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Introducing Family Therapy Into Your Workplace: A Guide For Clinicians

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Although family therapy has been with us since the 1930s, shortly after Dr. Nathan Ackerman joined the Menninger Institute, family therapy plays little part in the residency training of most psychiatrists, and none at all in the training of general practitioners.

It is perhaps for this reason that clinicians who have trained in family therapy methods find difficulty when attempting to introduce their new found skills into the workplace. Quite simply their bosses don't know what family therapy is, and among those who think that they know many are working under misconceptions.

In a series of recent papers published by The American Psychiatric Foundation Ira Glick and Douglas Rait, a psychiatrist and psychologist respectively, assert that: "Because biopsychosocial systemic thinking provides a powerful framework for looking at multiple levels of systems and their interrelationships, developing a strong family-systems perspective and acquiring basic "family skills" represent the minimum requirement for general psychiatric training. The authors argue for the addition of couples and family therapy to the five required psychotherapy competencies defined by the residency review committee in psychiatry."

Although Nathan Ackerman was himself an M.D. and a psychiatrist it isn't essential to be a psychiatrist in order to practice family therapy. Most of the pioneer family therapists were social workers, since in traditional treatments in children's mental health the psychiatrist treated the child, and the social worker helped the family. This model is still appropriate in some situations, but usually treatment progresses farther, and faster, when all family members are seen together.

The question arises in some institutions, such as hospitals and schools, should a psychiatric assessment take place before counsellors and therapists see families and commit to family therapy? The answer to the question is quite straightforward. A psychiatric assessment is not always necessary.

Family therapy may be split into two distinct aims. The first is to ameliorate someone's symptoms, change her, or his behavior, and relieve suffering; the second is to do the same function for other family members.

When someone is suffering with a psychiatric malady, a physical disability, or is diagnosed with a potentially life-threatening illness the whole family is affected. But this same family is also the best potential resource to help the troubled patient and make her, or his, recovery. Many families fail in this because illness and disabilities are experienced as crises and for this reason that the skilled help of a family counsellor or therapist may prove to be invaluable.

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One does not necessarily need to diagnose the refusal to attend school as 'School Phobia' in order to treat it, just as a psychiatric diagnosis of Arachnophobia isn't necessary to treat someone for a fear of spiders. The bully who beats his younger siblings may be considered to have a 'Conduct Disorder', but this in no way helps us when we consider what the most effective ways there are to change the behavior pattern of him 'beating' and his younger sibling 'getting beaten'.

On the other hand where a person is starving themselves, slashing their wrists, or engaged in other forms of self-harm a psychiatric assessment is prudent. People suffering the chronic symptoms of psychosis have been treated with their families by non-medical practitioners in family therapy, but usually such treatment is carried out in a multi-disciplinary context where psychiatric back-up is available.

Family therapy is based upon a number of interlocking theories. These range from theories of family structure and how that structure networks with the immediate wider community, to ideas about narrative and how families encode their experiences into stories which prescribe behaviors over generations. Between these two extremes there are ideas about human communication, particularly ideas drawn from System Theory, which sees communication as a complex lattice work of nodes and tracks that, left to its own devices, is self-organizing and produces predictable patterns of behavior for good or ill!

Students of family therapy must study both theory, and also practice under the guidance of more experienced clinicians before they may safely be let loose on 'unsuspecting' families. A key tool in their repertoire is supervision using audio and video recording, which may be presented to more experienced clinicians for comment. Video cameras also play a part in family therapy treatment. Where a team's presence would be too intrusive in a clinical session, the team may easily watch the session in real time via a video link from another room. This places the entire team's resources at the disposal of the primary therapist and the family.

If you are newly qualified as a doctor, psychologist, counsellor, or pedagogue but wish to introduce family therapy in to your working context your first step should be to share this document with your boss and discuss the content with them. Make sure that they know that a formal psychiatric assessment is only necessary in cases where there is a risk of self-harm, or harm to others, and/or where it seems that gross symptoms of a disturbance such as hallucinations have been observed. Make it clear that although you are not a qualified psychiatrist you have a basic training in your own field and would refer anyone for a psychiatric assessment if such symptoms were reported during your contact with a family.

Most of all, however, make it clear that you have taken the time to study family therapy and have the backing of therapists with many decades of experience in the field upon whom you may call for assistance. This will all place you, and your boss, in a better position as you consider building a family counselling service within your work place.

References:

Nichols & Schwartz (1998) Family Therapy: Concepts and Methods. 4th ed. Allyn & Bacon
Rait and Glick (2008) Reintegrating Family Therapy Training in Psychiatric Residency Programs: Making the Case. Acad Psychiatry 32:76-80