**Case report**

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# The Gothenburg Model of Family Work in Psychiatry:
# A Brief Introduction to Methodology and Theory

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## Abstract

In this paper a model of family work, developed in the western parts of Gothenburg's psychiatry, is described. The structure of the model, examples of patient cases and inclusion criteria are included. The model was developed during twenty years of clinical practice. The utility has been proven in practice for a wide variety of serious psychiatric conditions. The model is highly structured and therefore easily explained and transferred to others. The possibility to be able to offer family treatment adds to the work satisfaction by helping to moderate the conditions for team members who work with patients with highly complex and serious symptoms, and by offering the practitioner a strong alternative to the individualized approach to treatment of hardest and most worrying cases.

The prediction of the efficacy of the model is that it is to be shown equal or superior to other treatment interventions in psychiatry.

## Background

Historically, in 1988 the inpatient department "83", at the psychiatric clinic at Sahlgrenska University Hospital, was a five-day-ward led by a Professor/Senior psychiatrist, Tore Hällström, who introduced the notion of 'family work' to the hospital. Accordingly, the department began working with the families of patients under treatment. Particular insights from the existing literature and daily routines into family work were contributed by Paula Frenkel, the counselor and family therapist on the ward. She was specialized in working with families through education by Karl Gustaf Piltz and Kristin Gustavsdottir. When the ward was closed in 1997, the way of working with families was moved to the newly opened specialized outpatient unit Psykiatriskt Öppenvårdscentrum, where the method took its final form. The author was active in introducing the method, in training other team members, and in modifying the method when needed.

The model was formed and modified on the basis of participant observations of how a therapy intervention was tolerated and helpful in the work with real families. Any intervention that was judged as having a negative influence on outcome (formulated goals) was changed or omitted from the model. Elements of the practice are derived from existing management thoughts and therapeutic traditions. For example the long latency between sessions is inspired by the Milano School of family therapy [1]. The analysis of intervention level is derived from Maslow's formulation of the hierarchy of human needs [2]. The highly structured goal formulation was inspired by the rational of the SMART model [3]. The stipulation of treatment gains for renewal of treatment episodes is an intervention in Dialectic Behavior Therapy [4]. The approach to treatment time is inspired by the different short term therapies of cognitive and dynamic origin.

## Short History of Family Therapy

In his book" The possible and impossible psychiatry", Crafoord and Stödberg [5] writes about the long tradition in psychiatry of individualized treatment. The family was seen as an entity the patient should be isolated from, due to its potentially destructive influence.

Family therapy, where a patient instead of being isolated from the family was seen as a part of a family system, originated from the early research in cybernetics conducted primarily in the United States. Cybernetics was defined by Wiener as "the science of control and communication, in the animal and the machine" - in other words, as "the art of steermanship" [6]. The definition provided a theoretical framework for any kind of mechanical or biological system. Gregory Bateson, an early worker in systems theory, applied this general framework to psychiatry, introducing the notion of the family as a system in a cybernetic sense. In the article "Toward a theory of schizophrenia" [7], Bateson described the work with a young schizophrenic man, who after a visit from his relatives, suffered an anxiety attack. Here, the theory of the double bind was introduced, taking the first step towards the concept of family therapy. Double bind refers to a communication paradox where certain conditions are present: (i) the victim of double bind receives contradictory injunctions or emotional messages on different levels of communication, (ii) metacommunication is impossible, (iii) the victim may not leave the communication field, and (iv) failures to fulfill the contradictory injunctions are punished, e.g. through withdrawal of love.

Originally, there was a strong impetus to highlight the differences rather than the similarities between family therapy and the older psychoanalytic models. Crafoord and Stodberg [5] was inspired by the Mental Health Institute in Palo Alto to develop environmental therapy, and others followed, like the Ackerman Institute in New York that, in turn, inspired Johan Cullberg who brought back a video to Sweden in 1968.

In the 50´s, in the USA, work with families started independently in several different places. The older, purely individual psychological theories were no longer suitable. Instead, the newer developments in systems theory were better equipped for descriptions and work with multiple relations.

"Transparency" of treatment was facilitated through this procedure with a more openly communicative therapeutic climate. Access to the therapy rooms for team members was expedited through the use of one-way mirrors or video cameras.

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Kristin Gustavsdottir and Karl Gustav Piltz [8] formed the practice of family therapy in Gothenburg mainly by their tutoring of mental health workers in Gothenburg psychiatry. The author was one of the students of these lectures and workshops. They summarized their work in the book "The invisible family, partner or scapegoat" [8]. It describes a family model developed during several years of tutoring and consultation at the psychiatric clinic in Angered, Gothenburg, Sweden. They are both licensed family therapists, who since 1973 have run the institute for Family Therapy in Gothenburg offering treatment and training in family therapy.

## Family-work: The Gothenburg Model (GFW)

The starting point for family work in psychiatry is the situation that at least one person in the family is suffering from a severe mental illness or disorder. This perspective is invariably the starting point despite the suspicion that the situation with couples or families (hereafter called family) may be more "complex". Thus, the patient's relatives are contacted on the assumption that: "The patient has symptoms, we want your cooperation in order to understand (history), or help to improve the situation (treatment)".

- The "need for contact" can often be "taken over" by the specialized outpatient unit (SOU), through formulations such as "We, the SOU want/need this contact". The family thus acquires the role of "experts" and is not threatened by any danger of blame. This simple approach increases the possibility for a good and productive relationship with the patient's closest network, which is of crucial importance to the patient's continued health and development.

The procedure for family work is tightly structured in its form:

### Step one

Once a referral has been prioritized and suggests possible family work, the procedure may begin. Two therapists are selected. The therapists choose an occasion to discuss the referral. In this discussion, they seek hypotheses concerning the total situation. How may this referral be understood? What information is missing? The therapists choose if and how to demarcate the family, i.e. to start with just the parents in a family, the children in the family and so on.

The invitation is preferably formulated in a separate letter, which also explains the time frame and the purpose of the investigation. The letter may suggest the necessity of three exploratory visits, 1.5 hours per visit with the SOU address and the responsible Investigator.

### Step two

When the family has been invited the next step concerns management of the reactions to the invitation. These may include the declaration of one party that he/she is not willing to participate, messages from certain parties who wants to provide "secret information" about the party (ies), and a multitude of other therapy-interfering actions.

The SOU (the team) always refers all contact with family members directly to the responsible professionals of the case (therapist or co-therapist).

## The Initial Three (or Four) Visits

The objective of the first visit concerns mutual acquisition of knowledge, never intervention nor promises of continuation beyond the first three visits. It contains the introduction of the therapists themselves, the framing of the meeting, the purpose of the three visits, and the time frame (1.5 hrs per visit).

During the interview a neutral approach with systemic interview techniques is presented. The interview begins with a "framing". The purpose of framing is to reduce uncertainties inherent to the situation and to create a meaningful context.

A frame may sound like this: "According to the letter (referral) that we received from Dr. A, the patient seems to have been bothered by x (specified), during this period. We wish to find out as much as possible about your situation, to help plan for continued treatment for the patient".

The first question is often about identifying problems/difficulties:

"Can you tell us how you view the problems? Would you start (pointing to someone in the family)? How would you describe the problem?"

Then the question is repeated for the rest of the family:

"Do you have anything to add to this description? Tell us how you understand the situation". Do you think X described the situation accurately? Can you complement/add/change this?

"As an alternative input (i.e. if you want to stimulate empathy) it may be advantageous to use a cross-over hypothetical question:

"How do you think that Y (your partner) would describe the difficulty?" After which the other members of the family may suggest corrections / add their perspective and so on.

For a more detailed explanation of the technique of systemic interviewing, see the methods section. During the first interview the therapists seek to gain information about:

- Actual conflicts/difficulties/problems/issues

- The family members

- Sometimes the family's extended families and their cultures

- Vulnerability factors (Economy, relationship conflicts, mental symptoms and its impact on the family, communication style).

At the end of the visit arrangements are made for a return visit, usually about four weeks after the first. There are many reasons for the long interval between the first and the second visit.

- Changes have often already been initiated as a consequence of the letter the family received before the first visit. Change/blocking processes increase further after the first visit and need time to mature.

- Family work is not a psychosocial "acutely supportive" intervention, i.e., the intention is not to compensate for the defects in the family function. The family must never rely on rapid and concrete help from the therapists. However, the therapists may need to seek support for the family, and discuss the needs with the rest of the team.

After the first visit, the therapist and co-therapist "brainstorm" about the visit, generate hypotheses and observations and formulate questions about what is still unclear and clarify what information is missing. They also make decisions about who shall document the visit.

Before the second visit, therapist and co-therapist must examine the notes in the medical record, update the case and update current issues.

The second visit aims to further fill gaps in knowledge and to test hypotheses generated from the first interview.

After the second session: The therapists summarize the interview with their conclusions on the 'family matters', discussing possibilities for change and any suggestions that may be offered to the family. These are summarized in the patient journal.

Prior to the third visit (approximately four weeks after the second visit) the therapists meet to review the notes from visits one and two.

During the third visit, the therapists convey their views on the situation to the family. This view should be adjusted/supplemented/confirmed by the family. The future is discussed together with any desire for change that the family has expressed.

This meeting may possibly formulate common treatable/accessible targets (very important or critical issues) and any methods that are to be used are explained. The deadline/evaluation time is always thoroughly discussed.

Any treatment ought to be preceded by diagnosis, i.e. formulation of the problem that awaits intervention. This part of the work will require high competes and experience of the therapists. They should take an active part in the formulation and use a good portion of "negotiation" here. The skill and competence of the therapists is often reveled in this part of the procedure. The treatment plan specifying aims, methods, and evaluation date. This plan must be comprehended and agreed upon by the family. Patients should maintain an understandable and meaningful copy of the plan before the treatment begins (Appendix A).

Many families are ready to present goals and to accept treatment offers. Some families are satisfied with the investigation thus far provided and decide they can work on the identified issues by themselves. Others require more time to discuss among themselves. If it is not possible to reach a common goal/understanding (whether the family fails to do it between themselves, or that therapists cannot "negotiate" a reasonable achievable goal), a fourth visit may be planned. The premise is that the treatment method should be based upon patient requirements rather than therapist preferences.
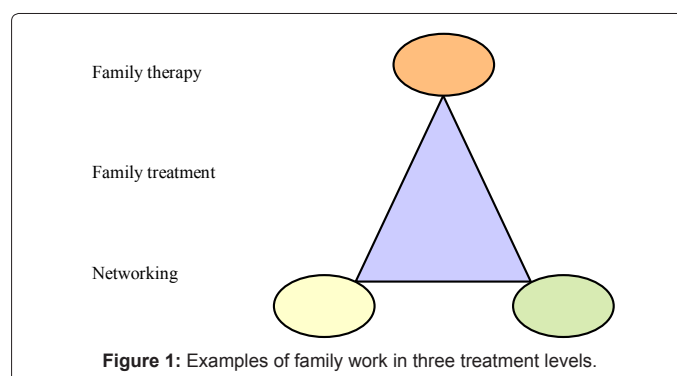
## Treatment

In the treatment of couples or families in psychiatry a wide spectrum of problems may be presented. The level of intervention must take the needs of the family into consideration. In the Maslowian way of thinking basic needs has priority before "higher" needs. That implies that the therapists have to judge the needs of the family to choose the correct intervention level and goal formation. Before other interventions are implemented the life, security and provision of basic needs of the family members is prioritized (Figure 1).

## Networking

*Networking is a Swedish term for active collaboration between professionals i.e. the social services or patient organizations or other support organizations, but also persons like friends to the family/individuals, in order to achieve sustainable solutions for families or individuals in the family.*

A man, aged 60 years, sought emergency psychiatric consultation after his son´s suicide. The diagnostic work revealed that the man behaved very atypically in the contact with the doctor during visits. He was diagnosed with "atypical grief reaction". During follow-up it was suspected that he had since his early years suffered from high-functioning autism, which was masked and compensated for by a high intelligence. His wife, who had never developed a close relationship with her husband, had in the previous years had an organizing function in the home. She now felt physically threatened by her husband and



**Figure 1:** Examples of family work in three treatment levels.

wanted a divorce and separation. The goal of the "treatment" developed into the preparation of the social services for a new client. It was quite clear that the patient did not have the capability to manage a household on his own, nor to take care of himself, and he also showed serious self-destructive behavior.

## Family Treatment

A patient in her thirties developed a severe psychosis a few days/weeks after her second childbirth. Her husband developed a severe crisis, while the patient was treated in hospital. He had no knowledge of psychiatry. The husband had a child at the age of three and an infant to take care of in addition to worrying about his wife.

The treatment goal was to support the husband by explaining his wife's symptoms and treatment, to support him in the role of a responsible parent and to reintroduce the mother slowly in the role of mother/wife in the family.

## Family Therapy

A couple wherein the husband was a trained physician and the wife worked as a teacher came for consultation; they had teenage children. Both the husband and the wife had been treated in psychiatry because of moderate symptoms in the affective spectrum (Depression/Anxiety disorders).

The aim of treatment was directed towards the development of communication skills between the spouses in order to increase their ability to give and accept comfort/intimacy and to reduce the risk of progressive symptoms (i.e. free resources), in accordance with the notion that "partnership relation quality modulates the effects of work-stress on health" [9].

## Ending Treatment/Conclusion

When the time to terminate the treatment period approaches, the therapists must specify how many visits are left and also the date of completion/evaluation of treatment.

Prior to the termination/evaluation visit, the therapists meet to prepare.

During the last visit the family is reminded of why the treatment started, the objective that was formulated is discussed and the length of the treatment is stated.

The interview revolves around the extent to which the family has moved closer to the treatment goal(s). What has been satisfying and what has been less satisfying with the treatment? Has the treatment goal been achieved?

Sometimes the family is satisfied with the treatment. At other times

the family needs to work with new targets. If this is judged to be a priority, discussion ensues (treatment planning).

Even if the family has not moved in the direction of the treatment goal, the family treatment is still terminated, with a common closing routine.

The main principle is never to continue a treatment that does not produce a response. Another type of treatment / action may have to be considered.

The treatment and its results are summarized in a separate closing note; (Appendix B). This note can be sent to the family after the treatment is terminated.

## Method: Systemic Interviewing

Interviewing with "systemic" or circular questions is enjoyable and relieving. The method helps to maintain a therapeutic perspective and often leads to laughter and smiles. The interviewer "plays" with the basic assumptions that exist in a given situation.

The method of interviewing can be learned fairly quickly, but the systemic "posture" often takes time to develop and generally requires a combination of theoretical training and practice. The systematic formulation always challenges assumptions about the relationship between cause and effect. It is assumed that for changes to occur the traditional formulation is merely an assumption, inadequate and 'ripe-for-challenge'.

The difference between a "linear" (or traditional) question and a systematic question can be exemplified:

The linear posture is that there is an obvious cause -effect relationship.

The question: "Why did you hit your wife?" is an example of this. Implicit is an assumption that the aggressor is an expression of some type of disorder/illness/weakness, whereas the recipient is a passive victim of the aggressor (operator). The relationship may be seen as dichotomous (either or) or unbalanced.

The operator is placed in the role of the strong, the evil or the sick (impulse control disturbance). The receiver is placed in the role of the weak, good or healthy.

However, this account represents only one of several possible. Even though it is the most common and well-rehearsed, an alternative approach may not be less true.

The question: "How did your wife entice you to make a fool of yourself in this way? How did she go about it in detail?" describes a different assumption: That in every relationship (system), which operates over time, cause and effect change in patterns that may have different characteristics. It might be less important to determine how a pattern starts, and much more interesting how these patterns change or maintain stability over time.

Systemic interviewing is both an information-collecting method and a therapeutic tool when used properly [10].

## Indications for Family Work

The following enumeration present conditions under which family work may be more advantageous than individual treatment strategies:

- When there are signs that the individual treatment falls into difficulties (e.g., discomfort from the therapist) or if the patient presents extremely severe symptoms.

- When an SOU at the same time receives referrals from various places or repeated requests concerning the same patient.

- When relatives spontaneously contact the SOU to mediate pain or anxiety.

- When the patient lives in his/her parents' home.

- When the main conflict/problem is described as problem in the patient's relationships.

All aspects of psychiatric problems can be worked with in a family setting, including psychotic symptoms.

## Documentation

In all family therapy, the adult members have their own journal and pay patient fees. This means that when one leaves the investigation phase and proceeds into the treatment phase, a journal must be established for the family members. Often a copy of the family interview is placed as the first note in the relatives "patient" journal.

## Discussion

The result of this work is formulating of the simple principles of the treatment practice.

We have found that it is both enjoyable and effective to work with GFW model with families in psychiatry if one can overcome bureaucratic, practical and ideological barriers that often hinder this work in adult psychiatry. This method has shown to work with a wide variety of psychiatric conditions, including psychotic disorders and has become a valuable additional tool in the treatment arsenal in psychiatry. We argue that any psychiatric treatment facility ought to be able to offer family treatment not just for the wellbeing of the patients but also for the wellbeing of the staff working in mental health facilities. The possibility to be able to offer family treatment has been an important part of moderating the working conditions for team members working with patients with highly complex and serious symptoms, by offering individual practitioner team support of the individual treatment of the hardest and most worrying cases.

In the future, the GFW might be a preferable model of family intervention in psychiatry because of its understandable, functional and highly structured way of working.

To evaluate the efficacy of the model it has to be compared to other treatment-approaches applied to similar cases. The intention of this paper was to formulate a model, which can be tested against other treatment methods.

It is our firm belief that GFW in comparison to other methods will prove to be equal or superior to other treatment interventions. It is predicted to have a faster treatment effect than individual psychotherapy and a more lasting effect than pharmacological treatment.

## Appendix A

### Guidelines for treatment planning[*]

The treatment plan might be the most difficult and complex journal document to produce. The treatment plan should state the *family's problems* and treatable issues which are translated into achievable treatment goals with existing therapy recourses. Formulate *treatment goals* that are realistic, based on existing treatment facilities, motivation and need of the family.

This is perhaps the most difficult part of a treatment planning. The goal need to be highly specific (Specific) and essential for the patients

in order to motivate, but also realistic enough (Attainable) that the therapists actually believes that the goal can be achieved.

In unclear cases it is justified to extend the investigative phase, instead of plunging in to a treatment with unclear/unrealistic goals or plans not in accordance with the needs of the family (Relevant). Timetable for the treatment and point of *time for evaluation* is established (Time bound). Description of the planed manner to achieve the treatment goal is also formulated.

When the goals are well formulated and specific they are also measurable. The answer to the simple question: "How do you know that this goal is reached?" will guide the mode of measuring change (Measurable). If this question can't be explicitly answered, then the treatment plan isn't ready.

*The guidelines are highly inspired by the SMART criteria's for setting objectives often used in project management and personal development. SMART refer to five criteria's for goal formation and include Specific(S), Measurable (M), Attainable (A), Relevant(R), Time bound (T).*

## Appendix B

### Closing statement (epicrisis) in outpatient work

Although the epicrisis work is strenuous and time consuming it can be an important quality assurance tool. It can also be a valuable basis for treatment of cases that are later to be treated in other psychiatric clinics or after long time intervals.

In the epicrisis the experience gained during treatment is summarized at the time when the matter is fresh in memory. It can provide a succinct yet pregnant synthesis of large and unattractive text masses in the journal. The epicrisis should be compiled when the treatment of a patient is ended, regardless of whether this comes about due to the active initiative of the clinic or the patient, or through passive behavior of the patient (staying away from planned visits; i.e., when one is quite sure that the patient will not reappear).

- It might include:The background to the treatment at the clinic and by whom and when the patient was referred.The kind of problems that emerged in the referral and initial assessment at the clinic (Both the degree and type)

- A description of the temporal structure of the treatment (when it started, time patterns and other agreed limits).

- Descriptions of the treatment process goals, content and possible complications.

A summary of the results of treatment with an overall assessment and a conclusion and reflections regarding possible future treatment needs and, if possible, recommendations to future reader or readers at another institution.

### Acknowledgement

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