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Family Therapy in Developing Countries Primary Care

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Abstract

Purpose: Mental health and psychosomatic problems are both widespread and disabling in low and middle-income countries (LMIC). There is a clear need for strategies to strengthen first line services for their treatment. Family ('systemic') therapy has been shown to be effective in this setting but there is a dearth of research investigating its use.

Methods: A family therapist, psychiatrist by training was interviewed by a public health doctor specialized in health services organization, to derive concepts useful for GPs and nurses working in LMIC first line services to handle the relational and emotional component of bio-psychosocial care. The interview was supplemented with a literature review.

Results: Concepts in systemic therapy conditions dealt with by systemic therapy are detailed together with basic concepts in systemic approach e.g. symptom persons, family homeostasis, neurotic vs. psychotic families, therapeutic resources, circular questioning, reframing, paradoxical injunctions, therapy steps, strategies to accompany changes, and required organization features.

Conclusions: First line professionals can be involved in the treatment of psychic and relational disorders without in-depth preparation. Family/systemic therapy appears more effective than psychoanalytical techniques in LMIC because there is limited tradition of introspection in LMIC, and families in LMIC remain strongly structured and a key social safety net.

Systemic therapies can have an important impact on quality of care where health professionals have no tradition of properly handling bio-psychosocial disorders and improve doctor-patient communication. However, more experience is needed to define the conditions for its optimal utilization in LMIC.

Keywords

Family medicine, Mental health, Health systems strengthening, Family therapy, Systemic therapy, Low and middle income countries

Abbreviations

AIDS: Acquired Immune Deficiency Syndrome, GP(s): General Practitioner(s), LMICs: Low and Middle Income Countries, NGO(s): Non-Governmental Organization(s), TB: Tuberculosis, WHO: World Health Organization

Introduction

Mental health and psychosomatic problems are both widespread and disabling in low and middle-income countries (LMIC) settings [1-3]. Up to 30% of patients attending primary care facilities in LMIC present with common mental disorders [4-6]. In addition, many other pathological conditions known to be made worse by mental factors (e.g. psoriasis, eczema, stomach ulcers, high blood pressure, and heart disease) require bio-psychosocial treatment [4]. Consider an asthma crisis in a child: like a regulatory shunt in an overloaded electric circuit, it often occurs when there is a need to diffuse tension between the parents.

However, in LMICs, mental health (for instance depression [7]) receives little attention [8,9] and scant resources [10]:

- In most LMICs less than 1% of the total health budget is allocated to mental health [10];
- There is no more than one psychiatrist and one psychiatric nurse per 100,000 people;
- There are even fewer psychologists and social workers working in the mental health field [11].

There is thus a clear need for strategies to strengthen LMIC first line services for the treatment of mental health problems and for the promotion of bio-psychosocial care [12,13].

A patient-centered perspective in primary care practice is barely reflected in medical curricula. Doctors in LMICs have rarely been exposed to concepts useful in the handling of individual psychological and family relationship disorders. Many tend, at the first opportunity, to refer any mental disorder to a hospital or a psychiatrist without having tried to solve the problems themselves. Because they lack the related concepts and practical tools, communication is rarely perceived as an intellectual challenge, even less an indispensable therapeutic tool [1]. This is true, despite established links between patient-centered care and positive outcomes of healthcare delivery, including patient satisfaction [14], resolution of patients' concerns and health outcomes [15,16] in both high and low and middle-income countries [17].

In industrialized countries, many patients with mental problems

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respond best to a combined approach. Experienced clinicians usually draw on various counseling theories and techniques to design interventions that fit a patient's problem. The format of therapy (e.g., individual, couple, family, or group) will vary with each patient:

– Psychoanalysis offers interpretations of the meaning of the patient's free association of ideas and feelings.

Brief psychotherapy attempts to achieve behavioral or attitudinal change and the clinician makes recommendations based on an understanding of the situation and the reasons for resisting change. This form of therapy employs empathy, suggestion, persuasion, education, reassurance, and insight. Supportive psychotherapy is used to reinforce a patient's defenses, but avoids the intensive probing of emotional conflicts employed in psychoanalysis and intensive psychotherapy.

It is not, however, so simple a matter as being able to transport strategies found to be effective in high income countries to LMICs [4,18]. This is largely because of socio-cultural and ideological differences [19] and because of differences in the range of barriers to addressing mental health issues faced by high and low income countries. Furthermore, classical forms of psychotherapy have been found to be less effective in LMICs than in high-income settings (see, for example, Patel et al. [20]). This is thought to be because psychotherapy reflects the (Western) culture in which it was developed [2]: in its traditional form, it is based on talk about the self, conceptualized in individualist terms. The constructions implicit in this approach do not fit well with LMIC's more socio-centric cultural frameworks, which often conflict with Western understandings of the person, his/her illness and the extended family structure [21,22].

A few researchers have shown that group therapy, rather than individual counseling, is more compatible with local understandings in many LMIC settings. Patel et al. [20], for example, showed, in a randomized control trial, that group therapy had significant effects in the treatment of depression in India, as compared with individual therapy, which had no greater effect than placebo. In response to these and similar findings, Verdeli et al. [24] adapted group psychotherapeutic approaches developed in Western countries for use in a rural Ugandan context. In one of few such assessments in the developing world, Verdeli and team tested the form of therapy that they had developed in the previous study, conducting a randomized clinical trial and providing solid evidence of the effectiveness of group therapy in this context [16,21]. In similar studies, Caldera et al. [25] in Nicaragua and Araya et al. [26] in Chile found significant positive effects in patients treated through group therapy sessions, in terms of both patient satisfaction and functional level.

In explanation of these findings, Verdeli [12] argues that people in Uganda tend to conceptualize themselves as part of a system, such as the family or community, rather than as self-contained individuals, and to understand mental health problems as interpersonal, rather than intrapersonal in origin. In similar vein, Patel, Araya and Bolton [7] have argued that an approach that emphasizes support and sharing between members of an existing community is more likely to be effective in many developing contexts than is an individually-oriented one, again due to its compatibility with local understandings.

It is further worth noting in the context of LMICs that treatment in groups may also help reduce costs - not only can a number of patients be seen at one time but all the above authors report on instances in which therapy was provided not by a psychiatrist but by general health workers. This has positive implications both for the likely effectiveness of such interventions at the level of primary care, as well as for the possibility of keeping costs down by training non-specialists to deliver group therapy.

These collectively-oriented approaches have also been found to represent useful tools in primary care practice in the Western world, (see for example Aitken & Curtis [27], Senior [28], Seaburn et al. [29], Graham et al. [30]), enabling easier access to mental health care and earlier treatment of mental health problems in a manner that accounts for the system within which the suffering individual is located. One such approach is family/systemic therapy [31,32]. Systemic therapy is one of the main schools of thought in psychotherapies, alongside psychoanalysis, transactional analysis and behavioral psychology. Systemic therapy focuses on how relationship dynamics influence the presenting problem and the therapist aims at altering these dynamics, rather than focusing on the behavior (as in behavioral psychology) or internal dynamics (as in psychoanalysis) of the individual. Family counseling, for example, brings the entire family or relevant key members together to discuss specific problems of one or more family members, including marital discord, drug abuse, or relationship problems.

The "systems" to which "systemic therapy" refers are essentially families, extended or not, according to the relevant situation. However, they may include religious or community leaders, friends, other relatives, traditional healers, and already or potentially involved health professionals and health services.

While there is a dearth of research investigating the use and effectiveness of this technique in LMICs, this paper aims to sketch out a broad professional orientation in systemic therapy for GPs, nurses, medical assistants and their supervisors working in LMIC settings.

Methodology

A family therapist, psychiatrist by training and experienced in Belgium, Senegal, Congo and Vietnam, was interviewed by a public health doctor specialized in health services organization. The purpose of the interview was to derive from the psychiatrist's 30 years professional experience concepts useful for GPs and nurses working in LMIC first line services to handle the relational and emotional component of bio-psychosocial care which they are expected to deliver under the primary health care strategy [33]. In a series of four one hour interviews, the therapist was asked to discuss key methodological issues related to his clinical and supervision experiences in systemic therapy. The interview was supplemented with a Google, PubMed and Medline literature review using the terms "primary health care", "first line services", "low and middle income countries" and "family and systemic therapy" as key words.

Key Concepts

Araya et al. [26] have suggested that the key factor accounting for the success of group treatments in LMIC contexts is the use of relationships as a basis for problem-solving. These authors argue that a collectively-oriented approach is more compatible with local understandings in many developing contexts than is an approach based on intra-psychic processes. Group-based treatment thus builds on social structures and mechanisms already present in the relevant contexts [18], as will now be seen.

Treatment objectives in systemic therapy

Suffering and conditions dealt with by systemic therapy encompass a wide array of problems: behavioral disorders, school drop-out, alcoholism, drug addiction, secondary depressions, neurosis, pre-psychotic disorders, suicide attempts, personality disorders, domestic violence and abuse, marital discord, social isolation, anorexia and bulimia, psychosomatic disorders, to mention a few. Notice that depression is identified by the WHO [7] and others [34] as an important global cause of disability and poverty, and is predicted to become the primary source of the disease burden in LMICs by 2020 [12].

In terms of demand, families may ask, for instance, that an adolescent who smokes and has dropped out of school be rehabilitated. Psychic/psychosocial problems and suffering are voiced by the patient and/or his/her family, as with any medical and bio-psychosocial complaint. However, more than in biomedicine, the treatment objectives are defined by these actors while the health professional merely helps them to formulate their needs in an effective and realistic way, taking into account his/her experience and available resources. A parallel can be drawn with patient-centered

general practice, in which therapeutic objectives are negotiated between patients and professionals.

The needs that clients voice in this context are distinguished from hidden suffering/complaints. For instance, adults may put forward the symptoms of a child (enuresis, nightmares, etc.) because their own suffering, and complaints (e.g. depression or infidelity) are too frightening to confront. First line health professionals should thus remember that the problems of one person may mask those of another. It is therefore important to disentangle voiced and hidden demands, as people may be ambivalent about a solution offered in response to a complaint (to treat the child's enuresis, for instance), which may expose its source in the family. Recognizing an important family event may relieve one member but destabilize the entire family system since the named events may have pervasive psychological, relational and even juridical consequences (e.g., the sexual abuse of a child by an uncle).

In practice,

- The person who is the "symptom" of the family suffering should be identified. To this end, it can be useful to ask a group of key family actors (possibly including a child) questions such as "who in the family system, including its absent members, is suffering the most?"
- Treatment objectives should mostly be defined by the family.
- Stability (e.g. family permanence and solidarity, or even previous homeostasis) should not be an objective per se.
- Objectives should not be formulated too rapidly as this may provoke resistance by some family members to relieving complaints (see above).
- These objectives should be evaluated/reconsidered with the family from time to time. The role of the professional is also to recall these objectives when needed because such therapy requires several contacts spread over a relatively long period of time.
- Indeed, both the complexity of therapy and the length of time that it takes to introduce effective changes in peoples' lives necessitate several consultations over a relatively long period of time. Experience suggests that consultations of 45 minutes long allow sufficient time for progress to occur in each session. Since therapeutic processes may be lengthy, it is appropriate to schedule the sessions for instance in the afternoon, when there is more time available and patients are not queuing. Lack of time may sometimes prove to be an insuperable constraint for the utilization of systemic therapy techniques and requires that the families benefiting from them should be carefully chosen.
- Finally, tools to steer continuity of care (such as appointments, schedule system, appropriate explanation, carefully kept records, home visits, phone calls, appropriate mode of payment such as fee per sickness episode and prepayment fee) are important to avoid drop outs, ensure consistency of decisions over time and increase the likelihood of long-term, overall effectiveness.

Having or being a problem? 'Neurotic' vs. 'psychotic' families and systems

To paraphrase Erich Fromm [35], having a problem is not being a problem. From a family and systemic therapy viewpoint, a differential "diagnosis" has to be made between two categories of families: those capable of being reflexive (those who have a neurosis and are aware of it) and the others (who pose a more difficult problem). Families may also identify a member singled-out as the patient and/or a healthy member, identified as a resource person. This can blur the family typology.

Families can identify/present their patient either as 'having a problem' or as 'being a problem'. The former is rather 'neurotic' in the sense that the patient does not feel stigmatized and his/her identity is not threatened by his/her sick status. The symptomatic patient is aware of having a trouble and has some insight into the nature of the problem. The latter often reveals psychotic individuals lacking such insight. In some psychotic families, only an external observer will be aware that the symptom patient is sick.

While we are aware that these nosological entities were tailored to describe pathologies of individuals, by extension we shall use them below to describe groups, systems and families.

The reason to establish such a family typology is operational:

- In 'neurotic' families, medical and psychological nosological categories and diagnoses may be used during the therapeutic process (provided that the family's intellectual level permits it).

'Psychotic' families may have difficulty dealing with a diagnosis and may internalize it - not because their cultural framework does not allow them to understand it but because their structure, personalities and relationships require a symptomatic/suffering individual and would be severely threatened by recognition of the diagnosis. In LMIC, the approach to such families often needs to build upon local beliefs and cultural symbols (rem.: as an exception, diagnosis can be voiced by professionals in such a family when one member is able to "hear" it and if he/she is sufficiently prestigious and vocal to be listened to by the others). Preliminary exploration of these beliefs, perceptions and explanations of the problem's causes should precede definition of therapeutic objectives. As in the case of problem definitions and identification of needs, these perceptions and explanations should be formulated collectively, through discussions between key system players together with the health professional.

Therapeutic resources and relationships

Therapeutic resources are those therapeutic tools most likely to contribute to the reduction of individual and collective suffering. The systems referred to in the concept of systemic therapy encompass the suffering family together with therapeutic and ecological resources, ranging from traditional to western medicine. Such therapeutic resources include professionals but also lay family members. Discussing the system resources encourages valuable debates within families. For instance, discrepant opinions may be voiced on the effectiveness of a traditional drug offered by a grandmother whose effectiveness had never been openly discussed. Or the intervention of a nurse may be collectively valued (or criticized). The effectiveness of resources thus needs to be discussed collectively, as does the way in which they should be mobilized in the future.

Particularly interesting therapeutic resources are those possibly unskilled family members who are capable of providing psychological support. However, such resources need to be managed cautiously as their use can raise problems at the system level as one family member only may benefit from it. For instance, an uncle may provide some emotional support to a child whose father systematically discredits his mother in front of this child. While this may provide some 'symptomatic relief' to the child, the uncle is not in a position to mend the cause of his/her suffering, namely the relationship between his/her parents.

Notice that therapeutic resources may be social rather than psychological: an NGO can support an elderly person, a mutual aid association can include group support for specific categories of patients (AIDS, diabetes, TB), and neighbors or municipal social services can pay home visits, for instance. Resources are to be defined as such by the family together with the professional, through answering questions such as "what has worked so far?". Such questions are important as families, hit by some dramatic event, may feel paralyzed and forget that their problem has not always been there. Therefore, the suffering timeline should be carefully described (permanent vs. temporary, repetitive or not, associated or not with events such as psychological support provided by lay people, divorce or marriage, moving house or changing work).

Importantly, factors of deterioration - negative resources - also

need to be identified. However, an individual cannot generally be considered simply as a negative resource because the same person can be a pathogenic agent for some and simultaneously a solution for other aspects of the problem. Therefore, the therapist and family will frequently have to choose the lesser of the two evils.

Clearly, the therapeutic frame is a key (positive but sometimes negative) resource. It may include a health center/dispensary, a hospital and/or a health program. These may be managed by the state, a commercial entity or an NGO. The institutional features strongly influence the therapeutic relationship. For instance:

- The advice of a doctor or a nurse will be more likely to be adhered to if the institution is prestigious.
- GPs have a role of confidant in Western culture (as priests elsewhere) but not in many LMIC where this role has to be acquired through sustained efforts.
- Hospitals are often associated in patients' minds with disease severity. Unfortunately, in LMIC urban settings they may also represent the only available alternative for delivering first line health care.

Definitions of therapeutic objectives and resources are related, and their link should be made explicit if objectives are to be realistic. One important resource is the therapeutic relationship itself. Therefore, it is generally appropriate to ask family members how they perceive the health professional, e.g. his/her role and status (cast, religion, profession and skills). The answer often enables an understanding of the family's expectations of the therapeutic relationship, which can be a resource but could also represent a threat.

In LMIC, therapeutic support is underpinned by a dialogue between two cultures. It exists even when the professional belongs to the same ethnic group as his/her patients, because his/her training has introduced a radical change in his/her perspective. Furthermore, his/her social status may exacerbate the distance between professional and patient, studies frequently representing for the nurse or the doctor a means of escaping the social class to which the patient belongs. Such social obstacles to doctor-patient communication are apparent, for instance, in statements made by professionals about the "ignorance" of their patients. Intercultural dialogue is thus needed in any education of a health professional working in first line services.

Specific Techniques

Family and systemic therapy mobilize specific techniques, which we will now briefly review.

"Circular questioning" consists of asking each family member what he/she thinks the others think. While obviously some may experience reluctance to answer, this technique has the advantage of inducing emulation and revealing unexpected or even hidden findings, as it obliges interviewees to take a stance and locate their own role in the functioning of the system. Circular questioning is likely to dynamize collective.

"Reframing" consists of suggesting that a (obvious, presented) problem may be a (discrete, hidden) resource. Consider for instance a child who refuses to go to school. The therapist may help discover that dropping out of school has enabled the child to help a grandmother who recently lost her husband. School drop-out may not have been a family decision: sometimes children on their own find a solution to a family problem at their own expense. Such a discovery permits the family to find an alternative solution to the isolation of the elderly person and to manage guilt emotions. This shows that homeostatic mechanisms may be pathogenic but are complex and may not only be pathogenic.

"Reframing" also consists of suggesting that the proposed series of causes and consequences is not the only possible interpretation of facts: sometimes an ostensible cause may in fact be a consequence and vice-versa. Consider a woman who wants to leave a man because he drinks. If interviewed, her husband may explain that he drinks because she wants to leave him. Or a woman who says that she wants a lover because her husband is constantly watching her, while the husband says that he is watching her because she is constantly after a lover. "Reframing" may thus imply a "punctuation" change - the punctuation being one of the two arcs of a causal circle. In practice, becoming aware of such a circle may not be sufficient to break it as hidden stakes (children, dependency, money, etc.) may feed it.

"Provocation" is intended to destabilize someone (and/or a group). It is sometimes advocated by therapists who want their patient to realize the relativity of an emotion or a belief ("you don't leave your husband because your lover is married?"). Such an approach may be useful in some circumstances, e.g. in cases of ambivalence and/or suspicion, but it can also generate dogged denial in the interest of familial homeostasis.

Finally, the "paradoxical injunction" is a manipulative technique. It consists of prescribing a symptom or an apparently counter-productive behavior ("be unfaithful", "neglect him/her") so as to induce the opposite reaction. In general practice, it should be used in specific situations only.

The Systemic Therapy Process

First steps

After exposing its demand, families are expected to provide some kind of an anamnesis, which amounts to providing the history and chronology of the problem and establishing the hierarchy of events in terms of their importance - their position in the family suffering. Even when dealing with somatic conditions, history taking should always explore relational and psychic dimensions of the pathology. Establishing the hierarchy or relevant events can enable professionals to define the available resources with their patients before setting the therapy objectives.

Setting the objectives together with the patients often requires delivering some health education - providing relevant information on psychology and relationships and how they may induce suffering, when families are intellectually and emotionally capable of hearing this. This should not be delivered as an ex-cathedra course but rather as part of a dialogue that permits patients to decide whether the taught concepts resonate with their perspectives. Given the importance and complexity of these first steps, some professionals devote up to three to four sessions to these issues.

Core strategy: accompanying changes

Some of the required changes relate to practical life organization, and some to emotional impairment. Professional experience suggests that therapists are capable of modifying patients' subjectivity - "working" on the way events and relationships are lived. Both emotional and material changes can help patients modify their narratives - the ways in which they formulate their own individual and family biographies and in which family members relate to each other. The therapist's job will then be to repeat/reformulate sentences, ask for some assumptions to be made explicit, raise questions, let paradoxes appear, underline facts, contradictions and forgotten issues, recall therapeutic objectives and support material changes in life organization. In this domain, the therapist's role consists of facilitating changes (entrusting a child to a grandmother, moving house, etc.), strengthening internal (family) and external (therapeutic) resources and reinforcing the ways in which they operate. In other words, the realm of possibilities needs to be extended if 'catch 22' situations are to be replaced by helical circuits designed to drive the family to a balanced relational and emotional situation.

Key decisions are to be made by family members themselves. In systemic therapies, patients cannot remain passive while receiving external, therapeutic processes. The therapist can only carry out earthworks and certainly not delineate a ready-to-wear plan for the family to implement. Although advice may be taken up ("the doctor said that…), he/she is not in a position to give orders because these would easily be dismissed or held in check. Therapists may need to

pay home visits and/or meet key actors (another doctor, a family member). However, this can be a double edge sword, since some families may be pushed into a passive attitude, the active role being ascribed to the doctor or to those who were contacted by the therapist.

Ending a therapy

A simple criterion for deciding to end therapy is when the therapist, the patient and the system agree that the patient and/or the system is able to prevent and/or manage potential relapses by himself/themselves. This includes seeking appropriate help when needed.

Reflexivity

Therapists, even experienced ones, may let their own emotions interfere with decision making, through projective mechanisms. Therefore, even the more experienced therapists can benefit from external assessment and advice. Supervision, seen as in-service training based on direct observation of practice, and intervision, whereby peers give opinions on a case story, are techniques that should be used regularly in systems therapy. Ideally, the supervisor should have significantly more experience than the supervisee.

Conclusions

As Verdeli [12] points out, for a treatment to be effective, it must, first and foremost, address the relevant illness as it is understood and experienced within the local culture of the person suffering from it. Any attempt to employ methods successful in Western settings should therefore be adapted to suit the cultural setting in which they are to be implemented [19,24].

Our experience in Africa and Latin America suggests that general practitioners, nurses and medical assistants can be involved in the treatment of psychic, psychosomatic and relational disorders without in-depth preparation. However, not just any professional is likely to do a good job and this likelihood is difficult to predict, except, perhaps, through the interest generated in an ad-hoc short training session. Besides such preparation, what is required is regular in-service supervision, opportunities to exchange experiences of systemic therapy with peers and some intellectual stimulation with concepts such as those provided in the present paper.

The approach developed here has not been scientifically validated. It belongs to a body of concepts and techniques that are:

- Part of professional knowledge yielded by repeated experience acquired in a variety of situations,
- Designed to orient action and to help professionals to implement their own decisions.

The related theory and practice are tightly inter-connected. Like surgical skills, teaching them through books may be insufficient and require field demonstrations e.g. rotations in pilot health care services.

Systemic therapy can contribute to relieving a wide range of common pathologies (mental or not). It may also, in terms of Maslow's needs typology [36], meet patients' often forgotten needs for self-esteem, creativity and feelings of belonging and security. Its key component is its ability to integrate a disease history with its emotional and relational dimensions.

Family/systemic therapy appears more effective than psychoanalytical techniques in LMIC. This is understandable since:

- There is limited tradition of introspection in LMIC,
- The person has not always emerged as an individual as in modern societies,
- Families in LMIC remain strongly structured and a key social safety net because of weak institutional social security. In such families, symbolic and material exchanges are determined by cultural rules and codes, which need to be taken into account when treating mental and relational disorders.

Our experience suggests that systemic therapies can have an important impact on quality of care where health professionals have no tradition of properly handling bio-psychosocial disorders. In particular, it can foster bio-psychosocial care, improve doctor-patient communication and thus advance the primary care strategy, long advocated by countries but rarely practiced even in countries pledging to do so [37]. However, more experience is needed to define the conditions for optimal utilization of systems therapy in LMIC first line services.

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