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Systems consultation: opportunities and limitations

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Summary

The paper presents the role of systemic consultation in the diagnosis and therapeutic process of the people hospitalised for the first time because of a psychotic episode.

The following questions are going to be put: What is the role of systemic family consultation in the diagnostic and therapeutic process on the inpatient ward? What are the differences between systemic consultation and others forms of family interventions e.g. family interviews, psycho-education, systemic therapy? What are the possibilities and limitations of such a consultation? What does it invite to?

These are only some of those questions, which are typical for daily clinical practice, in which the family consultation takes an important part. In this paper, we would like to share some of our thoughts on the questions put, according to our clinical experience. In spite of difficulties the family consultation confronts us with, we are deeply convinced that it has an important part in the therapeutic and diagnosis process.

Key words: systemic family consultation, psychosis, diagnosis, psychotherapeutic pro-

Introduction

What is the role of systems consultation in the diagnostic and therapeutic process for people hospitalised for the first time because of a psychotic episode? If it is a form of cooperation, with the hospitalised individual's family, then how is it different from other models, such as family interviews, psychoeducational meetings, and systemic therapy? What opportunities does it offer and what threats does it carry? What solutions does it postulate? These are some of the questions we confront in our day-to-day clinical practice, an integral part of which is the systems consultation.

Drawing on our personal clinical experience, in this article we are sharing some of the reflections that these questions have inspired. Whatever difficulty systems consultation may pose for us, we believe it plays a paramount role in the diagnosis and therapy of persons hospitalised for the first time due to psychotic symptoms [1]. Furthermore,

it seems indispensable if what we are aiming at is optimum family cooperation, i.e. cooperation that answers concrete needs [2][1].

Systems consultation as a model of cooperation with a patient's family

The ward in which the consultation takes place is coeducational, with 16 beds, mostly reserved for patients who have not suffered from psychosis before. Usually, the patients are young people. Their age as well as the specific nature of their psychic disorders makes the success of therapy conditional upon cooperation with the family. Therefore, we have long attributed utmost importance to various forms of such cooperation [3, 4].

The family cooperation models that we apply include family interviews, psychoeducational groups, systemic therapy, and systems consultation. Despite their common objective of successful therapy through family cooperation, these models differ from one another in at least three respects. Firstly, the relationship between the family and the therapist-consultant is different in each case; secondly, despite the primary objective that they share, these models vary in terms of their specific goals; thirdly the opportunities these models offer and the limitations they impose are not identical, either.

Individual interviews with a patient's family members are a good occasion to gather some information about the patient, the circumstances that preceded the hospitalisation, and illness warning signs (pre-indications). Most frequently, the therapist is seen by the interviewees as an expert who should know what to ask about. Family members give answers in hope of helping their relative. The prime aim of an interview is to collect data: an unquestionable advantage of this is that it objectifies the input from the patient, whilst its drawback is that it calls for objectivity itself as being just one of a number of possible perspectives from which the situation may be looked at. Moreover, if there is no connection with the family other than this procedure, the family may be led to believe that the therapist bears sole responsibility for the therapeutic process. The therapist is perceived to be the active party in this process, and the family the passive one. Another reason for scepticism is that interviews are usually held when the hospitalised person is not around. This may heighten the patient's feeling that they have no influence on the therapeutic process and that the key decisions are made behind their back.

Psychoeducational meetings are organised for the hospital patients' families. On the one hand they are meant to provide the family with basic information about the disease and the therapeutic process, and on the other hand they become a forum for sharing the anxiety of living with the sick person, and seeking the best methods of helping the patient and handling one's own onus [5].

Psychoeducational groups are intended to support the family. A therapist who

[1] The purpose of this paper is not to provide a theoretical description of systems consultation as a diagnostic or therapeutic method, but to present its practical application in inpatient wards. Derived from a systemic approach, systems consultation has a wide bibliography in the Polish language as well. A selection of important publications in this area is given at the end of this paper.

controls the meetings is looked on as an expert with specialised knowledge about the disease and therapeutic methods. Perceived as an authority, the therapist is expected to offer advice to the family, who tend to have a high respect for his/her opinions. The role of psychoeducation in the therapeutic process of patients with psychotic symptoms is indisputable [6, 7]. For example, its power to restrict the level of expressed emotions, one of the key predictors of relapse in schizophrenia, has been proved to be high in a number of research works. Also, by attending psychoeducational meetings the family keeps in touch with the institution where the patient is treated, which is presumed to contribute to the therapeutic success.

Despite these unquestionable advantages of psychoeducational meetings, this model of family involvement gives rise to serious doubts. It is emphasised that the patient is at risk of becoming stigmatised, overprotective attitudes may be reinforced and the role of co-therapists, which families are expected to perform, may be too demanding for some of them.

Systemic therapy, which is addressed to families of hospitalised patients, is conducted outside the ward, in the Institute of Family Therapy, the hospital's partner institution. The objective is to force changes within the family system. For the duration of a session, the therapist ceases to be an expert. Unlike in psychoeducational meetings, the therapist does not teach, but stimulates dialogue within the family instead, which is believed to have a potential of effecting changes in the family. The family is seen as a partner. The split between the sick and the healthy is put on hold, and the therapist becomes an element of the family system [8, 9].

Apart from more remote effects of systemic therapy, this model of family involvement results in equal treatment of all family members. The hospitalised family member is engaged in the therapeutic process along with his/her relatives. The patient is given an opportunity to shake off the 'sick' label and to find a non-medical description of the circumstances. Each participant of the process may feel they share responsibility for family changes [10].

Despite its potential, this model of systemic therapy cannot be used with every family. Offer of partnership often turns out too difficult: dependence on a therapist and expert better conforms to families' expectations and capabilities, although it requires more effort on the part of the therapist. Additionally, a family does not always look forward to changes, in which case the originally accepted therapeutic concept gets rejected at a later stage.

Systems consultation is, by definition, intended to neither collect information nor educate or reform the family. Rather, it is an opportunity for the family to get to know the therapist and vice versa. Attained gradually, this cognisance is a good footing for them to seek together the best style of cooperation for the therapeutic process. In other words, the key goal of systems consultation is to probe the family's expectations, the family members' understanding of their current situation, their openness for partnership, and the type of partnership they prefer. The therapist has a role of a consultant, not an expert. If the therapist should act as an expert it would only be to the extent of organising interviews and formulating partnership proposals on this basis [8, 11, 12, 13].

Consultation site and procedure

Systems consultation has superseded former house calls, i.e. visiting the family when the patient was already in hospital. The experience of that period, especially the doubts that this practice raised and the limitations it posed, became an impulse for organising on-site meetings with the patient and their family.

Systems consultation is held at the beginning of the hospitalisation process, usually a few days after a patient is admitted to hospital, by a therapist directly involved in this patient's therapy. It is, then, neither a doctor administering individual treatment, nor a psychologist responsible for psychological examination. Consultation meetings are attended by all of the patient's housemates. In a majority of cases these are family members, yet frequently informal partners are included too.

A consultation session is held in an office with a one-way window. Apart from the patient, the family members and the consultant, the session is attended by some observers, usually are trainees, less frequently individual therapists.

The consultation process is comprised of two parts: the essential phase, which usually takes around an hour, and a shorter recap. The meeting is begun by the 'moderator', i.e. the consultant, who introduces him/herself and gives a brief description of the consultation process. Next, the other attendees are asked to introduce themselves, yet the focus is not on their names or relationship with the patient, but on other essential information, such as their profession or interests.

Next, the consultant passes on to questions about the patient's and the family's expectations of the meeting, the family system and its structure, the roles within the family, the problems that the family find critical at the moment, as well as possible methods of and chances for solving these problems in the future. The first part of the meeting is over when the consultant leaves the family to hold a feedback session with the observers. Their discussion is on how they perceived the consultation and what drew their special attention. Then they think of what type of consultation model may be offered to the family. For example, depending on the language the family uses to define their problems, the offer may be psychoeducation (when medical language prevails) or systemic therapy (when psychological idiom prevails and a need for change is apparent) [8].

Following the feedback the consultant joins back the family and summarises the exchange with the observers. This is the moment when a specific model of family cooperation is proposed.

Rules of the procedure

The aim of systems consultation is to fathom the family's understanding of the situation, and on this basis to formulate the best method of cooperation, i.e. a model that matches this family's specific needs. It is critical that the consultant should not dominate the other participant in the session. Instead, the consultant should foster dialogue. As such, the consultant is expected to comply with certain rules.

The first of these rules is: "Be neutral", which implies that the consultant should not be judgemental or join any internal coalitions that exist within the family. In other

words, the consultant keeps the same distance with all family members. The second rule is: "Be curious", i.e. the consultant should refrain from interpretations, diagnosis or any other premature "knowing", or else they will not be able to listen with an open mind to what is being said. The third rule, "Ask circular questions", means that questions about "what it was/is like" are no longer asked, but get replaced by questions that inspire curiosity within the family, and make its members open to future developments [11, 14, 15].

Limitations of systems consultation

Clinical practice proves that the opportunities systems consultation open are limited. This is not only because it is hard for the consultant to implement the theoretical assumptions of this model, which may preclude the achievement of its objectives. Another reason is that this model may turn out too difficult for the family themselves.

The problems faced by the consultant who offers consultation to a family are discussed at length elsewhere [13], so we are only reiterating them briefly here. In summary, on the one hand the consultant needs to be wary of dropping the neutral outlook and giving priority to one of the idioms that come up during a session; on the other hand, the consultant runs the risk of adopting the role of an expert and imposing the medical language. Both of these risk types hamper free dialogue between people speaking different languages. As a result, systems consultation may reinforce some pre-existing misunderstandings or create new ones instead of promoting consensus.

Let us assume that during a session the consultant is successful in keeping a neutral stance, is curious enough, and abandons the role of an expert by taking an 'ignorant' position. However, if the consultant withholds their specialised knowledge, inquires rather than provides answers, and is curious rather than satisfies the family's curiosity, then such attitude does not necessarily need to be interpreted as an offer of cooperation. On the contrary, it may act as a deterrent, as it is not in line with the family's expectations or preconceptions of the purpose of the meeting. Medical consultation is commonly associated with getting advice from a specialist. An offer of consultation may therefore be seen as an opportunity to compare what one knows with expert knowledge, and the right moment to ask the expert some of the questions one has always found hard to answer. It is, then, fair and natural to expect the consultant to share their expertise. But here, the family ends up meeting a consultant who seeks their advice, and who inquires instead of providing information. What is more, they are confronted with neutrality whilst what they expected prior to the meeting was some support, compassion or sympathy for their problem.

How do family members take the consultant's neutrality and non-expert approach? Do they perceive this attitude as rejection? Does the consultant perhaps appear incompetent to them? Do they feel they are being misunderstood? And, consequently, is it clear to them that cooperation is being offered?

Is systems consultation an invitation to cooperate?

If the family is going to be invited to cooperate, the consultant not only needs to remain neutral and put the role of an expert on hold, but also should respect the fact

that the consultation circumstances may be quite out of the ordinary for the family. In fact, cooperation with the family begins with the offer, i.e. still before the consultation process proper is launched. It is critical how a therapist conveys an invitation to a session, whether the therapist him/herself is confident about its importance, and whether the point of the meeting is clearly communicated at the time of invitation. In other words, whether the family is aware that the sense of the term 'consultation' is different from its colloquial meaning.

Based on our experience, if the family is given a 'good invitation' to consultation, chances for effective cooperation are higher once the process is begun. For the most part, it helps reduce an anticipated mismatch between the consultant's expectations and the family's hopes. It may prevent unnecessary disappointments. Yet often 'good invitation' will not even out the differences in mutual expectations. In such cases, whether or not family cooperation is successful will depend to a large extent on the consultant's intention and ability to manage any such identified divergence. The gap is not between the consultant's expectations and the expectations of the family as a whole. It is fairly rare for all members of a family to speak in one voice. Usually their opinions are split, which is another problem the consultant needs to cope with. Provided the consultant is not apprehensive of them, these differences will be easy to pinpoint, and the consultant will not be seeking to eliminate this diversity or to impose a coherent interpretation of the situation from the position of an expert. The consultant will be cooperative and will prompt cooperation. This can be done by rephrasing the consultant's and the other participants' statements in such a way as to keep the differences between particular maps at a minimum level [16]. This way we let them know that the differences are accepted and will be acted upon accordingly: the family's grasp of the situation will decide whether psychodeducation, systemic therapy, or individual contact with a therapist will be proposed.

A model of cooperation with the patient and the family is thus selected to correspond to their individual needs and capabilities, rather than the other way round, which is one of the key advantages of systems consultation, and a postulate of modern psychiatry [2]. Despite 'good invitation', families sometimes reject offers of cooperation. This decision is easier for the therapist to accept if it is looked at from the perspective of selecting a cooperation model that matches the family's needs and capabilities. What is more, this philosophy does not discourage the therapist from inviting more families for cooperation in the future.

Conclusions

Presented above is the place and role of systems consultations in the diagnostic and therapeutic process of people hospitalised for the first time due to some psychotic episodes, and the opportunities that this model of family cooperation provides. The limitations associated with it are also highlighted.

We believe that in spite of the difficulties that this model of cooperation brings about, systems consultation is an irreplaceable tool in day-to-day clinical practice. In this respect we share the opinion of the editors of *Systems Consultations. A new perspec-*

tive for family therapy, who said that '...A consultation model induces a pause before plunging into therapy, and increases the likelihood that family therapy, or whatever services, will be thoughtfully, not automatically, offered and accepted.' [17].

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