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Ethical dilemmas of family therapy in the adolescent psychiatric ward

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Summary

The authors discuss ethical dilemmas concerning family therapy in the adolescent psychiatric unit. Those dilemmas are connected mainly with the medical context of the treatment in the psychiatric institution. They concentrate on ethical questions concerning: medical character of the treatment institution, relations between the patient family and the staff, as well as with the team psychotherapeutic work and limited time of psychiatric hospitalization.

family therapy / ethical dilemmas / psychiatric ward

INTRODUCTION

Family therapy is one of many forms of psychotherapy and as such is regulated by ethical code general rules and published principles of psychotherapeutic conduct [1, 2, 3, 4]. However, the fact of working with a family, meaning people connected by ties of loyalty, dependence and feelings, yields dilemmas specific to this form of therapy [5, 6, 7].

Additionally, psychotherapeutic work within a psychiatric unit for adolescents contributes to consecutive ethical problems related to its specific context - on the one hand there is the psychiatric hospital and on the other, young patients [8, 9]. In our opinion family therapy generates a new system of complicated interdependencies within the in-patient unit and brings up unique ethical questions.

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AIM OF THE STUDY

In our paper we will discuss questions concerning the work of a family therapist in the adolescent psychiatric unit only. We will not deal with numerous problems of family therapy in other contexts or general ethical dilemmas typical for this kind of therapy.

Ethical problems related to therapeutic work with families of hospitalized adolescents derive from the richness and complexity of the mental institution environment.

Special significance could be attributed to:

1. The medical character of the institution, in which the therapy is conducted; it shapes specific relations between patients' families and the hospital staff;
2. An integrated psychotherapeutic programme, in which systemic family therapy is only one of the many psychotherapeutic modalities among group and individual psychotherapy, music therapy, art therapy and body work. Among all of these forms of psychotherapy, family therapy occupies a special position in the staff's consciousness due to the under-

standing of how adolescence, being a difficult phase of family life cycle, contributes to the development of emotional problems of our patients;
3. Limited time of psychiatric hospitalization.

The medical character of the institution

A medical character of the institution implies that at least one member of the family shows symptoms qualifying him/her for the psychiatric diagnosis and hospital treatment. It puts the patient and his family (especially in case of the child's illness) in a position of dependency on medical services. In this situation the proposal of the family meeting (consultation) is regarded as an equivalent to a medical prescription and therefore found very difficult to reject by the family aghast at the child's symptoms. Patient's acceptance or refusal of the family therapy may be influenced by his/her relations with the hospital staff as well. The patient may be afraid of the reactions to his refusal such as anger, disappointment and worry or on the contrary he/she may use it to demonstrate his/her rebellion against dependence on the medical staff.

Parents are often afraid to refuse the suggestion of meeting with the family therapist made by their child's medical doctor. They want to be seen as a "good family ", one that does not avoid talking but has also no need for it because "is not pathological". One can say that this situation creates a paradox. The family has to come to therapy in order to prove that they do need it.

Ethical dilemmas concern the question to what extent the therapeutic team may take advantage of this binding to start therapy, when it is considered necessary; or having these doubts should we resign from the therapy in the hospital and take the risk that the family, free to decide, will never start family therapy outside the hospital, in which case it may be difficult to discharge the patient.

An integrated psychotherapeutic programme

In the hospital, the whole therapeutic team takes care of the patient. The progress and the effectiveness of the family therapy depend on the cooperation of all team members. Family therapists can easily find themselves trapped in a loyalty conflict between their colleagues and families they work with. It happens when the individual therapist or other hospital team member such as a doctor or a nurse identifies with the adolescent patient's anger or distress. In such case he/she takes patient's side and acts against the parents assuming, accordingly with the linear way of thinking about causality, that they are responsible for the adolescent's suffering and eventually - the illness. The family therapist finds himself entangled in a conflict between his own beliefs about the necessity of the family therapy, the assumption that the decisions of other team members should not be questioned and his conviction about greater effectiveness when all therapeutic influences are coherent. It becomes easy to break the rule about not criticizing colleagues' recommendations in the presence of patients.

The situation described above poses another ethical dilemma. One could expect that the discussion with all the therapeutic team members is the easiest solution to this conflict

If the therapeutic team members cooperate well with each other, confronting different points of view may enrich the understanding of the patient's problems and widen the whole perspective of the treatment. However if there is little cooperation, and this does happen at times, different opinions may be perceived as critical remarks.

In this case the family therapist is left with a choice to act consistently with his understanding of the situation which may intensify the conflict, to remain silent or to support an opinion of other staff member.

A large number of staff members taking care of the patients contributes to a serious risk of interpersonal conflicts - open or hidden ones. They could be played out in the form of discussions ostensibly dealing with different essential matters or in the form of inconsistent behaviours towards the adolescent patients and their families, which leads to using the patients for the sake of one's own arguments. If this phenomenon remains on the unconscious level - the ethics of our profession point to the need of supervision, as the best way of dealing with it.

Supervision may involve the whole therapeutic team, in which case it should be performed

by a supervisor outside the institution, or individual members when they declare such a need. However if the conflict between staff members is conscious, what does not happen too often fortunately - one may call it a severe violation of the ethical code.

In the case of family therapy, the presence of a reflecting team consisting of experienced therapists on the other side of a one-way mirror and typical for this setting discussions before and at the end of a therapy session are to some extend equivalent to a formal supervision. Ethical dilemmas related to the practice of family therapy occupies an important place during those discussions. There is always a possibility of additional formal supervision if it is needed.

Team work in the adolescent unit implies another problem, namely the necessity to cope in the session with additional information learned from the adolescent, members of his/her family or different staff members. It often provokes problems essential for the therapy but mostly ethical doubts. For example, a girl suffering from anorexia tells her doctor about her father's alcohol dependence as the main family problem. At the same time she asks her doctor not to tell her parents that she has revealed this information. She also refuses to bring up this problem during the family therapy session. Thus she confronts the family therapist with many dilemmas:

Is he supposed to conduct the family therapy "as usual" hoping that one of the parents will bring up the problem during the session (and what if it does not happen?). Should he bring up the issue himself? Should he reveal what the patient has said to her doctor or maybe pretend to have guessed that such a problem exists? Should he "manipulate" the girl through "clever" questions into telling about the problem during the session? How can one proceed with family therapy without revealing the knowledge about the alcohol problem? But most of all, how to cope with this very complicated situation – the father drinks, the mother, the daughter and now also the therapist know about it, but keep silent. Moreover the daughter is aware that the therapist knows but still does not bring up the problem and the family therapists knows that it is a "common" secret. Our professional knowledge prompts us to give up family therapy in a situation when we are condemned to ambiguity or even therapeutic dishonesty. On the other hand - is it ethical not to propose family therapy to the family with such an essential problem, without any doubt connected with the girl's illness. One may seek solution to these dilemmas working therapeutically with the patient herself hoping it will lead to her own decision about eventually bringing up the problem of her father's alcoholism during the family consultation and thus allowing to start the family therapy. But what if the girl will not take the risk?

Limited time of psychiatric hospitalization

A Hospital context confronts family therapists as well as families themselves with the problem of continuation of the family therapy (if there is such a need) after discharging the patient. The duration of the hospitalization is always shorter than the family therapy. The problem does not exists if the hospital has an outpatient unit, in which the family therapy could be continued. In all other situations, the therapist is faced with the problem where to refer the family further. Every solution seems wrong. If we interrupt or finish prematurely the therapeutic process and refer the family to a different therapist, we take a risk that the family will not continue the therapy feeling abandoned. If we finish the therapy prematurely and do not refer the family to another public sector setting it may mean that our decision was influenced by organizational issues rather than ones essential for the therapy. If we propose to continue the therapy in a different structure - what usually means private practice – we change the terms of the contract.

The offer to switch from unpaid (covered by the health service) therapy to a private one (paid by the family), means taking advantage of the therapeutic relation to built ones' own private practice. We consider this unethical. So in our opinion it is necessary to continue family therapy after discharging the patient by the same therapeutic team, even at the cost of our time devoted to work in the hospital. As mentioned above the optimal solution is to continue family therapy by the same team in the outpatient unit.

The situation, when we are faced with the problem of physical and sexual abuse in the family, especially abuse of children is the source of

many ethical dilemmas. Most often information about physical or sexual abuse comes from the adolescent patient, who discloses it during individual, group or other psychotherapy or reveals it to other patients in the ward. The question as to how we should react arises. Should we propose a standard family consultation hoping that the family will talk about the problem? Or is it better to call the family for an official confrontation with the situation? Another solution is to resign from family therapy and inform the family that we refer them to the juvenile court or other social services dealing with such situations. The decision is much easier when the perpetrator does not want to cooperate. Police and legal procedures are then necessary to provide security for the adolescent patient.

It is difficult to conduct therapy with someone who denies the problem. However, for many therapists, the process of relegation of competence and responsibility to the official lawful structures is a very difficult decision as we do not always have confidence in their effectiveness, including the juvenile courts. Additionally, it is difficult to accept our own helplessness when the therapy fails to be ample. It is not easy for the family therapist to accept that the child might be placed outside the family - which means that the therapist's intervention will lead to the family system destruction.

There is an even more problematic situation, when the perpetrator admits his guilt and the whole family wants to cooperate during therapy on the condition that the official agencies will not be notified. The family therapist is then forced to make a choice - family therapy or intervention of social agencies. If he notifies the court about the offence, it means the breaking the therapeutic process in most cases. However if he does not notify about the offence despite the continuation of the family therapy he puts himself in conflict with law (if the child was a victim of physical or sexual abuse). He has to take responsibility for the safety of children in the family, which often stretches out beyond his competence and possibilities. He may break the contract with the family concerning the protecting rules, but he has no instruments to enforce them or verify if they are being abided.

DISCUSSION

During the discussion about the ethical dilemmas of the family therapy in the adolescent psychiatric unit rather than formulating clear unequivocal answers, more often we pose questions. The area of ethical considerations does not promote categorical statements, except those in the official code of ethics, especially in the ethical code of the Scientific Section of Psychotherapy and Family Therapy of the Polish Psychiatric Association. As we were trying to point out the hospital context of the psychiatric adolescent unit is a source of specific doubts beside typical ethical problems common to all psychotherapists. It evokes many additional questions, but at the same time gives support and possibility for discussion. Thanks to the team work, the burden of the family therapist is lighter. Discussions about the therapeutic process and the presence of the therapeutic team is a form of controlling (in the positive meaning of this word) and helps to open up and consider the ethical dilemmas. Of course this does not diminish the personal responsibility of every therapist for his own actions as an ethical code should always guide his work.

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