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Family therapy of children and adolescents in the psychiatric unit – possibilities and limits

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Summary

The authors discuss specific features of family therapy in the psychiatric ward, which are mainly connected with its medical character. The influence of the medical context and the necessity of collaboration of many staff subgroups and many forms of the treatment on the course and effects of family therapy are discussed in details.

family therapy / psychiatric ward / children and adolescents

INTRODUCTION

In the discussion over the role and the specificity of family therapy in a psychiatric in-patient unit, one has to primarily take into consideration characteristics of the context, in which the therapy takes place [1]. In our paper we will concentrate first of all on the medical context and related social expectations, and secondly on the collaboration of many different specialists' groups typical for the hospital setting as well as on the relations between various forms of help.

MEDICAL CONTEXT AND RELATED SOCIAL EXPECTATIONS

Children and adolescents admitted to the psychiatric unit either are in the process of a psychiatric diagnosis or have already been medically diagnosed and have a record of their medical history. Many of them display burdensome symptoms that disorganize their psychological and social functioning and can even be dangerous. The very fact of admission to the psychiatric hospital defines the child as a patient (puts the child into the role of a patient).

It is obvious that parents adjust their expectations to suit that context - mainly they expect that the child will be treated and his/her symptoms will disappear. It was nicely expressed by a 12 year old sister of our patient who, when asked at the family consultation "What do they expect from the family therapy?" answered: "We came here to treat my sister". Many family therapists bear a grudge for such an attitude, quite unnecessarily to our mind. The above described attitude means readiness for cooperation but only in a form which is consistent with social expectations regarding mental hospital. Quite often therapists describe parents' motivation sarcastically saying: "They have come for the child's operating instructions" or "They brought the child for repairs." There however is a question of what we can expect from the parents who bring their child to the hospital. Leaving the responsibility for treatment in the hands of the hospital staff is congruent with social expectations and does not have to mean family resentment towards coop-

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eration. It can be an expression of parents' helplessness or anxiety [2], as well as uncertainty about their roles as parents. Every family therapist dreams of a family, who will come to him asking for help in order to improve family relations or to solve family conflicts. Unfortunately it is a very rare motivation in a psychiatric hospital context. Whether, the desire to support the child's treatment will turn into readiness for beginning a family therapy depends on the meaning ascribed by the family and the therapist to their cooperation.

Contemporary forms of family therapy, born out of the ideas of social constructionism, [3, 4, 5] are very sensitive to the family's feeling of security and integrity. They respect borders drawn by the members of the therapeutic dialogue thus protecting the family and the therapist against the conflict of expectations and hasty judgment about family resentment towards therapy [6]. This, slightly different than traditional, understanding of family therapy has lead to the decrease of the conflict between medical and family therapy perspectives. Of course it does not mean that such a conflict ceases completely. For example, if a doctor together with the family have a univocal, biological understanding of the child's illness and ensuing treatment, it would be difficult or even impossible to find suitable space for systemic family therapy. In such cases, the staff may propose psychoeducation for the family or even settle for an ordinary talk about the anxiety concerning their child's illness.

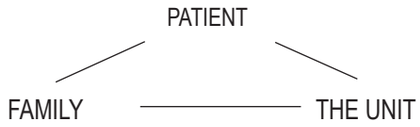
Hence the question, whether in the light of the above discussed limits, starting a family therapy during the hospitalization makes sense. Our answer is positive and we will try to prove it. First of all, the dialogue with the family helps to reduce the distress resulting from the child's or adolescent's hospitalization, and to lessen the anxiety, guilt and even shame. Secondly, in case of intense family conflicts, this therapy enables dialogue between all family members, often for the first time. Thirdly, it helps to promote readiness for profiting from family therapy in families, who otherwise will never reach for it. And last but not least, family therapy stresses the role a family plays in a child's treatment and awakens feelings of responsibility for the child - even during his/her stay in a mental hospital. It also creates a bridge between the psychiatric unit and home by diminishing anxiety that accompanies the child's discharge from the hospital.

COLLABORATION OF DIFFERENT SPECIALISTS' GROUPS

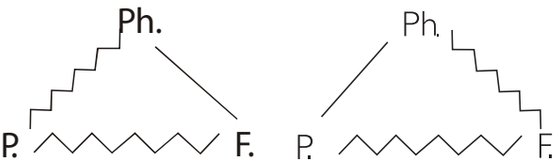
In the hospital, family therapy is only a part of a whole therapeutic system, which creates a necessity for cooperation, team work and taking into consideration all complicated connections between different forms of therapy - biological and psychotherapeutic ones.

The newly admitted patient, his family and the whole hospital staff form a specific system. Relations between all parts of this new system may change patient's position and possibilities, but also may consolidate loyalty conflicts. This new system can become a therapeutic one, generating new solutions, but also can turn into a "problem generating system" [4, 7].

The basic system emerging at the child's (or adolescent's) admission to the hospital



Often children or adolescents admitted to the mental hospital have a conflictual relationship with their parents. Conflicts are usually centered on symptoms and the admission to the hospital or on problems connected with separation. The physician representing the hospital staff takes a specific position in these conflicts. It becomes clear in a situation, when the patient and his/her parents have different opinions on the necessity of the psychiatric hospitalization.



In such a situation the physician is unable to preserve his neutrality and his decision will support only one party engaged in the conflict. Either he supports the family, demanding hospitalization and finds himself in the opposition to

the patient or he supports the patient and engages in a conflict with the family.

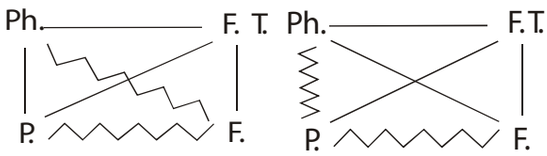
If the conflict does not concern the necessity of hospital treatment, the loss of the neutrality by the staff is less pronounced, although still difficult to escape. Staff members may make the coalition either with the family or with the patient. It is best seen during the clinical meetings, when remarks are made about "pathological family" or "manipulating adolescent".

It happens that the family and the patient are not in open opposition but a developmental conflict, typical for adolescence is deeply denied. Such families have less chance to start family therapy during the hospitalization as they have a "medical map" of the problem and expect pharmacotherapy in the first place. This attitude toward therapy concerns not only whole families, but also adolescents who often lack motivation for psychological treatment (individual or group therapy). As a result, symptomatic improvement leads to a quick discharge of the patient.

Position of a family therapist in patient-physician triangle

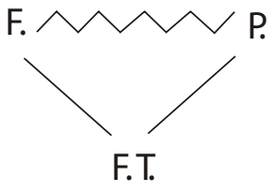
What is the position of a family therapist in the above described patient-physician triangle?

In order for the family therapy to be effective, the therapist must remain neutral [1, 8] It would require following relations:

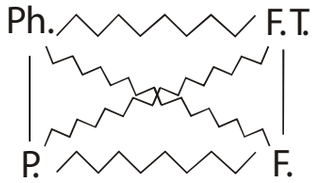


From the psychological point of view it is a situation difficult to reach, as it demands remaining in a metaposition by the family therapist, which means having distance towards the hospital team that he is a part of.

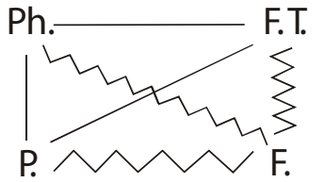
If he can master neutrality in the triangle between the family and the patient,



there is a real danger of polarization of his own and physician's positions. While talking over patient's problems, a "neutral" family therapist often tries to counterbalance a physician's position, thus loosing neutrality. For example, if the physician supports the patient and accuses parents - the family therapist may start to accuse the patient in order to defend the parents.

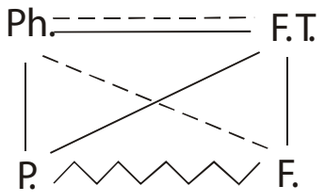


The family therapist may also support the physician and take his position in the conflict with the patient's family, accepting medical understanding of the family situation. This means losing neutrality as well. It happens when preservation of good relations between the physician and the family therapist is important.



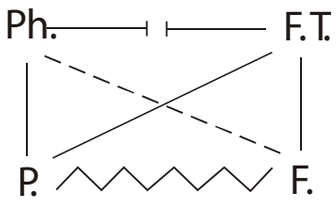
From these considerations in may be easily seen that the situation of a family therapist in a psychiatric unit is unstable and delicate. Effective family therapy and successful cooperation with other members of the therapeutic team requires great maturity and ability to deal with disagreements.

The role of the family therapist in this situation may rely upon taking responsibility for majority of the contacts with the family.



Our experience has clearly shown that helping families is easier and more effective when their relations with the rest of the staff are less intense, or when there is a clear division between different forms of help. For example, the

family is aware, that the physician deals with symptoms and psychopathological problems of the patient, while the family therapist is helpful in solving family conflicts. It seems crucial that the whole staff accepts this division and understands the role of different forms of therapy in a similar way. It helps to separate the scope of the family therapists and the physician's therapeutic activities and leads to the creation of two triangles:



Such a structure allows the physician to concentrate on his relations with the patient and the family therapist to work on the family conflicts.

It is obvious that such a solution is not the only one possible. The way, in which the members of the staff will divide their therapeutic duties, depends on the common agreement and professional competences, meaning roles within the therapeutic team and not the whole range of professional qualifications. In another situation or dealing with another patient they can switch roles, if the physician is a well-trained systemic family therapist and the family therapist is a medical doctor prepared to concentrate on the psychopathological problems of the patient. There are teams in which these roles are combined. However, in our opinion it is a very difficult or even impossible task to combine medical, individual and family perspective by one person, therefore in the Department of Child and Adolescent Psychiatry of the Institute of Psychiatry and Neurology we have decided to accept the above described division of roles.

During the first phase of a psychiatric hospitalization and first family consultation, the family therapist is usually perceived as the staff representative, and in this phase, the hospital context plays a crucial role (both positive or negative) in the therapeutic process. Families who accept the idea of family consultations, could be ones that otherwise would have never come for treatment. At the same time families, who engage in an acute conflict with the unit staff (for example concerning the premature discharge of the patient due to his violation of the unit rules) may drop out of treatment. If the patient is discharged in this phase of hospitalization, the family probably will break the contact with the unit and the family therapist.

With the patient and family treatment progress, the family starts to become aware of the differences in the range of competencies of the physician and the family therapist. This fosters distinction of the therapeutic contract from the hospitalization, which allows the family to continue family therapy independently of the way of separation from the psychiatric unit.

CONCLUSIONS

- The systemic family therapist working in the psychiatric unit cannot ignore the medical context of his work.
- He builds up relations not only with the patient and his/her family, but also with other members of the therapeutic team. It often leads to losing neutrality, for example while defending the family from the accusations of the therapeutic team.
- Conducting family therapy is reasonable, provided that the family, the therapist and other staff members attribute similar meaning to the therapy.
- This attribution of meaning allows the patient and his/her family to see and accept differences in a scope of help provided by the physician and the family therapist.
- Despite all limits and doubts we consider the beginning of family therapy in a psychiatric unit for children and adolescents beneficial and well-founded.

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