

Allmond

The family is the patient

CHAPTER 1

The family as the treatment unit and the pediatric practitioner as the interviewer

THE LOCKSLEY FAMILY

Joan, age 7, sits quietly, very prettily, in her chair. She is swinging her legs to and fro as her grandmother explains to Dr. Henry Abbott, the pediatrician:

Grandmother: She's not sleeping, Doctor. And neither am I—none of us has had a good night's rest in 7 weeks or so. Even if I get her in bed by 8 P.M., usually about 11 she wakes up—terrified, screaming. Then I'm up all night with the poor child. And once she does settle down again, maybe 3 or 4 A.M., she still thrashes and screams out—in her sleep! Why, I've had to bring her in to the emergency room twice in the past 2 weeks . . . she just gets hysterical. The doctor who saw her said something about epilepsy.

Doctor: Well, Mrs. Locksley, I wonder if . . .

Grandmother: Screams bloody murder—it wakes the neighbors. We're all on pins and needles now at night. And look at the circles under her eyes . . . low blood, somebody told me . . .

Doctor: What I meant to say . . .

Grandmother: I've tried everything—night-light, waking her up, talking, taking her to the bathroom, stories, rocking, hot milk—my own mother used to do that. Could it be worms, Doctor?

Doctor: That's something to consider. Now back to . . .

Grandmother: What could cause a child to cry out in her sleep like that? Well, I don't know if she's asleep or not. But I do know she just won't stay in bed once the whole thing starts . . . oh, and

stomachaches—I almost forgot. She complains constantly about that—in bed 5 minutes and then “Gramma, my tummy hurts.” Then I know we’re in for it for the rest of the night. Makes no difference when she goes to bed, early or late, it’s the same thing.

*Doctor:* When does she usually . . .

*Grandmother:* I think more of this child than myself, Doctor—I want you to know that. Why, I’ve raised her since she was 4 years old. We’re never apart, isn’t that right, honey?

*Joan:* (nods)

*Doctor:* Do the two of you live alone?

*Grandmother:* Well, we did, but no, my daughter, Joan’s mother, she lives with us now. She was separated recently. And my other daughter, divorced too, she’s moved back in with me. And she has her own little girl, Cheryl, just 6 months younger than Joan. The two kids get along really well. What’s that? Yes, the house is crowded, but we’re making do. But Joan’s business has been getting to everybody. With the last episode 3 nights ago, we *all* came to the emergency room. She certainly needs some sort of checkup, don’t you think? Can growing pains ever do this?

*Doctor:* Sometimes. The stomachaches you mentioned, just where does she complain of pain?

*Grandmother:* All over, isn’t that right, Joan? Show him, sweetie . . . now don’t be that way. The doctor is here to help us. Speak right up and talk to the nice man; he wants to know where you hurt. There’s nothing to be afraid of. . . she doesn’t like doctors. Doctor . . . you’re not going to give her any shots are you, she hates that. Now Joan, sweetie, don’t cry.

The culmination of this interview between a pediatrician, a patient, and her grandmother is maddeningly familiar. A history of sorts has been obtained, along with a physical examination. More than likely the youngster’s sleep disorder and other assorted symptoms have remained intact, as have grandmother’s notions about epilepsy, worms, growing pains, low blood—and physicians; she is communicating these notions to the child as well. Only the doctor is altered; he experiences a definite depletion of energy—his, which was to have carried him through his office day. This was the case with Joan, Mrs. Locksley, and her pediatrician. The situation, while not included as a laudatory example of fancy interviewing footwork, did occur, and it serves to introduce an initial

tenet of the authors: in many clinical pediatric situations it is useful to raise one’s sights above the child, focusing on the family constellation surrounding the child via a family interview. For Joan and others like her, the clinician would do well to enlarge his\* vision: to include *all* the family for the purpose of understanding the family’s interaction and its relationship to the presenting problem. Having done so, one may then recognize that the focus for both diagnosis and treatment is no longer a single individual, nor, if the family includes others, is it limited to one parent and child; it is rather that group of relationships called “the family.”

Focusing on the family constellation surrounding a child is hardly a new idea. It is a time-honored tradition in pediatrics to obtain a complete family history when undertaking the medical care of a child. Indeed, pediatricians seem to be particularly family-oriented in their views of children and children’s health care. No pediatrician finishes training without the realization that he is almost always working with at least two patients simultaneously—a child and a parent. So in this sense pediatricians are already committed to the idea that working with children means working with others (usually the mother) in a child’s family. Likewise family practitioners today need no convincing that treating children involves work with other family members. It goes with the territory, so to speak. Yet little is written in medical literature regarding the use of family interviewing or a family-oriented interviewing approach in pediatric or family practice.

We are suggesting something considerably more specific than a general consensus that families are important, something more direct than the compilation of a thorough family history obtained by talking with one parent. We are suggesting that, since pediatrics and family medicine are family-oriented disciplines and since children in most instances cannot be considered or treated apart from their family context, pediatric practitioners should consider the treatment unit quite often to be the family; the family becomes *the* patient. Most explicitly we are suggesting that physicians develop a specific skill for working with “patients,” name-

\*All three authors (two are women) recognize that pediatric practitioners and interviewers come in male and female varieties. It is cumbersome to use constructions such as he/she and so on repetitively in writing. Use of the masculine pronoun throughout the book was therefore chosen for convenience. Sexual inequity is acknowledged.

ly, the ability to conduct a family interview. It is a skill based on specific principles, as learnable as auscultation of the heart, and it may be equally useful in clinical pediatrics.

The specific principles to which we refer derive from a body of theoretical and clinical work developed over the past 30 years in psychiatry and social work. Family interviewing and family therapy began as a ground (or more correctly, an underground) swell, without credentials or acceptance, in the late 1940's. Haley, writing in 1962, stated:

The treatment of an entire family, interviewed together regularly as a group, is a new procedure in psychiatry. Just when family therapy originated is difficult to estimate because the movement has been largely a secret one. Until recently, therapists who treat whole families have not published on their methods, and their papers are still quite rare, although we may soon expect a deluge. The secrecy about family therapy has two sources: those using this method have been too uncertain about their techniques and results to commit themselves to print (therapists of individuals have not let this dissuade them), and there has apparently been a fear of charges of heresy because the influence of family members has been considered irrelevant to the nature and cure of psychopathology in the patient. As a result, since the late 1940's, one could attend psychiatric meetings and hear nothing about family therapy unless, in a quiet hotel room, one happened to confess that he treated whole families. Then another therapist would put down his drink and reveal that he too had attempted this type of therapy. The furtive conversations ultimately led to an underground movement of therapists devoted to this most challenging of all types of psychotherapy and this movement is now appearing on the surface.\*

Actually Freud himself gave a nod to the importance of family members in one of his most famous cases, "Little Hans."<sup>3</sup> In 1909 he undertook the treatment of that child's phobia by working exclusively with the father. Hans himself was not interviewed. It is a matter of record, however, that family therapy was not born of this case. Freud preferred to work with individuals apart from their families. And psychoanalysts eventually developed strong feelings against the inclusion of families in the treatment of individuals, stating as the major objection that transference between patient and therapist could never be satisfactorily established with intrusions by other family members.<sup>4</sup>

\*Haley, J.: Whither family therapy. *Family Process* 1:69, 1962.

Certainly the work of Harry Stack Sullivan, with his stress on the interpersonal aspects of mental illness, was an important developmental step toward the inclusion of family members in a child's psychiatric treatment. For him the mother-child relationship was all important and became the focus of treatment. His ideas were thus one of the most important foundations of the child guidance movement, which in some ways forwarded the cause of family treatment but did so unfortunately at mothers' expense. One of the negative outgrowths of this view of treatment was a tendency to blame mothers for all the difficulties observed in a child. In the zeal to shift sights off the child and onto the mother-child relationship, all too often the sighting was overcorrected and focused squarely on the other individual in the relationship, Mom. The (then) truism, "There are no bad children, only bad mothers" was unfortunately a hallmark of many child guidance clinics of the 1930's and 1940's.

The structuring of such a clinic was often as follows: the child (helpless victim) was weekly whisked into the playroom to spend a secret hour of play with the child psychiatrist in "the corrective emotional experience." In the meantime Mama (the cause) would spend the hour talking with a psychiatric social worker. In the 1940's in many clinics the psychiatrist and social worker did not talk together; each viewed the other's work as contaminating his/her own therapeutic efforts and professional silence was rigorously observed. Needless to say, fathers were almost never included in the treatment; even if they were considered important, they were usually dismissed as "unavailable." Siblings were ignored. This format, incidentally, may still be found in some communities even in the 1970's.

The 1950's produced the next forward surge in the growth of family treatment. At the Mental Research Institute in Palo Alto, California, four co-workers, Gregory Bateson, Don Jackson, John Weakland, and Jay Haley, were formulating a hypothesis that would become a keystone of subsequent family theory. In their now classic paper<sup>3</sup> they suggested that the symptoms of schizophrenia could be produced by a family's placing one family member in something called the "double bind." This "double bind hypothesis" will be discussed in more detail in Chapter 2, "Communication and the Family." Suffice it to say that such a hypothesis implicated the family directly and explicitly in the development of an individual's psychiatric symptoms. This hypothesis logically suggested to some that the treatment should include the family.

Coincident with the publication of this hypothesis, one of the investi-

gators, Don Jackson, introduced another term equally basic to the future development of family therapy, "family homeostasis."<sup>6</sup> He observed that families with a mentally ill member acted as a unit with all members in dynamic equilibrium; he perceived a balance in family relationships that was maintained by each family member in some way. Dr. Alan Leveton, our consulting psychiatrist, has pointed out the analogy with a mobile.<sup>7</sup> Visualize a mobile with four or five pieces suspended from the ceiling, gently moving in the air. The whole is in balance, steady yet moving. Some pieces are moving rapidly; others are almost stationary. Some are heavier and appear to carry more weight in the ultimate direction of the mobile's movement; others seem to go along for the ride. A breeze catching only one segment of the mobile immediately influences movement of every piece, some more than others, and the pace picks up with some pieces unbalancing themselves and moving chaotically about for a time. Gradually the whole exerts its influence in the errant part(s) and balance is reestablished but not before a decided change in direction of the whole may have taken place. You will also notice the changeability regarding closeness and distance among pieces, the impact of actual contact one with another, and the importance of vertical hierarchy. Coalitions of movement may be observed between two pieces. Or one piece may persistently appear isolated from the others; yet its position of isolation is essential to the balancing of the entire system. Virginia Satir (whose work is discussed extensively in succeeding chapters) also likens a family to a mobile:

In a mobile all the pieces, no matter what size or shape, can be grouped together in balance by shortening or lengthening the strings attached, or rearranging the distance between the pieces. So it is with a family. None of the family members is identical to any other; they are all different and at different levels of growth. As in a mobile, you can't arrange one without thinking of the other.<sup>8</sup>

Jackson also acknowledged "so it is with a family"—the whole and its pieces. In his view family members were moving constantly and in such way as to maintain a precarious balance in their individual relationship with one another. He concluded this after noting that in the individual treatment of a schizophrenic patient:

Other family members interfered with, tried to become a part of, or sabotaged the individual treatment of the "sick" member, as though the

<sup>6</sup>Satir, V.: *Peoplemaking*, Palo Alto, Calif., 1972, Science and Behavior Books, Inc., p. 119.

family had a stake in his sickness. The hospitalized . . . patient often got worse or regressed after a visit from family members, as though family interaction had a direct bearing on his symptoms. Other family members got worse as the patient got better, as though sickness in one of the family members were essential to the family's way of operating.\*

This notion of homeostasis also seemed to call for a treatment process that could include all parts of the mobile. It may have been that following the acceptance of this term "family homeostasis," clinical work including the entire family began in earnest.

In 1958 Nathan Ackerman in New York published the first full-length study combining theory and practice, in which he emphasized the importance of role relations within the family.<sup>1</sup> He was already an experienced family therapy clinician by this time, having independently moved from a theoretical set to one that utilized clinical intervention with the family unit. In 1964 Virginia Satir was on the family treatment scene with her famous text entitled, *Conjoint Family Therapy: A Guide to Theory and Technique*.<sup>2</sup> Hence by this time in the fields of psychiatry and social work, the technique of treating emotional disturbance by working with the family together had been aggressively and successfully launched. John Howells said:

In family psychiatry a family is not regarded merely as a background to be modified to help the present patient alone. Family psychiatry accepts the family itself as the patient, the presenting member being viewed as a sign of family psychopathology.†

These words, written in 1963, had by the close of the decade become accepted enough to be read almost as a commonplace. Currently in psychiatry the family therapy field is a burgeoning and already mammoth subdiscipline. It is now struggling with the dubious trappings of professional respectability: formalized societies, organization, journals, licensure, and bickering among the differing schools of family therapy. Differing schools or not, family therapy in psychiatry is here to stay.

Pediatrics has not been particularly quick to enter the family interviewing and family therapy field. It is understandable. In spite of the often-cited need for increasing liaison between pediatricians and child psychiatrists (most recently addressed in an article by Anders entitled

Satir, V.: *Conjoint family therapy: a guide to theory and technique*, Palo Alto, Calif., 1964, Science and Behavior Books, Inc., p. 2.

Howells, J.: *Family psychiatry*, Springfield, Ill., 1963, Charles C Thomas, Publisher, pp. 4-5.

"Child Psychiatry and Pediatrics: The State of the Relationship,"<sup>2</sup> with a succeeding commentary by Rothenberg<sup>3</sup>), an almost palpable "something" remains that keeps the two disciplines separate and wary of one another. Psychiatric treatment is too often dismissed out of hand by pediatricians as "impractical, too time-consuming, not worth the effort, unlearnable, illogical, and/or not within the province of pediatrics." Indeed in many ways a psychiatric model of treatment does not translate well into a busy clinical pediatric setting. Few pediatricians would be eager to initiate weekly play therapy for 1, 2, or 3 years with an encopretic 7-year-old. For one thing it would be an affront to the pediatrician's (almost inborn, it seems) need for action and visible results over a short period of time. Second, of course, very few pediatricians within the structure of their practices would have time for such an extended course of therapy. Third and most important, most pediatricians wouldn't know how to go about it. Nor would very many want to learn how. This is all reasonable. But it is not reasonable to extrapolate from this illustration and conclude that all forms of psychotherapeutic intervention with children are beyond the pediatrician's interest, skill, and tolerance. One should not throw out the baby with the play therapy. In selected pediatric situations family interviewing and family therapy have proved to be practical, relatively timesaving, worth the effort, learnable, logical, and very definitely within the province of pediatrics. We should be clear: we are not recommending that pediatricians undertake the long-term care of a schizophrenic teenager through the use of conjoint family therapy. All the objections by pediatricians to other forms of psychotherapy, those raised previously, would surface within 30 minutes of the first interview. Rather we are suggesting that a variety of conditions appear in a pediatrician's office that, were the physician equipped with some knowledge of family theory, family intervention techniques, and a modicum of courage, would lend themselves to alleviation and resolution under care by that physician alone.

What pediatric conditions would so lend themselves? In our experience the following have been successfully managed by pediatricians utilizing a family orientation in their work:

- School phobia
- Eating disorders including anorexia nervosa
- Enuresis
- Encopresis
- Sleep disorders

Behavioral aspects of psychosomatic conditions such as recurrent abdominal pain and headaches

Juvenile diabetes mellitus

Short stature

Acting-out behavior

Psychosocial complications of such chronic illnesses as asthma, seizure disorders, cystic fibrosis, hemophilia, and so on

Awesome psychosocial aspects of fatal diseases, for example, leukemia, solid tumors

Difficulties associated with a wide variety of developmental disorders, from specific learning disabilities to mental retardation

Coping problems accompanying physical handicaps

Multitudinous behavioral problems associated with no particular disease, for which anxious parents consult physicians regularly (in fact the physician is often the first professional to be consulted in such situations).

A review of the preceding list, which is in no way complete, will illustrate that we do not propose that physicians should expand their practices to include the treatment of serious mental illness. We are asking that they develop some additional skills for themselves to help the patients who are *already* sitting in their waiting rooms, patients whom they already know—Joan and her grandmother, for instance, the pair who introduced this chapter. These two would certainly not be out of place in a family physician's office, even though the doctor might like them to be.

The doctor who insists on an individual (versus a family) orientation to the situation that Joan presents may be headed for trouble. For doctor and patient are only a requisition away from an EEG, complete blood count, pinworm preparation, and maybe a barium swallow and upper gastrointestinal x-ray series. This could easily be followed by a chaser of Donnatal and/or Valium—and very likely a continuation of symptoms. We are not recommending such a course of treatment, but the reader must admit that the sequence is not unusual in current medical practice.

What if the physician were to utilize a family approach in this situation? In fact he did after the first encounter; all five females—the family—were seen together. In the initial family interview the following was disclosed: several years before Joan's mother had left the child in Grandmother's care to run off and remarry. She had recently returned, con-

trite, and desired very much to assume a responsible mothering role with Joan. Grandmother by now saw Joan as her own and resented the return of Joan's mother; the two quickly locked in a struggle over who would mother the child. To complicate matters, Grandmother's older daughter (with her own child) had returned to the family home to lick her wounds after a particularly bitter separation and divorce. These two joined forces with Grandmother against Joan's mother, and the battle was joined. Joan, squarely in the middle, was handling her situation by refusing to sleep, literally jumping from bed to bed at night, staying with whomever she could entice to comfort and hold her. Her sleep disturbance and psychosomatic symptoms were automatic triggering mechanisms for beginning the contest anew each night—who would mother.

What seemed called for then was not a diagnostic evaluation of Joan's gastrointestinal tract but a family cease-fire and a clarification of specific family rules. The physician facilitated this, and after three family sessions, Joan's (and the family's) difficulties with sleep disappeared permanently. Family counseling continued thereafter but around substantially different issues.

How to gather such diagnostic family information, how to use it, and how to facilitate a change in a family's behavior, all accomplished by the pediatrician just mentioned in three interviews—the hows—are really the subject of the remainder of this book.

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## CHAPTER 2

# Communication and the family

### CONTENT AND PROCESS

Two pediatric residents, a man and a woman, have just arrived in the Child Study Unit for the beginning of their 2-month training period in behavioral pediatrics. It is their first afternoon in the unit and their first teaching session with one of the authors (B.A.). At the moment, both are silent and busily engaged in an assigned nonverbal task. A large sheet of butcher paper, perhaps 2 feet by 3 feet, has been spread on a table before them, a box of crayons has been provided, and with a minimum of explanation they have been asked to "work together on the piece of paper for 30 minutes, without talking to one another or to me." Their requests for clarification have been handled mostly by a shoulder shrug. Their very obvious uncertainty, discomfort, and anxiety have been met by as reassuring a tone of voice as the instructor can muster. Otherwise they are being left to struggle with the task themselves. Within 3 minutes they have begun working in earnest, relatively oblivious to the clock and the presence of the instructor, and they are not at the moment visibly concerned with the silliness of the task. In fact, they appear to be enjoying themselves.

While she is busy drawing a country scene with mountains and trees and he is occupied with a tall fence around a structure, let us explain. This technique, the conjoint drawing, is actually a device that is often used with families in the course of family therapy.<sup>2</sup> (See Chapter 6.) We are also using it as a teaching device with our trainees in family interviewing. It has proved an immediate and effective method for introducing them to a focus on communication. We find it useful and interesting to begin a study of communication by insisting on silence, so our residents can experience the communication of silence. Also many of our