

Helping families towards greater happiness: Ideas from research into families and family therapy practice.

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Aims

To provide an idea of current knowledge in systemic family therapy and to show why we believe that people with psychological and mental health problems can sometimes best be helped by working with them and their families together

To indicate the knowledge that is available from family therapy research and practice about how to help families towards greater happiness

It is easy in the face of current statistics and dissatisfaction with changes in family structures, the behaviour of youth and maybe of our personal family experiences, to problematise the family. This can lead to an acceptance that people who are unhappy (which covers nearly all DSM classifications) should be taken out of their families to a different context, and cured. Research tells a different story about families, one that leads to therapy that treats the family as the most powerful resource for positive change. The task of therapy then becomes one of mobilising that resource especially in families that have somehow become stuck in unproductive cycles of functioning from which they are not managing to escape.

George Kelly, in creating personal construct therapy, said “if you want to know what is wrong with a patient, ask them. They just might be able to tell you”. My paper extends this thought to say that if you want to know what makes families happy, go by what they tell you. You may notice that I have avoided saying just ‘ask them’.

Viewed as a research question, our options are

1. to theorise about what ought to make families happy;
2. develop measures of happiness and then apply them to plausible interventions; or
3. find out from families what will actually make them happy.
- (4. Or of course we could do the usual thing of thinking what would have made our own family happier, and prescribe this for everyone else, but this is a sophisticated audience so we will not delay ourselves with this one). Though we will each watch out for when we are tempted to do it.

My orientation is to the third option of finding out what families want. Family therapists know about happy families because day after day we collaborate with families who want to be happier. So our knowledge is practice based in the hard reality of trial and error about what works. I am describing some of the kinds of insights available from SFT because we want to make it available / believe it has much to offer to everybody who is concerned with helping families towards greater happiness.

Research offers an optimistic picture of the family

Amid the doom and gloom about families, good research is finding a different story. I will present first the broad hopeful position, then look to research that gives more detailed examples of what we can learn from SFT.

Ungar (2004) studied 43 high-risk adolescents' accounts of their intergenerational relationships with caregivers. He found that teenagers seek close relationships with adults in order to negotiate for powerful self-constructions as resilient. High-risk teens say they want the adults in their lives to serve as an audience in front of whom they can perform the identities they construct both inside and outside their homes. This pattern was evident even among youth who presented as being more peer-than family-oriented.

Fiona Williams in her recent book "Rethinking Families" (2004) collates the research evidence within a framework of "compassionate realism" and concludes that an ethic of care applies across the great variety of family forms.

A study by Campbell et al (2003) drawing on a sample from their major outcome study of childhood depression across three European capitals, found that therapeutic change occurred when it was recognised that the child's depression was relational:

Many significant moments in our study clustered around the growing awareness during the sessions that sad feelings in a child were shaped by, and in turn shaped, relationships; and could be understood as being maintained by the interaction in these relationships. ...In some cases other family members could acknowledge their own depressive feelings and the way these interacted with the child. This process was very powerful; it seemed to lie close beneath the surface of family talk; and it seemed to be a great relief when other family members were able to share their own experiences. (pp. 426-427).

These and similar findings point to the extent to which children value relationships, especially family relationships, above other concerns. They also point to an almost universal wish to care which can lead to symptomatic behaviour in children when they feel they are failing to cope with parental difficulties.

Systemic Family therapists work the way they do because they believe that psychological difficulties of one person play out in the family context, and that help is best offered by finding out how the problem operates within the person's relationships, and how the relationships can be helped to free them from the problem. And for this to work efficiently, it is useful to be able to work with as many as practicable of the family members together. That puts us in a good position to find out what changes families need from therapy.

What can we learn from researching therapeutic change?

I want to briefly describe a current project that is being sponsored by the Association for Family Therapy. When we began searching for indicators of useful change in

families we found that most measures in current use are oriented to individual pathology, usually tied to a specific diagnosis and constructed in relation to the form of individual therapy being offered e.g. the Beck Depression Inventory. There are measures of family functioning but these are predominantly based on modes of family therapy prevalent in North America in the 1970s (Janes, 2006). Another option is to ask the family whether and how the therapy has been helpful. Such questioning, while valuable, does not generate data in a generalisable form. Also it is usually asked by the therapist, so is subject to social desirability effects

So family therapists have not found such outcome indicators to be adequately informative. Because most of us are not working in specialist clinics, a set of measures designed for a single condition would only apply to a small proportion of our cases. Also, the available measures are not consistent with the theoretical approach of family therapists. A diagnosis attempts to narrow the definition of what needs to be ‘cured’ in a way that is antithetical to the aspirations of systemic family therapists. If a family comes with one of its members trailing a diagnosis of anorexia, depression or attention deficit hyperactivity disorder we will have wider objectives than to reduce symptomatology of the labelled condition. Family therapists are likely to be interested in the relationships both to the label and within the family. The purpose of family therapy is more likely to be to broaden out understanding and increase the curiosity of the family rather than to narrow the thinking down into a single ‘correct’ explanation.

The measure that the research group¹ is currently piloting may give an indication of the kinds of change that family therapy has found to be useful. We took as a model the CORE (Clinical Outcomes in Routine Evaluation, Barkham et al 1998; Evans et al 2000)) which is widely used in psychotherapy as an indicator of change in the individual. Our parallel measure is oriented to relational systems and so became called the SCORE.

SCORE questions were distilled out from 40 years of family and family therapy research about the characteristics of functional families, and what constitutes therapeutic change.

Table 1. A sample of the SCORE questions

| |
|---|
| Our family shares enjoyable times together |
| It feels risky to disagree in our family |
| In our family it is best not to show how you feel |
| When one of us is upset they get looked after within the family |
| We blame each other when things go wrong |
| People in the family are nasty to each other |
| We feel hopeful about the future |

The items in Table 1 are examples of the aspects of family life that we believe are relevant to how well a family can cope with psychological distress of one of its

¹ The SCORE group consists of Julia Bland (Chair) Emma Janes, Judith Lask, Peter Stratton, and Ann Ward. Valuable early input was provided by Chris Evans who was one of the originators of the CORE outcome measure.

members. Like family therapy itself, our hope will sometimes be that the difficulties: the depression, problematic behaviour, eating disorder, drug abuse... can be resolved. In other cases, especially major mental or physical illness our hope is to leave the family with ways of maintaining the quality of their family life while ameliorating the effects of the condition on all of them.

What gets in the way of family happiness?

Two sources of limitation are directly addressed by relational therapies: narrow definition of self, and operation of only one style of attachment.

We have known since the pioneering research of Rudolph Schaffer (Schaffer & Emerson 1964) that even in infancy different attachments may be formed to several different people. So we should be thinking of adults as having a repertoire of attachment styles rather than being doomed to apply one style to all situations. There is a similar move in relation to the fluidity of the self. Instead of a fixed personality, therapists think in terms of a changing self, constructed anew in each dialogic encounter. Valsiner (2002) stresses the dynamic functioning of the dialogical self as the way that people create meaning in their relationships. Hermans and Hermans-Jansen (1995) suggest opposing modes of relating depending whether the focus is on a person's own needs, or on others. In the first they will attempt to dominate the encounters while pursuing their perceived needs and rights. In the second they will attend to caring for the other and pursue intimacy and love.

I want to enter a caveat that there will be situations in which Hermans' first orientation is the more functional, just as there are situations in which avoidant or anxious attachment styles are the more viable adaptation. However, the task of a relational therapy is most often to build the tendency to care and pursue intimacy. I will illustrate these ideas with examples from research into blaming in step-families before concluding with a brief review of how systemic family therapists are addressing these issues.

Imagine a recently constituted family in which the step-father and the 14 year-old daughter are in strong, sometimes violent opposition. Our research into such situations has operated by identifying and analysing all of the statements in which a specific cause is offered for a specific outcome (Stratton, 2003). The ways we code these attributions allow us to create groupings of statements with a common aspect. For example, there were many attributions in which the child was presented as in control, while the parent suffered the consequences. (We list the cause, followed by the outcome in each case):

- if I stop pushing
 - Mary is actually going to walk all over us

- because she'd be quite happy just to live with her mum
 - so I just think she has it in for me now

In keeping with Hermans' first mode:

- I am too old to change (he was 46)
 - It's up to her, children should fit in with what their parents say

The field of attributional research identifies 'characterological blaming' as the most damaging way of attributing responsibility:

- cos I don't think she's bothered
 - She is doing pretty much as she likes
- his speech has been far in advance of his understanding
 - he's always been argumentative

Note that these statements are being made with the children present:

- to compensate for all these real or imagined deficiencies (her poor self image)
 - she lies... she's a grotesque liar

As a summary, parents (and step-parents even more) in therapy often talk about their child as being the major source of problems; as causing problems because of the kind of person they are, and doing it deliberately.

While it seems to be the case that blaming has become dominant as a way of attempting to control other people in current society, it is likely that in therapy it becomes most visible in the process of family discussions. Here the corrosive effects of blaming can make it difficult for people to benefit and express their wishes. As Friedlander et al (2000) comment, "expert therapists do view blame as a prompt for action" (p.142). Stratton (2003) describes routes to therapeutic action guided by research into the roles of attributions in relationships.

How systemic therapists labour for family happiness

Current family therapy emphasises working with the positive aspects of families described at the start of this paper. We assume that all families, however desperate, incorporate these motivations towards better relationships and mutual care. The motivations may have become submerged under the difficulties the families are encountering, in which case the therapeutic response is to bring them into prominence. When people in a family have prioritised their own needs and as a result are making excessive demands on others, the therapeutic response is not to persuade them to abandon these needs. Plenty of people will have tried this already, and so the client will have become practised in maintaining the focus on what will certainly feel like an essential requirement. Instead, as the therapeutic relationship develops, it becomes possible to identify more precisely what these needs are, and to explore ways that they can be met but that are more consistent with care and good relationships within the family.

In a similar way, therapists oriented to attachment theory will attempt to provide a sufficiently secure base from which the person can elaborate their representation of themselves as engaging in more collaborative attachment styles.

Some of what we know about families comes from researching therapists who have a lot of experience of working with whole families.

In relation to blaming, Bowen et al (2005) researched the reactions of therapists to episodes of family blaming. The two themes that emerged from the interview data most frequently were 'unhealthy allocation of responsibility for problems', which is arguably the main source of overt blaming, and 'family identity and cohesion' as a major objective of therapy, but the area most challenged by blaming. The reporting of a negative outlook as intrinsic to the blaming was perceived as a direct challenge to therapist idealism. Interestingly, there was a tendency to be drawn into the blaming patterns and sometimes to accept the explanations in referral letters that blamed a child for the problem.

One therapist, responding to having the analysis fed back to her, said "The model plausibly suggests that within an episode of blaming we may be pushed towards ways of thinking that are culturally bound and not consistent with any of the current theories of therapeutic thinking. Therapists may become focussed on the problematic linear thinking of the family in ways that close down rather than open up possibilities." (Bowen et al 2005, p. 325)

Systemic family therapy is a rapidly developing discipline. In recent years it has moved to a more explicit concentration on helping distressed people and families towards happiness, and in developing forms of therapy that are commensurate with the range and complexity of problems that adults and children encounter. Some of these tendencies can be seen in the following trends:

Bringing effective methods into a Strengths/Solution/.

A focus on family strengths, on solutions rather than problems and on a positive future orientation.

Bringing multiple therapeutic methods together (Multidimensional) and working with a wide range of systemic contexts such as the local community, religious groups, school and work (multisystemic).

Working with several families simultaneously (Multiple family therapy) as described by Eia Asen on Day 1 of the conference

A systemic approach to Couples therapy: we so often find that we start with a child referred with some diagnosis – depression, ADHD, conduct disorder etc, and end up working with the parental relationship and at some stage remember to ask how the child is getting on and they say 'oh fine, Sam gave up X a while back'.

I hope this very brief sketch of systemic thinking is an encouragement to use the accrued wisdom of family therapy as one source of understanding about how to help families towards greater happiness. There are many texts, such as Dallos & Draper (2005) that provide a much more detailed and coherent account of therapy while Maehle reviews the ways that a knowledge of child development can be used in family therapy.

Conclusion

This paper is a claim that family therapy research and practice can provide substantial answers to the Conference questions of *What works....what we know* The third part of the strapline was *what we need to know?* I want to conclude that the answer is “lots”. Although we have come a long way in developing practice-based theories and techniques for helping families, we have to recognise that our knowledge is not well coordinated and our practice needs to be even more effective. We have good evidence for the effectiveness (and cost-effectiveness) of systemic family therapy (Stratton, 2005) but research lags behind practice, so very little in the literature relates to the innovations in practice that I have just described. We do need a mental health system that recognises that there is an enormous amount still to learn about psychotherapy and about fostering better relationships. That means supporting research that will release the benefit of what has been learned in the full range of relevant therapeutic practice, and service provision that maintains the variety of promising therapies.

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