regarding anorexia nervosa. In bulimia, CBT is superior to antidepressants, waiting-list controls and other psychotherapies, particularly for symptoms of the eating disorder and affective symptoms.

Personality disorders – there have been few trials of CBT. A form of therapy called dialectical behaviour therapy (Linehan *et al.*, 1991) has been found to reduce parasuicidal behaviour in borderline personality disorder.

Psychotic conditions – a number of cognitive–behavioural treatments are beneficial. These include psychoeducational family interventions, which teach patients how to recognize their particular 'relapse profile' and to enhance coping strategies. Direct work in patients with delusions and hallucinations also improves symptoms. For example, compared with treatment as usual, CBT brought about a significant reduction in overall symptomatology (Kuipers *et al.,* 1997). Fifty per cent of the CBT group responded to treatment, compared to 31% of the control group. These techniques have so far been tested in schizophrenia and delusional disorders; trials of CBT in bipolar disorder are currently under way. ◆

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Systemic and Family Therapeutic Approaches in Psychiatry

Sebastian Kraemer

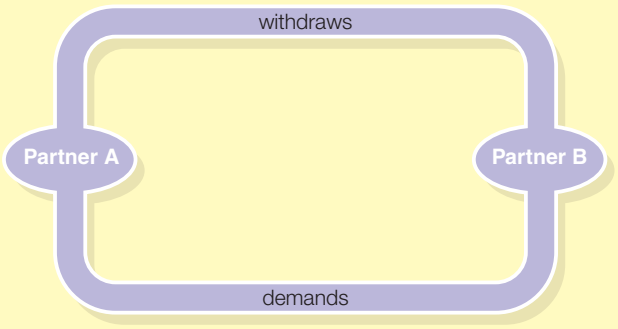
Most doctors are familiar with systemic processes, such as the homeostatic cycles of hormone and temperature regulation. For example, when the level of thyroxine in the blood falls the production of thyroid-stimulating hormone (TSH) is increased; the resulting rise in thyroxine reduces the output of TSH. A system of this kind is circular, with both A and B as cause and effect, in contrast to a linear process, in which A causes B. In human relations this pattern is most easily appreciated in a couple relationship in which one partner criticizes and the other withdraws (Figure 1). Each person feels that he or she is responding to the provocations of the other.

The application of systems theory to psychiatry and psychotherapy is potentially liberating for all practitioners as it becomes possible to look at any clinical problem in a systemic way without formally engaging anyone in therapy.

Cybernetics

Family and couple therapy developed separately but both were profoundly influenced by innovations in engineering and

Circular causality



Adapted from Dallos and Draper, 2000

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technology after the Second World War. Cybernetics, the study of communication and self-governing systems developed from the design of guided missiles. The now-familiar notion of 'feedback' offered new ways of understanding the emotional tensions and (often unconscious) power struggles between individuals in intimate relationships. Instead of asking what started a given situation, it was possible to see instead what kept it going.

Homeostatic systems are common in families where conflict is avoided and where any developmental change, such as the oldest child leaving home, is perceived as a threat to the family's survival. A very different pattern is escalating mutual confrontation (as was evident in the symmetrical escalation of the superpowers' nuclear arsenals during the Cold War) in families or couples where there are high levels of argument and violence.

Looking for patterns instead of causes

Systemic therapy developed theories and techniques that focused more on patterns of relationships and less on causes of pathology, an approach that is counter-intuitive; we naturally tend to look for causes, such as genetic traits and earlier life events. While it is essential to get a life history from the patient, this puts the clinician at risk of passing the blame back to the parents, either because of their genes, or because of what they did to their child.

Blaming parents is common. Not only do young people in difficulties do it themselves, but so do the onlookers of psychiatric and social breakdown – the press, the public, politicians and doctors. The interviewing doctor will usually (but not always) feel sympathetic to a young adult in a psychiatric crisis and take the patient's side against those who have let him down or abused him.

The same applies to a patient complaining about his or her sexual partner. Given the doctor's duty to the patient, it seems right to support them in this way, but it often fails to work. Those who are most outspoken in criticism of their parents and partners are also emotionally bound to them and will not readily accept an echo of the same attacks from a well-meaning outsider. The attachment relationship is a powerful bond even when the participants get on very badly (Goldberg, 2000).

Systemic thinking

Systems approaches offer a way of engaging those who are closest to the patient without taking sides. There are two key strategic questions to address:

- who is asking for help?
- who is in charge?

Who is asking for help? Whether or not the work is with an individual patient, it is always necessary to map the 'problem-determined system' – the people, both relatives and professionals, who have become caught up with the patient's problem. The common currency in almost all psychosocial cases is anxiety, whether the diagnosis is a formal mental (or physical) illness, or a less well-defined problem of disturbing behaviour. Besides family members, there may be others trying to solve the problem in some way, such as neighbours or colleagues, and other professionals – e.g. GP, police, social or voluntary workers, psychologists, and, in the case of children, teachers.

Defining the problem – it is important to define the problem that needs to be solved; this is not always self-evident. Defining a primary task for a family or network meeting is therapeutic in itself and may take some time. At the same time it is necessary to ascertain who in the group is the most concerned, and to specify what that concern is. What does this person think would happen if the symptoms complained of were to continue? Who would be most affected? Asking A to comment on the difference between his view of the problem and B's, for example, opens a rich vein of further questions for the clinician to pursue (this is called circular questioning).

As human beings are social animals intensely preoccupied with where they stand in relation to others, it is perhaps surprising that we tend not to reveal what we assume those closest to us are thinking, except in highly stressful crises such as a major argument or a life-and-death situation. Circular questioning is therefore a powerful probe into family life, especially when any difference between family members is perceived as a threat to family togetherness.

Adult patients may object to such enquiries but it is ethical to ask them if other individuals and agencies are already involved. In complex networks, a clinician who is interested and curious may be more effective than one who attempts to take charge.

Who is in charge? In the case of an adult patient the answer is usually obvious: the adult is responsible for his or her own affairs. Even so, there will be others who have specific responsibilities, e.g. for the care, education or treatment of the patient's children, partner or parents, or indeed for the patient himself. There will also be family members who exert influence, whatever their responsibilities.

If the patient is not an adult or is not fully responsible for him- or herself, it is important to establish where authority lies. In the case of children and adolescents this usually means both parents, even if they are separated or divorced. If the parents were never married the father will have no legal status, but he is usually still significant; he may still be needed – or blamed – by the young person, by the mother, or by both.

In the absence of clearly defined authority, doctors are readily credited with powers which they do not have. Power and authority are often regarded as undesirable qualities, or are projected on to those who can use physical force, such as the police or the army, or legal power, such as the courts. Of course, power can be abused – by parents over children, by partners (usually by men over women), by professional people over their clients, and by the machinery of the law. Yet social systems could not function without the proper exercise of power. Part of the task of family therapy is to support non-abusive (i.e. protective) power, especially in parents.

When anxiety is high, the authority of doctors is called for but is not always welcomed. Not all problem behaviour is due to mental disorder, and not all mental disorder is manageable by doctors alone. This is particularly so in child and adolescent psychiatry, but is also applicable in adult psychiatry, where it is more often obscured.

Therapeutic meetings

In order to be therapeutic in complex cases, it is necessary but not sufficient for the clinician to be interested, friendly and helpful.

There is often conflict about authority and responsibility between family members and between helping agencies. Typically, parents (or parents and grandparents) blame each other. Disturbing feuds can be replicated in the professional network, with the professionals spending more time arguing among themselves than helping the client. Taking a systemic view also involves clarifying what it is not possible to do and being ready to set up, or to recommend, further meetings where tasks can be defined; this is therapeutic in itself. The following must be clearly stated:

- who is to call the meeting
- where it is to be held
- who is to be invited (and why)
- what the primary task is to be.

Systemic approaches are available to any clinician and do not necessarily lead to undertaking systemic therapy.

Key concepts for systemic work

Neutrality and curiosity: the most inspiring contribution of systemic practice is the chance it gives the clinician to see the presenting problem in a fresh light. Given that the clinician is expected to do something about the problem, it is often surprising to the family if he or she shows genuine interest in how the problem is experienced by different members of the family, rather than going through the motions of taking a formal history from the patient alone.

Curiosity is closely allied with neutrality, which entails being equally interested in all points of view. It does not mean having no personal views or concerns, otherwise it would be impossible for the clinician to know what questions to ask. This approach provokes strong and often unexpected emotions in all participants and thus requires training and discipline.

Curiosity and neutrality are not ways of avoiding feeling bad or defeated by the sheer sense of futility that confront all workers in mental health, but rather are ways of processing despair and confusion, one's own and other people's. Nor is a systems approach the only way of doing this, but it has some elegant formulations that can be used in any meeting, especially in family interviews.

Positive connotation means being prepared to see a positive motive behind even the most absurd or damaging behaviour; it does not mean justifying it.

In the case described in Figure 2, Jodie's severe illness has a biological basis, but there is more to it than that. She is also overwhelmed by her obligation to her parents – to help her mother and to be admired by her father. The therapist might be tempted to argue with the father about the origins of mental illness, but would be better noting Jodie's devotion to her parents and the constraint that places her in. If Jodie gets better she is more likely to achieve what her mother never did – going on to higher education. She may receive her father's admiration but that will simply highlight her mother's failure of will, in his eyes, and Jodie's good fortune in comparison. However, reframing Jodie's predicament as an (unconscious) effort to stay close to her mother blames nobody, and means that her parents can be proud of their daughter's loyalty and self-sacrifice.

Why now? While it is necessary to make a diagnosis, the question remains, 'why has this happened now?' A hypothesis about the timing of a crisis is complementary to the psychiatric formulation and involves questions such as:

- who responded to the invitation for a family consultation?
- who decided that help was required?
- who arranged it?
- who was most/least keen to attend?
- what different explanations do people have for the identified problem?
- are family members aware of these different hypotheses?
- could it be worse?
- what if someone else had the problem instead?
- what stage in the life cycle is this family at?

'Life cycle' is a cycle of 'entrances and exits'; of birth/s, starting school, friendships and adolescence, leaving the parent/s behind, forming new couple relationships and producing another generation, promoting parents to grandparents in the process. Eventually the grandparents die, and the parents receive their own promotion. These events sometimes overlap, with births and deaths occurring close together in the family history. Parental separation is increasingly regarded as a 'normal' life cycle event, although it is usually very painful for those involved, and is commoner in psychiatric populations.

Genogram: a family tree (or genogram), composed in the room with all members present, is a powerful and manageable way of getting a shared family history. It should record all conceptions (including miscarriages and terminations) and deaths over three generations, and the key life events in-between (Figure 3).

There will be losses and disappointments to register. What comes next in the family's development? The threat posed by a forthcoming life event is sometimes obscured by the current crisis. 'Future questions' make these anxieties more evident, e.g. in 5 years' time how do you think your mother/father/sibling/child will be? Where will they be living? What will they be doing?

In answer to such questions, Jodie (Figure 2) thinks that if she

Jodie's story

Jodie, 17, presents with symptoms of major depression and is treated with a selective serotonin reuptake inhibitor (SSRI). She is certain that she is so bad that she deserves to die. Her mother has for many years suffered with disordered thoughts and is unable to use her high intelligence. She longed to study for a degree but was too ill to do so.

Jodie has always looked after her mother, but has now broken down at the point where she is within reach of leaving home to attend university. Her mother's psychiatrist has diagnosed schizo-affective disorder. The parents separated when Jodie was at primary school, but her father has returned to care for her mother. He believes firmly that mental illness can be overcome with will power. Jodie agrees with him, which only serves to increase her conviction that she is a failure, because she is still depressed.

How can the clinician think about and best intervene in a complex situation like this?

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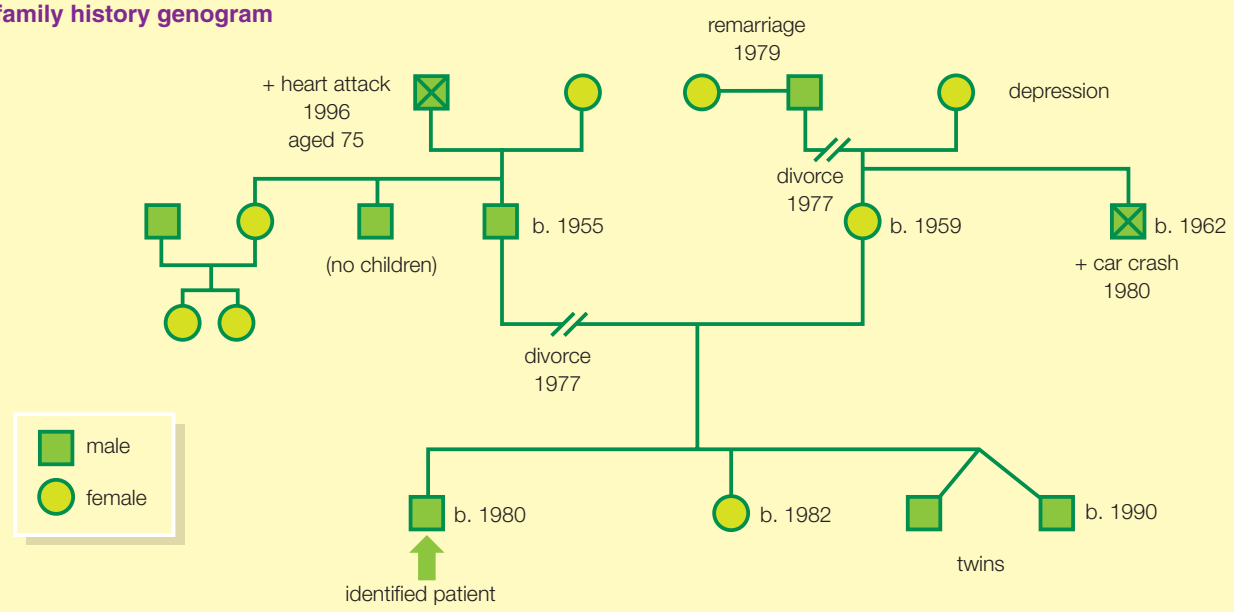
A family history genogram



A genogram records the sequence, and coincidences, of life events – entrances and exits – over three generations.

3

gets better her mother will get worse. She believes that her father would no longer support her mother and her family will fall apart.

Engaging with families

Therapeutic work with people who live together needs to be active, accommodating, open, flexible, challenging, hopeful and, from time to time, humorous. Being neutral is not the same as being stern and cold. Systems therapists cannot hide behind techniques (although they do use them), nor can they mystify their craft (though remarkable changes can occur, quite unexpectedly). A family or network meeting is a unique event and should not be regarded as part of a series of similar 'sessions'. The next meeting may never take place, or it may have quite a different purpose, some different personnel and be in another place entirely. The decision 'what to do next' is a therapeutic task in itself. Family and network consultations provide an opportunity to mark important changes, sometimes even to celebrate them.

A systems approach is not a way of ignoring biological conditions, psychosocial damage or mental pain. Using this approach is compatible with other treatments or psychotherapies (Pinsof and Wynne, 1995). Substance abuse is not a contra-indication.

Family and marital therapy are more likely to be effective when the participants:

- are willing to attend
- do not harbour secrets that they believe will change everything if told
- are not currently violent with one another.

Children and adolescents with eating disorders, psychosomatic disorders and behaviour disorders benefit (Carr, 2000), as do couples when one individual is depressed (Leff *et al.*, 2000). Systemic practice should not be attempted without colleagues with whom the process can be discussed. ◆

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