Family therapy by family doctors

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SUMMARY. The experiences of a group of general practitioners learning and attempting family therapy are described. Three principles for working with whole families—facilitation, formulation and focussing—are illustrated by case histories. Family therapy in general practice can be effective for patients and worthwhile for family doctors.

Introduction

JACQUELINE A., aged 17 with a history of school refusal, was seen by her general practitioner after taking an overdose of her father's Valium. Mr A., a strictly brought up but illiterate Pole, set intolerable limits to her freedom to go out and have boyfriends. He had been fruitlessly investigated for tinnitus of 40 years' standing, and spent his days in front of the television with the sound fully turned up, complaining about his deaf aid and requesting yet more hospital referrals. A depressed Mrs A. tried vainly to keep the peace, while the 11-year-old son "maintained a low profile" (Case 1).

Damaged members of similar families entrenched in mutual destructiveness and misunderstanding constantly present symptoms of distress to family doctors, who, while perhaps knowing something about each individual, may feel they lack the skills to help a malfunctioning family reorganize itself. The doctor may be able to offer only piecemeal palliation of symptoms in the presenting patient, instead of a more radical approach to the causes of the family's problems.

Family therapy as a distinct method of aiding pathological families to change is a comparatively recent development, and in Britain has so far remained the prerogative of child psychiatrists, psychotherapists and social workers. Yet it may prove to have a role in contemporary general practice similar to that pioneered for counselling and individual psychotherapy by Michael Balint. In the autumn of 1980 the British Postgraduate Medical Federation and the Institute of Family Therapy sponsored an Introductory Group in Family Therapy which met for two hours weekly for 20 sessions under the leadership of Dr Bryan Lask. The group comprised five general practice principals, two trainees and a consultant physician at a hospice for the dying. Our aims were to acquaint ourselves with methods of family therapy and to see whether, with what modifications and to what effect it might be used in general practice. Our methods included reading, case discussion and supervision, role-play, and video recordings of ourselves and experienced family therapists. This paper describes what we learned and how we used it.

What is family therapy?

Family therapy examines individual and family behaviour patterns in the context of the family grouping in which they arise and which they in turn affect. The presenting problem may be symptoms such as encopresis, anorexia or antisocial behaviour in children, depression, psychosomatic illness or marital disharmony in adults, or a family crisis like divorce, bereavement or serious illness. Regardless of any identified "patient", however, in family therapy the therapist engages with the complete family group to explore and modify interactions between the family members. Minuchin, one of the pioneer family therapists, views family therapy as a therapy of action, more concerned with altering the present than interpreting the past. Family therapy addresses the "how now?" rather than the "what when?".

Family therapy requires skills different from individual counselling, where the emphasis tends to be on the doctor's non-intrusive listening. In a family meeting the doctor is allowed, indeed encouraged, to abandon the sidelines and to direct the action. Given this permission to be authoritative, we novices looked for rules to guide our attempts at orchestrating family interactions. We found it helpful to see the task of family therapy as falling into three phases, the three Fs of Facilitation, Formulation and Focussing. These components will be described first in outline and then in more detail, illustrated by cases we have worked with.

The three Fs

Facilitation

Facilitation begins when the doctor senses that a presented problem might be helped by a family-based approach and shares this opinion with the patient or relative. If the suggestion of a family meeting is accepted, practicalities of place, time and duration are negotiated. We have usually allowed from half an hour to an hour. All members of the family are expected to attend, including young children and infants. Absenteeism, however well rationalized, shields vital family interactions from therapeutic scrutiny, and is discouraged.

From the outset the therapist needs to display concern for the family as a whole and respect for each individual. While allowing everyone's viewpoint to be heard, he avoids taking sides. He guides family members into interaction, encourages them to talk directly to each other and comments on what he sees happening, resisting the family's attempts to draw him into collusion with their games, myths and fantasies.

Formulation

Formulation is family therapy's equivalent of diagnosis. As the therapist gathers information and observes the family interacting he begins to form hypotheses about how communication blocks, power struggles, type-casting, misunderstandings and secrets act as obstacles to the family's well-being. He may detect pathological circularity, a repetitive vicious circle where the effect of one person's distressed behaviour is to provoke others to react in ways that only make matters worse. All the family's behaviour, whether spontaneous or in response to the therapist's interventions, becomes evidence for or against the initial hypothesis. Gradually hypotheses unfold and are refined to the point where a precise formulation can be made of the family's pathogenic processes.

Focussing

Focussing is holding the family to the task of change. The process of formulation redefines the presenting problem in terms of specific behaviour that could be consciously worked on and improved. The therapist's formulation is usually shared with the family, and attention focussed on how more positive relationships are to be implemented. Focussing leads on to selecting therapeutic tasks to be undertaken by the family either in the therapy sessions or as homework between sessions. During the sessions the therapist, giving instructions, suggestions, explanations and examples, tries to guard against any tendency for the family to lapse into old, familiar (but damaging) ways. In other words, focussing is like prescribing the necessary medicine and making sure it is taken.

Competent facilitation, accurate formulation and determined focussing should produce a satisfactory outcome. Two case histories will illustrate the sequence of events.

Case 2

Eileen and Tony B., Andrew (2) and Emma (1).

Presentation

Eileen wanted hormones to make her feel happier and more feminine, as she had been when on the Pill before the children were born. She regretted having the children and thought Andrew was hyperactive.

Facilitation

The whole family attended. Andrew began to wreck the room, making communication difficult. Neither parent controlled him and Eileen became distraught. Tony, preoccupied with business worries, knew Eileen was unhappy but had not realized she was thinking of divorce. They thought the marriage would improve if Andrew was better behaved.

Formulation

When Andrew misbehaved Eileen did not know how to set limits to his behaviour. Tony gave her no support. Without boundaries Andrew's behaviour became worse (circularity). In the mounting chaos, Eileen and Tony talked less and less to each other.

Focussing

The initial request for hormones was redefined as a problem of parenting and marital communication. The therapist, a trainee, insisted that the parents control Andrew there and then, allowing them to be strict and smack him. She asked them to discuss similar situations occurring at home, and to decide how and by whom discipline should be enforced. By electing to focus on parenting rather than marital issues, the doctor helped Mr and Mrs B. to realize that they could be good parents despite shortcomings in their own relationship. Three more family meetings were arranged.

Outcome

By the third session Andrew's behaviour became much more controllable. Eileen and Tony decided he was really a normal child, and when Emma played up as well they were able to cope. They volunteered that they were talking to each other more.

Case 3

Mrs Veronica C., 55, widowed for eight months; Dorinne C., 15, her younger daughter; Sandra D., née C., 24, primigravida near term; Tim D., 28, husband of Sandra.

Presentation

Dorinne was underachieving at school and defying her mother's wish that she should stay on. Mrs C. had not accepted her husband's death and was idealizing a marriage everyone else said had been unhappy. Sandra, Dorinne and Mrs C. each consulted frequently and

complained vehemently about the others' unreasonableness. Tim and his mother-in-law rowed constantly.

Facilitation

In preference to gruelling individual consultations the general practitioner arranged a family meeting. All four began to argue and criticize each other. The doctor imposed simple rules of speaking one at a time and listening properly while each person in turn expressed his or her own perception of the family's problems.

Formulation

Mrs C.'s bereavement was not resolving normally. She attempted to protect herself against loneliness by trying to exert excessive control over her daughters. Dorinne was rebelling against this. Tim and Sandra thought it would be wicked to leave while Mrs C. was still upset, but they could not lead a normal married life as long as they had to share the house. Mrs C. made them feel guilty if they talked of leaving (circularity).

Focussing

The need for Mrs C. to have bereavement counselling from outside the family was accepted and she agreed to contact Cruse, the widows' self-help group. The D.s promised to keep in touch with Mrs C. after finding their own home. Given this guarantee, Mrs C. helped by taking out an eviction order which would help secure them council accommodation.

Outcome

Mrs C. contacted Cruse. She and Dorinne consulted less frequently. Sandra often brought her new baby for reassurance, but said she did not take her mother's criticism too much to heart. Mrs C. made procedural errors with the first eviction order, but got it right the second time. Dorinne is now attending college.

Putting theory into practice

Facilitation

Our anxiety at working in a new way caused us difficulties at first in selling the idea of family therapy sufficiently convincingly to engage potential patient/families. We felt threatened at having to exchange the usual confessional type of psychotherapeutic consultation for the more prescriptive style of family interview with different ground rules. While it was not difficult to recognize problems which might benefit from the new family approach, patients sometimes reacted to our hesitancy by putting obstacles in the way—"I would come, but my husband doesn't believe in all that psychology stuff"—or by reneging on an agreed treatment plan. We seemed to fear either that we might provoke the family to some catastrophic disruption, or that nothing at all would happen and we might look foolish. However, with encouragement from Dr Lask we soon acquired some self-confidence in our role of family therapists. We coined the term 'lasking' for telling ambivalent patients "I've a lot of experience with this type of problem; this is how I want to tackle it, and I can't help you in any other way."

We found circumstances when a family approach proved unexpectedly rewarding, for example seeing normal families at a time of extreme stress when a dying member entered a hospice. In Case 3, where the general practitioner disliked individual family members, working with the whole family relieved him of his usual feelings of helplessness. Conversely, we sometimes discovered parents whose own childhood had been so deprived that they needed individual nurturing rather than interactional therapy.

Once committed to working with a family we usually agreed a treatment contract, such as "We'll meet three times, at monthly intervals, and then decide whether or not to continue." Although in crisis it was possible to do domiciliary family therapy in patients' homes, distractions there were more likely and we preferred to work in surgery premises. For some non-communicating families even the co-operation involved in getting themselves all to the surgery proved therapeutic. Meetings took place at a time, in a room or with a furniture arrangement that marked them as out of the normal run of consultations, thereby implying that the general practitioner's behaviour on these occasions might be different from usual. We specified our minimum requirements for who should attend (usually the entire nuclear family), but sometimes the family opted to include others such as in-laws, grandparents or intimate friends, and this was acceptable.

Once the family has assembled, a range of methods can be used to facilitate the meeting. One way is to invite everyone in turn (including the doctor) to state the problem as he or she sees it. Discrepancies, interruptions and interactions then become evidence on which hypotheses leading to a formulation can be based. Another way, peculiar to general practice, where the doctor may have biased prior knowledge of individual family members, is for the doctor to outline what he already knows and to invite the family to correct or enlarge on this. The therapist tries to remain a model of effective communication, using empathetic and non-judgemental listening, demonstrating good parenting skills in dealing and talking with children, and showing that he or she is at ease with physical contact, non-verbal communication and emotional release. It also helps to be able to walk on water. All the time the therapist's comments on what is happening lead the family on to further revelations and interactions. The doctor can hardly go wrong: anything he or she does brings more information about family processes. Spontaneous, intuitive or even whimsical interventions by the doctor are quite legitimate. What is important is noticing how the family deals with them. It is sometimes a good move to take five minutes time out from a family meeting, leaving the room in order to reflect on what is happening or to discuss it with a colleague.

Formulation

As the therapist unfolds details of the family system and observes people during the session, hypotheses should be made as soon as possible about how pathological communication and behaviour patterns contribute to the family's problem. An example might be: "The parents only stop arguing when the child cries. Then mother comforts her and they both blame father. Father then gets angry and won't talk to anyone." The occurrence of circularity is a strong indication of a problem area, as for instance when a wife says: "You don't do anything unless I nag you", and her husband replies, "When you nag I switch off." Substantiated hypotheses eventually coalesce into a formulation which is a redefinition of the problem in precise behavioural and interactional terms, devoid of judgement about who is at fault. Thus stated, the formulation implies clearly defined aims for therapy.

The formulation for the A. family (Case 1) was as follows: Mr A.'s strict Polish upbringing had left him ill-equipped for the role of father in contemporary London. He was fearful of his daughter's emerging sexuality, and deafness left him further isolated. His attitude to Jacqueline, his domination of the television and his intractable physical symptoms were attempts to maintain control over the family and keep his self-respect. Mrs A., by trying to keep the peace, blocked any real communication within the family.

Two further cases illustrate the type of formulation we arrived at.

Case 4

Malcolm E., aged nine, was encopretic, and 12-year-old Gary had asthma. Mother threatened to punish Malcolm when he soiled, but usually relented. Father tried bribery instead, but this made Gary jealous. Neither parent was consistent. Mr E. had low self-esteem and was treated like a third child by his wife, who saw herself as solely responsible for all the family.

Case 5

Robert F., 19, developed Hodgkin's disease. His parents kept the diagnosis to themselves, though Mrs F. tried to deny it. Nobody dared tell Robert, or find out what he and his two older sisters thought about his illness and treatment. Mrs F. developed an almost magical belief that she could protect Robert by adopting the sick role herself. She became depressed and obsessed with psychotropic medication, thereby blocking the family from expressing the grief and anxiety which would have been normal behaviour under the circumstances.

These are fairly complex examples. Sometimes the formulation is very much simpler, based solely on evidence gathered rapidly in the here-and-now of a brief encounter.

Case 6

Passing the reception desk one day, the doctor noticed a distressed Mrs G. about to consult another doctor. Her husband was waiting outside for her. The doctor knew that their younger son, aged seven, had just died. Mr G.'s uninvolved position on the periphery while his wife reported sick seemed to be an enacted formulation of the family's reaction to the bereavement. The doctor suggested to Mr G. that the family should consult together. At first he seemed offended, but half an hour later a fruitful consultation with Mr and Mrs G. and their other son took place.

Focussing

Ideally the formulation encapsulates not only the cause of the family's problem but also its solution. The task of therapy shifts so that therapist and family focus their attention and energy on finding alternatives to the family's previous damaging customs. Often the focus is quite circumscribed: in Case 6, for instance, all that was done was to encourage Mr G. to participate in his wife's consultation instead of waiting outside. Such is the interdependence of family relationships, however, that a corrective influence applied to only one small facet sends therapeutic ripples throughout the family system. It is as if the family before therapy was in stable but painful equilibrium: the therapeutic focussing dislodges the family temporarily into unstable equilibrium by obliging them to behave in unfamiliar ways. If the focus is well chosen, a different and more healthy stability results.

A working rule is: once the focus is clear, spell it out and stick to it. If a couple cannot communicate, help them; if they denigrate and undermine each other, stop them; if parent will not be consistent, make them; if they do not know how to talk to their children, show them; and when they try to do things differently, praise and encourage them.

The focussing in Case 1 was on opening out communication, clarifying the different roles of family members, and getting Mr A. to occupy himself more productively. In Case 4, Mr and Mrs E. were set the task of jointly devising a consistent policy for responding to Malcolm's soiling. When they were next seen several months later, the soiling had stopped. The F. family (Case 5) used their first family meeting to discuss the facts and their fears about Robert's illness openly together. Mrs F. was reassured that she could leave Robert quite safely with his sisters while she went on holiday. By the second meeting she had returned to work and cut down on her tranquillizers. Everyone reported feeling more relaxed.

Our experience has been that improvement can occur very rapidly using a family approach.

Case 7

Mrs H. requested help for Ian, aged 12, who was severely depressed and refusing school. She had three

younger children and a husband who was little involved in family life, being away on business for long spells. The formulation portrayed a family with a peripheral father unsupportive of his wife, and very poor communication between its members. Focussing in the first session attempted nothing more than getting the family to talk to each other in their own home. Afterwards Mr H. was livid, and withdrew to another room by himself for an hour. Then he came out and talked non-stop with his wife for two hours. By the second family meeting (to which Mr H. did not come) Ian was happy and doing well at school again.

One of our anxieties was that family therapy would turn into long-term marriage guidance counselling. This has not proved to be the case. In family work, issues of parenting can be tackled with perhaps more immediacy than marriage problems, and improved communications about parenting carry over beneficially into the marital sphere. Sometimes a session with just husband and wife is helpful, but this should be planned at a family meeting rather than letting it come about by default when other family members fail to turn up.

Discussion

We have learned above all that we actually can cope with seeing entire families, and that some good comes of it. Family therapy as we have practised it seems to make economical use of the doctor's time. Problems which might have taken innumerable individual consultations have proved tractable within very few family sessions. A family-based approach seems particularly suited to working with families in crisis; at such times, defences are down and change in the family system is more likely to occur.

Certainly we have had some families who have failed to improve, or even to come back. Reviewing our apparent failures suggests we need to work out more clearly the indications and contraindications for working with families. General practitioners, however, are better placed than their clinic-based colleagues to offer alternative help to patients who prefer not to involve themselves in family therapy. At worst we have apparently done no damage. On the contrary, such improvements as we have seen have been sufficient in number and quality to encourage us to extend the use of family therapy in our practices.

We have decided to continue meeting regularly as a group, both for case supervision and for further research and evaluation. One possibility to consider is whether or not family therapy in general practice needs to be done as rigorously as we have attempted it, seeing entire families on a formal basis. It may be possible to use the principles of interactional work on the shorter time-scale of a normal consultation with a sub-group of the complete family, involving something akin to Balint's 'flash technique' (Balint and Norell, 1973; Tomson, 1981). It seems that we have learned something very valuable to us. How? We should not divorce the content of our learning from the context in which it occurred. For translating theory and good intentions into action and regular practice, a small group led by an experienced family therapist is probably the best format. The support from such a group fosters confidence, motivation and willingness to take risks.

Three organizations of family therapists exist in Great Britain: the Association for Family Therapy, the Institute of Family Therapy (London), and the Family Institute, Cardiff. Some of their members would probably be willing to contribute their expertise to other groups of general practitioners in different parts of the country. Dr Lask, whose address is given below, would be pleased to act as 'marriage broker', putting interested general practitioners in touch with appropriately skilled teachers of family therapy. He will welcome enquiries.

Footnote

Some months after the last family meeting, the doctor involved in Case 1 found himself near the A.s' house and dropped in unexpectedly to see them. The television was off, father and daughter were conversing and there was no more talk of hospital referrals for Mr A: he was far too busy going to evening classes learning to read.

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