Practice Notes

Scapegoating and Therapeutic Storytelling Intervention

Hugh Clarkson and Ron Phillips

Scapegoating is an interpersonal process which is as old as humanity. It offers a means of protecting a social group from disintegration, but at the cost of blaming one individual for having a problem which he or she cannot then fix. Family therapy attempts to unravel the scapegoating process and address the underlying difficulty, but often fails because the family responds fearfully and reasserts the scapegoating. Therapeutic Storytelling Intervention (TSI), among other things, offers a means of adding individual therapy to family therapy without reinforcing scapegoating.

Family therapy began when therapists became interested in the interactions between individuals, rather than concentrating on mental phenomena within the individual. Early family therapists were more or less radically opposed to exploration of the individual's intrapsychic life. This did not mean that family therapists simply preferred a family or wider social systems focus, but instead declared, through such concepts as 'scapegoating' (Vogel & Bell, 1960), that intrapsychic exploration, particularly individual psychotherapy, was to be avoided; for example:

> An intake worker schooled in systems intervention will continue to press for all family members to accompany the identified patient, even under extreme duress ... and the duress will indeed be extreme in many cases (Carl, 1984).

This view held that, even if symptomatic improvement was achievable through individual therapy, the scapegoating process would be reinforced and the family stability would continue to be achieved at the expense of a symptomatic member. These theorists were equally unhappy with the idea of an individual therapist joining his or her client in a process of scapegoating the client's family by agreeing that the family was entirely at fault and encouraging the client to distance from the family (Stierlin, 1977).

In practice, there were two problems with this view; first, individual family members can and do have individual illnesses and psychological problems which are worthy of intervention on their own behalf. Family therapy's lack of interest in the intrapsychic world was counterintuitive for most people, who take considerable interest in their own inner worlds. Further, family systems theory was taken to deny the reality of psychiatric illness, or indeed, any influence on the mind of brain function or dysfunction. This had the effect of excluding family therapy from any place in mental health services, which are committed to treating the very conditions the family therapists pronounced, or were seen to pronounce, as nonexistent.

Second, given the purpose of the scapegoating process (to divert from, and therefore contain, problems which the system cannot deal with directly), any attempt to shift the focus from the individual pathology to whole family issues met with quite predictable 'resistance'. Systems theory predicted that the system (the family) would respond to attempts to broaden the focus with processes (interactional sequences) 'aimed' at maintaining the focus on the individual. This could be expressed in various ways:

1. Escalation of the symptomatic behaviour ('How can you tell us this is a problem with our marriage when our son is threatening us with a knife?').
2. The family attempting to persuade or coerce the therapist, either directly or through complaints processes, to focus back on the symptomatic individual.
3. The family finding another therapist who will act in sympathy with the scapegoating process.

Frequently the outcome was that many families dropped out of family therapy.

For this and other reasons enthusiasm for insisting on only doing therapy with 'whole' families has waned. Scapegoating, as a concept, has dropped out of usage. It is probably fair to say that most family therapists are much more relaxed today about who attends therapy.

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Nevertheless, particularly for family therapists working in settings where a variety of therapeutic modalities are practised, it remains unclear how to integrate individual and family therapies in such a way that these work synergistically. For that we need a family therapy which allows for at least some autonomy of the individual, and individual therapies which do not collude with scapegoating processes (however these are theoretically formulated).

Family therapy theories today have plenty of scope for individual autonomy. Some wonder in fact whether family therapy is in danger of 'overcorrecting' and conceptually losing 'the family' (Minuchin, 1998). There is perhaps a greater problem in finding individual therapies which avoid the risk of colluding with scapegoating processes.

The authors have been working together for some years in a public hospital child and adolescent mental health service in New Zealand combining various family therapies with a therapy which one of us (RP) has developed. This therapy has a number of characteristics which discourage scapegoating and make it suitable for working in combination with other therapies.

Therapeutic Storytelling Intervention (TSI)

TSI grew out of the struggles that I (RP) had in trying to reach troubled adolescents, both individually and in group work. I found that instead of trying to get them to talk about their problems, I got their attention better if I told them stories. Telling stories to children and adolescents is hardly new, but within the world of modern psychotherapy, which generally has a focus on exploring the individual's problems directly, it is a fresh idea. It is different to narrative therapy in that the story that is told has been written by me and is not unique to each client or family. This is intended to overcome the adolescent's fear of having to reveal his or her problems; developmentally the last thing they want to do.

TSI involves the therapist telling a story and asking the patient to imaginatively join a boy (it could just as easily have been a girl) on a journey of self-discovery. There are now two stories; *Gem of the First Water* (Phillips, 1990) and *The Travels of Plymouth* (Phillips, 2004). The stories can be described as lying in the fantasy/adventure genre. The therapy, at its most basic, consists of reading/telling a chapter from the story and then asking the listeners some questions about the story. The therapeutic process lies in the relationship between the purpose-built story(s), the guided questions and the interaction between the participants. The tale can be told to individuals, sibling groups, peer groups or families. We have shown that TSI is well accepted by young people and treatment completion rates are very good (Fortune & Philips, 2004). The therapy does not invite or require much self-disclosure from the client and does not attempt to clarify the problems a particular person is having. It attempts instead to universalise the idea that everyone has challenges and problems and that this is what everyone's life is all about.

The therapeutic effectiveness lies in the storyteller's delivery of the story. It must draw the listeners into the story so that they hear it in an altered state of consciousness; something that we call 'listening to learn'. When the listeners 'enter' the process, they make their own mind pictures and internally 'interact' with those images. This means that while the story is about the journey everyone takes in growing up and forming identity, the process is individualised because the action is mostly internal. So, while the stories offer models for overcoming the problems of life, when a young person does respond and changes his or her attitudes and behaviour, it is not because he or she has been *told* to, but because she or he *chooses* to.

Here is the beginning of the story where we are introduced to the boy:

> Bored, bored, bored, thought the boy. What a rotten day. He was on his way to the arcade. He charged a beer can sitting on the curb in front of him and, with a swift kick, sent it flying into the city traffic. He picked up a rock and threw it at a bird flying past. Every three or four steps, he uttered guiltily, 'To heck with her. Man, she can just ... '
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> The boy's day had started off typically. He and his over-committed mother had had their usual morning battle.
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> 'Honey, it's time to wake up,' his mother had said.
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> 'Aw, _____.'
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> 'Honey, get your room clean before breakfast.' Under his breath, the boy muttered, 'I'm not gonna clean my room. I'm tired of this. They get me up and then zoom off to work. Their work's more important than me. Then on Saturday it's golf and antique shopping.'
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> 'Honey, get up.'
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> 'I don't want to and I'm not going to!' The boy counted to twenty, the door flew open, and his dad stormed to the bed, jerked the covers off and shouted his usual, 'You will get up, now!' And of course, Dad's power had gotten the boy going.
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> The boy walked out to the breakfast table, mumbling to himself. Both parents were reading the morning paper, just like every other morning. Smiling and pulling faces at their raised newspaper, the boy was just three bites into his cereal when his father lowered the paper, glared and told him to be home on time tonight. At his father's first word the boy lowered his eyes to the cereal. An attitude, which naturally wound his father up, spread across his face. His father went on about mowing the backyard and the boy's room being a pig-sty, but the boy smirked, chuckled to himself and never raised his eyes from the cereal bowl. In exasperation his father stormed away from the table.

> The same script took place with his mother. When she finished she said, 'Hon, the back lawn's the size of a postage stamp. You'll get done in no time and the other stuff is simple. And if you get it done, we'll do something special tonight, okay?' With no response from the boy, she bent over to kiss him goodbye. However, as she leaned towards him, he leaned away and she missed him by six inches (Phillips, 1990).

The boy is plucked from his everyday life by forces outside his control into 'the land of confusion', symbolising his inner world, where his attempts to pretend that everything is under control become increasingly impossible. The boy's journey is in five phases:

1. He is confronted with the idea that his own choices are behind aspects of his life which he does not enjoy
2. He is shown behaviours which would help achieve a different outcome
3. He reverts to old behaviour patterns
4. He chooses the new ways of behaving which he understands are more likely to get him where he wants to go
5. He changes his attitudes and behaviour.

The picture emerging here is of a boy whose relationships are troubled. He might or might not have conduct disorder (or any other diagnosis for that matter). The point is that we are never told, and therefore not encouraged to concentrate on the details of his behaviour. If the text offers us any 'diagnosis' at all, it is that the boy has a problem with his attitude. In fact, each of the three family members in the story is shown as bringing unhelpful attitudes and patterns of interacting to the familiar drama. There is no suggestion that the boy has caused the whole problem. One of the main messages to young people is to avoid blaming altogether. The boy's parents are not his victims. Equally, he is not his parents' victim.

This definition of the problem gives little encouragement to scapegoating processes which define problems as specific to the individual and outside 'normal' life. Scapegoating necessarily offers a definition of the problem that has no hope of resolution (although this is not overtly stated), while at the same time holding the person with the problem responsible for striving to overcome it. Definitions of the problem in terms of illness, personality, learned behaviour, genetics or social environment readily lend themselves to scapegoating since all of these tend to suggest fixed characteristics of the individual which are more or less resistant to change. Attitudes, however, are subtly different. While attitudes are also seen as the responsibility of the individual, they are not regarded as a fixed aspect of the person, but rather as changeable. The process of attitude change is seen as a natural part of 'growing up': not easy to achieve, but not impossible or even unusual. Further, a 'bad' attitude is not seen as an illness. People generally have no trouble seeing a 'bad' attitude as having been shaped by past misfortune but nevertheless still the responsibility of the individual to correct. This view encourages a clear-eyed compassion towards other people's difficulties as opposed to a well-meaning hopelessness on one hand ('He can't help it, he's genetically programmed/he had a terrible upbringing') or harsh dismissal on the other ('He's just bad').

TSI, like family therapy, invites each family member to examine his or her role in life's successes and failures and to look at ways he or she can do things differently. The idea is to become more 'mindful' both as an individual and as a family member ('The trouble with you, boy, is that you don't think before you act').

What this means in practice is that TSI can be combined very effectively with family therapy. Two cases illustrate this:

1. The Ingham Family

> Morris (11) and James (14) were referred to the clinic for psychiatric assessment because their behaviour was considered so extreme and bizarre that the mental health workers who had been involved thought that the boys must be suffering from some kind of psychiatric condition. Both boys were causing difficulties at school with uncontrolled anger and fighting with other children. They were both strikingly oppositional and defiant and had racist and sexist attitudes. James was on the verge of expulsion from school after viciously attacking another boy. Morris was becoming increasingly provocative towards school authorities.
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> Diagnostically, both had oppositional-defiant disorder. With some investigation it became clear that their father, Keith, had coped poorly with the divorce from their mother Mary seven years previously. He was living alone. Mary had remarried. Our assessment was that the pressures on these two boys lay in the unfinished business of their parents' divorce and there was no compelling reason to consider a primary intrapsychic pathology.
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> Our formulation was that the turmoil in the relationship between Mary and Keith had severely disrupted the parenting subsystem of this family. Keith had unwittingly modelled frustration and anger; Mary and her new husband, Grant, had not been able to effectively settle down into a new family structure. At a symbolic level, it could be argued that Morris and James were acting as delegates of the old family, their 'task' being to get Mary and Keith back together. This would 'require' them to split Mary and Grant up first.
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> James and Morris had lived with Mary after the divorce (later joined by Grant). Neither boy accepted Grant's arrival in the family and James had gone to live with his father about a year before we saw them. However, his behaviour had continued to be a major problem at school. Morris had escalated his resistance to Grant. They barely spoke to each

other and when they did it was only to clash over something Grant wanted Morris to do. Mary felt terrible about James going to live with Keith, who had irregular work hours and left James to himself most of the time. She felt a constant pressure to choose between her husband and son, and just wanted them to get along.

As family therapists with a family systems formulation of the problem we began by meeting with all of the adults involved. If we had been able to continue the work with them it is questionable whether we would have needed to do anything more than help the adults work out a more satisfactory parenting arrangement. However, as is often the case, we were unable to do this, and it was not long before Keith dropped out of the treatment, leaving us without a key player in the family drama.

Two new problems then emerged. James began to skip school or to attend without any lunch and with unkempt or unlaundered clothes. The school felt that they had to notify the child protection service because they saw James as significantly neglected. Morris, on the other hand, continued to escalate his problem behaviours at school. He needed to be physically restrained by the school principal after he refused a simple request. This was the first time the principal had had to lay hands on a pupil in 20 years of teaching. The school wanted action.

This situation is all too familiar to family therapists. The attempt to engage enough of the system to create the circumstances for change proves difficult or impossible and the symptomatic behaviour begins to escalate. The escalation of the problem behaviour can be seen as an indication that the family therapy *had* been dealing with the important issues. Nevertheless, the symptomatic behaviour was threatening to disrupt the family therapy by undermining the credibility of the therapists. Furthermore the escalation tends to come to the attention of wider systems (in this case, child protection services) which often leads to greater pressure to return the system to equilibrium by the use of hospitalisation, medication or other processes. The original request for a psychiatric assessment of these boys represents this pressure operating on the previous treatment team.

At this point we suggested that both boys go into a TSI group.

Over the next 12 months or so, James completed the TSI group, and began to question the wisdom of staying with his father where he had a great deal of freedom but not much parenting. He moved to his grandparents' and has settled into school.

Morris responded with scorn to the whole concept of the TSI and was unable to be contained in one of the groups because of his disruptive behaviour. The therapist took him out of the group and continued the process with him on his own. Gradually, and without any admissions on his part that he was getting anything from the story, he settled down and began to behave himself at school. Interestingly, his behaviour at home with Mary and Grant did not improve during the same period of time. We formulated this as meaning that we had now got adequate containment of the situation but that the underlying family difficulties continued to exert a strong influence on him. Morris still needed resolution of the family pressure but didn't need to act out destructively outside his home.

In the meantime, we worked with Mary and Grant, focusing on their marriage, with the understanding that if they could withstand the pressure on their marriage, Morris's behaviour would gradually settle and the system would adjust to incorporate the new family arrangement. This required Mary to grieve the 'perfect' family which she had hoped to provide Morris and James and to risk temporarily alienating Morris by supporting Grant as a parent figure in the house. We also had to encourage Grant not to take the problem personally and to fight for Mary's heart and his own place in the family.

We succeeded in supporting Mary and Grant to weather the storm so far. Currently, Morris has decided that he would rather go to boarding school than stay and accept Grant's presence in the house. Keith has made no move to help, either in requiring his son to behave respectfully towards Grant, or to provide an alternative living arrangement for Morris. James's attitude to his mother and Grant has improved greatly. He visits frequently and allows himself a warm relationship with his mother and even some positive interaction with Grant. He has begun to tell Morris to cooperate with their mother and Grant. This, in turn, has given Mary some hope that Morris too may not be lost to her forever.

The introduction of TSI for the boys had a number of advantages but also ran the risk of colluding with scapegoating. The parents, school and child protection service were all reassured that 'something was being done' for the boys and would probably not have been satisfied had we simply tried to continue with family therapy alone. However, it is not uncommon for the introduction of separate therapy for the symptomatic individual to signal the end of effective family therapy. This did not occur here.

2. The Johnson Family

Family therapy theorists have been fascinated by eating disorders. Powerful systemic factors are relatively easy to see and describe in these conditions which are so clearly shaped by family and wider cultural issues. However, since these are psychosomatic conditions, the therapeutic task of shifting the focus from the physical condition of the individual to the developmental 'condition' of the whole family is especially

daunting. While the research evidence suggests that family therapy is the most effective (Russell et al., 1987), it is often unacceptable to the families.

> Sally was a 13-year-old with anorexia nervosa. She had been in individual psychotherapy, but her weight had dropped to a level that could not be tolerated by her family and treatment team, and she was admitted for nasogastric feeding. We saw her and her family an hour or so before the tube was due to be inserted.
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> With more hope than expectation, we suggested to the parents that nasogastric feeding was a backward step in the longer-term management of the condition, and advised them to take Sally home and feed her themselves. Sally's parents decided to take our advice but her mother, Anne, made it clear that she had serious misgivings about our approach. Her father, David, told us that he was a social worker with family therapy training and he was worried that his knowledge of the field would mean that he would unwittingly defeat our efforts. Nevertheless they took Sally home and reasonably quickly her weight stabilised, largely because David took over the task of getting her to eat.
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> During the process of getting the parents to examine their teamwork, a number of family-of-origin and relationship issues emerged. Sally began to talk about her resentment of David's chronic low back pain and her struggle to care for her lonely and demanding father. David began to talk about his resentment of Sally's anxious control of their family life and Sally's unwillingness to say no to her father's excessive demands. Sally's discomfort with her peer group and her bitterness about the family's return to New Zealand from Britain and Australia only a couple of years previously emerged as the central issues for her.
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> Sally and her parents continued to express their reservations about family therapy and asked for Sally to have individual therapy. Anne did not believe that Sally's problems with her father had anything to do with Sally's eating disorder. Sally was used to spending a lot of time talking about her problems to both her mother and her school guidance counsellor and asked to see one of our team.

This was a moment in which the scapegoating could reassert itself. Refusing individual therapy is seen by the family as unempathic and provocative, while agreeing to the request can easily lead to immediate dilution of the family therapy and worse, symptomatic escalation as the intimacy issues stirred up by the individual therapy pressure the patient into further psychosomatic 'retreat'.

> We offered Sally a place in a TSI group and continued to work with David and Anne in couple therapy. Sally has talked about getting time with the school guidance counsellor but so far has not done so. Her weight has slowly increased.

Without putting Sally in TSI, we would be risking a confrontation with her parents which could easily become an argument about whether Sally does or does not have her own problems and concerns.

In both cases, the introduction of TSI allowed family therapy to continue and thrive while offering the young people a therapy that did not burden them with a focus on individual pathology. There is, of course, no guarantee that adding TSI will always combat the scapegoating process successfully.

3. The Samuels Family

> Alan and Diana Samuels brought their nine-year-old son Adam to the clinic, complaining that he was defiant and aggressive. He had a diagnosis of ADHD and had been treated with stimulant medication. However Alan and Diana reported that the medication was largely ineffective. He had also had a trial of risperidone with similarly poor result. Alan had adopted Adam when he was one year old. Diana had separated from Adam's biological father when she was pregnant, and had not seen him since. She described Adam as being 'just like his father and he will end up in prison like his father too'.
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> Alan and Diana felt completely powerless to deal with Adam. They told us that they had locked themselves in their bedroom and phoned the police in terror when Adam had picked up a kitchen knife during a tantrum. They became angry at any questioning of their strategy for dealing with Adam, protesting that we clearly did not understand how dangerous and abnormal Adam was.
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> We invited Adam to join a TSI group and offered Alan and Diana couple therapy 'to help with ideas about how they could manage Adam'. However, they attended only two sessions. In the first session, we were unable to redirect the conversation away from Adam's behaviour. They both refused to discuss their developmental histories, saying that their own childhoods were unremarkable 'and nothing to do with Adam anyway'. Diana came alone to the second session saying that Alan was busy at work and that he couldn't see the point of the sessions.
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> Adam completed the TSI group and enjoyed it. His reflections on the story showed a growing awareness that he was not solely responsible for the family's problems and he also showed us how distressed he was at being unable to please his mother. By the end he was less willing to accept the scapegoat role,

telling his TSI therapist, 'Hey I'm not all the problem, my parents should take the journey'. However, Alan and Diana did not report any change in family life. Shortly afterwards, Adam was placed in a residential school and after numerous unsuccessful attempts to return him home, he was placed with foster parents who had little difficulty with his behaviour.

In this situation, the scapegoating was too powerful for us to overcome and it reached its completion in Adam leaving the family. However, it is probably true that no other outcome was likely and that our task was to assist Adam to emerge with as much self-esteem as possible from this difficult situation. His enjoyment of TSI at least suggested that he was not further traumatised at our hands.

Conclusion

The early insights of family therapists, expressed in concepts such as 'scapegoating', were revolutionary. But those of us who have inherited the 'revolution' have the task of turning the vision into reality. We have found that adding TSI to more traditional family therapy can help to make the therapy more acceptable to families without encouraging scapegoating.

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