Section: Modern PPT practice

FAMILY THERAPY AS A DYNAMIC BALANCE OF ACTION AND INACTION. TO ACT OR NOT TO ACT - DILEMMAS IN FAMILY THERAPY

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Abstract

Four principles of ethical questioning in family therapy dilemmas are the basis for ethical questions in family therapy as a guideline for to act, how to act, or not to act. An example of an ethical dilemma from the practice of family therapy is described.
A "package insert" for family and couples therapy as information about family therapy is comparable to information on the effects of medication: Why not apply the same standard when it comes to effective procedures?
Methods of family therapy and individual therapy have been developed side by side and one after the other, for which a clear differential indication and systematization of application still needs to be developed. An experience- and outcome-based family therapy (EBF) could be the goal. The therapeutic position and a guideline for families in therapy are discussed. The application of a five-step process model to find out and to solve the ethical questions is developed and presented.
We dare to present the thesis that a differential family therapy based on effect and side effect studies with informed consent of the patients or family members can be the basis for a critical classification of the methods to a general "Evidence Based Family Therapy" (experience-based family therapy).

Keywords: attachment, trauma, positive psychotherapy, psychodynamic therapy, ethical dilemmas, family therapy

Introduction

If family therapy were a surgical operation, the matter would be clear: A patient comes with complaints, an organ is diagnosed as diseased, which can also be proven. The team sits down to discuss the possible risks, the objectives and the expected course of the procedure. The team then discusses the surgical approach, what is to be removed, what is to be left in place, the anesthesia and how much the patient and also the surgeons can be expected to pay. The question of the price is - in this country - usually settled in advance by the insurance company. Standardized operations according to guidelines take place in acute hospitals. The ethics of surgeons are based on obvious and provable criteria.

An example will be presented here to visualize the dilemma therapists find themselves in: Family M., consisting of father, mother and their child comes to a family therapist. Other potentially powerful but optional family members are not brought (the mother's mother, who comes for the weekend; the mother's best friend; the father's deceased but still respected father). The 17-year-old daughter, L., is identified as the patient. She has anorexia, weighs 42 kilos with a height of 174 cm and continues to lose weight. Since the age of 13, she has been in

alternating treatments in university clinics, with psychologists and counseling centers The mother P. had the idea to now see this therapist. She herself is depressive, overstrained and in need of harmony, at the same time overweight and motherly caring. The father G. comes along. He drinks and decompensates at work. He will probably lose his job soon but does not yet see a problem.

The participants in a first meeting might come with the following, not verbally expressed expectations:

Daughter (index patient with anorexia): *Hopefully everything will end soon. They are always dragging me somewhere else. They should just leave me alone. I hope they'll leave me alone if I do everything right. They can't reach me anyway, they have no idea. I would much rather be somewhere else. (One of their ulterior motives: He looks all right. But that was also the case with the others before. And he won't understand me either. If only he could teach my parents that I'm finally allowed to live the way I want!)*

Mother of the patient: *I have almost no strength left, he (the therapist) should be in charge now. He should cure my daughter so that she eats, learns, never contradicts and marries well. He is supposed to teach my husband not to fly off the handle all the time. He is to give me comfort, praise and relief. (Afterthought: Oh, I'm so tired of this, I'm just living for the family, I finally need a cure myself!)*

Father of the patient: *I have to be careful. That I come is already too much. Let's see what he can do. Just don't reveal too much. It's not all that important/will be fine on its own. A beer would be good (ulterior motive: These psychos are all the same. This one doesn't have a clue either, the way he talks to us, he won't be able to talk my daughter and my wife into their conscience. Another ulterior motive, very deep: If only he knew how I feel!)*

Therapist: *A family is coming. They will certainly bring their daughter as a patient. Again, a piece of work until the others realize that they are also part of the system. What should I take on myself? Merely remove the life threat? Promote the daughter's autonomy? Or make the mother more detached as well? Or also want to make the father do something? Stabilize the family? Encourage the wife to separate? Who are the other important people who didn't come? Can the family even pay? (One of his ulterior motives: maybe I'll send them to the clinic after all).*

The first sentence from the mother was*: "Our daughter is very sick, maybe you can help her?"* The first session can begin.

The therapist is now faced with the question of priorities in the procedure from the very beginning. Which task and objectives can he accept, which one can he rejects, which one does he see implicitly for himself, which one is formulated? In the decision he wants to put the welfare of the individual person in the foreground - but for which one of all the persons in the family system? Is there something good for the family as a whole? He is faced with the decision to act or to refrain from acting, which he has learned in family therapy and psychotherapy training. He obviously needs clear criteria for an ethically sound decision.

His approach represents a result of simultaneously acting interests, implicit and explicitly expressed expectations, goals and appreciations.

Four principles of ethics

The four principles described by Beauchamp and Childress can be used here as a guide for ethical issues in family therapy to question the dilemmas of deliberate action and interaction in family therapy below:

1. **self-determination/autonomy of the patients**
2. **the treatment should not harm the patient**
3. **the treatment should be useful for the patient**
4. **equity in the treatment system**

(Modified after Beauchamp and Childress 1989).

1. The Patient's Right of Self-determination

"I can take care of myself, I know what is good for me" (patient).

The patient's right of self-determination to act or refrain from acting therapeutically in a treatment contract with informed consent is the first ethical guideline to look at.

In the case example the daughter will probably develop with therapeutic support in a different autonomy development than the

mother is currently comfortable with, and there may be heated arguments. As a therapist, do I inform her about this? Will the parents still support the daughter financially in treatment? Do the father and mother agree to bring in their own problems, which seem to find their outward expression in the daughter's symptomatology? Can the marital problems be addressed in the presence of the daughter? Who agrees to what, and are all involved aware of the possible consequences?

Especially with minors involved, as in the example above, ethical issues of informed consent of the adolescents versus consent of the parents regularly arise, e.g., in connection with the assumption of costs in aid proceedings on behalf of the parents. Self-determination in individual psychotherapy is easier to achieve than in system-oriented family therapy, in which several autonomous persons and at the same time an inherently specific family organism appears. Individual goal of one person and the possible goals for the family system challenge therapists:

Salus privata, the individual health is focused on for the individual family member. Therapeutic aids serve their assertion against interests of other family members, among other things, and one person might seek an alliance against the others. The priority for individuality and autonomy is typical for individual therapy settings, as individuation is seen in individualistic cultural environments as a sign of maturity, like the development of individual skills in competition with other individuals

In the example above, the anorectic patient wants to be accepted as she is by her parents, and involves the therapist into her understanding of her behavior, and wants to give the responsibility with all the consequences to the therapist. Anorexia in the index patient can be seen as an expression of the attachment-detachment conflict in individuation, as a case typical for central Europe.

Salus familiae, the health and functioning of the family means to see goals for the social community, for the narrow or wider family. This perspective carries the expectation that the therapeutic aids will serve their assertion against the outside world, and to unite them in their identity and function. Priority is given for family association, group, community, as in a collective cultural environment. In this case group coherence is seen as a sign of maturity, development of the unit's skills in competition with other groups and families.

Further possible restrictions of the patient's self-determination arise in the context of therapeutic interventions through the person of the therapist in the therapeutic relationship, valid especially in family therapy. *Leonore Kottje-Birnbacher* and *Dieter Birnbacher in* their article "Ethical Aspects of Psychotherapy and the Consequences for Therapist Training" present as possible negative consequences of therapy an instrumentalization of the patient for self-serving purposes, therapy as an end in itself, too strong identification of the therapist with the patient, or a systematic pathologizing. Resulting damages concern the next basic rule of ethics mentioned above.

2. The Treatment Should Not Harm the Patient

"What one particularly likes to do is rarely particularly good" (W. Busch)

Case study: Anorexia of an index patient: In the 4th family therapy meeting, the "paradoxically" intended advice is applied to consider whether the therapy should be continued. As an argument, the possible impact of therapy on the role of the individual members is suggested: the overprotective and depressed mother would lose tasks in the family, the threatening anorectic daughter could lose the care, the father, devalued in his job, would possibly lose the accustomed family cohesion. The intention was to stimulate a discussion within the family about the therapeutic path and to form an alliance, if necessary even against the therapist. The ***autonomy of the family system,*** not that of the individual family members, was in the foreground.

The ethical dilemma between the good of the individual and the good of the family as an organism is a constant theme in family therapy and the nature of interventions. Benefits and harms in acting or not acting were also for *Mara Selvini-Palazzoli* reason for a constant development and review of the interventions.

The intervention should not do any harm: There is little data on this from couple and family therapy. Some authors discuss rules of negative indication. Above all, the therapists' experience and ability to set boundaries is given as a variable

to define negative indication. The therapists' own image of man and their own family ideal as well as their family reality and couple relationship consciously or unconsciously enter into the therapy as a factor and can have a positive or negative effect on the affected person via countertransference. For this reason, self-awareness is sometimes given a lot of space in the training courses, in order to consciously reflect on the personal influence in the therapy.

Some situations seem tempting to ask conflict-discovering questions. Refraining from doing so may occasionally be far more effective and less dangerous to the continuance of a community expressly mandated to be fostered. The alternate action can encourage resources to promote mutual acceptance in a partnership. Subsequently, active action to promote the ability to deal with conflict is useful. Refraining from giving advice in therapy promotes autonomy of intra-family counseling.

Contraindications to procedures or techniques of family therapy are so far hardly named in therapeutic guidelines, in the literature - much less frequently than indications - defined for family problems and therapist factors, also relate to family typology. Official AWMF guidelines do not yet exist in Germany for family therapy, although guidelines for child and adolescent psychotherapy and psychiatry already contain the concept of family therapy in the cases of schizophrenia, affective or eating disorders in the context of therapy.

What in detail can be seen as possible *harm* to a family and its individual members as well as caregivers should be defined in the interview. Typical possibilities of harm known from previous research and experience should be shared by the therapist. This represents an initial characteristic of "evidence-based family therapy" or "outcome-based family therapy."

As a hypothesis, I would like to formulate from my personal experience in internal and general medicine that *omitting family therapy* or *not involving the family in* counseling and therapy can have a considerably more detrimental effect than specifically *involving the* relatives with the patients' consent and encouraging family therapy. The results of family groups of mentally ill patients are positive (Battegay), and obesity treatment is facilitated by family therapy approaches. The negative acting of relatives in the treatment can thus often be transformed into a positive family motivation to promote the individuals and the commonality (Peseschkian 2016a, 2016b).

3. Treatment Should Benefit the Patient

"There is nothing good unless you do it"

Effects of family therapy are well studied, a positive indication is well defined in the literature, as well as a possible different effectiveness of the different theoretical backgrounds. However, the differential indication for different procedures is rarely considered.

Accessibility of the family members, motivation, special problem areas, disturbance patterns are considered as indication criteria. Accepting outside orders for therapy is a relative contraindication: the skilled patient, the selected family member, the black sheep sent into the family therapy desert ("the black sheep in the family are often the nicest").

Family therapy achieves high effects on child behavior disorders, family problems, communication and problem-solving disorders, phobias, schizophrenic symptoms, psychiatric symptoms *(Shadish, Ragsdale, 1996)*. Couples therapy, according to the same research, significantly affects dissatisfaction in the partner relationship, specific problem-solving difficulties. The probability that a client treated with couples or family therapy will do better than a control group member is about 67% *(Shadish, Ragsdale, 1996)*.

What in detail can be seen as a *benefit* for a family and its individual members as well as reference persons is to be defined in the conversation. Typical effects known from previous research and experience should be shared by the therapist. This constitutes a characteristic of "evidence-based family therapy" or "research-based family therapy." Quality is defined in quality management as "the totality of the characteristics of an entity with respect to its ability to meet established and anticipated requirements". In treatment it is also the definition of the desired target criteria and their benchmarks. The yardsticks also yield a measure of disadvantage or harm.

Table 1.
Three interaction stages in family therapy

3 stages of interaction that are emphasized differently in various family therapy practices:		
Attachment	**Differentiation**	**Detachment**
Empathy, unconditional acceptance, emotional feedback	Communication change, clarification, reinterpretation	Dissociation, dissociability, historical interpretation
Proximity ability - Bonding -	*Ability to distinguish* - Differentiation -	*Ability to distance* - Autonomy -
Emphasis on commonality, Loyalty and harmony	Conflict ability and Assumption of differences	Emphasis on autonomy and boundary setting
above all humanistic orientation	especially: behavioral therapy, systemic oriented therapies	mainly short-term therapy, psychodynamic and analytical methods

4. Justice in the Treatment System

Justice in the treatment system is to be applied within the family therapy first of all to the circle of the participants and the question of the inclusion of relationship partners in the therapy. The decision about the inclusion of relatives in a therapy always deals with the question of the rights of the individual to achieve a treatment success of an individual kind or to achieve the change or improvement of a relationship system for himself, if necessary, also at the expense of the relationship partners or in coordination with them. Typical for this is the situation of today's individual therapy especially of analytic character, not to include parents or relatives at all. To the detriment of a positive, understanding relationship, they are not actively enabled to participate in the therapeutic clarification and change of relationship. As a rule, an analyst will not include partners or parents in individual therapy, but will recommend separate therapists for other family members if necessary. In behavioral therapy, too, the involvement of relatives is useful, appropriate to problem solving, effective in extending symptom success by stabilizing relationships.

Justice in the therapeutic system also means making the selection of people who seek family and couples therapy dependent on criteria that do not affect their dignity. Thus, poverty cannot be an ethically justifiable criterion for non-acceptance of clients, but a lack of fees for the therapists can be an individually justifiable criterion for non-acceptance (salus publica - salus privata). Here a new ethical question arises, especially for the field of preventive and curative family therapy, which arises in the overall social context as well as in the individual therapeutic encounter. Action by individual therapists even in the face of low remuneration or refraining from action due to economic constraints are everyday dilemmas that also resurface in the context of the health care system as the issue of budgeting and rationing. In the private sector setting of today's family therapy, which also involves illness, this ethical issue arises daily in the low availability of family therapists for suffering families alone.

Yet missing: A "Package Insert" of Family and Couple therapy

"For effects and side effects, ask your family therapist": Information about family therapy is analogous to information about medications. Since both are proven effective procedures, the same standards can be applied. A "package insert" can provide guidance for action and inaction between client and therapist.

- *Indication:* Which procedure will be useful and how?
- *Contraindication:* What speaks against the procedure?
- *Main effects:* What is the likely effect of the procedure?
- *Side effects:* What are the possible adverse effects?
- *Interaction:* Which simultaneous action is useful or detrimental?

Suggested Model of a Systematized, Outcome-based Family Therapy

The thesis is ventured that a differential family therapy based on effect and side effect studies with informed consent of the patients or family members can be the basis for a critical classification of actions and omissions in a general "Evidence-Based Family Therapy".

A cross-method view of family therapy indications yields advantages of various procedures. As *Grawe* notes, "the interpersonal perspective is ... far too important for psychotherapy to be left to *one* school of therapy " He urges research into family and couples therapy, which obviously works but is not substantiated on the basis of the evidence requirements that apply to medicine. Despite relatively lower effect representation the humanistic family therapy is effective in its approach, the eclectic family therapy, the behavior therapeutic, the psychodynamic and the systemic can prove in studies in the approach a positive effect on the therapy goals. The difference in effectiveness seems to be partly related to the theoretical approach, different target approaches, implicit outcome desires, and different operationalizability, not solely to actual differences in effectiveness. For the individual family, a selection from the available methods must be made that is indicated by the family's mission and the therapist.

The need for a clear indication, as described by *Bommert (*1990) and listed by *Shadish (*1997), becomes particularly clear in the case of disorders that were treated by family therapy without any demonstrable success. According to this, so far, no effect of family therapy can be secured in the studies examined by him in delinquency, on school performance, substance abuse, dealing with physical illnesses. According to *Shadish's* meta-analysis, couples therapy showed, for example, no significantly demonstrable effect on affective psychoses, physical illnesses and their coping, divorce problems, sexual disorders.

The systematization of a method-spreading family therapy was brought by *Peseschkian* 1980 and 1991 already in a quite comprehensive form. In a five-step procedure the advantages of the different methods are combined and applied in a sequential order for therapy, self-help and family therapy. The research situation on differential indications and side effects or interactions has not yet been explicitly considered. Implicitly, some of the dilemmas mentioned are taken into account by the step-by-step procedure and the inclusion of the individual and the involved reference persons:

Five stages of Positive Family Therapy according to *Peseschkian (2016):*

1. Observation, distancing: Empathy and emotional feedback as in humanistic methods is supplemented by early change of location and positive reinterpretations of problems At the same time, stimulation of early self-help by those involved counteracts dependence on therapists; the actions of family members are given priority at an early stage.
2. Inventory: *Grawes* clarification dimensions used systematically by inventorying the bonding and conflict abilities of the family members, their strong and their developmental areas, similar to behavioral therapy. Conflict level and relational ability are considered in parallel with the understanding level in the clarification phase: Primarily, the solution orientation is omitted.
3. Situational Encouragement: Family resources are verbalized and systematically used, increasingly independent of the therapist.
4. Verbalization: Conflicts are narrowed down and deliberated in the couple and family group. Autonomous individuation and group cohesion are promoted at the same time, conflict ability and solution strategies are developed. The family is the acting part, the therapist is still the moderator but refrains from active intervention.
5. Goal expansion: The goal development according to the original intentions gives the family and the individuals involved new motivation and perspectives. This phase is only prepared by the therapeutic side; the actors are family members.

The Five Steps apply to the initial interview with the family, the course of therapy, and self-help guidance for those involved.

The step to a Dynamic Family Therapy, whose differential indication of interventions is based on the evidence of previous studies and regular exchange of experience about unexplored areas, is not far from this systematics of *Peseschkian.* By Dynamic Family Therapy is meant here the consideration of sociodynamics and individual psychodynamics as well as the ability- and conflict-content-related use of procedures, which enables a dynamic and autonomous development of family systems.

An evidence-based or experience-based family therapy (EBF):

Self-determination in an informed consent treatment contract based on the following steps:

Data-based information on
already verified or still innovative action and possible, reasonably required or intended omission
and the possible consequences for all involved

Outcome-Based Family Therapy takes into account the autonomy of the family, partners, and individuals in the family and asks about goals of the individuals, the group, and outsiders. The possible negative consequences of an intervention are verbalized based on prior experience and research findings. This is contrasted with the goals and requirements that are achievable for the individuals, couples, and families. The quality of a treatment is defined by the participants in relation to their own requirements on the family and treatment side. Within the development of the therapy, the selection of treatment interventions is again based on the goals defined here. In the individual psychotherapy and in the couple and family therapy setting, the secondary consequences for the interpersonal relationships are to be mentioned. The concept of the "ecological frame", the harmlessness for the extended environment, accompanies family and couple therapy as an ethical issue.

The goal is differential family therapy based on efficacy and side effect studies with informed consent of the patients or family members. Through this, action and inaction are jointly deliberated by the therapists involved and family members present, similar to what happens before surgery. In contrast to the surgical procedure, in family and psychotherapy a continuity of informed consent and an explanation of possible consequences of the therapy is continuously possible.

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