

From monologue towards therapeutic dialogue. Some remarks about systemic family consultations in a psychiatric in-patient ward

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Summary

Based on the example of one patient and her family, the paper discusses the concept of system family consultations as a way forward towards a therapeutic dialogue.

The patient was hospitalized and diagnosed with schizophrenia, following which the psychiatrist attended the patient's family consultation, conducted by a psychologist. The consultation allowed for the development of a much more complex understanding of the situation. It gave the members of the patient's family the opportunity to present their own view of what was actually happening. The description of the situation from multiple perspectives exposed the ways in which the patient's symptoms functioned; this, in turn, raised doubts for the psychiatrist about his diagnosis, and made him consider to what extent the diagnosis of schizophrenia was actually justifiable.

According to the authors, systemic consultations, which create grounds for feeling empathy for the patient's existential, psychological and family problems, lead to a dialogue with the patient's family and therefore play a significant role in the therapeutic and diagnostic process.

schizophrenia / systemic family consultation / diagnosis / therapy

INTRODUCTION

L.C Wynne, in his conclusion to "Systems consultation. A new perspective on family therapy", says that the consultations give therapists time to think [1]. What does he mean by "the time to think" in the context of a psychotic patient in need of urgent medical assistance being admitted to a ward? It is only natural that at such times we will analyse the patient within the categories we know best; the categories dictated by our theoretical preferences, clinical experience

and the language that we use to describe experience. We order reality by projecting onto it the categories we know from our previous experience. This is how we make it comprehensible to ourselves and, in consequence, less threatening.

However, the ordered world, regardless of whether it is organized in the language of psychodynamic, systemic or biological theory, is not the same as the actual order of the world. *A map is never the actual territory.* It is a very likely situation that whereas we, the therapists, think that we understand a patient (we can put forward a diagnosis, list the symptoms or propose the treatment), the patient does not feel understood at all. And this is not because (as we often tend to think) "he or she is so ill that they cannot feel understood by anyone" but because his or her order, and so his or her way of "taming the world", is different from ours. In consequence,

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our cooperation with the patient becomes either illusory or simply impossible. In any case it is very difficult and it does not bring the results expected by the patient or by the therapist.

How can we avoid this misunderstanding that makes it difficult and sometimes impossible to treat the patient?

Based on our clinical experience in the in-patient ward, where we diagnose, treat and rehabilitate patients with schizophrenic psychosis, we think that a useful tool to avoid the traps of "tamed order" (i.e. apparent understanding resulting in the illusory dialogue with a patient) are systemic family consultations. Here, we wish to present an example of how family consultations can lead to a real dialogue with a patient.

SYSTEMIC FAMILY CONSULTATIONS

Systemic family consultations belong to one of the forms of cooperation with the families of patients hospitalized in the clinical environment due to psychotic disorders. These are neither family interviews nor family education or therapy. Their aim is not to find the answer to questions about the objective state of things, for example to questions of the type "what is the patient's family like?" (its members and their mutual relations) or "what is the family's influence on the development of psychopathology in one of its members?". The consultations are an opportunity to get acquainted with the languages used by the family for explaining the world and for the family members encounter in the world. In other words, it is not "what really is and how is it?", which is the object of interest of the consultant who holds the meeting, but "how, whatever is, is discussed in the family". For instance, a consultant may ask what is most important to each member of the family at that particular moment in their life, what would they like to discuss with the others in the family, in what way, if at all, the consultant may be of help to the family [2, 3].

To reach the main goal of the systemic family consultation, the consultant in charge of the meeting must observe the following principles:

The first, which we think is most important, is that the consultant – a doctor or psychologist – suspends his expert knowledge for the time of

the meeting. If he or she is an expert it is only in creating favourable conditions for conversation and then formulating, on the basis of the conversation, further proposals for cooperation with the family. The consultant should not plan the subject matter of this conversation, have a ready-made script or create a list of questions to be asked. He or she should merely follow the problems discussed by the family.

The next principle says that the consultant should be neutral, must not pass judgements or join any of the coalitions existing in the family. In other words, an equal distance should be kept from all family members. The consultant should follow the principle of "staying curious" i.e. refraining from formulating early hypotheses about what is and how it is and then testing the theory.

Finally, the consultant should adhere to the principle of circular questioning, expressed in giving up questions of the "how was it" and "how is it" type in favour of questions which increase curiosity within the family, questions that open into the future i.e. "What would happen if...?" "How does the family think, what does X think?" etc. [4]

Family consultations take place at the beginning of hospitalization. They are conducted by a therapist who is not directly involved in the therapy of a given patient. All co-habiting persons are invited to attend the consultation. Apart from the family members, the meeting is also attended by observers such as the patient's individual therapist and other members of the therapeutic team. The consultations consist of two parts: the first, main part, in which the family members introduce themselves and share their experience relating to the current situation, and the second part, preceded by a break, in which the consultant communicates to the family the way it has been understood by the observers. Usually it is at this later stage that a proposal of a further, more clearly defined and closer form of cooperation is made to the family, such as the ideas for individual, group, psycho-educational meetings or systemic family therapy.

PATIENT CASE STUDY

Ewa, a 19 year old first year student of the Faculty of Nursing, was brought over to the clinic

by ambulance, and directed to the acute psychosis treatment ward. When admitted, Ewa was described as experiencing increased anxiety and psychomotor performance, strong fear and difficulties in verbal contact. Her thinking was formally distorted through dissociation and symbolic thinking and her thought content was also dysfunctional, exhibiting illusions of grandeur and mission to fulfil; Ewa talked about her telepathic and healing skills. She was clear about her own person but confused about place and time. In psychiatric evaluation, her behaviour during examination was peculiar. She had auditory hallucinations, hearing voices addressing her and saying things like "This is the sister of the man who committed suicide". Her mood was unstable, from sudden outbursts of tears to laughter.

According to her colleagues from the students' hostel, Ewa had began behaving strangely a few weeks previously. She started to isolate herself from the group, neglected her personal hygiene, stopped attending classes, barricaded herself in her room, painted the walls in black, strangely shaped patterns, shaved her head and stayed up all night. Her friends were positive that she had "gone mad".

The initial diagnosis put forward by a psychiatrist on the basis of the examination and an interview with the patient, aroused no doubts: Ewa met the criteria for disorganized schizophrenia according to DSM-IV (hebephrenic schizophrenia according to ICD-10). The patient received anti-psychotic medication, and her family was informed of her hospitalization.

In the next few days of hospitalization, the initial diagnosis found further confirmation. Ewa's thoughts were still distorted; she was irritable, displayed symptoms of increased anxiety and emotional lability. She often talked about her dead brother who committed suicide. The patient said "If I say I feel it I feel it", "I was a madwoman, a child, and who knows what else", "I wanted everything and I wanted nothing", "when my brother hanged himself, I began to see him in every man".

Family consultation

A few days after Ewa was admitted to the ward, we invited her family for consultation.

The meeting was attended by Ewa and her parents.

The family were farmers from a small village in the Podkarpacie province. Both parents, in spite of their young age, were retired due to poor health. They were sad, depressed by the difficulties in their lives and worn-out by hard work. They complained of poor health and financial troubles. They cried, and complained mainly of the harshness of fate. When the parents wailed and complained of their fate, the patient walked around them, cuddled and kissed them, just as a mother would try to comfort her small children.

At one point the consultant asked what was the most important matter in the family now. The patient spoke first: "I'll start, as I always do", she said and continued with the story of her brother's suicide who hanged himself at nineteen years of age. She spoke of him as the oldest of the three children that the parents put their hopes in. As the oldest child he was supposed to inherit the farm. He was also her beloved brother. She could not understand at all why he had killed himself. "I thought that I did something wrong and he died because of me. I prayed for him". At the end of her story Ewa said: "Now I feel like an adult. Now I feel it was a miracle. His life ended then just as mine is truly beginning now".

The patient's parents listened in silence. They admitted that they never talked about their son since his death. What happened was deeply hidden inside them. They were ashamed in front of other people, and never talked about what had happened. They prayed together every day and this is what they thought kept them close together. The patient's mother said "I cannot comprehend any of this. Our whole life became so complicated. I can't even smile since my son's death. For me nothing exists any more". Her daughter's hospitalization, like her son's death, was completely incomprehensible to her.

During the break, the consultant had a chance to speak to the observers, including the patient's individual therapist. Everyone agreed that the family meeting had provided the first occasion to break the silence about the oldest child's death. They also noted the convergence of the fact that the patient's brother committed suicide at the age of nineteen. she left home to study at

the same age and shortly after found herself in the clinic with the symptoms of psychosis.

Against the background of family history and the feelings expressed by the family members, the patient's behaviour, which was earlier considered as bizarre, made much more sense to the observers. The patient's talk, which had previously appeared to her doctor as disassociated, now seemed much more coherent and adequate to the content it expressed. The psychopathological context, in terms of which the patient's situation was first described, stopped being treated as the only possible and justified perspective. Restricting it within the diagnostic process seemed like a great simplification.

The individual therapist asked whether the patient's experiences, treated as symptoms of schizophrenic psychosis, could not also be treated as a distant reaction to her brother's death, especially as the symptoms appeared when she turned the age her brother has died at. Could they not be understood as an adequate response to a hushed-up family tragedy, and so treated not only as pathological, which the medical language authorizes, but also as a normal response, which the family context gives grounds for?

With these questions in mind, the observers' team put forward a hypothesis to the effect that perhaps the patient needed this psychosis to interrupt the silence. She had to leave home to tell others about what happened and to talk about herself. She had to turn her brother's age for the memory of him to return. Perhaps the patient, who was considered to be the weakest family member, as psychiatrically treated people often are, displayed the most strength: not only by becoming the first person ready to talk about her brother's suicide but also by giving support to her grieving parents during the consultation meeting.

In the second part of the meeting, the consultant shared these reflections with the family and suggested another therapeutic meeting.

POST-CONSULTATION THERAPEUTIC DIALOGUE

The fact that the whole perspective on understanding the patient had broadened, and the idea of concentrating solely on the psychopathological perspective had been abandoned, made

the therapist revise his therapeutic plan. It simply appeared that it was not enough to treat the symptoms alone any more, even if the medical perspective would justify such a move. The therapist thought that perhaps it would be advisable to talk to the whole family, because it was possible that the patient alone experienced what the family had not been able to experience for years. Even if the family gave no approval for such proposal for some reason, should he not talk to his patient in terms of her loss rather than about her illness?

These questions and thoughts, aroused as a consequence of the family consultation, changed the one-way comprehension of the patient's problem into multiple options; one understanding (in terms of psychiatric diagnosis) into many possibilities, a focus on the patient alone into interest in the whole family system. As a result, maintaining the initial diagnosis of schizophrenia as the only correct one began to be quite doubtful, especially from the epistemic and ethical perspectives.

From the point of view of the actual classification of psychic and behavioural disorders, there were still reasons for adhering to the diagnosis of schizophrenia. If, however, we are inclined to go along with some of the increasingly popular opinions in psychiatry [5] and abandon the idea of looking for the description of the world as it actually is in medical classifications, then the question of whether the diagnosis is correct or not will not be restricted to asking whether what the psychiatrist sees during the examination of the patient complies with the criteria included in these classifications. Classifications of psychic and behavioural disorders refer both to the preceding and historically modified theories and to the reality they aspire to describe. Reality is always more complex than its descriptions; the world systematized and ordered through classifications does not mean the same as the actual order of the world, and the attempt to understand the individual in general terms unavoidably leads to simplifications [6]. On the other hand, each diagnosis, even if it does not describe the world as it actually is but simplifies it in the language of theory preceding the origins of classification, influences reality through very specific effects it exerts upon it. This often leads to a paradox: a psychiatrist, who recogniz-

es schizophrenia in his or her patient, as dictated by current classifications, may at the same time be right and fail to be so. The diagnosis is right when referred to general categories but wrong when understood in the context of the patient's individual life history.

The diagnostic process must therefore consist in the psychiatrist asking at least two main questions; the first is whether the diagnosis meets the criteria of current classifications, and the second asks if the general diagnosis refers to the patient's life and how it is likely to affect it. The second question is incomparably more difficult than the first, as what we refer to as "the patient's life" runs concurrently in many, often incompatible, contexts (individual, family, social, metaphysical etc.) The diagnosis right in one context might prove wrong in another.

The consideration of these issues made the therapeutic team interpret the patient's experience in the categories of psychotic reactive disorders, although the latest classifications give up this diagnostic concept. What seemed merely pathological on first glance, after the conversation with the family gained a developmental significance, meaning the type of experience that perhaps serves the development of the patient and her entire family.

This changed way of understanding the patient affected all future relations with her. The therapist's conversations with her stopped being about the symptoms, their differentiation and insight into them. Instead, they became conversations about their function, aim and sense in the context of family history. The patient recognized herself in this new way of seeing her problems by her doctor. The diagnosis did not stigmatize her but revealed an inherent power for further development. When the patient's understanding of herself changed she was able to think, together with her therapist, about her plans for the future. She began to think that her parents might perhaps need her, that she should perhaps move back home and continue her studies somewhere closer to her home, to support her parents with her presence.

Finally, as a consequence of her therapy, the patient decided to go back home and study nearby. Perhaps this decision was possible because Ewa did not think of herself in terms of a person ill with schizophrenia but in terms of a person

who is faced with the issues of life and death, with loss, bereavement, loneliness and fear for her family.

Years later, the patient's doctor obtained information about her to the effect that she finished her studies, took on a job and, after losing it, she took another. After she completed her treatment in the clinic she never returned to hospital.

CONCLUSIONS

Family consultations are an essential element of diagnostic and therapeutic processes, allowing for the creation of cooperation for the purposes of treatment, adequate to the needs and possibilities inherent in the patient's system and his or her family. They open options for a patient and his or her family to participate in reflecting on their situation and planning for the future. At the same they help to avoid the traps of imposing just one understanding of the situation, as it is the case in a narrowly understood medical paradigm, where it is the doctors who put forward diagnosis and decide on the treatment, and patients simply do as they are told [7, 8]. The consultations open up the option of a dialogue in the therapeutic team; hence they provide support to the individual therapist and prepare him or her for a similar dialogue with a patient. Family consultations are not, as is sometimes suspected, anti-psychiatric. They do not negate the sense of diagnosis or sense of therapy of the persons suffering from psychic disorders. They create the opportunity for listening to the family story, helping to avoid a one-sided view of the patient; they also show other perspectives on the patient's problems than those expressed in the language of psychopathology. At the same time they allow for a systemic diagnosis which takes into account multiple descriptive perspectives.

The circumstances described above increase our chances of proposing an effective treatment, as it is only through the understanding of various systems that the patient lives in (biological, personality-oriented, developmental, family, social and spiritual) that we can create therapeutic plans and visions. These visions are beneficial (accurate, effective) when they result from a dialogue with patients and their families. The

simplified therapeutic plan set up on the basis of psychopathology summarized in the diagnosis is neither effective nor ethical.

As Wynne, who we mentioned at the beginning of this paper, said, family consultation gives us time to think and therefore it increases our chances of matching our later therapeutic interventions with the needs of the entire family, rather than ordaining them automatically. With our clinical experience in mind we can add that family consultations provide an opportunity for dialogue.

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