Archives of Psychiatry and Psychotherapy
Volume 7, Issue 4, December 2005
pages 45–56

The context of referring to treatment and the course of family consultation vs. readiness to start family therapy

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Summary

The aim of the study was to analyse family and social context of referring patients and their families to the Family Therapy Unit of the Department of Child and Adolescent Psychiatry of the CMUJ, as well as to analyse the course of the family consultation session. The assumption was that the study would make it possible to determine which factors of the familial-social context are connected to the family's motivation towards treatment and what the direction of this connection is. The analysis of material shows that factors affecting the readiness to start therapy include: shorter duration of symptoms, a proper referral by a person referring to therapy (a psychiatrist or another specialist), parents' sense of helplessness in the face of the child's symptoms, and also, to a smaller degree, specificity of the psychopathological picture. Problems which have lasted for more than 2 years, even if the family participates in the family consultation, do not imply readiness to start family therapy. Chronicity of the patient's problems may be maintained by difficulties in understanding relational and psychological aspects of the problem; a "medical map" of the understanding of difficulties, shared by patients and parents; the fact that treatment is started only in a later phase of the difficulties.

Key words: context and motivation to the treatment, family therapy, family consultation

Introduction

Motivation towards treatment is one of the significant factors affecting readiness to start psychotherapy as well as its effectiveness. In psychiatry of developmental age this issue is very complex, as it includes not only motivation of patients but also that of their families. The role of the family in the treatment of children is of fundamental importance as well, since family therapy is considered significant in the treatment of numerous psychic and behavioural disturbances in children and young people. The understanding of family relationships, the child's position in the family or the style of family communication is essential for the understanding of the child's psychological situation and for the assessment of etiological factors of disturbances. Motivational factors influence the moment when the child is referred to a treatment institution. Research shows that the family's motivation to seek help is very complex, and the

context of referring to treatment requires an in-depth analysis, as it significantly affects the family's readiness to undertake therapeutic actions [1, 2, 3]. Clinical experience gained during the work in the Family Therapy Unit of the Department of Child and Adolescent Psychiatry of the CM UJ in Kraków – an institution which for many years has specialized in conducting family therapy – indicates that another significant element influencing the decision to start treatment is the course of a consultation family session. An introductory quantitative analysis carried out in the Family Therapy Unit, which included families consulted and treated between 1998 and 1999 proved that 20% of the consulted families decided against further diagnostic process and family therapy [4]. Considering the fact that patients consulted in the department usually manifest psychopathological symptoms of great intensity, patients' rejection of suggested specialist treatment is quite worrying.

The aim of the study

The aim of the study was an analysis of the family and social context of referring patients and their families to the Family Therapy Unit of the Department of Child and Adolescent Psychiatry of the CM UJ, as well as the analysis of the course of a consultation family session. The assumption was that the study would make it possible to determine which factors of the familial-social context are connected to the family's motivation towards treatment and what the direction of this connection is. This, in turn, would help to improve the therapy model, worked out in the Department.

Subject and methods

The study included 100 families who were consulted in the Family Therapy Unit of the Department of Child and Adolescent Psychiatry of the CM UJ in Kraków between 1st November 2002 and 31st October 2003.

The study was naturalistic in character and was based on the analysis of the following material:

1. medical documents collected before the patient was referred to the Family Therapy Unit
2. data gathered in the special registration form SRF
3. documents recording the course of a consultation family session.

The analysis took into consideration the following aspects:

1. the family's socio-demographic data
2. the patient's psychopathological picture
3. the duration of the problem
4. previous methods and places of treatment
5. the amount of time spent waiting for the admission to the Family Therapy Unit
6. the patient's understanding of the problem
7. the family's understanding of the problem
8. the patient's social adaptation

Results

Between 1st November 2002 and 31st October 2003, during a psychiatric consultation in the Consultation Outpatient Unit of the Department, 100 patients together with their families declared their intention to participate in a family consultation in the Family Therapy Unit. These families filled in the document known as the special registration form SRF and set a suitable date for a family consultation. It should be noted that the aim of the family consultation is to diagnose the patient's problem in the context of family relationships as well as to establish the motivation to family therapy. The appointment for the consultation was usually made by phone but there were also families who made a personal appearance at the Family Therapy Unit in order to set the date and fill in the preliminary registration form. These data included not only formal information, but also information about the problem, the duration of the problems, the context in which they had appeared, the patients' and their families' understanding of the problems, previous forms of treatment as well as the circumstances in which the family decided to seek help in the Family Therapy Unit.

In the studied group of 100 families who declared their intention to participate in a family consultation, 19 families (19%) eventually did not come for the appointment, 11 families (11%) did not start therapy after the consultation, and the remaining 70 families (70%) started family therapy (table 1).

Table 1

Categories of families	Number of families	Number of families in %
Number of families altogether	100	100%
Number of families which started therapy	70	70%
Number of families which did not come to the appointed consultation	19	19%
Number of families which did not start therapy	11	11%

Considerable differences in the size of the differentiated groups of families made it possible to use percentage statistics as the basis for a qualitative analysis. The description of particular groups of patients and their families, according to given criteria, is presented below.

I. Formal description of the groups

The conducted analysis shows that in all groups, pubescent patients were the majority (over 50%). It is worth noticing that in the group of subjects who did not come to the family consultation the percentage of families with a child aged up to 12 was higher, as compared to other groups. The group of those who started therapy was clearly dominated by patients over 16, who attended secondary schools.

The comparison of the place of living of the three groups shows that the distance from the patients' place of living generally does not differentiate the group of the families which did not come to the consultation from the group of the families which

started family therapy. It is possible, however, that this factor was important in the case of families which decided against therapy after the consultation, as in this group over 60% of the families live more than 100 km from the Department. At the same time, it is worth noticing that 40% of the families who started family therapy live more than 100 km from Kraków as well, which indicates their high motivation towards treatment.

Table 2

Patients' age

Patients' age	Group I, those who did not come to the appointed consultation N = 19		Group II, those who did not start family therapy N = 11		Group III, those who started family therapy N = 70	
	Number of patients	%	Number of patients	%	Number of patients	%
6 – 12 years	3	16	1	9	2	3
13 – 15 years	6	32	1	9	23	33
16 – 18 years	10	52	9	82	45	64

Table 3

Type of school

Type of school	Group I, those who did not come to the appointed consultation N = 19		Group II, those who did not start family therapy N = 11		Group III, those who started family therapy N = 70	
	Number of patients	%	Number of patients	%	Number of patients	%
Primary school (a six-year school for pupils aged 7-12)	3	16	1	9	2	3
Gymnasium (a three-year school for pupils aged 13-15)	8	42	6	55	24	33,5
Secondary school (a three-year school for pupils aged 16-18)	8	42	4	36	42	60,5
Others					2	3

Table 4

The family's place of living

	Group I, those who did not come to the appointed consultation N = 19		Group II, those who did not start family therapy N = 11		Group III, those who started family therapy N = 70	
Place of living	Number of families	%	Number of families	%	Number of families	%
Kraków	8	42	2	18	23	32
Up to 50 km	3	16	2	18	18	28
More than 100 km	8	42	7	64	29	40

Table 5

Diagnosis

Diagnosis	Group I, those who did not come to the appointed consultation N = 19		Group II, those who did not start family therapy N = 11		Group III, those who started family therapy N = 70	
	Number of patients	%	Number of patients	%	Number of patients	%
Anorexia nervosa	5	27	2	18	34	48
Bulimia nervosa	2	10	2	18	12	18
Behavioural and emotional disorders	7	37	3	27,5	5	7
Depression	2	10	1	9	5	7
Others	3	16	3	27,5	14	20

In all three groups, disturbances which appeared most frequently were those typical for pubescent patients, such as eating disorders or behavioural and emotional disorders. There are noticeable differences among all the groups in the frequency of diagnosis of these two types of disturbances. In the group which started and continued therapy, it was psychic anorexia that was diagnosed considerably more frequently (48%). In other groups it was the families with behavioural and emotional disorders who constituted the highest percentage. Research shows that behavioural disorders are often related to the type of family relationships, which are described as "centrifugal" [5]. The term means that in such families there are mostly weak family ties and relationships which do not provide a sense of belonging but which hinder the socialization process and prevent the members from achieving autonomy. Such families, due to the type of family structure as well as to the character of relationships, are generally quite weakly motivated towards any effort for the sake of other family members.

It is interesting that among the families who did not come to the family consultation, those with girls with diagnosed psychic anorexia constituted 27%. Because of the parents' anxiety caused by the fact that the child refuses to eat, families with the problem of psychic anorexia are usually interested in a quick possibility of consultation and beginning therapy. Two hypotheses can be formulated. Firstly, it can be assumed that the consultation in the Family Therapy Unit was one of the many possibilities the family had. Secondly, the decision against the consultation may have been related to the development of strong denial mechanisms in patients. These mechanisms make it difficult for patients to perceive the scale of symptoms and they maintain the attitude of resistance towards treatment.

The comparison of groups shows interesting differences. It can be noticed that in the group who did not start therapy after the consultation the reported problem was of a chronic or long-lasting nature. In the case of all consulted members of this group the symptoms had been appearing for more than two years. One can believe that the family was adapted to the symptoms and the aim of the consultation was not to make an effort to solve the problem but rather to participate in a consultation in a clinic recognised as a place of specialist treatment. It was typical for this group that families could present

Table 6

Duration of problem before the problem was reported

Duration	Group I, those who did not come to the appointed consultation N = 19		Group II, those who did not start family therapy N = 11		Group III, those who started family therapy N = 70	
	Number of families	%	Number of families	%	Number of families	%
Up to half a year	3	16	0	0	18	25
Between half a year and one year	2	10	0	0	20	28
Between 1 year and 2 years	4	21	0	0	13	10
Between 2 and 5 years	4	21	6	55	11	16
More than 5 years	3	16	5	45	6	9
No data	3	16	0	0	3	1

a large number of medical documents and they were using medical language in order to describe the child's problems. Parents were not aware of relational aspects which could have affected the remaining symptoms. They treated the consultation as a next appointment with experts, who would not so much look for psychological methods of solving the problem but who would rather recognise the fact that the situation of an ill, difficult child's parents cannot be changed and who would sympathise with them. Most of these families were also receiving treatment in other institutions.

In the group of those who did not come to the consultation, families who had been experiencing problems for more than 2 years constituted 53%, while in the group which started therapy this percentage was significantly lower (38%). This clearly indicates that there is a relation between motivation towards treatment and the duration of symptoms.

Table 7

The amount of time spent waiting for the consultation

Duration	Group I, those who did not come to the appointed consultation N = 19		Group II, those who did not start family therapy N = 11		Group III, those who started family therapy N = 70	
	Number of families	%	Number of families	%	Number of families	%
Up to 2 weeks	5	26	4	36	16	22
From 4 weeks	6	33	6	55	34	49
From 6 weeks	5	26	0	0	16	23
Up to 10 weeks	3	16	1	9	3	5

It seems that the amount of time spent waiting for the consultation was not a significant factor differentiating the group of families who started therapy from the group of families who decided against it. This factor, however, could have been of some importance in the case of the group who did not come for the family consultation.

Table 8

Previous places of treatment

	Group I, those who did not come to the appointed consultation N = 19		Group II, those who did not start family therapy N = 11		Group III, those who started family therapy N = 70	
	Number of families	%	Number of families	%	Number of families	%
Patients not receiving treatment beforehand	4	21	1	9	10	14
Patients receiving treatment beforehand	15	79	10	91	60	86
in a hospital	9	47	5	45	27	40
in an outpatient unit, including:	15	79	10	91	50	70
Psychological assistance	6	31	5	45	30	42
Psychiatric treatment	6	31	3	27	15	23,5
Other kinds of medical assistance	2	10	6	55	15	23,5
Including the assistance of – an endocrinologist					5	7
– a neurologist					4	6
– a family doctor					3	4
– a paediatrician					2	3

The analysis of previous places of treatment implies that most of the families have already received treatment in other institutions. Such families constituted 91% of the families that did not start therapy, 86% of those which started it and 79% of those which did not come to the consultation. It is significant that in the last group there is the highest percentage of families that have not received treatment beforehand. One can speculate to what extent this is a factor affecting the chronicity of the problem.

Table 9

Reasons for visiting the Family Therapy Unit, given by the families

Reasons for visiting the Family Therapy Unit, given by the families	Families which did not come to the consultation N = 19	Families which did not start therapy after consultation N = 11	Families which started therapy N = 70
A referral by a psychiatrist or another specialist	3	3	34
Parents' sense of helplessness towards the child's problems	5	4	25
Increase of alarming symptoms in the child	12	6	15
The intention to change relationships in the family	4	2	10
The patient's intention to fight against the illness, problems	0	0	7
Others (acquaintances' recommendation, inefficient previous methods)	2	1	7

The comparison of the reasons for visiting the Family Therapy Unit, which were given by the patients' parents, shows interesting differences among the compared groups. In the group of those who started therapy the important reasons given most frequently were as follows:

- a referral by a psychiatrist or another specialist,
- parents sense of helplessness,
- increase of alarming symptoms in the child.

It is worth noticing that the first two of the above-mentioned factors are not significant in the remaining two groups. It should be added that according to the procedure followed by the Department of Child and Adolescent Psychiatry of the CMUJ, all families referred to the Family Therapy Unit are seen by the psychiatrist; the aim of this appointment, apart from the diagnosis, is to establish which form of treatment would be the most suitable. It is strange that families belonging to the remaining two groups did not mention the referral as a reason that they find important. What raises questions, then, is the role which a referral by the specialist plays in the group who started therapy. What is the decisive element: making a psychiatric diagnosis, explaining the relational context of disturbances, explaining the ways of behaviour and motivating to begin treatment in the form of family therapy, or rather recognising medical authority by the family? One can believe that each of these elements could have been of some importance in the discussed process. In the light of the collected data, referral procedure, including the role of the referring person, should be regarded as significant aspects of the complex process of the family's decision to start therapy [3]. Parents' sense of helplessness was another important factor inducing the parents to start therapy. The impaired sense of parental authority and the sense of losing influence over the child, which parents were troubled by in the context of the patient's increasing symptoms and difficulties, triggered in parents the need to solve the situation with the help from outside the family system. This shows, it seems, the family's appropriate assessment of the problem and adaptive strategies of the family system.

A. Families which started therapy

Apart from similarities, the list shows also a number of differences in the understanding of the problem by the patients and their families (parents and siblings). Both parties relate the appearance of the problems with the family situation, particularly stressing the role which difficulties in family relationships play in the development of the symptoms. In addition, parents more often feel responsible for mistakes in upbringing and they also mention a wider family context, which, in their opinion, could have been influencing the future patient's behaviour and emotional situation (e.g. death of the grandparents, conflicts among more distant relatives). Another important mechanism is related to the patient's individual characteristics. In their search for explanation, parents mentioned such features of the child's personality as: excessive perfectionism and ambition as well as the desire to live up to social expectations on the one hand, and on the other, lack of self-confidence, nervousness, low self-evaluation, lack of acceptance of one's own appearance as well as over-sensitivity to criticism. The patients were aware of their own difficulties in the enumerated fields to a smaller extent, one exception

Table 10

Understanding of the reported problem

Understanding of the problem	Families which started therapy N = 70		Families which did not start therapy N = 11	
	By the patient	By the family	By the patient	By the family
Difficulties in family relationships	30	30	3	2
Mistakes in upbringing	7	12	0	2
Other family factors (death, conflicts with more distant relatives)	7	15	0	2
Low self-evaluation	10	16	1	3
Excessive ambition, perfectionism, the intention to live up to the expectations	7	15	1	2
Lack of acceptance of one's appearance	19	13	1	0
Over-sensitivity, nervousness	4	15	0	3
School problems	5	12	1	0
Difficulties in peer relationships	2	6	1	0
Peers' influence	5	6	0	2
Illness	4	4	0	1
Lack of understanding	9	4	1	0
Others (genes, sexual abuse)	4	4	0	1

being lack of acceptance of one's own appearance in patients suffering from eating disorders; in the patients' opinion, this was an important element in making decisions to reduce the amount of food. The problems related to adaptation at school and peer relationships were also mentioned by the parents as important elements explaining the mechanism of the child's increasing difficulties and emotional problems. In the patients' view, these elements of the situation were slightly less important.

Interestingly, there were only few references to the illness, understood as a biological illness. One can assume that the psychological understanding of the mechanisms which can influence the appearance and persistence of symptoms – the understanding which dominates among parents and patients – was decisive in making the decision to choose family therapy as a suitable therapeutic procedure.

Some of the statements of patients and their parents and siblings, illustrating their understanding of the symptoms and problems, are quoted below.

The patient's understanding of the problem:

The desire to live up to one's own expectations as well as those of the family

"I wanted to be the best at everything"; "I was to be the best; when I got a 5, my dad would ask: why didn't you get a 6"

Difficulties in family relationships

"there is no closeness or communication with my parents; now, when I feel fear in the morning, I go to my parents' bed so that they can give me a hug and comfort me"; "I stuff myself when I am hurt for some reason, when there are some conflicts at home, with my mum or grandma"; "everybody's my enemy, everybody shouts at me, they are nice when they want something from me; my sisters stick together, they leave me alone and they tell on me";

"I don't want to have anything to do with my parents' conflict, it is a burden to me; I feel like a bridge between my parents, I feel responsible for the situation between them"

Difficulties in adaptation at school, difficulties in peer relationships

"I happened to have the worst teacher, I avoided history classes", "one of the reasons was the change of school – I thought it would be different; there was very strong competition from the beginning, I did nothing but learn", "I had few friends", "I lost my best friend, because he'd become so strange, he'd started to brag"

Difficulties in self-acceptance

"I wanted to lose weight for myself; I wanted to do it out of spite", "after I'd been attacked by this man I lived with the thought that I could have provoked this, I disliked my own body"

The family's understanding of the problem

The intention to live up to one's own expectations as well as those of the family

"she is a sensitive person, she wanted to stand out"; "my son thinks he always has to be the best"; "the school and excessive ambition contribute a lot towards the illness"

IP's sister: "my parents' expectations are too big, they want my sister to have the same marks in her secondary school as she used to have in a country gymnasium";

mother: "the symptoms are related to the end of education in gymnasium – my daughter treated the end of the school year in a very ambitious way; it is then that the first fainting fits and fears appeared; she applied to a very good secondary school but her score in the gymnasium final exam was too low and she ended up in a less ambitious one";

Difficulties in family relationships

IP's sister: "we talk very little about our personal matters; parents are busy working till late; my sister needs support";

mother: "my daughter's illness made me realize that a child needs a lot of attention, no matter how old he or she is";

"our marital problems influenced the appearance of the illness – my daughter was upset by the quarrels, she wanted to draw our attention to herself"

B. Families which did not start therapy

A small number of families that did not start therapy after the consultation (11) makes it impossible to reliably analyse the terms in which the patients and their families think about the difficulties which made them seek help in the Family Therapy Unit. Therefore, it is impossible to state whether it is the difference in "maps" of the understanding of the problem which is the factor differentiating one group from the other. The reasons for abandoning treatment, given by the families, implied, on the one hand, the increase in the psychopathological picture, which required the change of the treatment method (patient hospitalisation – 4 cases), and on the other hand, the unique character of family therapy itself (unwillingness to talk in the presence of other people, conditions in which therapy is conducted, the effort necessary to get the whole family involved in it – 5 cases). In two cases, families cancelled the appointment without giving any reasons.

It seems that one of the reasons for abandoning therapy after the first consultation was the fact that some of the families were not ready to face difficult problems. During the interview with the psychologist some parents said they had come to find some help for the child but they would rather the child continued therapy alone. They claimed that they did not want to talk about other problems, as they found them insignificant. It was important for the family to focus the conversation exclusively on the child's symptoms in order to eliminate them ("the only thing we want is for her to gain weight, for him to start going to school again, for her not to be so nervous", etc.).

For some of the families, who were too afraid of the assessment or discovery of difficult problems, what could have been a pretext for deciding against therapy was a two-way mirror and the presence of graduate trainee doctors behind it. This issue was mentioned as an impediment in therapy by our former patients and their family members, who were asked to assess the effectiveness of the treatment [6].

Conclusions

The conducted study provides a lot of data improving the understanding of the context of families' decision to start or abandon family therapy carried out in the Family Therapy Unit. The analysis of the material makes it possible to draw the following conclusions:

- factors affecting the readiness to start therapy include: shorter duration of symptoms, a proper referral by a person referring to therapy (a psychiatrist or another specialist), parents' sense of helplessness in the face of the child's symptoms, and also, to a smaller degree, specificity of the psychopathological picture
- problems which have lasted for more than 2 years, even if the family participates in the family consultation, do not imply readiness to start family therapy
- chronicity of the patient's problems may be maintained by: difficulties in understanding relational and psychological aspects of the problem; a "medical map" of the understanding of difficulties, shared by patients and parents; the fact that treatment is started only in a later phase of the difficulties.

A small number of families which did not start family therapy, makes it impossible to answer an interesting question: whether different "maps" of the understanding of the problem are the factor differentiating one group from the other. It is worth mentioning that in the group of families who started therapy parents made references to the relational understanding of the problems and they emphasised difficulties in family relationships, unfavourable changes in the family situation as well as their own difficulties as parents, which, in their opinion, could be significant aspects affecting their child's behaviour and symptoms. On the one hand, these factors could strengthen in parents the sense of guilt, but on the other, they could increase the parents' motivation to change family relationships. In this context, the concept of family therapy could have been seen as appropriate treatment, the aim of which is not only to solve the child's problems, but also to change family relationships. It should be stressed that parents hardly ever referred to the understanding of the problem as an illness. If they mentioned any other factors, it was the child's specific characteristics or inability to cope with difficult situations.

The conducted study clearly shows how significant the role of the parents is in making the decision to start family therapy as well as in motivating other family members to participate in the meetings. This stresses the importance of assessing the parents' motivation not only during the first family consultation but also during the first interview with this member of the family who arranges the appointment with the doctor. Being sensitive to the signs of low motivation (such as the difficulty in setting the date of the appointment, absence of an important family member on a consultation session) can help to discuss the problem openly and clarify the expectations of the family members.

References

1. De Barbaro B. *Wpływ czynników wewnątrzrodzinnych na okoliczności pierwszej hospitalizacji psychiatrycznej osób chorych na schizofrenię*. A doctoral thesis. Kraków: 1981.
2. Pietruszewski K. *Cechy systemu rodzinnego a hospitalizacja pacjenta młodzieżowego*. A doctoral thesis. Kraków: 1990.
3. Selvini-Palazzoli M. *The problem of referring persons*. Journal of Marital and Family Therapy 1985; 1: 21–34.
4. Ulasińska R, Ślosarczyk M. *Droga to terapii rodzin pacjentek z zaburzeniami odżywiania się. Analiza wstępna*. I Krakowska Konferencja: Leczenie anoreksji i bulimii psychicznej. Kraków: 2002.
5. Stierlin H. *Separating parents and adolescents. A perspective on running away, schizophrenia, and waywardness*. New York: Quadrangle; 1974.
6. Józefik B, Wolska M, Iniewicz G, Ulasińska R. *Ocena terapii przez pacjentów i ich rodziny. The analysis of questionnaire results*. Psychoterapia 2003; 2: 69–84.

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