A view from 1991

Crisis: Home-Based Family Therapy

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Originally prepared for publication in 1991, but now appearing for the first time, this article discusses home-based family therapy in the context of families experiencing psychiatric crises. Strategies of engagement, interventions and safety issues related to this form of family therapy are outlined. The advantages of home-based family therapy in terms of direct observation and intervention and the minimisation of the need to transfer learning are discussed. Reflecting from the perspective of the present, the author notes with regret that most crisis teams today do little more than gatekeeping; a great opportunity for effective home-based treatment appears to have been lost.

Over the 1970s and 1980s, the application of therapeutic approaches and theories of change has broadened from intrapsychic processes to encompass family contexts and societal issues. A parallel trend has been towards treating psychiatrically distressed and disabled people in their own environment. Despite these trends, therapists for the main part have continued to work in offices and have been content to assume that this method not only best meets the needs of their clients but is also the most effective way of assessing symptoms, understanding family interactions, and formulating interventions.

I suspect that part of the reluctance of therapists to undertake home-based work is a result of the shadow of psychoanalysis. Psychoanalytic work is governed by rules and rituals that convey consistency and control. One example of this is that therapy requires an appointment in the same place, at the same time, in the same manner. It is time to ask whether our adherence to consistency unnecessarily limits the diversity and impact of our work. Given the shift towards community-based treatment, it is important to consider ways in which the effectiveness of family therapy can be maximised when conducted in clients' homes. The particular focus of the following discussion is on families in crisis.

Background

Despite dating back at least to the mid-to-late 19th century, home-based work has largely been ignored in the psychiatric literature. Early models of home visiting were the general practitioner and the social worker who acted as a paid agent, 'friendly visitor' or, especially in protective services cases, as a benign detective (Hancock & Pelton, 1989). None of these models is particularly suitable for family therapy. As far as I am aware, there is no comprehensive model of home-based family therapy, nor are there any controlled studies comparing home-based with centre-based family therapy.

The practice of home-based family therapy has, however, been discussed in social work journals. The usefulness of home-based work has been acknowledged as an aid to diagnosis (Bloom, 1973), as an adjunct to centre-based work (Norris-Shortle & Cohen, 1987), and as a way of increasing the potency of interventions and maintaining changes (Woods, 1988). Bloom (1973) also noted the usefulness of home visits in focusing the therapist's attention on the total family situation.

Home visits have also been common in the assessment and treatment of child abuse cases. Although not specifically related to family therapy, home-based treatments in this area have been found to be of value in treating emotionally disturbed children (Heying, 1985), in reducing the need for foster care placements (Bribitzer & Verdieck, 1988; Reid, Kagan &

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Schlosberg, 1988), and to hold promise in the prevention of child maltreatment (Dubowitz, 1989).

A number of studies have compared community treatment with psychiatric hospital treatment by randomly allocating people presenting for admission to a psychiatric hospital to either hospitalisation or treatment by a mobile 24-hour crisis team. Most of these crisis teams have involved the family in the treatment process and are described as having a family orientation. Generally, these studies have found that community treatment has clinical outcomes equal to or superior to hospitalisation (Hoult, Reynolds, Charbonneau-Powis, Weekes & Briggs, 1983; Stein & Test, 1978), results in less time subsequently spent in hospital (Hoult, Reynolds, Charbonneau-Powis, Coles & Briggs, 1981; Hoult, Rosen & Reynolds, 1984), and is preferred by the majority of patients and their families (Hoult et al., 1981; Hoult, Rosen & Reynolds, 1984; Hoult, 1986).

While the above studies provide indirect support for home-based family therapy, there is a need for further research to clarify the respective effectiveness of centre-based and home-based family therapy and, more generally, to clarify the role of family therapy in psychiatric crises. This article attempts to address the role of the family therapist in working with families experiencing psychiatric crisis.

Construction of Crises

Of the many and varied theories relating to crises (Bateson, 1972; Caplan, 1984; Jacobson, 1979; Langsley, 1972, 1981) one thing is certain — the most important theories are those contained within the family and the therapist. For it is their construction of the crisis that will determine how the problem will be resolved.

To borrow a concept from the work of Milton Erickson (Haley, 1973) it is essential to use what the person brings. No matter how carefully the therapist has read the latest research, the family will always have their own construction of events and this needs to be incorporated into therapy. The constructions a family may place on a crisis range from out-of-control 'sick' behaviour to 'bad' behaviour, and may or may not include environmental stressors, developmental milestones or 'evil' causative agents such as drugs, alcohol or 'bad company'.

Most commonly, crisis calls are of a 'removal' nature; that is, the implied directive to the professional is: 'Remove this out of control person from my home or waiting room'. Often the prescription is for the therapist to take the problematic persons away, usually to hospital, and to 'fix them up'. Overcoming this prescription while engaging the family is essential, if community-based treatment is to be conducted. It is, I would argue, the therapist's job to take the family's construction of the crisis and to use it to define problems so that they become solvable. To do this effectively, therapists need to hold their own constructions of the crisis flexibly, and instead to take a stance of active curiosity (Cecchin, 1987).

During crisis, it is usual for people to employ more primitive coping strategies in an attempt to gain control. It is also frequently the case that therapists who may be alarmed or frightened by the crisis try to lower levels of distress or danger by taking the role of controller. While not denying the need at times to lower levels of distress, it is important that therapists do not unnecessarily prevent the families from resolving their own crises. As Whitaker (1981) succinctly stated, 'When family members are desperate, they change; when they are not desperate, they stay the same'. Therapists involved in home-based crisis work will always be faced with the problem of balancing the need to lower levels of distress via medication, hospitalisation and crisis containment, with the need for families to develop new restraints and thereby achieve a new homeostasis.

At the outset of any crisis work, I find it useful to consider whether I am primarily providing *protection* or *treatment* (Cecchin, 1987). Some forms of crises seem to contraindicate home-based treatment and require that we as therapists provide some form of protection and/or social control. In these crises, protection in the form of hospitalisation, removal or confinement is necessary. Examples of crises requiring protection include instances where ongoing exploitation is likely, where there is substantial risk of harm to self or others or where organic factors requiring medical treatment are contributing to the disturbance. Interestingly, the numbers of crises falling into the protection category appear to diminish as therapists gain more experience in home-based work.

Particular indications for home-based work include situations in which there has been a series of hospital admissions with no ongoing resolution of the problem or where patterns of family interaction appear to have contributed to the crisis. Home-based work also holds the promise of engaging client groups who are suspicious or 'shy' of attending a centre. Home-based therapy is also particularly indicated when clients may have difficulty in transferring changes made in the therapy to their own environments. Friedman (1962) noted:

> The transfer value of therapy conducted 'in vivo' in the real milieu of the family and home, is greater than that of psychotherapy done in the socially isolated context of office or hospital. In conventional therapy the patient has to transfer what he has learned in his therapy, secondarily, over to the relationships with the members of his family (cited in Woods, 1988: 213).

Home-Based Family Therapy

Home-based family therapy is not merely centre-based therapy displaced into patients' homes, but rather requires the therapist to integrate different rules of conduct and, at times, different forms of intervention. It requires a second order change in therapy styles. As Speck stated,

> In the home, the family is more apt to play their everyday roles. If anyone has to undergo an unnatural role shift, it will most likely be the therapist (1964: 72).

Entering a client's home after an initial crisis call can be a delicate moment and it is never certain whether you will be greeted with a cup of tea, a knife, a gun or a snarling dog. The success of the initial session will be determined by the therapist's ability to fit into the client's world as early as possible. In a sense, it is a reverse form of engagement. Whereas in the clinic you want to engage the family so they will come back, in home-based therapy it is necessary to engage the family so that they will let *you back* in!

Particularly in crisis situations, it will not always be clear who is the 'identified patient'. Therefore, it is crucial to acknowledge quickly the role of everyone present. Asking general questions and observing who responds is a reasonable gauge of 'Who's in charge here?'. Even where you sit may be important. For example, it is not a good idea to sit in father or mother's 'special' chair. Once a structural assessment of the family hierarchy has been completed, the therapist can then commence to define the problem, usually starting with those who appear to hold the power in the family.

Engagement

One of the main problems facing mental health is the rate of noncompliance. These are the clients that most often become crisis clients after they have given up on treatment. These are the clients that we despair over, label as 'difficult', 'resistant', or sometimes as 'personality disordered'. Clinical experience suggests that most often noncompliance is a result of poor relationships, poor rapport building and lack of engagement. Some general principles and strategies that I have found useful in engaging families in their homes are outlined below.

The Social Versus the Therapeutic

With some families there is a risk that the session will remain a social occasion. It appears to be a tradition in Australia to offer visitors to one's home a cup of tea or coffee. The thirsty (or tired) therapist meets dilemma number one: to drink or not to drink. In early sessions, the acceptance of an offer of a drink can assist in engaging the family, acknowledging the parental subsystem and can provide a useful way of observing the family system as it accepts newcomers. There are dangers in this, however. One mother, in the style of Monty Python's *The Meaning of Life*, would have gladly filled the therapist with liquid well past bursting point anytime anything conflictual arose.

Once guest-oriented processes are completed, however, work clearly begins. Usually beginning to take notes or asking a series of investigative or circular questions is sufficient to override social mores. However, when the atmosphere remains purely social, the therapist needs to change the family's perceptions about the nature of the visit. Making overt the family's unwillingness to discuss the matters that concern them is one possibility, but may also be inferred as criticism. One way of creating a shift in the way the visit is perceived is to rearrange the seating of the family to mirror some aspect of their behaviour. In one session, moving the mother's seat (done playfully) was such an event that all family members attended the next session just to see whose seat was going to be moved next.

Defining the Problem

In terms of engaging families, it is essential to define the problem in an acceptable way. O'Hanlon (1989) has pointed out that the person is not the problem, the problem is the problem. Often hospitalisation as a means of restraint during a crisis has an historical precedent. However, where community treatment is desirable, this precedent must be overcome. One way is to promote a sense of success in the family through overcoming the 'grip of the past', and deciding to beat this problem and to maintain the changes that are made.

It is also essential at this stage to define solvable problems. As de Shazer (1985) stated, 'The larger the target the easier it is to miss it'. Externalising the problem and framing it as a challenge for the family is always useful (see White, 1988).

Framing the Therapist's Role

The manner in which therapists frame their role can be crucial to the engagement of families (Fisch, Weakland & Segal, 1982). Especially when working in clients' homes, it is important to utilise the family's expectations regarding the therapist's role while retaining therapeutic manoeuvrability. Several strategies exist to achieve this aim. I often use the strategy of telling people not to trust me too soon and this often acts paradoxically, as untrustworthy people do not tell you not to trust them. Another strategy (Pawsey, 1985) is to liken the therapist to a tradesperson such as a plumber. I often say to the family that 'You've called us in to do a job, and if I don't do the job you want, you should get another worker'. This is particularly empowering for recipients of public-sector therapy services, and leads nicely into asking the family to define what changes are required. Where the family appear to be suspicious of the therapist's ability to assist, given the failure of previous attempts to change, it can be valuable to admit powerlessness and to enlist the family as consultants in their own mental health. One client, with a 26-year history of regular admissions to psychiatric hospitals, found this approach so valuable that she was able to begin to break her 'revolving door' pattern.

Obviously, some families require the therapist to have an air of authority and expertise and this too can be catered for. However, therapists need to be wary of setting themselves up as experts only to find that they are being steadily sabotaged. When in doubt, go one down! Framing the therapist's role acceptably is especially important when working in clients' homes as it provides a demarcation between guest and therapist roles, and also provides the family with a comfortable construction to place on having such a visitor to their home.

Looking for Hooks

One of the great advantages of home-based work is that subtle cues are often visible that may be missed in centre-based work. As Woods commented,

> In-home reenactments of behaviours or incidents offer a therapist the opportunity not only to see the problem behaviour or situation as it could never be described in words, but also to use interventions to alter it as it occurs (1988: 212).

Upon entering a client's home, particularly during a crisis period, the therapists have before them a vignette of family life, rich with motifs, patterns of interaction and treasured possessions (Firestone, 1988). It is important to notice such things as whose photograph is displayed on the television set, how the interior of the house is set up, what the interests of the family are, how they achieve comfort and pleasure, and so on. Some of the questions I consider when initially seeing a family in their home are: what have these people got at stake, what is important to them, what are they proud of, and how do they respond to praise?

Absent Members, or Therapy as a Moveable Feast

Unlike centre-based therapy where the therapist has few ways of retrieving absent family members, home-based therapy offers the therapist a number of options. Generally, absent members fall into two categories:

Those in the house but not in the room where the session is taking place. Most often it is the identified patient who is still in bed. This can be resolved in a few ways. The therapist can leave the family and (after knocking) enter the bedroom to commence 'end of bed' therapy; or the therapist can ask the family if it is all right to conduct the session in the patient's bedroom. This form of 'end of bed' therapy is usually short-lived, as the patient generally agrees to get up and join the family in a more suitable room. When more than one family member is in the house but absent from the session, then therapy can truly become a 'moveable feast' and shuttle from room to room.

Family members who are not in the house. They can be telephoned and consulted on various points regarding the session; or where it is impossible to contact a family member during the session, a strategic letter can be left for that person on their return home. Depending on the content of the letter, it can either be left open (where it may be inspected by other members of the family) or can be sealed in an envelope. Where advance warning has been given of someone's absence, that person can be asked to telephone home during the time that the session is taking place.

Safety

Situations involving danger are not common but they do occur in home-based crisis work. Generally, these situations arise when the client thinks you are about to admit them forcibly to hospital. It is possible in some cases to resolve such crises without the need for police or admission. Usually clients are not angry with the therapist personally and it is best to state that your aim is to try to keep them out of hospital, and then quickly ask about what is happening to them. Externalising the danger and the problem from the

client and yourself are important elements in both surviving the crisis and utilising it clinically. Reflective statements are of little use and may well prove dangerous. Instead, it is preferable for therapists to state their aims, ask the person not to trust them too soon and to externalise the threat.

It is useful to have a co-therapist with you on such occasions, but for one person to take the main role with the client. Most potentially threatening clients are often already known to the system and, where possible, it is advisable to meet such people in your catchment area well before a crisis develops, either through an assertive follow-up visit or a discharge planning session.

Some other guidelines to minimise the risk of danger are:

- When waiting for the front door to be opened, always stand back and if there is a screen door, close it, to allow the person a sense of distance and a chance to invite you in
- Never stand between an agitated person and the door. It is better if someone wanting to escape does not have to push you out of the way to do so — near the door but not directly in front of it is probably advisable.

A detailed review of safety and security measures, for those interested, is available in Everstine & Everstine (1983).

Interventions

One of the great benefits of home-based work is that interventions can be tailored to take into account specific aspects of the family's environment, and tasks can often be performed immediately. The following are examples of interventions based directly upon aspects of clients' home environments:

'The Bathroom Drama'

A crisis involved a mother–daughter conflict in which the withdrawn daughter locked herself in the bathroom for prolonged periods while the mother stood outside the door trying to convince her daughter to come out. The therapist directed a reenactment of this battle, moving between the bathroom and the hallway, encouraging both to continue. This was the last time this battle occurred.

'Pressure Free Zone'

A young man who experienced quite distressing auditory hallucinations and perceived pressure coming from his mother would occasionally attempt to relieve the pressure by hitting her. He slept in a rather dilapidated bungalow, designated a 'pressure free zone', in the backyard. Over subsequent sessions he was encouraged to renovate his refuge, and this led to his both becoming more actively involved in life and dealing with conflict more effectively.

'Tapestry'

A woman with a 26-year psychiatric history and more than 37 admissions had spent almost the entire past two years in hospital. In the first session, she complained bitterly about the failure of the psychiatric system to assist her. The therapist agreed with her that the system obviously did not know how to treat her and asked if she would be prepared to act as a consultant on her own mental health. With continued statements by the therapist indicating powerlessness and ineptitude, she agreed. Initially she could not recount one good time in her life. With persistent questioning for exceptions she was able to recall one. Gradually four good memories were found in her 40-year life. These were framed as being like mountains that were able to rise above the mist of her sense of failure, and below the mist were many more, forgotten, good experiences (Madanes, 1988). During the sessions, the therapist asked about the artworks in her home. She had once been an art teacher. The therapist developed the metaphor of the past as an 'old tapestry' and that now was the time to create a 'new tapestry'. Threads of the old pattern would occasionally come to the forefront, only to be replaced by new threads. She spent only two weeks in hospital in the next seven months.

A Rebel with Rights

The therapist interviewed an adolescent girl in her bedroom who engaged in minor self-mutilation and became suicidally depressed. Formerly a champion runner, she had given up the sport when her parents also took up athletics. It had also been alleged that she had been sexually abused by her brother. She was instructed to make her room into a safe place and to create a Bill of Rights for all who entered there. A far happier young woman was seen in the next session and a Bill of Rights (including the words 'No cutting') was displayed prominently. There was no recurrence of the depression or the self-mutilation.

Conclusion

Home-based therapy, as illustrated in the above cases, provides therapists with additional opportunities for

facilitating change. The directness with which family patterns can be observed and altered provides an immediacy that most families appear to enjoy and most therapists seem to find challenging. The purpose of this paper has not been to denigrate centre-based family therapy but hopefully, to encourage therapists to consider home-based sessions as an adjunct to their work.

Postscript: 2004

As I read over this article (that I had completely forgotten about) I grew misty-eyed and heavy of heart. I became wistful over the lost opportunity for crisis teams. These teams should specialise in systemic thinking and contain some of our most adept practitioners of brief therapy. Instead, most crisis teams I have had contact with seem to work as gatekeepers rather than change agents. They medicate and case-manage a narrow group of people with diagnostic disorders. Assertive follow-up is not the same as effective therapy. I think a great opportunity for home-based family therapy was lost.

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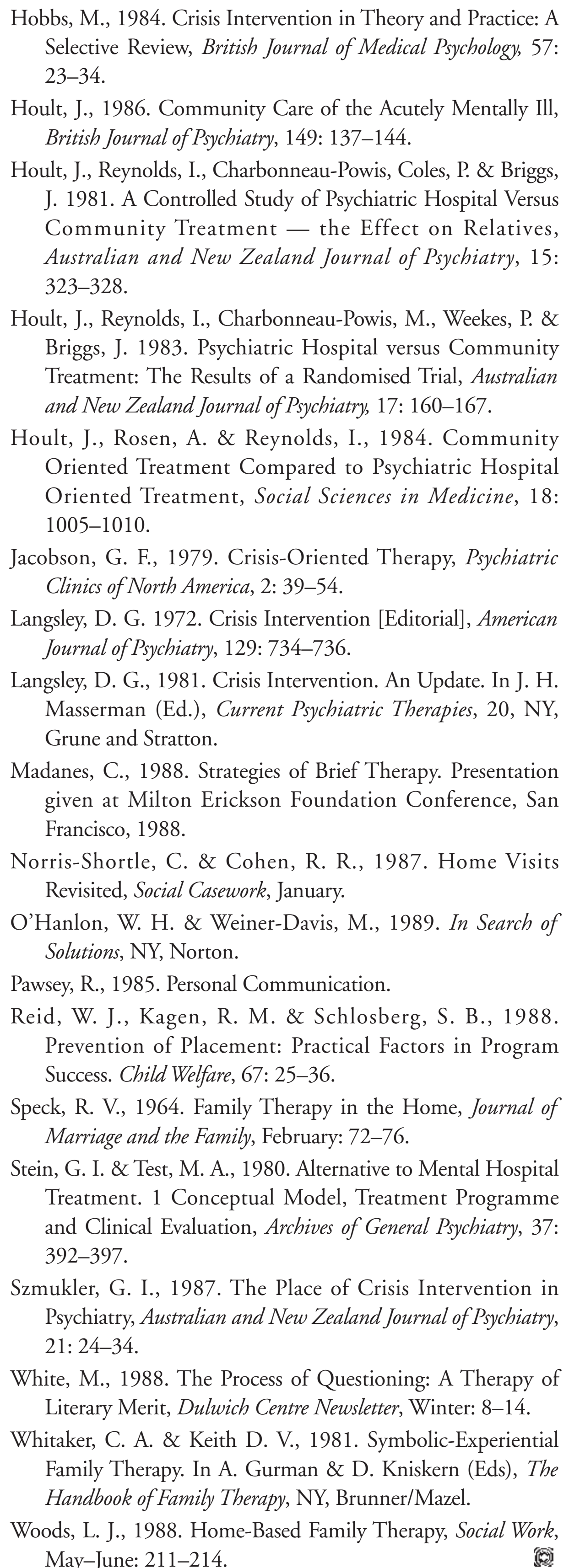

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