A MODEL FOR PSYCHIATRIC CONSULTATION IN SYSTEMIC THERAPY*

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INTRODUCTION

In the early decades of the discipline, many family therapists hoped that restructuring family relationships would prove curative for most psychiatric illnesses. By the end of the 1980s, however, most family therapists were acknowledging more complex perspectives, including the view that adequate explanations for psychiatric illness must often include impaired brain physiology as a contributor to psychiatric symptoms. Today, many family therapists who twenty years earlier derided psychopharmacology work collaboratively with psychiatrists who prescribe medications.

However, changes in the language used to describe clinical problems often lag behind changes in clinical practice. This is particularly true in collaborations between systemic family therapists and psychopharmacologists. Systemic therapists and psychopharmacologists use quite dissimilar ways of construing a patient's problem, and the different metaphors used to describe the problem can be fundamentally incongruous. This incongruity may be problematic for family members who are presented with language from multiple systems of meaning in the absence of any overarching description that includes all the perspectives.

We are interested in the kinds of metaphors with which problems are described when family therapy and psychopharmacology are employed together. We have identified coupling metaphors that support both family therapy and pharmacological therapy as valid treatments and exclusionary metaphors that invalidate one approach or the other. We have designed a consultation model for psychiatrists consulting to family therapists wherein the psychiatrist utilizes a coupling metaphor to frame the problem whenever prescribing medications to a family member in family therapy.

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COUPLING METAPHORS

Metaphors contain implicit assumptions about reality. When metaphors are used to describe human problems, these assumptions give birth to a particular story of the reality of the problem. Coupling metaphors create stories of a problem in which it makes sense to work at the problem from more than one perspective. The language systems out of which each perspective arises are coupled in the metaphor. Introduced into a psychiatric consultation to a family therapy, a coupling metaphor creates a story of the problem in which it is reasonable to seek change in both the physiological domain and the social domain in order to resolve the problem.

Useful coupling metaphors that may arise when considering the use of an antidepressant include:

1. Psychophysiological Metaphor—“Perhaps you have been under so much stress lately that the systems of your brain built to process worry and stress are exhausted. This medication may help to replenish the chemical stores of these systems to their normal baselines so that you will have the resources needed to work on the problems of your life that got you so run down in the first place. Then you can work effectively in your psychotherapy.”

2. Stress-Diathesis Metaphor—“Since your family history is so strong for depression, you may well have a greater biological vulnerability to depression when stressed than the average person you meet on the street. It would seem to make sense for you to take this medication in order to render yourself somewhat less vulnerable while continuing to work with your therapist to create a way of living that will protect you from stress.”

3. Metaphor of the Protective Physiological Reflex—“Some types of reflexes appear to be built into the brain for self-protection. They make sure that important brain systems shut down if the amount of life stress reaches a particular level. Perhaps your depression is like that—it takes you out of commission and puts you into a kind of “hibernation.” It may make sense for you to take this medication now to buffer the influence of your life stress upon your nervous system, but it is also important for you to find ways, with your therapist, to lower the level of stress you experience as you go through the rest of your life.”

4. Metaphor of the Externalized Problem (White, 1986b)—“I understand you have been badly depressed. Has the depression invited you and your family into any bad habits that have added to the problem?” There are two implied phenomenological domains here—that of “depression” which reasonably might be treated with medication and that of “bad habits” which reasonably would require behavioral change through psychological or social approaches.

All four of the above metaphors contain presuppositions about the reality of the problem that are consistent with possible use of both medication and psychotherapy. However, exclusionary metaphors, some of which are commonly used in family therapy, invalidate problem descriptions made from either the psychobiological domain of medical psychiatry or the interpersonal domains of family therapy, or both. Exclusionary metaphors include:

1. Disease Metaphors—“You have a chemical imbalance in your brain,” or “You have a disease called Major Depression that needs to be treated.”

2. Misbehavior Metaphors—“I don’t know about depression, but I do see that your husband does not spend much intimate time with you or fulfill his job commitments” (Haley, 1980; Madanes, 1981).

3. Family Game Metaphor (Fisch, Weakland, & Segal, 1983; Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1978)—“I would worry if you became less depressed.
too quickly. Your husband might feel less of a man if you were more assertive, and your children might find it difficult to learn independence if you were keeping close tabs on them."

4. Addiction Metaphor—"You are depressed because of your addiction to a dysfunctional relationship. You must break through your denial, confess your powerlessness, and get back to your 12-step program to recovery."

5. Metaphor of a Spiritual Problem—"Your depression is evidence of your lack of faith in God to heal you."

Each of these five types of metaphors disqualifies either the use of medications, or the use of psychotherapy, or both, by creating a story of the problem in which the excluded treatment is nonsensical as a solution.

A CONSULTATION MODEL

In our approach for psychopharmacological consultation to systemic therapists, the decision whether to seek a consultation is made collaboratively by the systemic therapist and client. The psychiatric consultant and client then meet, typically for one hour, with the consultant initiating the conversation by relating the consultation request received from the therapist. The consultant then frames the encounter by describing the client’s work with his or her therapist as an effort to find a solution through understanding the client’s life story; the psychiatric consultation will seek instead simply to understand the pattern of symptoms—what kind, when they occur, how intense they are—because this information predicts most reliably whether or not a specific medication might be helpful. Psychobiological information is then elicited through a chronological history of the pattern of symptoms and their progression, a family history of similar symptoms, a history of past medical and psychiatric illness and treatment, and administration of assessment instruments, such as the Hamilton Depression Scale (Hamilton, 1960) and Hamilton Anxiety Rating Scale (Hamilton, 1959). When sufficient diagnostic information has been gathered, the consultant discusses treatment options with the client in the manner of a “cost-benefit ratio” of probable benefits in symptom remission versus monetary expense and medication side-effects.

During the consultation, the psychiatric consultant listens carefully to the client’s descriptions and explanations of the problem. If the underlying metaphors are coupling metaphors, the consultant adopts the client’s language, building upon it in the ensuing conversation. Otherwise, a coupling metaphor is introduced.

A report of this consultation dialogue is transmitted back to the therapist to be incorporated into the dialogue of the therapy. If the consultation dialogue cannot evolve into a mutually acceptable problem description that arises out of an adequate coupling metaphor, then the consultant recommends postponing a decision about medication, referring the matter back to the therapist and client for further discussion.

SYSTEMIC THERAPIST SATISFACTION WITH THE CONSULTATION MODEL

As an initial assessment of the usefulness of this consultation model, we sought to determine the degree of therapist satisfaction with psychiatric consultations among 10 therapists in a private practice community counseling center. This community counseling center offered structural and strategic family therapy to clients and constituted the teaching faculty of a marriage and family counseling graduate program at a local college. Forty consecutive psychiatric consultations over an 18-month period were evaluated, 29 of which were specifically for psychopharmacological consultation.

Each therapist completed a 20-item questionnaire about each consultation, describing the impact of the consultation upon the therapeutic alliance, the client’s and the
therapist’s original perceptions of the problem, any changes in these perceptions following the consultation, and therapy outcome. An independent study administrator maintained therapist anonymity for their responses.

 Frequencies of responses and group means were computed for each question in the questionnaire. A Fisher’s exact test was utilized to compare “the extent to which the request was answered by consultant,” “the change in client’s perception of the problem,” and “the change in the therapist’s perception of the problem” across measures assessing impact of consultation (“change in the speed of the therapy,” “improvement or deterioration in the therapeutic alliance,” and “strength of impact of therapeutic interventions by therapist”).

 Following the psychiatric consultation, the clinician in 93% of the cases reported that his or her consultation request had been largely or completely fulfilled by the consultant. Several clinicians spontaneously related narratives of past negative experiences with other types of psychiatric consultations in other settings when the psychiatric consultation damaged the psychotherapeutic process.

 In 64% of cases the alliance between client and clinician was described as strengthened following the consultation; only 4% reported it to be weakened. In 67% of cases therapeutic interventions were reported to have had a greater impact than previously. Variables that correlated most highly with improved therapy outcome following psychiatric consultation were (a) change in client’s perception of the problem ($p = 0.004$), and (b) change in clinician’s perception of the problem ($p = 0.023$). In only a single case did pharmacological treatment appear to have disrupted the progress of a family therapy. In this case, in which the family ceased family therapy following remission of a teen-aged son’s hallucinations with antipsychotic medication, the clinician rating the consultation negatively commented, “The real problem was masked when the family labeled the symptoms as a chemical or biological problem, which was solved by the medication.”

 In the absence of patient outcome measures and a comparison treatment group, we cannot draw conclusions about treatment efficacy or make comparisons between other consultation models and the approach presented here. However, this strongly positive response by systemic therapists in a community setting suggests that this approach may offer useful possibilities.

REFERENCES


