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Family therapy

'No man is an Island, entire of itself;
Every man is a piece of the Continent, a part of the Main'
(John Donne 1571–1631)

Donne's irrefutable logic goes a long way to explaining the current popularity of family therapy. In trying to understand and overcome a child's problems, to ignore the family is as mistaken as to omit a physical examination. Paediatricians were first to recognise the importance of the family in relation to childhood illness and behaviour problems,[1 2] but psychiatrists, psychologists, and social workers have been to the fore in developing family therapy as a technique for treating these problems.

Family therapy (probably a misnomer) is an orientation as much as a technique of therapy. It is a way of conceptualising how problems may be perpetuated, and in some cases initiated by the family. Childhood problems, be they behavioural or physical, can play an essential part in maintaining family stability, while the family's particular way of handling them may perpetuate the symptoms.[3] The emphasis, therefore, is on the family as a whole as well as the individual child.

Family assessment

Assessment of the family involves interviewing all its members. This is a skill based on specific principles as learnable as any other skill within medical practice. There are three main components to the family assessment; the family history, details of the problem, and examination of the family. The first two are akin to the conventional medical procedure of taking a history and ascertaining details of the presenting problem. The examination of the family is the equivalent of the physical examination. This observation of how a family functions is the most important aspect of family assessment. The interviewer not only listens to what is said, but observes various features of family relationships.

He notes the general atmosphere of the family; the closeness or distance between family members; how the family communicates, whether people listen to each other, are heard, and responded to; what feelings are expressed and whether they are recognised, acknowledged, and appropriately handled; how conflicts and problems are managed; whether decisions are made and acted upon. If any of these aspects of family life is persistently or frequently dysfunctional, problems are liable to arise or existing problems be aggravated.

Once the interviewer has a clear understanding of any dysfunctional elements in the family relationships, he explains to the family what he considers to be the main areas of difficulty and how these might be overcome. He may consider for example that one child and parent are too close, to the detriment of the whole family, or that a child's worries may not be understood or appropriately handled, or marital difficulties may be creating tensions throughout the family. There are many possible permutations of family dysfunction.

Treatment techniques

A wide range of techniques exists to help families change. The therapist's sharing of his view may in itself be a catalyst. Teaching families to communicate more openly and directly and to recognise subtle and non-verbal cues helps overcome misunderstandings and bad communications. Helping parents to support each other and to take a consistent and united approach in handling a difficult or symptomatic child provides a more secure environment for the child and a greater sense of appreciation for each parent. Encouraging separation of an over involved child by drawing in the other parent and siblings allows the child the necessary age-appropriate independence. Teaching families to identify problems or conflicts, to negotiate solutions, and to carry them through ensures a satisfactory resolution of difficulties.

Indications and contraindications

In considering the place of family therapy it is important to understand that family assessment does not have to lead to treatment of the family. Rather, it provides a broader understanding of the underlying difficulties. When family tensions or difficulties are recognised it is usually appropriate to offer therapy to the family. Family therapy is not necessarily an alternative to other treatments. It may be

the only treatment necessary or it may complement other therapies.[3]

In paediatric practice those conditions in which family therapy seems to be of value may be categorised as:

(1) Physical disorders in which psychological factors play an important part in causing or aggravating the problem (for example asthma, diabetes, epilepsy, migraine, inflammatory bowel disease, anorexia nervosa, and recurrent abdominal pain).[4 5]

(2) Physical disorders in which although psychological factors may not necessarily be maintaining the problem, there are adverse psychological sequelae (for example congenital heart disease, cystic fibrosis, chronic renal disease, malignant disease).

(3) Behaviour problems such as severe separation anxiety, school refusal, or other phobias; soiling, difficult, disruptive, and defiant behaviour.

(4) Relationship problems such as non-accidental injury or obvious family tensions.

In some of these conditions family therapy can complement the use of necessary physical treatments, while in others it may provide a useful and positive basis for the application of other psychological treatments, whether these be behaviour modification, psychotherapy, environmental manipulation, or psychotrophic medication.[6] Frequently a family approach alone is sufficient to alleviate many of the problems seen in paediatric practice.

The only contraindications to using family therapy are when the family does not want treatment and the therapist lacks the necessary skills or support. Gurman and Kniskern[6] have provided a comprehensive review of outcome studies in family therapy and have noted an average improvement rate of about 73%.

Who should be the family therapist?

While family therapy has been predominantly the preserve of mental health professionals, the skills of family interviewing and treatment are readily learned by those interested in so doing. For example, there is increasing interest among general practitioners.[7] Paediatricians, be they consultants or junior staff in training can learn and apply these skills, both in outpatient work[8] and on paediatric wards.[9]

Therapy can be conducted in any setting provided there is sufficient space to accommodate the family in comfort, and outside interruptions are limited to the most urgent matters only. An initial assessment interview lasts about one hour, and should involve all members of the family living together. Grandparents can also be invited if it seems appropriate and the family are agreeable. Subsequent sessions last from 30 to 60 minutes, and involve whichever members of the family the therapist considers should be included. On average a course of treatment lasts from three to five sessions.

Given the central role of the family in the child's life, and the effectiveness of family therapy in many aspects of general paediatric practice, it is to be hoped that yet more paediatricians will feel inclined to familiarise themselves with at least the ideas, and perhaps also the techniques in the treatment of families.

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