From Family Therapy to Family Intervention

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KEYWORDS

• Family therapy • Family intervention • Developmental psychopathology

KEY POINTS

- Clinical work with the family must always be part of the identity of the child and adolescent psychiatrist.
- In every case, the child psychiatrist should evaluate for family vulnerabilities and coexisting family strengths.
- The family regulates affect and behavior and shapes the formation of mind.
- The child psychiatrist should assess and intervene with the family enough to understand the patient's context, to communicate with nonmedical colleagues, and to avoid diagnostic errors.
- Families are a core component of resilience: they confer genetic/experiential protection against genetic/experiential risk.

The term, *family therapy*, has been part of psychiatric lexicon for several generations, yet it may have outlived its usefulness. For many, the term conjures up the notion of all family members being present for each session, but the field has been moving away from this very specific meaning. The seminal idea of the "family as a system" is no longer the sole theory guiding family work. The systemic perspective sees individuals in a family system as interdependent, with no change occurring in a family without everything else changing accordingly. Analogous to the overreach of interpretation in the history of psychoanalysis, systems interpretations became overused.

Although the system remains a viable and important construct, there are now other ways that clinicians work with families. Some of the terms used to encompass this trend include *family treatment*, *family-centered treatment*, *relational processes and disorders*, *family psychiatry*, *family skills enhancement*, *family intervention science*, and *parent management training*.[1]

The term family therapy has become problematic in that, for some, it communicates that it is the province of the nonmedical therapist, marginalizing its significance.

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Ironically, the family's systemic properties are congruent with numerous physiologic mechanisms (eg, increase of heart rate with a drop in blood pressure). Equally problematic, for many clinicians, family therapy communicates a specialized set of skills, even esoteric, that many practitioners feel ill equipped to implement. This article proposes the use of the term, *family intervention*, to encompass the many ways contemporary clinicians work with families beyond the activities connoted by family therapy.

Family intervention is defined as a coordinated set of clinical practices designed to alter family interaction, family environment, and parental executive function. This collaborative intervention utilizes parents, child, and siblings to strengthen protective factors and mitigate family risk factors associated with child and adolescent psychiatric disorders. In addition to the amelioration of symptoms, family interventions typically address any factor that impedes child and adolescent development.

Contemporary clinicians face a question not contemplated in previous generations: what is a family? There are many changes in the contemporary family that are fully reviewed by Sargent.[2] For the purposes of this article, the term, *family*, refers to individuals who have regular contact with its children and assume the responsibility of meeting their developmental and emotional needs. The term family implies biological, affective, and legal bonds, occurring together or separately. The term, *parent*, refers to the individuals who make decisions on behalf of children. In this article, the terms, *child* and *children*, refer to any individual younger than 18 years of age; hence, the use of child includes adolescents.

The family must be considered in each case. Avoiding family work, under the guise, "I don't do family therapy," is not an option. In each clinical encounter, the clinician must consider the ways in which the family ameliorates or exacerbates psychiatric symptoms. What is the most appropriate family intervention? What are the target points for a family intervention? Who implements it? What is the knowledge base required of a clinician for a safe and effective intervention? This article responds to these questions and prepares readers for this issue's discussion of family work in specific disorders by providing an overview of the next paradigm in family treatment.

CHALLENGES FOR THE CLINICIAN MAKING A FAMILY INTERVENTION

Many contemporary challenges take psychiatric clinicians away from a family focus. These include but are not limited to

- The promise and peril of empiricism. "Not everything that counts can be counted, and not everything that can be counted, counts" (Einstein).[3]
- Family-based treatments must follow the available evidence, yet there are helpful family interventions that may not have been studied. Such interventions, addressing known risk factors, cannot be assumed to lack efficacy.
- The frequent use of medications, and the aggressive marketing of them,[4] has directed attention away from psychosocial interventions[5,6]
- Reductionism limits seeing the big picture.[7–11] Scull has noted, "a simplistic biological reductionism has increasingly ruled the psychiatric roost. Patients and their families learned to attribute mental illness to faulty biochemistry…It was biobabble as deeply misleading and unscientific as the psychobabble it replaced."[12]
- Contemporary psychiatry provides less time for understanding patients, gathering developmental histories, and carefully developing clinical case formulations
- The "med check" approach severely limits a gathering of data that allows a family formulation.
- Psychiatric diagnoses often lack relational context and suffer from oversimplification. Disorders are reified when a developmental explanation is more