Family Therapy Techniques for the Family Physician

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Since 1960, family therapy has emerged from the general field of psychotherapy as a discipline in itself. An extensive literature has been developed, much of it based on general systems theory.

Family physicians have routinely recognized problem families within their practice. Skills and techniques are suggested in this article for introducing changes within a family system.

A physician admitted a 16-year-old girl to the hospital with anorexia nervosa. The mother rarely left the patient's room because her daughter seemed to depend on her for so many things. The physician noticed that the patient's father and maternal grandmother talked a great deal to one another in the hall but seldom to the patient or her mother.

A. Which course of action by the physician would be most helpful to the family?
   1. Talk individually to the patient and family members.
   2. Talk to the family members wherever they are: mother and daughter inside the room; father and grandmother in the hall.
   3. Talk to the patient only.
   4. Insist on talking to the whole family at once.
   5. Talk mostly to the parents.

B. Which of the following situations would be most helpful to the patient?
   1. For the patient to eat alone.
   2. For the patient and her mother to eat together.
   3. For the patient and the entire family to eat together.
   4. For the patient and her parents to eat together.
   5. For the physician to eat with the patient and her family.

C. Which alliance, if any, should the physician try to reduce in his/her efforts to treat this patient?
   1. None.
   2. Father and mother.
   3. Mother and daughter.
   4. Father and daughter.
   5. Father and grandmother.

According to Minuchin, a psychiatrist who practices family therapy from a viewpoint called "Systems Theory" and who wrote a book on the subject entitled *Families and Family Therapy*[1] in which he describes a similar case, the best answers to the above questions are 4, 5, and 3, respectively.

Physicians have always known that family in-

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teractions are important. Some of the dynamics in families that family therapists look for will also be of use to the physician. Some of the techniques that family therapists use could also be used by physicians. Family therapists usually see and work with the family as a group. The following remarks will be most useful to the family physician at those times when he/she sees the family together as a group, or has known the family and treated each member for long enough to be well acquainted with each.

Physicians have traditionally treated individuals: the patient. However, physicians have always seen *families* on certain occasions too. Children are brought to the office by one of their parents. House calls are still made when the situation demands it. But today's family physician probably sees the family together most often in the hospital.

Some Useful Approaches

Family therapy is a method by which the therapist introduces change. The presenting problem is usually manifest in the behavior of one of the children: the "designated patient." Because of the way parents usually describe the child's symptoms to the physician, it would be wise for the physician to see the parents alone at first before seeing the entire family. If they are not seen privately first, parents will often launch into the problems of the child (or children) and try to enlist you on their side against the child. If they are allowed to berate the child in the beginning, the child will become defensive and will not respond.

In this private discussion, let the parents express their hostility toward the child, but do not reinforce their attitudes. Point out that the problem must be in the *whole* family. Be careful not to place blame on anyone. Simply try to understand why the situation is considered by the family to be a serious problem. Prepare the parents for how they should function in the sessions. The first step will be to help the children speak up freely. They will not be comfortable at first and will have to be put at ease.

Also explain to the parents that the children will test out the situation to determine how freely they can talk about the family. Usually they will make petty requests and voice small annoyances. Parents should be made ready to accept some of these to show the child that they are ready to make changes. The physician will never make any decision regarding change, however.

Prepare the parents for the hostility that the children will bring out against them as the sessions progress. This is normal. It may hurt the parents' feelings, but the children's attempts to communicate must be protected.

The First Family Session

Once the boundaries have been set as to who will be included in the family group—usually including all members of the family living in the same household, unless there are children who are very small preschoolers—the boundaries should be followed, and no sessions should be held when all the members are not present.

In the first session, at which all persons who live in the home together as a family are present, the children should have the physician's attention. Look at and talk to them directly. Tell them about the meeting with their parents. Get the stated problem out into open conversation as soon as possible and discuss it freely with the children. Explain that the problem is in the family and that the parents realize that some changes need to be made and are willing to make the changes.

Explain that it is important that everyone have his or her say and that everyone else listens. It is the physician's job to ensure this. No restrictions need to be placed on what a person can say during the sessions, even though this might mean breaking some of the rules that are normally kept at home concerning taboo topics and certain language. Get the parents to agree with this rule.

The following excerpts from an actual first hour's interview with a family will illustrate some of the typical stages that the family will go through. Even though this is taken from the first

hour, the stages presented are somewhat similar for any given session with a family.

Socialization Stage

The family will naturally be nervous about coming, especially for this first session. "Touching" each member of the family in some way, either physically, with a handshake, a pat, with gestures such as good eye contact and a nod of the head, or verbally, greeting each family member by name, helps to begin to put the family at ease. These greetings and introductions can usually be handled quickly during the time the family is getting into the room, getting seated, and settling down for conversation.

To further relieve tension, the physician can ask different individuals to share their feelings about coming together to see him. Questions such as the following are in order: "What do you think about coming this afternoon?" "How do you feel about talking to me about your family problems?" "Do any of you have any problem about being here today?" Check to see that the children know that you have talked to their parents previously. Explain to the children what you told the parents: that you see the problem as a family problem that needs to be dealt with by the entire family together.

Problem-Presenting Stage

The family which will be used for illustrative purposes presented a 23-year-old daughter, Jan, who had been dating black men though she was from a white family, and who had recently given birth out of wedlock to a baby boy with Negroid features. She was the identified patient in the family. Julie, 17, was a high school junior, cheerleader, and "A" student. Phil was 11 years old and in grade school. This family gave its signed permission for the sessions to be televised on video tape, and for the material to be used for teaching or publication.

About ten minutes into the interview, Julie (the parent-supporting child), started to cry. She seemed to be feeling the hurt that the entire family had been experiencing but hadn't yet acknowledged in the interview. They avoided looking at her. The following is a verbatim account of the family's and physician's interactions.

DR: Julie, something seems to be bothering you. Sorry, I don't have a tissue. Does someone have one? (Thus the family was made aware that one of its members was crying and needed some assistance which would better come from the family than the physician. The mother produced a handkerchief from her purse and gave it to Julie.) Do you want to tell us what's bothering you?

JULIE: I don't want to offend anybody.

DR: You don't want to offend anyone and you feel there's a pretty good chance that you would if you talked about what's bothering you here in front of your family?

JULIE: (She nodded affirmatively.)

DR: Would you want to ask somebody if they were willing for you to talk about it? You see, this is the reason that we are here, to talk about things that are pretty hard to talk about at home.

JULIE: (Without saying a word she pointed her index finger, without moving her hand, toward Jan).

DR: Jan, are you easily offended?

JAN: No, I know how she feels.

DR: Would you be willing for her to tell you? Would you be willing to give her permission to talk about it? (Families sometimes avoid discussions by claiming to know how its members feel.)

JAN: (She nodded affirmatively.)

DR: Julie, you have Jan's permission.

JULIE: She doesn't realize what it is like.

JAN: Well, she thinks that I have too many black friends. Really, she is prejudiced, she doesn't think she is prejudiced, but she is. I've gone out with white guys and I've gone out with black guys and it really doesn't make any difference, but to her, she thinks I only like black guys.

DR: It sounds like you two know one another pretty well and *you* are kind of saying what *she* thinks. That is called "mind reading." I would like to suggest that we can get further if each person says what she thinks rather than talking about what the other person thinks. Would you be will-

ing to have this kind of rule in talking this over?

JULIE and JAN: (Both nod in agreement.)

DR: Then, would you each say again what your position is?

JAN: My position is that I don't care what color people are, but she seems to think that white people are better. She won't say what she thinks, and I know what she thinks!

DR: Julie, did you say what you think?

JULIE: Well, I don't see why whites can't stick with whites. Whites are white and blacks are black. Anyway, it seems like things are that way...you just can't change the world all at once.

DR: Now we are talking about thoughts, aren't we? What about feelings? Julie, you were obviously having pretty intense feelings when you were crying. Can you talk about those feelings?

JULIE: Well, I really don't hate Jan. I have normal feelings like everybody else.

The conversation proceeded along these lines for a period of about 30 minutes. The physician tried to model good parenting, to focus on the problem, to facilitate better communication, and to make observations about the behavior of the family members, such as the fact that no one looked at Julie when she was crying.

Task-Presenting Stage

Before the session ended, the physician made an assignment to try to break up some of the structure of the family that had produced the problem. Families all develop many nonwritten rules that they live by. These sometimes cause problems. The technique used here is usually called "paradoxical intention."

DR: I'd like to make a kind of assignment if you are willing. I'd like for you, Jan, to tell the family why you like to date black fellows and how to go about getting dates with black fellows. I'd like to ask the family to do the same thing: to talk to Jan about how she can get dates with black fellows and why you think she ought to go out with black fellows. I know that may sound really weird. It does. (Laughter).

JAN: How can they tell me how to go about doing that if they don't want me to date black guys?

DR: I am asking them to try, if they are willing. This is the tricky part. They don't necessarily think you ought to date black guys, but you do anyway. So, I am asking them to talk to you about some of the ways you can go about meeting them, getting dates, and where you can go on dates. Are you all willing to try this kind of an assignment?

The family all agreed and this changed their communication pattern. It gave Jan a lot of attention but in a much different way, in that it stimulated rather than inhibited communication.

Later Sessions

Bell, a psychologist who first wrote about what he called "Family Group Therapy" in 1961, recently published a book entitled *Family Therapy*.[2] A summary of what happens in the later sessions in family therapy follows.

When the children feel comfortable, they usually begin a hostile attack on the parents. The parents should have been made ready for this before the first family session. Latent hostility that is in all families must be expressed if treatment is to proceed. In order for this to happen, the physician may need to open new channels for expression. To do this, he may focus on the interaction or transaction between individuals rather than on the individual. He may call attention to the behavior of certain individuals in the group so that others will notice that one member of the family is crying or wringing his hands or squirming around in the chair.

The parents may introduce problems that are irrelevant during this time because they are uncomfortable. This should not be encouraged as it makes it harder to get at the problem that the fam-

ily members have with one another.

The core problem usually comes out when this hostility has been expressed. The chidren put into words what they see as the reason for the problem. At first the parents may see the reason as just willful misconduct on the part of the chidren. Later, they may learn that there are reasons for the conduct.

There should be a gradual transition in the focus of conversation from the parent/child relationship to parent-to-parent relationship. Talking about the problems of the parents is helpful to the children. That the parents have problems is no surprise to the children, although the parents may believe that it will be. The children are reassured by their parents' willingness to talk about working on their problems. Then the children can see the reality of the problems and do not have to rely on their fantasies.

Often parents are reluctant to discuss these problems extensively during the sessions. Therefore, they may talk them over at home and report only the interaction in the sessions. It really is unimportant whether this is done at home or at the sessions, as long as it is done.

When the parents start to work on their problems, the children's symptoms often disappear or take on a new light. It often results in a move from attacking the child to supporting him. For example, a family may stop attacking a child for his poor school work and start supporting him in his problems with his teacher.

Termination

Toward the last of the sessions, practical suggestions for outside help can be made by the physician if necessary. Often humor begins to come into the sessions toward the end as the family starts to handle its hostility by this means.

Decisions made by the whole family regarding roles to be carried out are sometimes reached toward termination. It is essential that these decisions be agreed on by all members of the family and not just assigned to the children by the parents. The family members will also become less dependent upon each other and will begin to encourage outside activities for their members.

Conclusions

The family is a unit and should be worked as a unit. Thus, individual conferences should be very rare. If they are allowed at all, everyone in the family should be aware of any individual conferences that are held.

The family should be reminded to keep working on the problem. The presenting problem should be brought up for discussion at every session. The physician should not become part of a nonverbal collusion with the family to avoid the discussion of the presenting problem.

The physician can enter freely into all of the decisions concerning therapy, such as the time of the sessions and what can be done during the sessions. However, he/she should not interfere with any family decisions, such as the time when the family has dinner, or other family rules unless the family decides to change them. These rules can, of course, be thoroughly discussed in the family sessions, but the decision concerning any changes is left to the family.

References

1. Minuchin S: Families and Family Therapy. Cambridge, Mass, Harvard University Press, 1947
2. Bell JE: Family Therapy. New York, Jason Aronson Publishers, 1974