

A richer system: a reflecting team in primary care

Sebastian Kraemer, Hilary Graham, Rob Senior, Sue Dickie, Irene Bard & Mark Chan, Context 2018; 160: 22-25

The reflecting team was introduced into systemic therapy almost by accident. In 1985 Tom Andersen and colleagues were viewing family therapy through a one-way screen, and noted that the therapist was getting into a pessimistic *cul de sac*. Andersen suggested to the family that they could watch the supervising group behind the screen discussing what they had seen. The clinicians quickly reversed the lighting and sound systems. The newly-minted reflecting team were more positive about the therapeutic process and thereafter so was the family (Andersen, 1995, p. 17). Anderson later said that he and his colleagues had been thinking about a reflecting team since 1981 while working with the Milan systemic method, but because their conversations about the family in a separate room could be quite critical, they did not dare. "We thought we might end up hurting and offending people" (Andersen, 2007 p. 160). When they finally decided to go ahead with it "we stopped saying what people should do or think, and then alternatives popped up almost by themselves" (Andersen, 2007, p. 159).

The family's experience of hearing a number of different voices *talking not with them but with each other* creates a richer therapeutic system. Under this scrutiny a reflecting team converses with great care, avoiding pejorative observations and technical shorthand, while trying to be truthful, courageous and sincere. The more hopeful aspect of reflection seems to have been favoured by many writers; "reflecting teams draw upon occasions in the main session to intensify and extend positivity in the reflecting session. This analysis identified positive connotation as a device by which a hopeful orientation is established" (Williams & Auburn, 2016, p. 535). Yet, as it expands the frame for thinking, the power of this method can just as helpfully focus on negative perceptions if these have been sidelined so far.

The family clinic

Our reflecting team is in the same room as the family and interviewer. With several changes of personnel, and one constant (HG), this unique group of systemic practitioners has worked together in a GP surgery for 30 years (Graham *et al.*, 1992; Graham *et al.*, 1993; Senior, 1994; Mayer *et al.*, 1996; Graham, 2009). There have been other ventures incorporating family systems therapy into UK primary care but as far as we know none has survived. On the other hand, systemic *thinking* in primary care is more resilient (Tomson, 1990; Asen *et al.*, 2004; McDaniel *et al.*, 2005; Larivaara *et al.*, 2009; Launer, 2018). Originally there was a video link to another room but when it became unavailable, despite at first complaining about its absence, the team got used to working without it and saw no further use for the technology when it was restored to them; another accidental development. "We much preferred the transparency of all

working with the family” (SD). The fortnightly family clinic has four appointments in an afternoon in two parallel streams, each with an interviewer and a reflecting team of one or two. Sessions last around an hour, with time before each for preparation. What has evolved seems deceptively simple, as if there were hardly any rules. This paper is a joint effort to describe some of our practice.

The usual format is that one person interviews while the others take a back seat and tend to talk only with the interviewer, rather than the family. This is not a strict protocol – sometimes it seems to make more sense to direct a comment or question to one of the family members – but the default process of reflective conversations creates a different order of therapy, a play within a play “... so that the family witness the different perspectives at first hand ... shifting the focus of the therapy session ‘gaze’ temporarily from the client onto the reflecting team, thus alleviating the clients’ feelings of being under constant scrutiny” (Willott *et al.*, 2012, p. 184). This is a step change from co-therapists in systemic therapy. While co-therapists *may* talk to each other, a reflecting team must do so.

The seriousness of this interaction has a powerful effect on therapist and reflecting team, who are in a real sense performing, but the parts we play are ourselves. We look at each other while talking and listening. Our exchanges are more measured than the ones we have during breaks, where there is the usual banter and interruptions. Having witnesses brings a proper discipline to the task. At these moments we are less aware of the family members, whom we may assume are watching and listening intently. If any of them seems not to be attending we have occasionally suggested that they might benefit from doing so. But of course they do not have to; “when the team reflects they are encouraged to look at one another when they talk and not to look at those who listen. This gives the listeners the freedom to *not* listen” (Andersen, 1992, p. 60).

Where is the expertise?

It may not be easy for families to object to this set up but when asked for impressions they say that it is good to hear a range of different views, as the literature attests: “Listening to others (two or more) raising questions, without having to immediately respond, may put the client in a more reflexive position, one that would allow more possibilities for pondering” (Janowsky *et al.*, 1995, p. 168). In a qualitative study of trainee therapists’ experience of reflecting teams Smith *et al.* (1992) conclude that multiple realities were helpful to clients and that, although challenging and intense, disagreement was positive for the interview therapist in particular. Pocock sees reflecting teams as a container for families. “One of the skills in a reflecting team seems to be this kind of empathic monitoring by each team member of the likely effect that earlier comments in the reflection may have had on particular individuals in the family. Team members’ contributions to the reflection then appear to be subtly adjusted by this de-centering process. This, I think, gives reflections their extraordinary potential for

holding family members while at the same time introducing fresh ideas” (Pocock, 1997, p. 297). Mason’s concept of ‘safe uncertainty’ – “not understanding too quickly while at the same time opening up the area of meanings” (1993, p. 197) – is animated by a reflecting team. It generates a kind of informality that takes family members off guard. As one client commented after a session: “it just feels as though we are having a chat, but we always feel much better afterwards (I’m not quite sure how you do it)”.

Andersen’s goal of removing the authority of the expert seems thus to have been realised. But is that correct? Our sense is that we are pooling several kinds of expertise, rather than abandoning any of it. Though transparent in that everything said is heard by everyone in the room there is a reserve of implicit knowledge to be called upon; these interventions are far from random instances of curiosity. This little theatre provides an observation break for the family who have been on stage themselves since the start of the meeting. What they see is not the absence of experts but a demonstration of improvisation, appreciation, collaboration and safe dissent between them which, because achieving consensus is not our aim, puts more responsibility on family members to draw their own, equally various, conclusions.

A clinic within a general practice

The relationship between family and clinic team is a novelty in most peoples’ experience. They have been referred by their GP with a problem, but are seen in the same premises as the doctor’s surgery. The letter of invitation is signed by the GP in the family clinic (SD), also a partner in the practice. An accompanying leaflet says that the clinic is for “families, couples and individuals who want to talk about family concerns”, and explains that “one or two of the team meet with the family while other members may follow the discussion, quietly from the corner of the room, and are able to contribute their ideas”. Patients are invited to “bring anyone you consider is affected by the problem or who can help us understand your situation”. The description concludes “There is no charge for this Clinic”. At the beginning of the first consultation the therapist introduces him or herself and explains that the others are here to observe and comment from time to time. Then the reflecting team introduce themselves. We have wondered how much information is needed, especially when there are three (or more) clinicians in the room. What do the family really need to know about us? One of the team (MC) says “I suspect families ‘get it’ very quickly and can’t wait to get into their personal worlds rather than listen to dry explanations of roles and rules”, but we are clear that at least all our names and the sounds of our voices need to be heard at the start.

The therapist in a reflecting role keeps notes. These are essential for review and preparation for any future session. We explain that our records remain only on paper and are kept in folders secured in the practice, but are not included in the formal digital NHS files of any family member. This is sometimes a concern for patients and families.

As if suddenly aware of the clinic and its context, a patient who had experienced serious abuse in childhood urgently wanted to know precisely what had been recorded of his account of it in a previous session, and who was entitled to read these notes. The therapist read out from the file what she had written, and said that only the family clinic team had access to it. This was sufficient, but it was a tense moment. The family clinic therapists do however have access to NHS practice files, which can yield vital intelligence about medical and other history of family members. Having two of the primary care staff in the clinic – a GP partner and the practice counsellor (IB) – justifies this one-way traffic of information. Their dual roles make it possible for patients to move seamlessly either way between clinic and medical or counselling consultations. From time to time referring GPs will attend the clinic with their patients.

Developmental change in primary care

There has been a debate among us about setting and defining clinical goals. When meeting a family for the first time it is obviously necessary to ask what they want help with but does this have to be monitored in every session? In therapy where small, fragile changes are taking place it is not always wise to draw attention to them, as in the children's game 'grandma's footsteps' where little advances take place when 'grandma' is not looking. Decades ago strategic therapists would advise us not to celebrate positive changes in case it came across as a triumphant claim that 'the therapy is working'. A less provocative approach with such families is to show interest in developments whichever way they go, not implying any pressure to get better. While proposing a further meeting a month ahead a therapist said that we wanted to see "the next episode". This raised an amused response from the father, who compared the sessions to the TV soap East Enders, but the therapist said "it's a lot better than that". Mother then added "and we are writing the script!". At this stage of therapy it was preferable not to ask what they want from us, but rather to suggest that we are the ones who want something from them, which is more of the unfolding story.

A similar process occurs when parents offer themselves and their babies as subjects for weekly infant observation. They are not seeking therapy at all; they are helping research or training. "Those families who felt drawn to being observed often benefited by the experience: that the presence of an adult who was interested in everything about their baby, and who was there in order to learn rather than to instruct (let alone being critical or judgemental) could be experienced as a genuine support" (Rhode, 2018). Infant observation is a subjective process. It includes the observer's emotional states as part of the data to be recorded. Though saying little, he or she is an involved participant in the relationship between infant and either or both parents.

Likewise the reflecting team's demonstration of collective, attentive interest is potentially therapeutic. We all begin postnatal life in the presence of people talking about us. Besides evidence from infant observation at home, meticulous laboratory

studies show how actively engaged babies are in triadic family process. “Infants who are enabled to monitor their parents’ relationships and are able to be party to the dynamics of warmth and animation between them are far more likely to excel at understanding relationships ..” (McHale *et al.*, 2008, p. 459). By tapping into these primary impulses a reflecting team rekindles the earliest dramas of family life.

Though referrals to the clinic from other GPs in the practice are usually made with mental health or therapy in mind, its name does not specify either. Nor do we only see families where the referred individual is a child. For example, the clinic has also worked with families trying to adjust to new diagnoses of chronic or terminal disease. Many patients have a lifelong relationship with their GP practice. Working in a stable community in a rural part of the Netherlands in the mid twentieth century the general practitioner F. J. A. Huygens (1977) graphically demonstrated from appointment records how consultations for different family members cluster around major life events – exits and entrances – such as birth, starting school, leaving home, marriage, grandchildren, old age, illness, and death. The family clinic is so-called to allow for exploration of turning points in the life cycle. A modern collaborative general practice harnesses the passage of time, during which patients are aware that practitioners consult each other about them, keeping them in mind. The clinic visibly embodies these kinds of conversation.

Speaking up and speaking for

The team can be particularly helpful when the voice of a family member has been marginalised, either because they are actually absent or simply not saying anything. A silent teenager – presented to the clinic as the ‘problem’ – raised his eyes for the first time when hearing two therapists (IB and SD) talking about how problems in families can alight on one individual, and finally found his voice to confirm that this was indeed happening to him. Reflecting therapists can be outspoken, saying things ‘from the back row’ that could not, without risking offence, be directed at family members. One of us lost some sleep after making a challenging comment about a passive father of a family in a destructive crisis; yet his intervention seemed in a subsequent session to have galvanised the man to become more involved, and was a turning point in the therapy. Differences between therapists may appear sharp. During a recent session the office phone rang and the reflecting colleague answered it briefly, revealing almost nothing of the content. After the call was over the therapist said to the mother that he felt this was an intrusion in the session, which she probably thought was a call about her. She agreed. This seemed like a criticism of the reflecting therapist, who began to apologise but it was actually a deliberate attempt to identify with mother’s terror of being talked about behind her back, a recurring and damaging experience in her life. (This is not a family who could have tolerated a one-way mirror). An external impingement provided a therapeutic opportunity.

Our emotional connections with family process become explicit when a reflecting therapist says something about his or her life as child, grandparent, parent or sibling. One of the team mentioned his sister and within a few moments the mother in the family began to speak of her own. Would she have followed this promising path without that intuitive prompt? A humorous conversation between a grandfather (HG) and a mother (SD) about 'grandparent duties' allowed a mother and grown-up daughter at an impasse to acknowledge necessary differences between their caregiving roles. Talking about personal experience comes spontaneously into day to day conversation but is to be used carefully in therapy, where it can be awkward (Roberts 2005), or simply fail to connect. We want to monitor these trials and errors of identification, "... the earliest expression of an emotional tie with another person" (Freud 1921, p. 105).

Besides being a place of reflection for families in the practice, the clinic is a developmental resource for the team. Our founder member [HG] said that it is "a privilege working with people whom you respect professionally, whom you love as colleagues and who can both challenge and support and bring new slants on the therapeutic process, as well as your thinking and your own prejudices and misconceptions". During breaks the team supervises each other's cases, a 'third order' contribution to sessions at which not all of us could be present. Like soldiers back from the front or actors after the play, we have shared intense experiences and need to debrief – even to re-enact them (Mattinson, 1975) – to make sense of what happened. The family clinic is a secure base for exploration for ourselves and for the practice.

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Hilary Graham, when still a GP partner in the Highgate Group Practice, was one of the founder members of the Family Clinic in 1989 and though retiring from general practice in 1997 has remained in the Clinic throughout. He now also works as a systems therapist in Lowestoft CAMHS.

Rob Senior, now ending 12 years as Medical Director of the Tavistock & Portman NHS Trust, helped set up the Clinic while completing his IFT training, leaving in 1994. He has since become the clinic team's termly group supervisor.

Others who are no longer part of the team include *Myrna Lazarus*, *Penny Loudon*, and the late *Rob Mayer* (1960-2008) who in Hilary's words was "a rock for the clinic", a role taken over by **Sue Dickie** who, largely because of the Family Clinic, joined the group practice in 1995. Sue trained at IFT between 1997 and 2012 (with a big family gap in the middle).

Irene Bard completed a psychodynamic training in 1991 and in 1998 joined the Family Clinic while a trainee at IFT. In 2000, once qualified, she became a permanent member of Highgate Group Practice staff and was appointed as practice counsellor the following year. She subsequently completed training as a systemic supervisor at the Institute of Psychiatry in 2007.

Mark Chan joined the team in 2012 during his systems training at the Tavistock, and stayed until December 2017 to accommodate an expanded systemic therapy post in adult mental health in Buckinghamshire.

Sebastian Kraemer joined the Clinic following his retirement from the Whittington Hospital paediatric department in 2015. He did his systems training in the 1970s while a psychiatric trainee at the Tavistock Clinic, where he later became a consultant.