Family Systems Psychiatry: Principles, Good Practice Guidelines, Clinical Examples, and Challenges

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This article describes a collaborative action research project, carried out in Germany and designed to promote the integration of family systems thinking and methods into the core practices of everyday psychiatric care. During 1997–2002, “good practice” guidelines were compiled in an initial research project, involving 17 in- and outpatient psychiatric services. In the second phase of the project (2002–2008), the approach is now well established, being taught and evaluated in three state hospitals in Germany. This article outlines the development of the project and the application of family systems psychiatry principles, demonstrating their feasibility and value in a number of different psychiatric hospitals. Two clinical vignettes illustrate the usefulness of the family systems approach as a comprehensive framework for delivering recovery-focused inpatient care.

Keywords: family therapy, family systems psychiatry, inpatient psychiatry, systemic self-reflection, negotiating with patients

Family therapy for patients with psychiatric (and particularly psychotic) disorders has evolved since the 1950s, going through conceptual shifts that provide us with a rich body of interesting concepts and practices (for an overview see Marley, 2004; Nichols & Schwartz, 2004; von Schlippe & Schweitzer, 1996; Keller & Greve, 1996). The 1950s and 1960s saw mostly qualitative research on family dynamics of psychiatric disorders, particularly in the United States. Researchers at Palo Alto (Bateson, Jackson, Haley, & Weakland, 1956) and at various centers on the East Coast (e.g., Bowen, 1978; Lidz, 1973; Wynne, Cromwell, & Matthyse, 1978) studied communication deviances as well as the “weakness” or “strength” of intrafamilial boundaries.

The first controlled outcome study was carried out in Denver (Langsley, Pittman, & Machotka, 1968), with patients in acute crisis being randomly assigned to either conventional inpatient treatment or to a family crisis outpatient unit. In the 1980s, family therapy met increasing resistance in the United States, but at the same time started to flourish in Europe. The Milan group’s approach (Selvini-Pallazoli, Boscolo, Cecchin, & Prata, 1977; Selvini-Pallazoli, Boscolo, Cecchin, & Prata, 1980), using circular hypotheses and questions as well as paradoxical prescriptions, influenced many European teams, among them our own Heidelberg team (Retzer, 2004; Stierlin, 1988; Weber, Simon, Stierlin, & Schmidt, 1988).

In the 1990s, some more reflective-dialogic and less strategically informed approaches to psychotic disturbances were developed and applied, particularly in Finland and Sweden (Aderhold, Alalen, Hess, & Hohn, 2003). Influenced by epistemological shifts, such as radical constructivism (von Glasersfeld, 1981) and social constructionism (Gergen, 1994), the perspective on families with psychotic members changed considerably during these years:

- from a narrow focus on family process, to a wider systems approach;
- from a focus on interactional family pathology as a “cause” of mental illness, to a focus on systemic coping and the construction of solutions;
- from a more strategic, interventive, and “technical” stance on seemingly “resistant” and “homeostatic” families, to a more collaborative, dialogic and “relaxed” therapist-family relationship.

Our own work has been very much influenced by these developments. However, we still value and utilize quite a number of the original systemic ideas and practices in our clinical work.

In recent years, family systems therapy in adult psychiatry has competed against the psycho-educational approach (Lukens & McFarlane, 2004; McFarlane, Dixon, & Lukens, 2003). Some aspects of the latter’s conceptual framework, such as the illness concept inherent in the idea of vulnerability and the strong focus
on compliance with psychopharmacological treatments, has been regarded as not being compatible with the family systems approach by many systemic family therapists. In fact, it is at present not a mainstream approach in Germany. Mainstream care is probably best characterized as a combination of psychopharmacology and milieu therapy, with some psycho-educational and behavioral interventions. However, systemic family therapy is not a total outsider either, as many professionals working in the field of psychiatry have been trained in systemic approaches, and a considerable number now hold responsibility in leading institutions. Furthermore, in Germany there is a rather positive image of family therapy held by the general public, which is being promoted by the media. There are also quite a few good collaborative projects with patient and carer associations. The financial support for psychiatric services, including psychotherapy, is much less restricted than in the United States. All this implies that the chances for developing family systems psychiatry nationwide have been and remain fairly good.

Development of the Family Systems Psychiatry Project

The Family Systems Psychiatry project was initiated by a psychiatrist, Gunther Weber, and a clinical psychologist, Jochen Schweitzer, at Heidelberg University in February 1997. Weber and Schweitzer both had worked in psychiatric state hospitals and later joined Helm Stierlin’s “family therapy in psychosis” team (Retzer, Simon, Weber, Stierlin, & Schmidt, 1991; Simon & Weber, 1988). Over the years, they trained large numbers of systemic therapists who were also psychiatrists. Both had also conducted research on family therapy for psychotic disorders and on systemic consultation for community psychiatric services. However, both thought that while there had been many advances in therapeutic techniques and an increasing number of well-trained psychiatrists with systemic expertise, the family systems orientation still played only a rather minor role in the delivery of mainstream psychiatric services. They decided to embark on the Family Systems Psychiatry project and established close collaborations with a group of directors and assistant directors of psychiatric hospitals and services, all of whom had a family systems training background and orientation. Most of these were psychiatrists, some were clinical psychologists, and others clinical social workers. The psychiatrists tended to be in charge of publicly funded state and general hospital departments; the psychologists and social workers led or coled outpatient rehabilitation services.

In its first year (1997–1998), the project saw intensive discussions about how to define, identify, and apply the often seemingly abstract family systems concepts in everyday psychiatric practice. For example, how would one be able to spot “reflective conversations” or the “positive connotation” of a psychiatric symptom? Could this be done by observing team discussions, or would one have to interview patients or staff members, most of whom had never heard about systems theory? While it seemed easier to establish agreements in the domain of clinical practice, when it came to discussing the domains of staff participation, leadership issues or interhospital relations, things became much more difficult. However, we eventually arrived at a number of potential indicators for using a family systems psychiatry approach that are summarized in Table 1 (Schweitzer, Nicolai, & Hirschenberger, 2005).

Table 1

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<th>The Family Systems Psychiatry Indicator List</th>
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<td>I. Working with patients and their family members</td>
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<td>Negotiating about goals, contents, and duration of treatment</td>
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<td>Internal information policies: transparency and invitations for dialogues</td>
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We then defined what a family systems approach would generally look like and how it could be explored by using direct interviews and the method of participant observation. For example, when considering the systemic practice of “contextual conversations about illness and health,” we defined this in the following way: “When staff talk about patients, they will aim to use more contextual, solution-focused and resource-oriented words and sentences, rather than focusing on pathology, deficits, incompetence and neediness.” Specific key words were then described more precisely, for example: “Resource- and solution-focused words and phrases stress the patient’s capability to actively influence the problem patterns he is involved in, as well as his potential to realize and utilize that capability.” We agreed that it was most valuable to examine such words and phrases during case conferences when the patient was not present.

During the second and third year of the project (1998–2000), our research team visited 12 hospitals and psychiatric services to observe their specific attempts to apply the principles and guidelines of family systems psychiatry. Eight of these were psychiatric inpatient units in state or general hospitals, the remaining four were community-oriented outpatient and rehabilitation services. Each setting was visited twice, with approximately one year in between these “reflective visits” (Schweitzer, Weber, Nicolai, Hirschenberger, & Verres, 2000). Each visit took three days. During the first two days, group interviews were conducted with selected groups of patients, family members, staff members, and team leaders. Case conferences, psycho-educational groups, and activity planning sessions were attended and observed by our team. On the third day, we provided a formal 1 ½ hour feedback session during a staff conference, usually with between 10 and 30 people attending. Our presentations were structured along the topics of the “Family Systems Psychiatry Indicator List.” In some cases, pre-

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1 We thank the Heidehof Foundation Stuttgart for the funding of the project.
sentations were immediately followed by a workshop on how to utilize the feedback to change current clinical procedures and practices. This methodology not only enabled us to identify practices of family systems therapy already present in the clinics, but also initiated self-organizational processes of developing and establishing new clinical approaches. For details of this methodological approach see Schweitzer, Nicolai, and Hirschenberger (2005).

In order to evaluate our initial data and to advance our own thinking, we invited in the year 2000 some 60 clinicians, management consultants, and head of departments with a systemic orientation to join an expert conference in Heidelberg. Their experiences, gained at many places all over Germany, Austria, and Switzerland, inspired us and significantly contributed to our findings. Encouraged by this, we subsequently designed in 2001 and 2002 the next project period, namely to transform these different practices into a comprehensive and coherent “package” and to test it thoroughly in selected clinical settings. This new project started in 2002 and will run to 2008. It aims to provide training, implementation, and evaluation of the family systems psychiatry package in three large hospital inpatient units. This involves more than 100 staff members, with a 27-day training program, a treatment manual, and a controlled outcome and process evaluation study.

Guiding Principles

The project started with consensus-building about what constitutes family systems psychiatry. The group agreed on the following general guiding principles (Hirschenberger, Nicolai, Schweitzer, & Weber, 1998):

- **Family involvement.** Family members and significant members of their social network are actively invited to participate in the planning of treatment—both as “cotherapists” or “coconsultants” for the patient, as well as with regard to their own agendas as relatives and caregivers.

- **Systemic self-reflection.** Family, network and professional team members engage in joint ‘reflective conversations’ about how the psychiatric problems emerged within the patient’s multiple social contexts and systems, and what each of the participants could possibly contribute to the solution of these problems. These conversations may take place in different settings, for example, during family therapy sessions, family consultation, multifamily group therapy, family and larger system meetings, supervision and case discussions.

- **Making sense of symptoms and questioning chronicity.** A contextual understanding of the “meaning” of psychiatric symptoms from a social systems perspective facilitates two positive outcomes. First, the increased acceptance and positive connotation of seemingly pathological behavior, thus reducing stigma, pressure, and social marginalization for the patient. Second, there is an encouragement to search for ways to “exit” from chronic psychiatric “careers.”

- **A culture of negotiation.** Family systems therapy engages in a different sort of “negotiation” between patient and treatment team when it comes to dealing with critical treatment issues, such as medication, compliance, treatment adherence, diagnosis, duration of treatment, or restricting measures when difficult situations arise. The patient is seen as a responsible partner who can be—and has to be—actively integrated in those negotiations.

- **Family systems psychiatry as an organizational principle.** Beyond offering specific treatment modalities, such as couple therapy, family therapy, and network therapies, family systems psychiatry is used as an overall approach to conceptualize and organize clinical everyday procedures—from admission to discharge, from medication to compulsory measures, from diagnosis to discharge letters. It aims to foster an increased sense of agency, participation, and self-reflectivity for patients, relatives, and staff. This requires more than relying on individual professionals who are well trained in systems family therapy. It calls for a managed organizational change so that the model can be appropriately implemented as a basic general approach in the delivery of psychiatric services.

Good Practices in the Field of Family Systems Psychiatry

The procedures presented below represent the most interesting findings we made during our hospital visits. We restrict ourselves to good practices relating to work with patients and their family members. Practices regarding staff cooperation and collaboration with other agencies are beyond the scope of this article.

*Conversations About Illness and Health: How to Talk in a Contextual, Resource- and Solution-Focused Manner*

We found many examples of clinic teams demonstrating considerable sensitivity to “exceptions to the problem” (De Shazer, 1988): that is, to focus on the strengths and competencies patients had retained despite their illness—like humor, concern for others, responsibility for their family, and personal resources. However, the techniques of positive connotation or reframing of symptomatic behavior—that is, of appraising seemingly pathological behavior as a useful way to communicate in a particular social context—was used much less frequently.

Some services had changed the way they conducted their case conferences significantly, by beginning to invite patients to attend these when their own “case” was being discussed. The patients listen to the entire staff discussion, and at the end they can comment on it—whether they feel the team understands their situation and if and how the team can improve the treatment. In this way patients become the clinical team’s “case supervisor,” challenging the professionals’ “language” habits and requiring them to talk more respectfully. However, we found that inviting patients to case conferences only happens intermittently and has not become standard practice. It seems that staff members at times need a place and time to express anger or frustration about their patients in less controlled ways and for their own relief, which would not be possible if patients were present.

Many systemically oriented clinicians complained about the dilemma of their reports for health insurance companies having to contain as many diagnoses of severe psychopathology as possible, in order to ensure payment for treatment, while at the same time attempting to “de-pathologize” their patients’ behaviors in the course of their therapeutic work. This requires clinicians to develop some form of ‘professional double talk’ if not “professional duplicity.” On the one hand, they have to make meticulous diagnoses and must not hesitate to opt for the more severe end of the diagnostic spectrum. On the other hand, they have to explain to patients, family members, and staff how and why these diagnoses are necessary to ensure adequate treatment payment. They also...
have to discuss with patients how one can use even a serious psychiatric diagnosis strategically without necessarily making it a dominant part of one’s identity.

Clarifying Goals, Contents, and Duration of Treatment—
and How to Negotiate These

We met good practitioners with regard to early clarification of patient–relative expectations and treatment goals, but this was more frequent in outpatient than in inpatient psychiatry settings. In the latter, the often very acute mental states of patients at the time of admission seem to require immediate action, and it is the clinicians who must decide what to do. Because inpatient treatment often combines many services “under the same roof,” such as nursing, psychiatry, psychotherapy, social work, and so forth, one response is to “offer the whole machinery.” However, this becomes frustrating when patients behave noncompliantly by refusing to accept some specific parts of these “all-in services.” However, during our investigation we met quite a few clinicians working on inpatient units who did a very good job in early task clarification with patients and relatives. They tended to ask questions like these:

- Who is the person who really wants this inpatient admission? Is it the patient, his relatives, or (only) his doctor?
- What is the unofficial (secret) goal: For the relatives to get a rest from a restless patient? For the patient to get away temporarily from a stressful job or to be certified as a person who is “really ill”?
- Which of the treatment components are needed to achieve these unofficial goals and which might as well be suspended? How strategically useful are psychopharmacology, psychotherapy, “hotel psychiatry” or any of the other treatment components?
- How many days or weeks of inpatient admission would be needed to achieve these unofficial goals?

To ask these questions skillfully in a first interview, usually with the family members present, and then to negotiate these instead of negating them, helps to implement a family systems psychiatry approach from the outset. It also helps to avoid the unnecessary “overdosing” of purely medical treatments. When the suggested treatment is perceived as being controversial by the patient or family members, the idea of conducting several trials may be helpful. For example, a patient who distrusts neuroleptic medication may first be encouraged to participate in a 1-month trial on medication in order to evaluate the pros and cons in collaboration with the treatment team. Another approach is to suggest a non-neuroleptic experimental phase first, as described in the Soteria projects (Bola & Mosher, 2003; Bola, Mosher, & Cohen, 2005) or in some projects carried out in Finland (Aderhold et al., 2003), with similar evaluations built in and possible subsequent changes in that strategy.

So-called chronic patients, often seemingly afraid of change and their psychiatric institutions, frequently accept implicit contracts for long-time (maybe lifelong) treatment. Such contracts are usually put at risk if the patient improves clinically. Whenever patients have based their identity, and even their income, on a patient role, the danger of no longer being “sick” and having to totally rearrange their whole life, can then become a major threat. This fear can be reduced by making explicit paradoxical long-term contracts with chronic patients. Groth (2000) states, “We promise we will try to keep you here for a long time, unless the health insurance company or you yourself terminate this contract” (p. 121). In response to this intervention, patients often start to develop ideas of being more autonomous and competent, as they realize that they do not have to fight any longer for a safe sanctuary in the institution.

Increased Choices in the Treatment Program

We found that many residential units for psychiatric patients had considerably changed their practices with regard to individualized patient care, allowing much more individual freedom in the areas of shopping and preparation of meals, cleaning and furnishing of rooms, and organizing social activities and vacations. A day hospital on the Swiss/German border had even introduced complete freedom of choice for all treatment components that were listed on a weekly timetable of therapeutic activities (Krueger, 2000). However, as a somewhat unpleasant side effect, this stimulated some competition between therapists as to who had a lower dropout rate in his therapy group, resulting in the freedom of choice being reduced and limited!

When introducing collaborative practices, our task was made easier by the fact that the ground had been prepared in Germany by the Campaign for Mental Patients, a group advocating the improvement of psychiatric treatment, which had developed an integrated treatment and rehabilitation plan (Aktion Psychisch Kranke, 1997). Its goal is to tailor community services very specifically to the individual needs of patients, and to provide these services within well-integrated service networks. One major tool used in this approach is a questionnaire, which requires the patient and a social worker to jointly take stock of all competencies, deficits, and service needs of the patient. This questionnaire then becomes the basis of an explicit treatment contract. Research shows that the process of introducing this questionnaire has significantly altered the “culture of negotiations” between patients and professionals (Herrmann-Woitas, Speicher, & Schweitzer, 2000).

Is It Possible to Negotiate About Diagnoses, Drugs, and Discharge Letters?

Because most German systemic family therapists have been strongly influenced by radical constructivist (von Glasersfeld, 1996) or social constructionist (Gergen, 1991) epistemological orientations, they tend to regard diagnoses, discharge letters, and even drugs as social constructions, which either widen or restrict the patients’ range of options on how to live their social lives. It is obvious that within this framework, psychiatric diagnoses are viewed quite ambivalently, especially when associated with biological and vulnerability theories pointing at deficits. Diagnoses may “teach people how to make very tiny little steps instead of walking upright” (Simon & Weber, 1988, p. 58) and promote or sustain a fearful attitude of “be cautious—it’s dangerous!” to one’s own life (Herzog & Schweitzer, 1992, p. 186–195). Diagnoses can at the same time unhelpfully protect psychiatric patients from taking any kind of personal responsibility, which they might find too demanding. The value of psychiatric diagnoses seems to be particularly important for chronic patients, whose disability pensions, sheltered housing and sheltered job arrangements depend on the continuation of a psychiatric diagnosis (Schweitzer &
Schumacher, 1995). Thus, many systemically trained clinicians discuss with their chronic patients how they can secure the economic and social protection provided by their psychiatric diagnoses without “having to feel ill all the time.” Recently, systems therapists have suggested considering diagnoses as more of a tool for patients rather than for therapists (Spitzcz & von Brisinsky, 2000). This stance implies discussions with the patient about advantages and disadvantages of a diagnosis, in order to help him or her to make a choice as to whether to adopt or reject a specific diagnosis and/or how to make use of it in everyday life.

Clinical experience in German hospitals shows that the dose and type of neuroleptical medication prescribed in state hospitals largely depends on what behavior nursing staff can tolerate from patients, especially during critical periods when only a few staff members are present on the ward. This is well illustrated by a controlled experiment carried out on an acute psychiatric ward (Pallenberg, 2000). Nursing staff were given an important role in making joint decisions about the actual dose prescribed. They received extensive training on wanted and unwanted drug effects and they were given permission to increase the dose during night shifts if or when required. Patients were informed what kinds of behaviors would lead to the prescription of higher and lower doses. Every week the consumption of psychotropic drugs was published on the ward and, following these interventions, drug consumption was reduced by a 5:1 ratio without any clinical deterioration.

In the course of our project, we found that some clinics invited their patients to read their discharge letters to the referring physicians. Patients were asked for comments and possible suggestions, a practice inspired by the writings of Imber-Black, Roberts, and Whiting (1988).

Different Settings for “Systemic Self-Reflection”

Psychiatric conversations between staff and family members often consists of providing information about diagnoses and treatments and sometimes of giving instructions on how to manage the patient at home. Systemic clinicians usually do not use purist psycho-educational practices, nor do they try to convince patients and family members of a particular scientifically based theory. They also tend not to teach patients and their families a particular style of communication or formal problem solving. Rather, they try to help patients and family members to develop their own understanding (“What did we do to get into this mess?”) and find their own idiosyncratic solutions (“What can we do to get out of this mess?”). This can be achieved by various forms of self-reflective conversations. In the course of our visits of various hospitals, we have found that many clinics employ the “reflecting team” approach (Andersen, 1991; Hargens & von Schlippe, 1998). This involves several observers, separated from therapists and clients often by a one-way screen or video-link, listening to the therapeutic conversation. After awhile, the clients and therapist(s) stop their conversation and the therapist, with the permission of the family, then asks the members of the observing team about their perceptions and ideas of what went on in the clinical interview. The family and therapist observe and listen to the team discussion and the therapist then asks the family to comment on what they have heard and to discuss what may—or may not—fit their situation. This may happen once or several times during the course of a clinical interview. This approach brings the observers’ views directly to the client, providing multiple ideas in a nondirective, solution-focused and appreciative manner.

Cooperative conversations (Deissler, Keller, & Schug, 1995) are designed to foster better collaboration between patient, family members and staff in difficult conflict—ridden or intransigent cases. This conversation is led by a small group of professionals—one of them serving as a facilitator, two or three as an external reflecting team—who are not directly involved in the treatment case. Patient and family on the one hand, treatment staff on the other, are consecutively interviewed about their perceptions of the issue or problem, with the others listening. As a third step, the reflecting team discusses its hypotheses and solution-focused ideas. Finally the patient, family members, and treatment staff are again interviewed and asked for feedback. This process treats patients and family members as experts with knowledge equally important to that of the professionals.

The reflecting team approach has also been further developed and applied to the field of child and adolescent psychiatry to include family, group, and institutional levels of intervention within, in one single setting, “reflecting families” (Caby & Geiken, 2000). All the children, family members and staff members affiliated to the same ward meet in three separate circles in one big room. First, staff members talk among themselves about their work with the children—about events, achievements and difficulties. Then, the children discuss among themselves how they view the issues that the staffs’ discussion has raised. Finally, family members converse as a reflecting team about what they think with regard to the collaboration between children and staff. To make this approach work well, a prior brief discussion with all three subgroups can help to establish useful ground rules on how to conduct solution-focused talk.

Reflective conversations can also be practiced in traditional group therapy, including patients with psychosis (Greve & Herder, 2001). Patients are invited to present their current concerns, for example, about treatment, about their current well-being, or about the organization of their daily life. The group selects a particular topic for each member that it wants them to deal with on that day. After 20 minutes of interviewing that patient, the two group therapists first serve as a reflecting team to the presenter’s stories and then all other patients in the group share their related experiences and thoughts.

These and other systemic techniques have been put in place in one of Germany’s largest long-stay hospitals, the von Bodelschwing’sche Anstalten in Bielefeld, which established a “Central Office for Family Consultation” some time ago (Klekamp, Knirsch, & Vieten, 1996). One coordinator and a number of part-time systems therapists from all different wards and departments of the hospital now provide a diversified setting of systemic conversations for more than 1,400 patients and their families, including couples therapy, family counseling, “brother and sister seminars,” cooperative reflections between family and staff, and family systems training for staff.

Negotiating in Acute Crises

Having to manage acute psychiatric crises involving suicide attempts and serious physical aggression poses special challenges for systemic therapists. How is it possible to act in a way that increases the patient’s range of options, when violence calls for...
restrictive measures like locking ward doors, administering compulsory medication, or even using physical restraint? As difficult as it may seem, it is often possible to negotiate the type and degree of restrictive measures with the patient, by discussing how he can influence control exerted by staff. First, staff members explain why they have to restrict the patient and what different options are available to utilize in doing so. Second, they inform the patient about the different outcomes that are possible in response to different behaviors: for example, the patient will be allowed to go home for the weekend if he drops his suicidal threats; medication will be increased if he behaves aggressively; he will be restrained to his bed if he behaves very violently. Once the patient understands how and to what extent he can influence the staff’s actions and the overall situation, he may have a choice to decide which controlling procedures or measures are least humiliating to him and least stressful to the staff. This kind of negotiation often results in less restrictive measures for the patient.

Many inpatient psychiatric crises signal the patient’s discomfort with his or her situation on the ward. Offering those patients who are not compulsory admitted a number of “vacation days” they can take without having to provoke discharge by showing acting-out behavior can help to prevent escalations.

It is possible to negotiate written “reuptake treatment contracts” (Hollander, Mecklenburg, & Ruth, 2001) with patients who are likely to return to the clinic repeatedly in an acute psychotic state. Such contracts address the question: “how shall we treat you, if next time you are admitted in such a state of mind that makes it impossible for us to enter into any negotiations with you.”

The answers and suggestions of the patient are written down and deposited with the patient, or on occasion with his relatives, with a copy kept in the clinic. Other community services involved with this patient during acute crises may be included in negotiating these contracts. Experience shows that during nonpsychotic periods many patients have very clear ideas how they wish to be treated during times of crisis and confusion.

Integration: Two Clinical Studies

Two short case histories illustrate the integration of family systems approaches into mainstream psychiatric practice.

Acute Treatment: The Case of Mrs. Miller

Having been admitted to the acute ward of a psychiatric hospital 6 months ago, Mrs. Miller is at first unable to converse. After about one week, when her condition begins to improve, she and her husband have an initial conversation with a psychiatrist and a nurse.

Intervention 1: Negotiating about purpose, content and length of inpatient treatment. There is a conversation about what the couple feels may be the reasons for this psychotic episode. They are asked about their expectations and goals for psychiatric treatment, and how long they think Mrs. Miller should stay in the hospital. Together, all parties involved negotiate the duration of treatment, the general treatment goals and some specific details of the treatment plan.

Intervention 2: Negotiating about medication and diagnoses. Mrs. Miller is offered medication along with individual psychotherapy. She says: “I know that the medication will not solve my problems, but it helps me to solve the problems more easily because with medication I am less confused.” Mrs. Miller is shocked when she first hears that her diagnosis is “schizophrenic psychosis.” This does not fit her self-image as she associates schizophrenia with chronic illness, dependency, and passivity.

Rehabilitation Treatment: The Case of Mr. Schulz

Mr. Schulz has been a long-term resident in a residential setting for psychiatric patients for several years. He is not at all keen to engage in the occupational therapy strongly recommended to him by various professionals. He is repeatedly admitted to a psychiatric ward during episodes of acute crisis, often presenting himself aggressively and being seemingly incapable to hold a coherent conversation.

Intervention 1: Contextual and resource-oriented language in case discussions. Mr. Schulz is quite surprised to hear he is invited to attend a case discussion that concerns his treatment. He is expected to listen first. The team is very aware of the patient’s presence, which influences their use of language. The staff members talk about Mr. Schulz in a solution-oriented and respectful manner. At the end, he is invited to make comments or ask
questions. After attending for the first time, Mr. Schulz says he feels strengthened and self-confident. He has listened very carefully to both the critical and positive feedback provided by the team, and he then comments on what he likes and dislikes about the recent treatment and the ideas put forward by staff.

**Intervention 2: Negotiating the amount of rehabilitation activities.** At the rehabilitation center, the staff uses circular questioning to clarify the context of the request for rehabilitation: “Who is it who most wants you to come to this work rehabilitation therapy center—you, your doctor or someone else?” Such questions help to construct an individual agreement regarding the frequency of his attendance and the goals for the joint work. Mr. Schulz estimates that his own interest to engage in “work therapy” is only at 10%, but that his mother’s interest is at 30% and his psychiatrist’s at 60%. As a result, the following agreement is made: “The interest of another person can be a sufficient reason for attending a work rehabilitation program. In the next few days, please consider how great the favor is you want to do to your mother or to your psychiatrist. You can then judge how many days and hours you want to work here.” Mr. Schulz decides to spend three hours every week at the rehabilitation center.

**Intervention 3: Negotiating conflict situations—readmission contracts.** When discharged from the hospital after yet another psychotic episode, Mr. Schulz is offered to negotiate a contract that specifies how he wants to be treated next time, in case he presents himself to the hospital in a very confused state of mind. “How do you want us to treat you when nobody regards you as being a person who is capable to make responsible decisions?” The doctors are surprised how easily Mr. Schulz can express his expectations. This agreement is given to Mr. Schulz, a copy is placed in his hospital file and further copies are sent to two other services, which are likely to be involved in a crisis situation.

**Intervention 4: Negotiating conflict situations—vacation allowance.** Following his discharge, Mr. Schulz returns to his former residential accommodation. He is provided with a “vacation allowance” which he can use when he feels he needs some “time out.” This permits him to retreat from the residential setting for some days, with official consent, and without him having to misbehave, run away, or to threaten with suicide.

**Family Systems Psychiatry and Current North American Models**

Family systems psychiatry, as defined in this project, shares several fundamental principles with two current American models: the community-based systems of care approach (e.g., Pumariega, Winters, & Huffine, 2003) and the recovery model (e.g., Jacobson & Greenley, 2001; Onken, Dumont, Ridgway, Dornan, & Ralph, 2002). In fact, many of the practices described in this article can be seen as an operationalization of critical elements and processes of a recovery-facilitating environment, as described by the National Technical Assistance Center for State Mental Health Planning (Onken et al., 2002).

Like the recovery model, family systems psychiatry enhances choice and empowerment for the patient by promoting transparency as well as reflective and active participation in the treatment process. Self-advocacy and self-determination are encouraged by involving the patient in treatment planning. A culture of negotiation with regard to restrictions, medication, discharge letters, “re-uptake treatment contracts,” and “days off” further contributes to the patient’s feeling of self-determination and supports a collaborative relationship between service users and providers. By focusing on the patient’s concerns and resources rather than on his diagnosis and deficits, family systems psychiatry also individualizes and destigmatizes the therapeutic process, a goal equally aimed at by the systems of care approach and the recovery movement. Offering systems therapy to families and to other important parts of the patient’s social environment supports the maintenance of active social relationships, which is considered another core feature influencing recovery from mental illness. In addition, family systems psychiatry advocates two further core principles of the systems of care approach (Pumariega et al., 2001): family inclusion in assessment, care planning, and service delivery in the least restrictive setting possible. Based on a contextual understanding of health and disorder, family systems psychiatry not only highlights the importance of including the patient’s social environment, but also initiates collaborative work between in- and outpatient service providers at an early stage of the treatment process. It counters the fragmentation of care and often avoids unnecessary hospitalization. Family systems psychiatry thus offers a conceptual and theoretical framework which enables inpatient psychiatric wards to combine recovery-oriented and networking approaches.

**Achievements and Challenges**

Our hospital visits and the experiences and ideas gained at the conference held in 2000 have helped us to identify some major achievements and challenges for family systems psychiatry in Germany. We found that psychiatric patients are increasingly accepted as partners for negotiating their treatment plans. Negotiating with patients about meaning, content and duration of treatment now seems fairly widely practiced, particularly in community-based, nonacute treatment settings. In hospitals, negotiating with patients about how to treat them in acute crises and in likely crisis situations in the future has become increasingly more common. Patients are also frequently offered choices between alternative treatment options and between different components of treatment packages. Staff members increasingly seem to look for the remaining strengths and resources in severely disordered patients.

When it comes to considering the challenges that still need to be faced, these mainly concern the general availability of, and easy access to, family consultation as a psychiatric standard procedure. This needs to be integrated into basic hospital routines and to be offered not only for the patient’s sake, but also to meet the personal needs of the often very burdened relatives or caregivers. To achieve this, it is critical to organize in-house family consultation training for nursing staff. Such training should focus on a systemic understanding of acute psychiatric crises, as well as on ways of positively connoting relapse and chronicity from a systemic perspective, and to communicate this understanding effectively to the patient and his relatives. Patients and family members should be invited more frequently to “their” case conferences, so as to be in a position to listen and to give comments. Finally, family consultation needs to be appropriately funded during inpatient admissions by health insurance companies.
Implications and Consequences for Clinical Practice and Research

During the 1997–2000 period of our family systems psychiatry project, it became evident to us that in order to demonstrate the feasibility and usefulness of this approach, we needed to:

- implement the approach in a limited number of hospitals (3), where the medical directors are actively identified with the approach;
- devise a multiprofessional, multihospital training program for all staff members, including the nursing staff;
- develop a flexible, but manualized clinical handbook, detailing the techniques and procedures used, so that large teams with very differing degrees of clinical experience among their members can use these uniformly;
- and research the clinical outcomes in a well controlled study.

We have since started to put into action these plans within the SYMPA Project (Schweitzer & Grünwald, 2003; Schweitzer, Schmitz, Engelbrecht, Borst, & Nicolai, 2005). The training program is described in Schweitzer et al. (in press). First results indicate an increase in frequency and time of staff-patient therapeutic conversations following the SYMPA training. Video-ratings of staff-patient-conversations showed that systemic interviewing techniques are utilized by staff members more frequently than before the training (for a detailed description of both studies, see Schweitzer et al., in press). Qualitative interviews with 49 staff members revealed that systemic interviewing techniques, like clarifying context, conducting genogram interviews, and holding family sessions, using reflecting teams and generating a systematically inspired culture of negotiation, resulted in an increased effectiveness and intensification of psychiatric work as perceived by the staff (Zwack & Schweitzer, in press). A significant decrease in staff burnout was measured using the Maslach Burnout Inventory. In addition, better team cooperation was found, as measured by the Team Climate Inventory (Brodbbeck, Anderson, & West, 2000; Zwack & Schweitzer, submitted). The treatment effects for patients and their closest relatives are at present the subject of a major outcome study and this research is still not completed.

References


