On Treating Two Members of the Same Family

Should a psychiatrist ever treat more than one member of a family at the same time and what are the potential pitfalls? I encountered these questions in a recent forensic case involving a clinician who had been treating a father and young adult son, neither of whom was aware that the other was seeing him. As the therapeutic relationships progressed, the clinician felt compelled to tell each that he was seeing the other and did so counter to their wishes. Father and son, in turn, brought a malpractice action against him claiming breach of confidentiality. I was unable to find anything in our ethical code that would prohibit seeing more than one member of a family at the same time. This type of situation might arise in a busy clinic with only a few therapists or in a private practice in an underserved area where there are no other psychiatrists to whom one may refer siblings of index patients. There are basically two scenarios. In the first, presumably first degree relatives are aware that you are seeing each of them. Or more commonly, having successfully treated one child you are later presented with a request by the parent to see a sibling. In the second scenario, family members are unaware of the dual relationship. The psychiatrist might unwittingly get into this awkward situation if family members not living together have different last names or very common names.

Although it is not unethical to see more than one member of a family, ethical problems may soon arise down the line. Double bookkeeping, which involves remembering which family member told you what and what you can and cannot use in therapy, becomes exceedingly cumbersome and there is always risk of leakage. I am reminded of the time I was after my son about not studying for the exam he had in school the next day. He turned to me and asked how I knew he had an exam. With chagrin, I realized I had heard this not from him but from a classmate of his whom I had seen in treatment that day. A second problem involves hearing things about patient number one which you cannot use with that patient because the information came from patient number two and is confidential. The psychiatrist becomes privy to such information from unrelated patients as well, but presumably with less frequency. Such information may also color the psychiatrist's feelings about his patients. Rivalry may ensue between the patients for the therapist, particularly if they are siblings. They are likely to have concerns about confidentiality, as well. If the situation becomes untenable, the psychiatrist may then be in the unenviable position of having to drop or transfer one patient. Yet another potential problem involves the psychiatrist's advocacy for his patient which may be at cross purposes with advocacy for the related patient, whom he is also treating. If only medication management is involved, transference issues are likely to be less but with time they will develop and also need to be addressed.

A final issue concerns the degree of psychopathology one is dealing with and the particular family dynamics. Unfortunately, these are not always fleshed out prior to beginning therapy and one could be in for nasty surprises if, for instance, two related patients are in an abusive relationship. A rather flagrant example of dual agency involved a woman seeing a therapist in an attempt to break away from her abusive husband. The therapist requested to see the husband because, as she boasted, she was "good with men." She saw them briefly as a couple then began doing individual therapy with the husband. The woman felt abandoned by her therapist who was now advocating for her husband and accusing her of being a shrew. The husband, in turn, confronted the patient with things he only could have learned about her from the therapist. Once the divorce was final, the husband and therapist married and the ex-wife brought suit against her.

I have made it a rule not to treat more than one member of a family at a time. A few times, I have treated a sibling or parent of a child at a much later time but only with full awareness and consent/consent of the original patient. If a new patient called, unaware that I was treating a relative, I would either cite conflict of interest or say that I wasn't taking patients at that time. Sometimes we may be asked to evaluate multiple siblings in a family. This is not a problem if there is no expectation of providing treatment. If treatment is indicated, one may be forced to pick between sibs unless one opts for family therapy.

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