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СИСТЕМНЫЙ ПОДХОД В ДЕТСКОЙ ПСИХИАТРИИ: ВЗГЛЯД НА ЭТИОПАТОГЕНЕЗ И ОРГАНИЗАЦИЮ ПОМОЩИ

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Цель. Интеграция существующей в литературе по системному подходу информации и собственного практического опыта психотерапевтической помощи детям с различными формами тревожно-фобических расстройств (ТФР) для повышения эффективности лечения, улучшения социальной адаптации пациентов с ТФР и поиска организационных форм медицинской помощи данной детскому населению.

Материалы и методы. В исследование были включены пациенты (61 ребенок 8-17 лет), проживающие дома и поступившие в ГБУЗ Научно-практический центр психического здоровья детей и подростков им. Г.Е. Сухаревой в 2018 г. по поводу различных психических расстройств, в структуру которых входили ТФС. В исследовании использованы анализ историй болезни и протоколы занятий с семейным психологом.

Результаты. На основе параметров семейного функционирования выделены три группы системных гипотез тревожно-фобических проявлений: нарушения структурного аспекта (границы, иерархия, коалиции, треугольники), коммуникативной сферы или семейной истории. Рабочие системные гипотезы иллюстрированы десятью клиническими примерами.

Заключение. Системные гипотезы формирования ТФР у детей позволяют выстраивать стратегии лечения и реабилитации**,** направленные на улучшение состояния пациента через формирование в семье условий для длительно существующей устойчивой ремиссии. Включение в план лечения и реабилитации занятий с семейным психологом/психотерапевтом позволяет сместить акценты помощи ребенку во внебольничную сеть.

Ключевые слова: *подростки; тревожно-фобическое расстройство; семья; системная гипотеза; семейная терапия.*

SYSTEMIC APPROACH TO CHILD PSYCHIATRY: INSIGHTS IN ETIOPATHOGENESIS AND ORGANIZATION OF ASSISTANCE

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Aim. Integration of information on systemic approach published in literature, and of the own practical experience in rendering psychotherapeutic assistance to children with different forms of phobic anxiety disorders (PAD) aimed at improvement of effectiveness of treatment, of social adaptation of patients with PAD, and at search for organization forms of medical assistance to the given category of children's population.

Materials and Methods. Into the study 61 children of 8-17 years old were involved living at home and admitted to G.E. Sukharevskaya Research and Practical Center of Mental Well-Being of Children and Adolescents in 2018 for different mental disorders including PAD. In the study, analysis of medical histories and protocols of classes with a family psychologist were used.

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Results. On the basis of the parameters of family functioning three groups of phobic anxiety syndromes were isolated: disorders of the structural aspect (limits, hierarchy, coalitions, triangles), disorders of communication sphere, or of family history. The working systemic hypotheses were illustrated with ten classic examples.

Conclusion. Systemic hypotheses of formation of PAD in children permit to construct treatment and rehabilitation strategies directed at improvement of patient's state through creation of conditions for a prolonged stable remission in the family. Inclusion of classes with a family psychologist/psychotherapist into the plan of treatment and rehabilitation permits to shift the accent of help to a child to the outpatient environment.

Keywords*: adolescents; anxiety-phobic disorder; family; systemic hypothesis; family therapy.*

A stimulus to development of systemic approach and of family therapy/psychotherapy in the 40-50s of XX century in the USA and Europe was Bateson's theory of schizophrenia and practical observation of the course of the disease by psychiatrists. It was found that in many cases when patients returned home, to the family, after successful treatment in clinic, symptoms reappeared [1]. This fact was explained in terms of Jackson's concept of the *family homeostasis* – a tendency of the system to restore its stability – in which a pathological symptoms is assigned a certain role [2]. Indeed, a child being in the hospital, 'is living' in a different socio-emotional environment where his symptom is 'not needed'. Returning home, a child gets into familiar *circular communication*, where the symptom again becomes required being a part of the intrafamily interaction that considerably impedes recovery [3].

In the second half of XX century a concept of a *unit of therapeutic influence* underwent changes: it was expanded from two persons (ill child – mother), to three (mother, father, child) and more (grandmothers, grandfathers, brothers, sisters) persons [3-5]. The ideas of systemic approach formed a new paradigm in thinking of psychiatrists, that is, instead of understanding that the causes of symptomatic behavior are rooted only in the individual himself, there appeared an interest in the shift of the focus of diagnosis, analysis and description of the case from one member of the family to the pattern of functioning of the family. Now the central position was assigned to suggestion that for diagnosis not only taking history from a member of the family is important; understanding of the symptoms in one member of the family is possible only on condition of understanding of the joint functioning of the whole family (that is, the whole) [6]. Penetration of systemic understanding of a clinical case into psychiatry induced appearance of an independent term and of a separate trend – 'systemic psychiatry' in which a psychiatrist interprets symptoms of a mental disorder as having a certain function in the family and directed to solution of the problematic situation in patient's environment [8]. The concept of 'family diagnosis' (identification in the life of family of characteristic disorders that promote initiation and reinforcement of different psychological problems and mental disorders in a patient) [9], simplifies the diagnosis and helps plan treatment and rehabilitation.

Despite the proven effectiveness of inclusion of relatives into rehabilitation measures in case of adult patients and of family psychotherapy in case of children in many mental disorders [10-13], organization of medical assistance to children and absence of family psychologists in the majority of psychiatric hospitals and primary medical care units, practically do not permit realization of treatment cycle with attraction of family resources, and family consultations and family psychotherapy far not became a standard of medical assistance to a child with mental problems and behavioral disorders [14]. Empiric studies convincingly showed

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that it is more convenient for a physician to deal with relatives of the patient who are not knowledgeable in medicine; physicians are convinced that interference of relatives into the treatment process is a risk factor that may provoke malpractice and, consequently, may lead to reduction of the quality of medical care [1]. Training of physicians in family psychology and familiarization of them with systemic approach permits to move the accent from the medical intervention to prophylactic medicine and to provide effective cooperation between polyprofessional teams and to increase the quality of medical care [16].

In this work the ideas of systemic approach in child psychiatry are illustrated in phobic anxiety disorders (PAD) in children. The choice of PAD is, on the one hand, dictated by their high prevalence in children and adolescents [17]. On the other hand, numerous epidemiological and clinical studies of adults described many-year chronic PAD traced to childhood with relatively high resistance to pharmaceutical therapy [18-20]. In this connection, it seems important to seek for such mechanisms of etiopathogenesis of PAD in children and adolescents that had not been studied earlier or did not find sufficient practical use. Thirdly, within the theory of attraction and of systemically oriented family and dynamic psychotherapy, it is reasonable to consider family interrelations as an important factor for initiation and course of disorders of affective spectrum [4, 21-23].

The *aim* was integration of information on systemic approach in the existing literature and of our own practical experience in rendering psychotherapeutic assistance to children with different forms of PAD to increase the effectiveness of treatment, improve social adaptation of patients with PAD and find organization forms of medical assistance to children's population.

Materials and Methods

Patients of 8-17 years of age (61) were examined that were living at home and were admitted to G.E. Sukharevskaya Research and Practical Center of Mental Well-Being of Children and Adolescents in 2018 for different mental disorders including PAD. In the study, analysis of medical histories and protocols of training classes with a family psychologist were used. All the participants (above 15 years of age) or legal representatives of participants (under 15 years of age) signed informed consent for participation in the scientific research at training classes with a family psychologist. The research was approved by Local ethical committee of G.E. Sukharevskaya Research and Practical Center of Mental Well-Being of Children and Adolescents (Protocol №4, 12.12.2017).

Peculiarities of research. Since all the patients had anxiety and fear in their affective sphere, the group was considered uniform only within the aim of research (irrespective of syndrome and nosological aspects). Analysis of the history data, of clinical presentation, results of psychological diagnosis and dynamics of psychotherapeutic process *in terms of systemic approach* permitted to formulate hypotheses and to identify the common regularities characteristic of children and adolescents with affective pathology of phobic anxiety spectrum. The given study is a multidisciplinary one, and the interpretations and conclusions may seem excessively 'psychologized' and disputable. However, an opportunity to propose to the professional community a different way of looking at the known problem (and thus to promote development of a biopsychosocial model and of a humanistic aspect of prophylactic and social psychiatry) seems important for organization of specialized assistance to children and for formation of professional outlook of young specialists.

Systemic hypotheses and psychotherapeutic strategies. For effective work in systemic family therapy an operational hypothesis is required that could provide a physician of a psychologist with an idea about processes provoking emergence and reinforcement of disorders in an individual or in a family. Systemic hypothesis describes interaction of family members as circulatory sequence in which all family members are *connected* and

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behavior of each member influences behavior of all the other members. In many cases existence of such *connection* is provided by existence of a disease. A study of a family implies a study of parameters of its functioning [24]: of the family structure (boundaries, hierarchy, coalitions, triangles) (1), of communicative sphere and other dynamic characteristics (2), of the family history (3).

Results and Discussion

Tables 1-4 present data of patients included into the study.

Table 1

Distribution of Patients by Gender and Age (n=61)

Age	Boys	Girl	In Total (n and %)
8-10 years	2	-	2 (3.3%)
11-13 years	6	6	12 (19.7%)
14-15 years	10	13	23 (37.7%)
16-17 years	9	15	24 (39.3%)
In total	**27**	**34**	**61**

Table 2

Distribution by Family Type (n=61)

Family Type	Amount of children (n and %)
Two-parent family	19 (31.1%)
Incomplete family (a child lives with mother)	22 (36.0%)
Incomplete family (a child lives with father)	1 (1.6%)
Mixed family*	15 (24.6%)
Combined family**	4 (6.6%)
Patched family***	-

Note: * is a 'restructured family' formed in result of marriage of divorced individuals. It includes non-natural parents and non-natural children, since children of the previous marriage are included into a new family; ** a family couple living in a registered marriage or in civil partnership where one or both partners have a child for whom the other partner is not a biological parent; irrespective of whether the child is adopted officially or not, living with the given family or not; irrespective of whether the second partner has his/her own natural or common children; *** a family in which partners have already been in significant interrelations, and children from these interrelations are present in the life of family

Table 3

Distribution of Patients by Content of Fears (n=61)

Kinds of Fears	Quantity of Children (abs. and %)
Fear for life and health	20 (32.7%)
Fear for life and health of parents	9 (14.7%)
Fear of school	14 (22.9%)
Fear of leaving the house	8 (13.1%)
Fear of darkness	4 (6.6%)
Polymorphous non-differentiated fears	6 (9.8%)

Table 4

Distribution of Patients by Diagnosis (n=61)

Diagnosis according to ICD-10	Quantity of Children (abs. and %)
Schizophrenia, schizotypical and schizoaffective disorders (F20, 21, 25)	7 (11.5%)
Mood disorders (F31, 32, 33)	15 (24.6%)
Phobic and other anxiety disorders (F40, 41)	19 (31.2%)
Reaction to stress and disorders in adaptation (F43)	14 (22.9%)
Mild mental retardation (F70)	2 (3.3%)
Behavioral and emotional disorders with the onset usually occurring in childhood and adolescence (F93, 98)	4 (6.6%)

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Main systemic hypotheses being the basis of PAD in children. The analysis of literature and the own research permitted to conventionally divide hypotheses into 3 groups according to parameters of the family functioning.

I) Hypotheses associated with disorders in family structure:

1.1. Emergence of disorders may be associated with peculiarities of family boundaries: ***outer*** (between family members and the outside world) (***A***) and ***inner*** (between parents/married couple and children) (***B***):

A) Fear and anxiety of a child were caused by insufficient information of a child about the outside world and/or by nonconformity between the knowledge about the outside world, social skills, understanding of potentials and the age of child. In the observation, a child's fear of a large amount of contacts with the outside world was similar to the corresponding fear of parents before active social interactions. By that, the symptom of a child was a symbolic protection of the family against excessive tension and supported avoidance behavior in all members of the family. Helping the child to cope with his fears, parents united and helped the family as a whole. In families with dysfunctional outer boundaries ('rigid' in all observations) there existed a difficulty in asking for help, and, consequently, parents first addressed a specialist (psychiatrist, psychologist) rather late although children were complaining of fear within previous 2-3 years.

In most cases 'rigid' outer boundaries of the family combined with 'blurred' inner boundaries. The highest anxiety in families with 'blurred' inner boundaries was caused by separation. In our observations fears of a child bound the parents with each other, and thus not only a child, but the whole family system had a 'secondary benefit' from the presence of the symptom, avoiding separation and reducing the general level of anxiety in the family.

Clinical case 1. *Alexey A., 12 years old. Complaints of polymorphous fears (of visiting school, of a thunderstorm, getting out on the street, a crowd of people, communication). In the conversation parents told the doctor that they live aloof from the world (practically do not visit recreation places, have no friends, rarely visit relatives and rarely invite guests). The attitude of parents to what is going on outside the family and in the outside world was described by the father in the following way: "We really don't know what will happen. Maybe now I will go outside and a brick will fall on my head." The mother required the child to go along the street holding her by the hand, father expected more independence from the son, but, with this, did not allow him to go out alone (for example, to take out the trash), since "it is dangerous". To reduce manifestations of fears, parents and the child were everywhere together: mother helped the son take a bath, the teenager was sleeping in the marital bed.*

1.2. PAD evidences a derangement of the hierarchy in the family. The given variant of PAD was manifested by fear and anxiety not for the patient himself, but for other members of the family, in particular for the parents. This may be an indirect evidence of the so called 'inverse hierarchy' metaphorically expressed in 'protection' by a child of his parents from imaginary or real difficulties. The inverse hierarchy is characterized by a style of interrelations in the family, when a child, but not parents have the power in the family. The mechanism of formation of inverse hierarchy may be associated with the phenomenon of parentification (a child becomes 'a parent for a parent').

Clinical case 2. *Lena S. 13 years old, was admitted to hospital with fear of contamination. The girl was tidying up every day for hours. To reduce the probability for appearance of dirt in the flat, the girl required the members of the family to observe certain rules, for example, to wear a mask on the face when going out and to leave the footwear outside coming back and twice wash hands after returning home. Parents completely fulfilled the requirements, but the symptoms were building up.*

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1.3. Phobia or another PAD developed in the child is a reflection of dysfunctional coalitions. In cases when this hypothesis was central, the symptoms of the child copied similar manifestations in another member of the family. The symptom permitted the child to openly or latently 'unite', for example, with one of parents. With the help of this symptom the child and one of parents 'legally' formed a special link, similar variants of avoidance and a similar lifestyle. Thereby the other parent was moved to the periphery of the family problem or formed a coalition with another (often healthy) child.

Clinical case 3. *Vika I., 11 years old. The family presents with complaints of the daughter's fear of leaving the house, which led to a complete refusal to visit school. In the process of collecting information about the family, it was found that besides the girls, her father very rarely left the house. He said that he had not left the house for more than a year. He contributed to the financial support of the family by doing home-based job on the computer. He considers himself healthy and denies complaints of the girl. He is glad that in recent years the contact with the daughter established, they became closer, and relations between them are more friendly than between the daughter and mother.*

An important diagnostic criterion for identification of dysfunctional coalitions was a struggle for 'power' between parents/ married couple. A child who occupies a lower position in the hierarchy than any of the parents has to participate in this interaction and to unconsciously 'undertake' actions to prevent changes in the status-quo of the family (which is in general characteristic of families with ill children). The actions of the child are directed to provide a psychological support to a parent who has a weak position at the current stage of family life and of struggle for power, which permits to equalize the forces and to avoid sharp changes in the family system.

Clinical case 4. *Denis P., 15 years old. The boy presents with complaints of fear of hooligans in the street and because of this practically does not stay in the open, spends all his free time at home, but goes to school. It is known from the family history that father of the child is courageous, manful but tough person working in the paramilitary security unit. As mother said, he "does not know what fear is and hates cowards". The mother of the patient is a soft-hearted person lacking confidence. She has serious problems in interrelations with her husband in attempts to carry her point in important family issues.*

In clinical case №4 the presence of an ill child partially brings the mother and child together and enhances position of the mother in the family, since the fact of appearance of fears in a child of such a courageous person like father indirectly indicates his inability to be an example or the weakness of his parental or, probably, other positions or functions in the family. This fact enables the woman to present respective claims to her husband.

1.4. PAD of a child creates a 'pathological triangle' (according to M. Bowen). Anxiety and fear reduce possibilities of a child to communicate with the outer world outside the family or without the family, and substantiate the necessity for a permanent presence of parents beside him (who must render assistance to the child who is unable to adapt). Finally parents having a marital conflict and tension, unite. Drawing a child into marital relations is 'conventionally salvational' for these relations, and, consequently, it is 'conventionally beneficial' for parents to hold the patient (the child) beside themselves which implies formation of a chronic course or frequent recurrences of the disease.

Clinical case 5. *Yulia K. 14 years old was admitted to hospital with complaints of suffocation attacks, palpitation, fear of death which suddenly occur among full health several times a week. The parents said that within 2 years the family was in the 'pre-divorce' condition: permanent quarrels and conflicts, threats with divorce on both parts, highly charged atmosphere at home. Initiation and formation of the disease in the girl sharpened interrelations between the parents – absence*

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of rules in the procedure of achievement of agreements. Treatment of the daughter introduced changes to the life of the husband and wife. Now parents had to learn to agree about the schedule of accompanying the girl: who, how often and at what time can take the daughter to school, take her home, take her to the training session. The disease required coordinated actions of parents for recovery of the child's health (search for doctors, choice of examinations, decision about hospitalization and psychotherapy). Besides, manifestations of the disease had characteristic peculiarities: in panic attack the condition of the girl considerably abated and duration of the attack reduced if both parents were beside her and encouraged her together.

It is important to note that the task faced by the family where an adolescent grows, is to provide his separation. Triangulation of the child into the relations between parents makes transition of the family to the next stage of the life cycle impossible or delays it.

Clinical case 6. *Zina O., 15 years old. From the history it is known that starting from the new academic year, the girls is studying at the cadet school and comes home only at weekends. On Sunday when the girl was returning to the school, she suddenly felt palpitation, a sensation of lack of air and fear of losing control over herself. Further on these 'conditions' repeated both on the way to school (that now required obligatory presence of parents) and at classes at school. At weekends at home the conditions were not observed. In result of exacerbation of the condition the girl no longer attended classes and 2 months before hospitalization stayed at home. At the consultation parents were constantly discussing the issue about unpreparedness of the girl 'to live without parents' and impossibility of studying off-the-house. In the course of psychotherapy a parallel process was identified in the family – unpreparedness of parents to 'live without their girl'.*

II) Hypotheses associated with communication sphere and with other dynamic characteristics of the family system:

2.1. PAD is the result of dysfunctional communications in the family. In this type of families a prohibition for expression of feeling (including anxiety) was observed in combination with the low level of support or with a setting for superachievements. Parents placed inflated demands to themselves, their children and to the surrounding people in fear not to live up to the expectations of society, they focused on failures, and demonstrated polarized thinking of 'all or none' type. Besides, they showed a tendency to see other people as malevolent, indifferent or evil-eyed. Many children said that they lack trust-based relationships with other people and a feeling of belonging to some reference group. Most children from such families noted a high level of parental criticism and distrust in people. Other common variants of dysfunctional communication were cases of 'loss of logical connectives' and 'double messages'.

Clinical case 7. *Kirill Z., 14 years old. Mother who raises her son alone, said many times at a psychotherapeutist's in the presence of the child that she "cannot wait for the boy to grow up", but by her actions she forbade the boy to use the gas stove and kitchen knives. In this way she gave a double message to her son, on the one hand stimulating his moving to adulthood and on the other, blocking acquisition of practical life skills possessed by children of younger age than her son. In result the boy noted an evident anxiety and fear, since all his actions would contradict mother's 'messages'.*

2.2. PAD of the child is associated with change of the roles in the family. All members of the family have a certain number of roles in the behavioral 'repertoire', but if the range of roles is narrow and does not change over time, members of the family may gest 'stuck' in most habitual for them roles. This may impair adaptation and increase the level of anxiety in new life situations requiring change of habitual stereotypes. Thus, in 6 observations a child was assigned the role of an 'ill' or 'disabled' person, he was liberated from all home duties which were placed on other members of the family. Reconvale-

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scence of the child met some resistance, since the model of behavior was fixated not only in the elder members of the family performing these duties, but in the child himself. In the child a 'secondary benefit' formed, and reconvalescence for him was not 'advantageous'. In case of cessation of symptoms, he will again have to fulfil his duties which would mean their redistribution. And this redistribution in some cases initiated a new wave of anxiety, since the habitual roles stabilized in all members of the family, will have to be destroyed again. Thus, the efforts of a psychiatrist (the fact of treatment by a doctor in itself assigns the role 'patient' to a child) trigger a new wave of fears in the family, which form a 'vicious circle' in the pathogenesis of the disease. Besides, initiation of PAD was observed in cases where children were performing unusual for them functional roles.

Clinical case 8. *Egor U., 15 years old presents with complaints of anxiety and worry occurring without any evident cause. A boy grew up in an incomplete family and, in the words of mother, was 'everything for her'. She expected to receive emotional support from him, tried to discuss health problems and work difficulties with him, delegated to him organization of leisure activities and responsibility for the family budget. According to the adolescent, he felt "fully responsible for the family". Hospitalization of the child in this case can be regarded as a metaphor of separation, and at the same time a 'mechanical' method to return to the role of a child, to recover the child-parent relations in opposition to the role of a 'functional husband' which was assigned to him by his mother before admission to hospital.*

In addition to the described case it should be specially noted that in some Western countries all therapeutic measures for PAD in children under 12 (!) years irrespective of the evidence of symptoms, are realized without direct participation of the child, but only through his parents to avoid the 'labeling' effect (fixation on the problem) [25].

III) Hypotheses associated with family history:

3.1. PAD may be caused by peculiarities of family life and situations when a child feels lack of psychic, physical, spiritual and other forces for his healthy life. The described families were characterized by lack of 'strong' male figures (incomplete families in result of death of father or o divorce, cases of deprivation of father of parental rights, father turning to an alcoholic, missing fathers and grandfathers). In many children the story of fear included events of the family past, fears were accompanied by a feeling of defenselessness, helplessness, of lack of support. Patients were characterized by a hope for 'strong figures' mostly of male gender (grandfather, doctor, psychologist, coach, the God) and faith that these significant figures will take care of them, protect, help cope with the problems.

Clinical case 9. *Ivan S., 15 years old. Complaints of polymorphous fears of different content (bad companies, narcotic drugs, AIDS, violence). The boy several times expressed a desire to "have more communication" with the doctor (man) and was glad to get a psychologist who was "also a man!" From the history it is known that the boy grew up in an incomplete family – his father was killed during mother's pregnancy who at the moment raises him with her mother.*

3.2. Anxiety and fear are manifestations of concealed loyalty to the 'excluded' members of the family system. 'Excluded' members of the family in the systemic family psychology are understood as both living and dead relatives to whom a specific attitude exists in the family. In most cases these members of the family are not spoken of and sometimes are not remembered. These 'excluded' relatives may be children who died in infancy, in deliveries or before deliveries, biological parents of fostered children, who committed suicide or disappeared, relatives with mental diseases or those that committed a crime. Despite the fact that this family member is forgotten or abjured, he remains in the family system. The fact of rejection ('exclusion') may produce a destructive effect on the family members, sometimes irrespective

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of whether the 'excluded' members are living or the living members of the family know about this story. The existence of the family mystery (both intentionally constructed or unconscious) being a source of anxiety, produces a negative effect especially on the members of the family who know nothing about it, in particular, on children.

Clinical case 10. *Katya M., 15 years old was admitted with complaints on the obsessive counting of objects. The symptoms appeared 3 years before, gradually built up and enhanced to such extent that it became impossible to concentrate on something else, except counting. From the family history it follows that in this family a similar disorder was earlier observed – grandmother from the maternal line also suffered from obsessions. In the great Patriotic War the grandfather became a policeman, and was rejected by the family who tried not to remember him. The 'finding'-coincidence and the hypothesis of a psychotherapist bewildered the parents. However, after use of the technique of 'reconstruction of the family history' that included investigation of the grandfather's life and stories of relatives about him, search for his photographs and his tomb, manifestations of symptoms in the girl significantly reduced. Finally, the presence of symptoms permitted the members of the family again to actualize the feelings associated with the right to belong to the family history and to the memory.*

Conclusion

General recommendations on organization of psychotherapeutic assistance to children with phobic anxiety disorders:

1. Involvement of the family into the therapeutic process. Phobic anxiety disorders in children and adolescents may be directly linked with the problems of functioning of the family. Conflict in the family may tell on the child's problems. Such children discharged from hospital in satisfactory condition after pharmaceutical treatment, in a short period of time again come to the attention of a psychiatrist with the previously existing problems. Thus, the symptoms in the child are supported and/or enhanced by family dysfunction. 'Vicious circle' may be overcome by inclusion of the family into the complex treatment and rehabilitation program.

2. The main operating systemic hypothesis determines duration of psychotherapy, participants, the central topic (target) and a set of techniques.

Systemic hypothesis determines the choice of tactics and strategy of family consulting by a psychotherapist. The mentioned above techniques are used depending of the operational hypothesis (disorders in the structural aspect, of communication sphere or of family history) taking into account the stage of treatment (beginning, middle phase, completion, work with children-parent and wife-husband relations). In case a doctor has several operational hypotheses, each requires testing in the process of interaction with the family:

1. In most cases a stage of marital therapy is required. A marital couple is a system-forming wedge. Dysfunction in a pair is usually reflected on behavior and health of children. Besides, many systemic hypotheses reflect problems existing between husband and wife and/or parents. Involvement of parents into helping their child not only provides formation of responsible parenthood, but plays in important role in further rehabilitation of a child.

2. Fixation on the resource.

In our opinion, a psychotherapist should construct his interaction with the patient himself and with his family in a way that permits him to find and emphasize those resources of an individual and of the family that may positively influence duration of remission and the process of recovery. It is important to explain to the patient which of his family members and of people outside the family can provide support; what personal qualities of the patient himself and of surrounding people can be most effective in coping with the disease. Use of feedback from a psychologist/psychotherapist may also produce a positive influence on the patient.

In the integrative model of systemic family psychotherapy a special attention is

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given to the factors of social environment that produce the highest influence on the patient, namely to patients' families. Systemic hypotheses of phobic anxiety disorders in children permit to construct strategies for treatment and rehabilitation directed to improvement of the patient's condition through formation of conditions for prolonged stable remission in the family. Inclusion of classes with a family psychologist-psychotherapist permits to move the accents in the assistance to a child to the outpatient network.

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