. This increases the positive reinforcement contingency from the peers, raises the child's status, and improves his or her academic skills. Later on, the work box is discarded and is replaced by the token system. The therapists may also arrange for consequences if a crisis should occur (e.g., the parents have to fetch their child at once and make him or her work at home if he or she attacks another child). Philage and colleagues (1975) also involve teachers in a token program, ask them to report any progress, seek their recommendations, and discuss problems with them.

Foster and Culp (1973) organize Home-School Conferences. As parents and teachers see children from different vantage points, ex-

perience them in different situations, and have different concerns and goals, they should share their views in these meetings. Thus, they will become more objective about one another and the child, better understand one another's feelings, attitudes, and problems, and recognize the impact of ethnic or cultural values and of class or language barriers. The therapists prevent mutual blaming, establish meaningful communication, and explore the consistency of the parents' and the teachers' approaches, as well as their similarities and differences (e.g., those concerning philosophy of discipline, child-management techniques, or guidelines). They also offer a more realistic view of the child and his or her problems and needs. Including the students in the conferences alleviates their fears about secret machinations and allows them to explain misunderstandings, express their feelings, and develop motivation for change. Later, parents, teachers, and children can establish more realistic behavior expectations and achievement goals, devise a mutually acceptable approach to the child's management, and draw up a problem-solving plan. The therapists teach them better techniques, such as reward systems, behavior extinction, shaping, and other reinforcement methods.

Another group of family therapists (e.g., Andolfi et al. 1977, Aponte 1976, Freund and Cardwell 1977) intervenes in schools, using a systems approach. They conceptualize family, school, and peer group as different systems embedded in even larger systems (neighborhood, community, school bureaucracy, government, economy, culture, and so on). Each system is separated from the others by nearly impermeable boundaries and has some impact on the others. Each system consists of horizontal (family: spouse and sibling subsystems; school: subsystems of administrators, of guidance workers, counselors, psychologists, and social workers, of teachers, and of students; peer group: leader and member subsystems) and vertical subsystems (family: grandparent-parent and parent-child subsystems; school: administrator-teacher, administrator-counselor, administrator-student, counselor-teacher, counselor-student, and teacher-student subsystems; peer group: leader-member subsystems). These subsystems usually have more permeable boundaries and interact more frequently with one another. Each subsystem contains several individuals (who are also conceptualized as systems made up of subsystems like body and psyche) whose behavior is related to and dependent on the behavior of any other member of

the subsystem. Here we find the most permeable boundaries and the highest frequency of interaction. An individual can be a member of several subsystems and will behave differently in each one.

Each system or subsystem has a different internal structure and operates according to different rules and transactional patterns. It always tries to maintain its equilibrium even if this can be achieved only by pathological processes (e.g., scapegoating, repression of conflicts) or by extruding members (e.g., sending them to hospitals or agencies). Systems therapists believe that they can help an individual only by modifying the subsystems that have a pathogenic impact on him or her. But then changes in one subsystem will "cause" changes in all other subsystems and the total system because of their interrelatedness. These therapists, then, tend to work with those subsystems that can be most easily entered and modified. But interventions in one system (e.g., family) have only little impact on other systems (e.g., school or peer group), as they do not interact frequently with one another. This explains why a child's learning or behavior disorder may disappear at home after family therapy but still be evident at school: It fulfills a certain function for the school system or is caused and maintained by pathogenic processes within it. Therefore, these therapists intervene in all important systems and subsystems to which the problem person belongs.

These family therapists should be familiar with systems theory and the characteristics of family, peer-group, and school systems, maintain contact with key school personnel, bureaucracies, parent associations, and community agencies, and have techniques for systems intervention. They either work with all systems themselves (often being assisted by cotherapists), or they use a specialist at their agency who intervenes only in schools. They always consider the impact of any intervention on all subsystems and systems.

Systems-oriented family therapists can proceed in three different, but not mutually exclusive, ways.

1. They may work with individuals or horizontal subsystems, like spouses' and teachers' groups. For example, they help children understand themselves and their behaviors, discuss feelings and personal concerns, gain some control over their lives, and solve their own problems. Working in a group may help these students share similar experiences, support one another, and acquire social skills. Or the

therapists help teachers better understand problem children, learn new techniques in behavior management and instruction, discuss their concerns, and learn from one another. Sometimes it is helpful to organize classroom visits.

2. Systems therapists may also work with vertical subsystems like teacher-student groups or with total systems like families and peer groups. They facilitate interaction within these systems, increase their flexibility and adaptability, solve conflicts, and change structures, boundaries, functions, and rules. For example, they have a group of teachers, administrators, and counselors openly discuss their problems, break away from hierarchical decision making, develop a plan for handling the problems, and support one another in carrying it out.

3. The therapists may also combine different systems or some of their subsystems in order to alleviate mutual blaming or defensiveness, solve conflicts, intervene in intersystemic failures, and encourage collaboration. For example, they may organize a conference with family members and the involved school personnel, get them acquainted in a friendly and confidential atmosphere, and urge them to communicate openly about the problem child (e.g., how he or she behaves in different systems, how they feel about him or her, which goals and expectations they have), their own difficulties (e.g., family crises, problems with the whole class or exorbitant requirements), and how they perceive one another. Each individual develops empathy for the others, recognizes and accepts different viewpoints, learns more about the presented problem, and understands other systems, their significance, and their impact on the problem child. The therapists describe the different systems, their boundaries, distribution of power, psychological and sociological linkages, and vectors of interaction (e.g., by drawing a model). Then all members of the conference together can draw up a mutual problem-solving plan, review it step by step to prevent complications of interpretation, collaborate in carrying it out, and evaluate it. The therapists leave if the plan is successful but offer their help in case any unexpected crisis should occur.

Family therapists tend to neglect to modify the social, cultural, and economic context in which these systems are embedded. They should contact newspapers, TV stations, politicians, and bureaucrats in order to point out problems and negative developments in the school system (unattainable demands, school stress; lack of warmth, no help for

personal problems, little consideration of social, emotional, and personality growth; negative side effects of school reforms; and the like). They should also describe the problems of minority and lower-class children, recommend solutions, and improve the situation by organizing self-help groups or community activities. Family therapists should also offer lectures and discussion groups in which they can point out dangers for the healthy development of children (e.g., TV, lack of social contacts), advise people on how to provide a better environment for them (one that is more stimulating and offers more opportunities for observation, exploration, imitation, and help), and improve the cooperation between community and school. They should also help establish marriage and family preparatory classes at schools, colleges, universities, adult education centers, agencies, or churches in order to prepare people for the most difficult jobs of their lives—being a spouse and a parent.

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