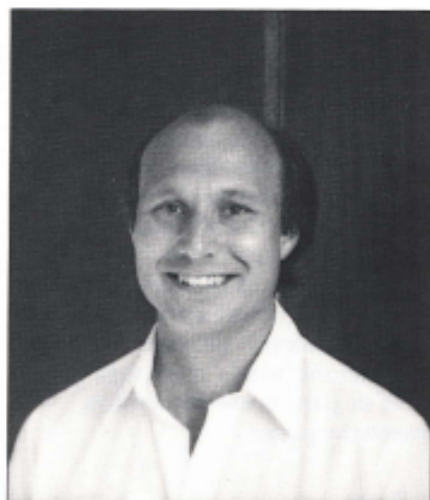


Family Therapy for Family Doctors A Systems Approach — Ron Henbest



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Curriculum vitae

Ronald J Henbest was born in Edmonton, Alberta (Canada) where he qualified in 1974 with a BSc in Maths and Psychology and in 1978 with an MD from the University of Alberta. He then completed two years postgraduate study (residency) in Family Medicine with the Department of Family Medicine at the University of Western Ontario (Canada) and obtained his CCFP from the College of Family Physicians of Canada. Ron joined the Department of Family Medicine at Medunsa in 1980. He has a particular interest in the doctor-patient interaction and its importance for healing. He returned to the University of Western Ontario in 1984 to take their Master of Clinical Science Degree in Family Medicine (MClSc) which emphasizes patient care, teaching and learning, and research. His thesis on Patient-Centred Care involved the development of a method for measuring patient-centredness and testing it against patient outcomes. In 1989, Ron returned to his home city, Edmonton, for a period of 21 months where he was engaged as an associate professor in the Department of Family Medicine at the University of Alberta. During this time, he also completed further training in systemic family therapy. In October 1990, Ron returned, with his wife Judy and four year old son Benji, this time as associate professor and deputy head of the Department of Family Medicine at Medunsa.

Summary

The origins of systemic family therapy is described, as well as its key concepts, and then seven major approaches explained. It is argued that whereas family therapy is conducted by many and varied professionals, family practitioners are very well, or even better placed to offer this valuable service to their patients.

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Introduction

There are a number of levels of involvement that a doctor may engage in with a family. These range from minimal involvement to ongoing medical information and advice, to systematic assessment and planned intervention to family therapy¹

Family therapy is a relatively new, somewhat controversial and rapidly growing field. Systemic family therapy is the application of systems thinking to family therapy. Perhaps most simply stated, systemic family therapy conceptualizes human problems and their resolution in interactional rather than individualistic ways.

The purposes of this paper are:

1. to provide an introduction to

systemic family therapy for those unfamiliar with it,

2. to motivate those who conduct other forms of therapy to consider some of what the systemic approaches to family therapy have to offer,
3. to encourage those who do not do therapy, but do see families in need of help, to consider referral for systemic family therapy when appropriate,
4. to make those in need of personal help aware of this exciting and powerful opportunity for change, and
5. to suggest that the relevant concepts of systemic family therapy be applied to the practice of medicine.

I shall provide a brief background to the field of family therapy, describe its key concepts, and summarize 7 major approaches to family therapy, all of which are systemic in nature.

Development of the Family Therapy Movement

The family therapy movement began in the 1950s,² primarily as a result of dissatisfaction with individual therapy. Gregory Bateson and others observed, in their work with schizophrenic patients, that the improvement achieved in hospital was soon reversed when the patients returned home. In 1956, Bateson, Jackson, Haley and Weakland published a paper entitled, "Toward a theory of Schizophrenia,"³ which described the powerful influence of the family in producing schizophrenia (the so-called schizophrenogenic family). One of the important phenomena described was that of the 'double bind', a term

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now used frequently as part of everyday language. The double bind is essentially a 'no-win' situation in which contradictory messages are given - you are had, either way. Their theory was that as a result of repeated double binds, some children out of self-defence gradually withdraw into themselves, becoming increasingly out of touch

The presenting problem is often a metaphor for the real problem

with others and with reality. This paper was a major influence in moving things toward systemic thinking and in the establishment of family therapy.

Key concepts of systemic family therapy

A number of key concepts can be identified:

1. *Interconnectedness*

All parts of a system are connected and are, in fact, interdependent. I think interdependence can best be understood as part of a process. Infants are totally dependent. Powerful drives for independence begin remarkably early, usually by about 18 months leading to the so-called "terrible two's." Independence is also one of the crucial developmental issues during adolescence. Both periods are usually experienced, and I think one could say normally so, as difficult or challenging. This is no mere coincidence but is because of the

drive for independence. Those who never achieve an appropriate degree of independence, struggle mightily with the next stage of development, namely, interdependence, which is the very basis of relationship. A lot of what we do, is designed to make connections with others, but many of the ways we try are pathological. One, increasingly common, somewhat literal example is family violence, (for example a husband beating his wife). It should be no surprise that a great deal of human misery and suffering comes from painful relationships and it should also be no surprise that individual therapy alone is often insufficient.

2. *Self-regulation*

Behaviour in families can be seen to be self-regulating in much the same manner as biological systems with their homeostatic and other feedback control mechanisms.

3. *Recursiveness*

This term refers to the understanding that one person's behaviour influences a second person's behaviour which in turn influences the first person's behaviour, and so

Problems are maintained by wrong hierarchy in the family

on. Simple cause and effect explanations are denied. One can observe recursiveness almost anytime one interferes in a fight between two children of any age, (including adults), by asking, "Who started it?" Recursiveness says that it is not any particular person's fault, but is due to the interaction.

4. *Wholes rather than parts*

That the whole is more than the sum of its parts is a familiar concept. If one further considers the concept of a hierarchy of wholes, from the atom to the universe, then family therapy deals with the level in the hierarchy that is one step larger than that usually dealt with in individual therapy. Doing so places the problem within a broader context. I think that the main thing that makes the 'whole' more than the sum of its parts is the relationship between the parts.

5. *Patterns*

The recognition of patterns emphasizes the importance of understanding the context, both in time and in place. Many problems are only identified and fully understood once recurrent patterns have been recognized.

6. *Positive intention*

The assumption that all behaviour is positively intended, that is, makes sense in some context, is useful both for understanding the behaviour and for establishing rapport.

Seven major approaches to systemic family therapy

1. Structural
2. Strategic/Problem-solving
3. Construct
4. Communication
5. Symbolic experiential
6. Multigenerational genograms
7. Narratives

All of these approaches apply systems thinking to family therapy. Rather

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than being considered discreet entities, they can be seen as part of a continuum, perhaps from the more intuitive approaches at the one end to the more concrete at the other. Their varying emphases broaden our understanding and provide a rich variety of methods to utilize.

1. Structural approach

The structural approach was developed by Salvador Minuchin⁴ during the 1950s while working among inner-city slum children in

Systemic family therapists see human problems and their resolutions in inter-actional, rather than individualistic ways

Philadelphia. Its basic premise is that family dysfunction is due to problems with the structure or organization of the family. Its key question is, "How is this family organized?"

Goal: To correct the structure of organization of the family.

Key concepts:

1. Hierarchy: Who is in charge? There needs to be a hierarchy, a separation between the generations. The parental subsystem should be separate from the child subsystem.
2. Boundaries: There needs to be appropriate boundaries between the members of the family and groups of members of the family (subsystems). The boundaries can be too rigid, leading to distant relationships, or too open

(inadequate), leading to enmeshed relationships.

3. Marital conflict is dealt with indirectly through the children.
4. Change takes place during the session and will carry over at home.

Methods:

1. Respect the hierarchy in the family: The therapist typically starts with the father, then mother and then children from oldest to youngest. This lets the family know that the therapist respects the parental subsystem. The therapist goes through the parents to the children, for example, "Is that something you want your child to do?" Rapport is also established in the order of the hierarchy.
2. Assess the relationships within the family: The relationships between the various subgroups of family members (subsystems) are assessed. Special attention is paid to the boundaries between the subsystems. Are the boundaries clear? Are they too rigid or too open?
3. Combine therapy with assessment: For example, the therapist may build up or strengthen the various family members as he goes along by underlining their various competences.
4. Enactments: This is one of the powerful methods frequently employed by structural therapists. It consists of setting up an interaction between two (or more) members of the family to enable the therapist to directly observe

their relationship. It also allows the therapist to observe how the other members of the family behave when the two involved in the enactment, talk. Enactments serve to bring problems into the room, to have them enacted. Enactments also form and reinforce boundaries around subsystems. The hope of the enactment is that people will take home a new way of relating.

5. Unbalance the system: Various means are used to change the balance of power in relationships. For example, the therapist might physically move next to father to give him support so that he can talk to his wife.
6. Intensify the emotion: An example might be, "Part of you is very angry. It is amazing to me how calm you are."
7. Tracking: This involves observing the reaction of others to what is going on in the session. For example, the children may become

"I don't believe in people. I just believe in families"

- anxious as the parents start to express emotion. The therapist might describe what she observes and say to the children, "This is not about you, your mom and dad can handle it."
8. Re-label and define behaviour in a way that connects or disconnects as appropriate.
 9. Homework: One of the goals may

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be to reinforce or create a boundary. Thus the husband and wife might be asked to schedule time together.

2. *Strategic/Problem-solving approach*

The major proponents of this approach include the Mental Research Institute (MRI), Haley,⁵ Madanes^{6,7} and Weakland.⁸

Goal: to solve the problems of a client.

Key concepts:

1. Patterns and sequences: How does this behaviour fit in with the patterns in this family? What sequences are there? What happened before and after? Where was 'everybody' in this process? The purpose is to establish the context, including the sequence of the behaviour.
2. Take responsibility for influencing clients.
3. Focus on change in contrast to family therapy per se.
4. Symptoms result due to misguided attempts at changing a system difficulty (for example: prohibition resulting in increased

Think in terms of function and dysfunction

drinking). The solution chosen by the family may be the problem. For example, a child's misbehaviour may lead to a spanking which may lead to further misbehaviour, or sexual

dysfunction may lead to trying harder which exacerbates the sexual dysfunction.

5. The presenting problem is often a metaphor for the real problem.
6. Problems are maintained by a faulty hierarchy.
7. Think in terms of function and dysfunction.

Methods:

1. Focus on changing family interactions and thereby changing family structure.
2. Focus on the solution the family has chosen (which may have become the problem) rather than on the presented difficulty, itself.
3. Focus on behaviour rather than cognition. Break thoughts into behaviours. Instead of, "What do you think?", say, "What do you say to yourself?"
4. Identify sequences in order to interrupt them.
5. Prescribe, often seemingly paradoxical, interventions. The interventions may appear paradoxical from the family's perspective, not from the therapist's systemic perspective. Consider a seesaw or a balance with the fulcrum in the centre, 'status quo' at one end, and 'change' at the other. If the therapist puts weight on change, the family counter-balances by clinging to the status quo. But, if the therapist advocates for the status quo, the family may counter-balance by change. An example of the therapist

advocating the status quo would be to prescribe the symptom. Prescribing the symptom may also help to bring it under control.

6. Pretend. Ask person to have the symptom in the room; if they can't, have them pretend. This too, helps to bring the symptom under control.

All parts of a system are connected

7. Create ordeals. The creation of an ordeal that is worse than the symptom provides motivation for change.
8. Take a one-down position. The therapist takes the responsibility or blame when things go wrong. For example, when a family fails to perform a specific task, the therapist responds not by blaming the family, but by stating something like, "How foolish of me to have allowed you to attempt such a task when you clearly were not ready for it."

The overall focus of strategic therapists is to devote more time to the problem than to health. They work out of their heads rather than from their instincts. To some extent they consider themselves to be technicians using techniques which can be learned and that are not dependent on the therapist's personality.

3. *Construct approach*

The best known group using this approach is the Milan group,^{9,10} b

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used in Italy, which now consists of two teams: Selvini & Prata, and Boscolo & Cecchin. They are considered by some, to be the purists as regards systemic therapy.

Goal: to change people's perceptions.

Key concepts:

1. A change in perception leads to a change in behaviour.
2. Perception or meaning is influenced by information.
3. Information is anything that makes a difference and is found in differences.
4. Problems are always subjective rather than objective and do not exist until experienced.

Methods:

The major focus is on how people see things, on how they think about things, on information rather than

Rather "What do you say to yourself?" than "What do you think?"

intervention, and on helping the family find new meaning for themselves. This method is characterized by three key ingredients:

1. *Neutrality.* No positive or negative judgments are made. Participants are considered as equals. The therapists do not take sides such that, if you were to ask any member of the family whose side the therapist was on, they would

not be able to tell you. Neutrality has been criticized in terms of gender and power issues, that is, that you can not be neutral when faced with a power differential.

2. *Hypothesizing.* Hypotheses are made about the relationship of the symptom to the system and the purpose that it serves.
3. *Circular Questioning:* A method of questioning based on the assumption that information is in differences. Family members are asked to describe differences between other family members. For example, one of the children might be asked, "Which of your parents shows more concern for you?" Differences in relationship and behaviour are explored before, after, and in the future. For example, a child who is doing poorly in school, might be asked, "If you were to change some of your behaviour and become the top student in your class, how would your mom and dad respond to you differently?" Circular questions not only help test hypotheses, but also and even more importantly, generate information which allows people to alter their way of thinking.

4. *Communication approach*

This approach is exemplified by the therapy of Virginia Satir,¹¹ who believed that if you could get people to communicate more openly, they would function better.

Goal: to facilitate honest communication.

Methods:

1. Focus on feelings.

2. Expose discrepancies in communication. For example, the therapist might observe, "You are saying one thing with your body and another with your words."
3. Help people accept the 'differentnesses' between them.

Therapy is entirely emotional

4. Remove the labels off 'identified patients'.
5. Satir always focused on positive intent. A classic example would be the story of the minister whose son had impregnated two of his female classmates. Satir says to the boy, "At least we know you have good seed."
5. *Symbolic - experiential approach*

The best known name associated with this method is that of Carl Whitaker, who stated his systemic position clearly when he said, "I don't believe in people, I just believe in families." and, "There is no such thing as a person, a person is merely a fragment of the family."^{12,13}

Goal: to re-empower the family, to make the family more creative.

Key Concepts:

1. Use of self.
2. Spontaneity versus prescription.
3. The strength of the therapist assists the family.

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4. The focus is on the family's growth versus symptoms.
5. The absurd. It is absurd to argue with absurdity, rather articulate it, for example, by taking it to an absurd extreme.
6. The dialectic of individuation and togetherness or belongingness. Intimacy is one pull of this dialectic. The need or desire for intimacy for most people is much greater than their tolerance of it.
7. There are healthy and unhealthy families.
8. You can't teach people, they have to learn.
9. Therapy is entirely emotional, assessing the unconscious rather than the rational.
10. Change leads to insight versus insight leading to change; experience leads to insight.
11. The better the context, the better the process, so sort out the context first.
12. The process is critically more important than the progress.
13. The family massively outranks and outpowers the individual therapist.

Whitaker describes healthy families as having the following characteristics:

1. the family functions as an integrated whole,
2. the family supports change as well as security,
3. the family group acts as therapist to individual family members,

4. there is freedom of choice with periodic role shifts,
5. there is flexible power distribution,
6. the family can operate at an 'as if', or fantasy level,
7. family members seek to expand experience,
8. stress stimulates growth,
9. the family is evolving rather than static,
10. there is a high level of affect,

The therapist should be courageous enough to take the blame when things go wrong

11. there is a wide range of intimacy and separateness present,
12. the family is realistically responsive to needs between generations, and
13. the relationship with the extended family is secondary to the nuclear family

Methods:

Whitaker focuses on the use of self. He believes that the most essential precursor for psychotherapy is the personal 'reverberation' experienced by the therapist in response to his or her introjection of the family's pain. If the therapist is unable to empathize with this pain, he is not able to do good therapy. Whitaker's approach can be described as follows:

1. An initial assessment is made, including: the emotional age of

each family member, how the interpersonal nature of the pathology of the family is expressed, how underlying culturally visible pathology is expressed, and the relationship of the family to grandparents.

2. The therapist includes himself in the interpersonal network of the family.
3. The therapist monitors his own responses during the therapy session, such as his own anxiety level.
4. The tolerance level of the family for anxiety and ambiguity is determined.
5. The therapist engages in and wins the "Battle for power or structure"; that is, the family must capitulate to the treatment mode of therapist.
6. Thereafter, the "The Battle for initiative" follows and the therapist must do what is necessary for family to take responsibility for itself.

6. *Multigenerational genogram approach*

The multigenerational genogram developed by Bowen¹⁴ provides a systematic framework for family facts and patterns.

Goal: to understand the multigenerational context

Key concepts:

1. Explores problems in context, broadens the frame of reference and takes pressure off of the blamed person.

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2. Lifts the problem out of an individual into the context. No one member or small subgroup can be held responsible for the problems.
3. Undifferentiated family ego mass and Notion of choice. Each person must choose either to remain undifferentiated from the family mass or to differentiate from it and become oneself.
4. Provides a great deal of information, and may be a non-threatening way of sharing information leading to changes in perspective.
5. It is a powerful means of allowing people to make connections which gets away from using the genogram as an interpretive tool.

Method:

There is usually a good response from families if introduced to the genogram in the first session after a brief introduction to lessen anxiety.

Prescribe the Symptom; it may bring it under control!

For example, one might say, "I need to diagram the family to see where everyone fits in." The information that is most useful to obtain depends on the family and the problem. For example, in a family comprised of mother, father and son, where the son is presented as having trouble with his homework, the following information would likely be helpful:

1. facts of the family system at the time that the problem emerged,

2. facts of the system at the time of the son's birth, and
3. facts of the system regarding sibling position.

One could also look at patterns across the generations such as:

1. the male models in the family,
2. unresolved multigenerational issues,
3. manifestations of tension in the family, and
4. similarities and differences amongst family members; for example, "Who is your son similar to?"

7. *A Narrative approach*

Michael White^{15,16} emerged some 6 years ago as a bright light in family therapy. Based on the observation that the problematic behaviour and the person often became one, White's initial focus was to separate them, to "externalize the problem". He has since shifted to a narrative focus.

Goal: To co-author an alternative story.

Key concepts:

1. Stories organize our experience.
2. We have far more story than we know what to do with, we 'story' only a small (select) part of it.
3. Healthy people have access to a larger number of stories and can move from story to story.
4. We enter into and live stories (a process theory rather than a structural one).
5. It is the story that we choose to live that shapes our lives and relationships.

Method:

1. Identify the present problem/story. It is important to arrive at a mutually acceptable description or name for the problem.
2. Externalize the problem: define it as external to the person and explore the influence of the problem over family members and the influence of the family over the problem. This is the opposite of

Problems do not exist until experienced

owning a problem. Externalization allows you to see the person rather than the problem, to see other aspects of the person. For example, one might say, "Tension is taking its toll in this family", and then discuss the tension, including when and how it took control.

3. Co-author an alternative story.
4. Intensify the dilemma (Double Description): that is, state the dilemma in terms of a 'conservative' option versus a 'radical' option. The conservative option is to remain under the influence of the problem, the radical option is to make some change. White often uses the language of alcoholism, such as being 'addicted' to the problem.
5. Open space for new possibilities: discover the preferred option, identify experiments and tasks.
6. Respond to the responses: if the family refuses to move, one can

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say, "Perhaps you are not ready for the radical option yet, when will you be ready?"

7. Contribute to endurance: have the family members take roles as consultants to the therapist. For example, "tell me what I could do to help the family continue". Acknowledge the inevitability of slips or relapses (hiccups) and frame them as opportunities for come-back practice.

Conclusion

This paper has briefly described the origins of systemic family therapy, its key concepts, and seven major systemic approaches.

Systemic family therapy applies system theory to families in order to provide a systems understanding and a systems approach to family problems. It thinks in terms of interaction and context rather than isolated problems and individuals.

Systemic family therapy can be seen as part of a wider movement towards a systems understanding during the past few decades. Medicine too, has increasingly recognized the contributions of systems thinking in its rediscovery of holism and the concepts of patient-, family-, and community-centred care.

While some may view family therapy as yet another speciality to be left to specialists, I would argue differently. A large number of helping professionals of widely varying backgrounds and expertise conduct family therapy, including social workers, ministers of religion, psychologists, and medical practitioners (including psychiatrists, paediatricians, gynaecologists, and

family doctors). In my view, family practitioner generalists who share both the breadth and the depth of their patients' life experiences and who have the interest and the aptitude, are in a better position than most to offer this valuable service to their patients.

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