Guidelines for Family Interviewing and Brief Therapy by the Family Physician

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Psychosomatic and behavioral problems are commonly seen in the practice of family medicine. If these problems are viewed as difficulties with family interaction, rather than as difficulties of an individual family member, intervention may be more successful. Treatment of families with problems involves interviewing the family unit, identifying and altering dysfunctional behavioral patterns within the family which serve to maintain the problem, and making selected referrals to experienced family therapists.

Psychosomatic and behavioral problems appear often in the practice of family medicine.[1-4] A broad perspective must be adopted toward such problems in order to make a complete diagnosis. Family physicians are in a favorable position to intervene early and to prevent problems from becoming chronic because of the opportunity they have to treat whole families instead of individuals. Recently, articles have appeared in family medicine journals describing the use of family interviewing and family therapy.[5-7] Most of this literature has concentrated on the skills and techniques required of an experienced family therapist, but if family physicians are to implement this knowledge in daily practice, a set of clear, basic guidelines is needed. The purpose of this paper is to present such guidelines using a systems orientation toward the family (Table 1).

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View the Family as a System

The systems approach to the family views behavior in its broadest context. The behavioral symptoms of any family member are viewed simply as one link in a circular chain of events that involves the interactions of all family members. Consequently, problems and causes of problems lie within the interaction of family members and not within one person.[8] For example, in the case of a clinging, dependent child, the parents may claim they must do everything for the child because he or she is so dependent and helpless, while the child claims he is helpless because the parents are so protective and do everything for him, and both parties are right. No one is "the patient." The problem is the pattern of family interaction and the solution is to change the pattern. Most behavioral problems can be seen in this light. That is, each member of the family (or part of the system) is interlocking. A person's behavior does not make sense without seeing how it fits with the behavior of those around.

Another example illustrating this point is the woman patient whose complaint is fatigue. After she is questioned in more detail, she reveals that she is really depressed about her husband whom she says is withdrawn and pays little attention to her. Later her husband comes for medical attention because of his hypertension. He complains

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Table 1. Guidelines for Treatment of Family Problems

- View the presenting problem as a product of the family as a system
- Interview the family unit
- Identify and alter dysfunctional family behavior patterns
  - Redefine the problem as existing among family members instead of within one person
  - Alleviate rigid family labels
  - Interrupt family triangles
- Make referrals when necessary

that his wife nags him all the time, and so he seldom says anything to her, hoping that if he ignores her, the nagging will stop. Thus, a circular pattern has developed. She nags, and he withdraws and is silently angry (which worsens his hypertension). She feels isolated and ignored, and nags more to try to get his attention (which fails and makes her more depressed and more fatigued). This pattern of escalating dysfunction between husband and wife is seen only when information is collected from more than one family member and the connecting links are sought.

Interview the Family

In order to uncover the problems of a family system, information about interaction patterns must be collected, and this can best be done by interviewing the family as a unit. All family members are asked to come to the initial session—including father, who may have to take off work, children, and grandmother if she lives with the family. Sometimes an evening or a lunch hour may be most convenient for everyone concerned.

In arranging the session, be sure the room will hold the entire family and that there are enough chairs for all. Notice where each family member sits. Who sits next to whom? Where are the children in respect to the parents? Begin by meeting each family member. It is important to talk to everyone, even the six-month-old infant. Make the initial part of the interview as nonthreatening as possible, and in most instances, do not start an immediate discussion of the problem. Learn something about the family first. For instance, who works what hours, what are some of their daily activities, and how are these done each day? Note who answers, who seems to be controlling the interchange, and pay special attention to the nonverbal behavior. For instance, is one of the children sitting on the father's lap, and picking a fight with the mother? Do the parents look at each other and talk to each other, or do they look at you and talk *about* each other?

Now, ask about the problem as the family sees it. Be sure to notice who describes the problem first, and whether or not a particular family member is singled out as the identified patient or problem.

Identify and Alter Dysfunctional Behavior Patterns in the Family

Although each family is unique, certain general behavior patterns occur in most families that are in trouble. A dysfunctional pattern is a sequence of behaviors that occurs repetitively between family members. In the family interview, the physician may identify the common patterns by observing how each member behaves while discussing problems as well as by asking questions.

The following are dysfunctional patterns that are often seen: first, the identification by the family of one member as the patient or the person with all the problems; secondly, the establishment and maintenance of confining and unrealistic labels or roles for individual family members; and thirdly, development of family triangles—situations in which two members who are having a problem avoid resolving it by somehow involving a third person.[9] When the physician is working with the family as a system, he must redefine the problem, alter the family labels, and disrupt family triangles.

Redefine the Problem as a Family Situation

When problems arise, most families tend to identify one member as the patient, ignoring the fact that each family member influences all others. The first task in the family interview is to help redefine the problem as one in which all family members are involved. When this is done supportively, it accomplishes three goals. First, it broadens the focus of study to include other family members and other areas of family life. Secondly, it interrupts unhealthy blaming of individuals and guilt finding in the family. Neither the identified patient nor other family members need feel solely

to blame. Thirdly, it arranges for cooperation of all family members, partly as a consequence of a simple restatement of the problem by the family physician: "Family members often form habits of relating to one another in a way that allows problems to develop. We need to work on these habits." Such a statement will be enough to explain to the family why each is needed and to prepare them to work together. By labeling the patterns simply as habits, the family's resistance to admitting their problem is reduced.

Numerous methods of redefining the problem are needed in addition to simple restatement. Early in the interview, each family member should be addressed directly by the physician. After the problem is introduced by one of the family members, the physician can broaden the focus of exploration by seeing how each family member is involved and giving each an opportunity to present his/her point of view. Other areas of family life are explored in addition to the problem presented, once again by eliciting each family member's story.

In many situations, establishing ground rules can facilitate the interview. One rule for family interaction is that no one in the family can talk for anyone else during the session. A second rule is that each family member must talk *to* another member rather than *about* him. Such rules can be very helpful in reducing fault finding and in helping members solve problems between one another. These rules have greater impact when introduced after a need for them has been demonstrated in the interview. The very need for such rules further demonstrates how all family members are involved in dysfunctional interaction.

All of the techniques for redefining the problem may be used within one session. For instance, a mother brings her eight-year-old son to the family physician with fecal soiling. The family physician first ascertains that there are no physical problems and in so doing becomes suspicious of some family problems. The physician astutely directs the whole family to come in for an interview. The family consists of the eight-year-old boy, his seven-year-old sister, and the parents.

When the family is asked to explain what they see as the problem, the mother explodes immediately into a lengthy, derogatory monologue describing how she and her husband have tried everything to cure the boy and nothing works. The boy hangs his head, eyes on the floor, and says nothing. The father smiles slightly and nods in agreement with his wife. At the same time he engages in warm, playful behavior with his daughter who sits by his side seeking his attention. When asked if there are any other problems, the parents state firmly, "no." When the seven-year-old sister is asked what kind of things bother her, the father answers for her. He insists his daughter is perfect and causes no problems. He consistently allies with his daughter against his son.

The family physician asks each family member to describe in more detail what each does when the boy is encopretic. In this particular instance, the seven-year-old girl quickly says she is not involved. The parents do not agree on methods of handling the situation. The father establishes harsh disciplinary programs, which the mother undermines by being lenient. The boy takes great advantage of this situation. The parents argue, but never resolve their differences and the son continues to get them both extremely angry at him, not only because of his encopresis, but because of his misbehavior.

In an effort to explore the family interaction further, the children are asked about how the family has fun. When the boy is asked what his parents do for fun, he replies, "Nothing, Dad is never home." The parents then reveal that for the past five years, the father has held two jobs and attends school at night. This routine allows little or no time with the family. The mother tentatively indicates this angers her, but then quickly withdraws from the discussion. She turns immediately to harangue her son, who has just at that time become noisy. Apparently, the mother finds it difficult to express anger or disagreement with anyone except the son. Neither parent returns to the subject. The problem has broadened to include areas of nonresolved disagreements and distance between the parents and the taking of sides and manipulation by the children.

Alter Family Labels

Many families develop labels or narrow roles for each individual member.[10] Unfortunately, labels can be unrealistic and inhibiting. Thus, an-

other task of the family interviewer is to identify and help modify rigid labels. Labels such as "the good child," "the housewife dependent upon her husband to make all decisions," "the quiet, impotent husband," "the adolescent troublemaker"—all place the burden upon the holder to live up to those expectations and deny all other parts of one's personality. They limit an individual's ability to try out new behaviors and thus they inhibit personal growth.

In family interviews, the physician can help the family members look for and alter the label each wears. For example, in a family where one member is seen as the only strong one and everyone else is weak, one might say, "Oh, so you feel you have to be the 'strong one' who must solve all the family problems. When do others in the family get a chance to be strong?" This rigidity can also be loosened by turning to another family member and asking, "When are you the strong one? Tell me about the tasks you do for others." All family members have strong areas, but finding them may take some probing. The physician must realize that labels are not only given by the family, but are accepted and maintained by the individuals playing them. Therefore, each role or label has emotional significance to the holder, and even the negative or burdensome ones may be difficult to give up. Abrupt or nonsupportive attempts to alter these labels will be met with much resistance.

In a family where there is an identified "bad child," the child may be receiving a lot of attention through misbehavior. In addition, the child's discipline problems may be keeping the parents busy and communicating, and that may be all they have to talk about. Consequently, if the child gives up bad behavior, without some attention given to providing positive feedback for good behavior, the child will lose his parents' attention. Also, a worse consequence may occur in fighting and disharmony between the parents unless they are encouraged to resolve their conflict through the physician's supportive efforts. The child must be able to see that his bad behavior is not necessary to keep the family together.

Disrupt Family Triangles

A third dysfunctional pattern that many families develop is the formation of triangles among members to avoid resolving conflicts.[11] This overlaps somewhat with the last example presented, but a more detailed explanation may be helpful to understand the concept. A triangle develops when one family member is having difficulties with another family member and cannot settle it. A third person is brought into the relationship to avoid resolving the conflict. This can manifest itself in many forms, but the effect is always to avoid resolving conflicts between the original two persons. An example is the grandmother who lives with the family and always has a "nervous spell" when her son and his wife are having an argument. The couple stop their interaction because of concern for the grandmother's health and they never seem to resolve their conflicts.

Any emotional stress detected between two family members should be resolved, whenever possible, between them without the involvement of a third family member. Thus, a third task in the family interview is to identify and interrupt such triangles and encourage resolution of problems. This must be done in a supportive way by emphasizing to the family that no dire consequences will result when family members attempt to resolve their conflicts, even if it does involve the display of angry feelings.

Refer Some Families

Some families may need more than a few interview sessions, and the family physician cannot afford to spend hours a week for many months or years with one family. Many families can benefit from short-term intervention. Many will respond to clear, direct suggestions and will interrupt dysfunctional patterns before they become chronic and hard to change. Table 2 lists warning signs that may indicate the need for referral.

Has this family been in therapy before on several occasions? Sometimes a single family member may have sought psychological counseling, but the whole family was not involved. This might be a family you would want to see once or twice. On the other hand, avoid the families who "doctor shop," who have been seen by various psychiatrists, social workers, and family therapists. Their patterns may already be too well set for simple intervention techniques to be effective.

Table 2. Indications for Referral

History of repeated attempts at therapy
Missed appointments
Commitment to sessions as family unit, but at no session does everyone attend
Long duration of dysfunctional pattern
Refusal to pay prescribed fees (disrespect for counseling)
No improvement after five or six sessions

Missing several appointments is an indication that the family is more resistant and may need referral. The same thing applies to the families in which all members agree to come, but then never manage to show up at the same time.

If a problem has been going on for years, it may be that too much of your time would be involved in trying to interrupt rigid dysfunctional patterns, and a better plan would be to refer the family to a more experienced therapist.

Do not see families who do not pay you the agreed fee, or who are not willing to negotiate a payment plan. Families will have no respect for free counseling.

If you have seen a family five or six times and no symptomatic improvement can be seen, it is likely that they may need more extensive therapy, and it would probably be wise to refer them.

Applications

Brief sessions with entire families can be used by family physicians to intervene in many of the persistent behavioral problems presented by patients. Three major tasks during interviews are to redefine the problem as one that involves patterns of family interaction, to alter rigid labels that seem to fix family members into a narrow range of behavior, and to identify and interrupt triangles among family members so that any two family members can resolve their differences without the disruption of a third. The family physician who becomes skilled in accomplishing these tasks may be more efficient in helping family members resolve problems.

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References

1. Medalie JH: Family Medicine: Principles and Applications. Baltimore, Williams & Wilkins, 1978, pp 10-19
2. Rakel RE: Principles of Family Medicine. Philadelphia, WB Saunders, 1977, pp 24-29
3. Shank JC: The content of family practice: A family medicine resident's 2-1/2 year experience with the E-Book. J Fam Pract 5:385, 1977
4. Malcolm R, Foster HK, Smith C: The problem patient as perceived by family physicians. J Fam Pract 5:361, 1977
5. Bauman MH, Grace NT: Family process and family practice. J Fam Pract 4:1135, 1977
6. Saalwaechter JJ, Heinrichs R: Family interviews: Shortcut or drawback? Patient Care 10:95, 1976
7. Bulger JJ, Dettore DD, Donnally GA, et al: When the whole family needs your care. Patient Care 8:172, 1974
8. Watzlawick P, Beavin JH, Jackson DD: Pragmatics of Human Communications: A Study of Interactional Patterns, Pathologies, and Paradoxes. New York, WW Norton, 1967, pp 19-46
9. Papp P, Silverstein O, Carter E: Family sculpting in preventive work with well families. Fam Process 12:197, 1973
10. Hayley J: Toward a theory of pathological systems. In Zuk GH, Boszormenyi-Nagy I (eds): Family Therapy and Disturbed Families. Palo Alto, California, Science and Behavior Books, 1967, pp 16-21
11. Zuk GH: Family Therapy: A Triadic-Based Approach. New York, Human Sciences Press, 1972, pp 3-16