

# Contributions of systemic ideas to psychological therapeutic practice



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The systemic approach is essentially a contextual approach to therapy. That is it views the presence of illness or dysfunction as being located within the family system rather than in one of its individual members (Asen, 2002). Practitioners use the term systemic rather than family therapy, because being at the receiving end of family therapy can have strong connotations of blame (Asen, 2002). Systemic ideas have led to major contributions to modern day psychological therapeutic practice, for example, the premise that multi-systems account for the problem and not just the individual experiencing difficulties, a commitment to positive connotation and a non-blaming approach.

Several different versions of systemic therapy have emerged over the years. It began with the initial concept of systems theory and cybernetics being applied to the study, and subsequently the treatment of families (Dallos & Urry, 1999). In the 1950's Bateson and his colleagues studied the patterns of transaction and communication in individuals with schizophrenia. The group hypothesised that the family of the patient was forming his or her thought processes through the peculiar communication requirements imposed (Bateson et al, 1956). The family was seen as a system with homeostatic tendencies. Family members were considered as various parts of this system and seen as behaving according to a set of explicit and implicit rules that determine interpersonal behaviours and communications (Watzlawick et al; 1967). Systemic therapy developed on this view of the family as a system. It aimed to challenge and disrupt unhelpful interaction patterns and dysfunctional communications, subsequently, allowing new ways of communicating to emerge (Asen, 2002).

In fact therapy based on systems theory presented itself as a radical breakthrough in the treatment of mental illness. The prevailing models of therapy at the time considered pathology as predominantly residing in the individual experiencing difficulties. With the introduction of systems theories, it came to be seen in terms of characteristics of the family system. Thus it presented an extremely diverse view of many conditions, such as depression, anorexia, schizophrenia, phobias and anxieties. Dallos & Urry, (1999), provide the example of a child displaying a school phobia. Systemic ideas suggest that the child might be carrying conflicts on behalf of others in the family. “ The child’s symptoms are seen as functional; possible functions could be to ensure a role for an otherwise isolated and lonely mother, to keep a disengaged father involved, and to distract attention from unresolved conflicts in the marriage” (Dallos & Urry, 1999 p. 165). Importantly, this implied that individual treatments might not only be ineffective but could actually exacerbate the problem. To just treat the child in the above example, could serve to reinforce the erroneous view that the problem was residing in the child rather than tackling the causes, which could lie within the family system. It was this breakthrough of seeing the illness not solely as residing in the individual but in the person’s family system that could indeed be regarded as one of systemic therapy’s greatest contributions to psychological therapeutic practice. Thus therapists began to examine the patterns within systems or the family surrounding the individual experiencing difficulties. This first wave of the application of systemic ideas became known as first-order cybernetics (Dallos & Urry, 1999) and are briefly outlined below.

## **FIRST-ORDER CYBERNETICS**

### **Structural approach**

Initially Minuchin and colleagues, (1974), proposed the structural approach.

This approach assumes a normative family model, claiming families function particularly well when certain family structures prevail (Asen, 2002).

Normative families were seen as those with embedded structures, such as hierarchies between generations within a family. It was considered important that these structures had semi-permeable boundaries permitting a sufficient flow of information up and down between hierarchies (Asen, 2002). The aim of structural family therapy is to make a particular family structure approximate the typical (normative) model. Challenging directly absent or rigid boundaries, unbalancing the equilibrium by temporarily joining with one family member against the others, or setting homework tasks designed to restore hierarchies, are some techniques used within a structural approach (Asen, 2002). As mentioned above seeing the problems as residing in the family system rather than the individual was the ground-breaking and somewhat revolutionary at the time and a major contribution to psychological therapeutic practice.

### **Strategic systemic therapy**

Strategic systemic therapy, is founded on the hypothesis that the symptom is being maintained by behaviours that seek to suppress it (Haley, 1963; Watzlawick et al, 1974). Asen (2002) provides the example of a woman with depression and low self-esteem which may elicit her partner's over-protectiveness, a solution that maintains the presenting problem. A strategic therapist may re-frame the problem. For example, suggesting that the

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woman's depression is an unselfish act designed to protect her partner from his own problems. The therapist may then prescribe a ritual whereby for a week on uneven days, the partner needs to experiment with discussing his own concerns (Asen, 2002). It is argued, by strategic therapists that once some changes are achieved in relation to the presenting symptom, a domino effect sets in affecting other interactions and behaviours in the whole family system. (Asen, 2002). The pervading problem is put into a different meaning-frame that provides new perspectives and therefore potentially makes new behaviours possible (Asen, 2002). Once again this reframing of the problem was innovative at the time and led to subsequent developments in therapeutic practice.

## **SECOND ORDER CYBERNETICS**

“ Mental illnesses are indeed mental, in that they are at least 90% made up of blame, or casual attributions that are felt as blame.” (Hoffman, 1993: 391)

The shift towards what became known as second order cybernetics was broadly paralleled with a move in the social sciences towards constructivism and a departure from the mechanistic version of systems theory (Dallos & Urry, 1999). Observations of patterns within systems were still seen as the major starting point but the emphasis was moved to an exploration of how the particular patterns within a family were shaped by their beliefs, explanations and meanings. Therapists began to make no assumptions about how family life should be and what represented a ' healthy' family.

The basic premise of this ' second wave' of systems theories (Dallos & Urry, 1999) was that the therapist and supervision team were seen as formulating

certain ideas about a particular family's dynamics. These were regarded as no more than working hypothesis (Selvini Palazzoli, 1980) and it was believed there was no objective reality waiting to be discovered (Dallos & Urry, 1999). It was imperative that therapists worked in teams rather than individually because it was seen as essential that the therapists continually reflected on and questioned their perceptions.

### **The Milan systemic approach**

The Milan systemic approach advocated by Selvini Palazzoli and colleagues, (1978), holds great emphasis on a particular style of interviewing – circular and reflexive questioning (Selvini Palazzoli et al, 1980). The approach focuses on questioning the various family members' beliefs and perceptions regarding relationships. Asking each to comment and reflect on the answers given by the various other family members creates feedback that changes the fabric of family interactions (Asen, 2002). The Milan group's commitment to positive connotation produced a non- blaming approach. Selvini Palazzoli, Boscolo, Cecchin & Prata ,(1980), succeeded in establishing three principles that they considered indispensable to interviewing the family correctly. They called these principles – Hypothesising , Circularity, Neutrality.

“ By hypothesising we refer to the formulation by the therapist of a hypothesis based upon the information he possesses regarding the family he is interviewing. The hypothesis establishes a starting point for his investigation as well as his verification of the validity of this hypothesis based upon specific methods and skills. If the hypothesis is proven false, the therapist must form a second hypothesis based upon the information

gathered during the testing of the first” (Selvini Palazzoli, et al, 1980; p. 1)  
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A fundamental point emphasized was that every hypothesis had to be systemic, therefore, include all components of the family. The hypothesis was seen as neither true or false but more or less useful. That is, it was used by the Milan group as more of an investigative tool. By investigating proposed hypotheses of the problem, whether they proved true or false, the hypothesis served its essential function of providing the team of therapists with new information.

The second principle proposed by Milan systemic therapy was that of circularity.

“ By circularity we mean the capacity of the therapist to conduct his investigation on the basis of feedback from the family in response to the information he solicits about relationships and, therefore, about difference and change” (Selvini Palazzoli et al, 1980, p. 4)

The acquisition of such an ability demands that therapists free themselves from the linguistic and cultural condition that make them believe they are capable of thinking in terms of “ things” so that they may rediscover “ the deeper truth that we still think only in terms of relationships” (Bateson, 1968; p. 173). Circular questioning has subsequently been described as both an information-gathering and a change-inducing procedure. According to Tomm “ the purpose of a systemic interview is not so much the removal of a problem but the discovery of its systemic connectedness and hence its temporal necessity (Tomm, 1985; p. 44). The recognition of this necessity makes the need for alternatives self-evident and may result in a problem resolution that appears to be spontaneous (Tomm, 1985).

The third principle was termed by the Milan group as “ neutrality”:

“ By neutrality of the therapist we mean a specific pragmatic effect that his total behaviour during the session exerts on the family (and not his intrapsychic disposition).” (Selvini Palazzoli et al, 1980; p. 6). Ideally if the principle of neutrality is maintained throughout a family session, the family members should feel that the therapist had not sided or supported any one family member in particular. Instead the Milan- systemic therapist builds successive alliances, the end result of which is that the therapist is allied with everyone and no one at the same time. The therapist works to provoke feedback and collects information, the more the therapist does this the less apt to make moral judgements of any kind. It is also the responsibility of the therapist to observe and neutralize as early as possible any attempt towards coalition, seduction, or privileged relationships with the therapist made by any member or subgroup of the family (Selvini Palazzoli et al, 1980).

## **Social Constructionist approach**

The Social Constructionist approach is based on the reality that the therapist observes is created, with perceptions being shaped by the therapist’s own cultures and his/her ingrained assumptions and beliefs. This approach is influencing many systemic therapists and has led to an examination of how language shapes problem perceptions and definitions ( Asen, 2002). Family therapists are interested in the active process of meaning-making and the greater variation of possibilities – the inherent ideas in particular discourses and the ideas that had been excluded (Boston, 2000). If the narratives in which clients describe their experience- or have their experience reported by mental health professionals- do not fit these experiences, then significant

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aspects of their lived experience will contradict the dominant narrative (White & Epston, 1990: cited in Asen, 2002) and be experienced as problematic.

## **Narrative Therapy**

Systemic narrative therapy proposes to help families to produce and evolve new stories and ways of understanding events to make sense of their experiences. Family and therapist together co-construct new ways of describing the individual and related family issues so that they no longer need to be viewed or experienced as problematic (Asen, 2002).

## **Brief solution-focused therapy**

In brief solution-focused therapy, the problem-drenched ways of talking are deliberately ignored, with the focus instead on the patterns of previous attempted solutions (De Shazer, 1985). The approach is based on the observation that symptoms and problems have a tendency to ebb and flow. During times when a symptom is less or not present, the therapist designs therapeutic strategies around the exceptions, as they form the basis of the solution. “The theory postulates that by encouraging families to amplify the solution patterns of their lives, the problem patterns can be driven into the background” (Asen, 2002; 231).

## **Psychoeducational approaches**

Psychoeducational approaches (Leff et al, 1982; Anderson, 1983) combine behavioural interventions with structural approaches. Family members are educated about the causes and the course of the individual's mental health problem. The general aim of therapy is to reduce the emotional intensity in

the family as well as the degree of physical proximity (Asen, 2002). One of the main important aspects of this approach are regular relatives' groups- to share experiences and solutions- and family sessions (Kuipers et al, 2002) (Asen, 2002).

## **Behavioural family and couple therapy**

Behavioural family and couple therapy views the family as a major health-enhancing resource, with each member doing his/her very best to maximise pleasant and minimise unpleasant events in the family unit and the immediate social environment (Asen, 2002). Therapists in this framework employ such things as contingency contracting or operant conditioning to illicit behavioural change. After observation and analysis of recounted family or couple interactions, concrete goals for change are targeted by both family and therapist. The therapists and families work together on behaviours which can be easily modified and changed. Initially the focus is on positive feelings, ideas and plans and once some progress has been made, the focus shifts to the expression of negative feelings, in a constructive manner so that problem resolution can be facilitated (Asen, 2002). The therapist then adopts a structured- problem solving stance to encourage family members to agree on the problems and goals, discuss solutions and to highlight advantages and disadvantages of each proposed solution. Finally an implementation plan is put in place and the family and therapist continually review the efforts and results (Falloon, 1988).

## **Summary**

In summary there are extremely diverse systemic approaches which have developed since the initial application of systems theories to therapy in the <https://assignbuster.com/contributions-of-systemic-ideas-to-psychological-therapeutic-practice/>

1950's. In its very conception, systemic therapy challenged the psychiatric/medical prevailing attitudes of the time and offered an alternative to the oppressive practices of stigmatization, isolation, confinement and enforced treatments. The innovative idea of externalising the problem to the individual's wider systems and a fierce commitment to positive connotation has had a major impact on current therapeutic interventions. In addition to this, the premise of enlisting family members or 'system' members as therapeutic agents, surrounds the individual experiencing difficulties with an invaluable support system. The next section of this paper highlights the impact and contribution of systemic ideas to therapeutic practice by discussing the evidence base for anorexia, schizophrenia and child-focused problems.

## **ANOREXIA NERVOSA**

Over the past two decades family therapy has gradually established itself as an important treatment approach in eating disorders. It has been found to be particularly effective in adolescent anorexia nervosa. Its impact to the treatment of anorexia nervosa, particularly in adolescent sufferers could be considered to be one of Family therapy's greatest contributions in a clinical setting.

There is a consistent body of empirical evidence for the effectiveness of family -based treatments which adds significant weight to the earlier clinical and theoretical accounts of some of the pioneers of family therapy such as Minuchin (Minuchin et al. 1975) and the Milan group (Selvini Palazzoli et al. 1974) and has undoubtedly been one of the important factors in the major

changes in the treatment of eating disorders that the field has witnessed in the past 20 years (Eisler, 2002).

However in contradiction, alongside the evidence for the effectiveness of family therapy, there has also been growing evidence that the theoretical foundations from which this treatment has evolved are flawed. The 'psychosomatic family' model proposed by Minuchin et al (1978) suggested that there was a specific family context within which the eating disorder developed. It was suggested that a particular family process evolved around the symptomatic behaviour in interaction with vulnerability in the child and the child's role as mediator in cross generational alliances (Minuchin et al. 1975) (cited in Eisler, 2002). Minuchin et al. (1975) emphasised the evolving and interactive nature of the process and saw the resulting 'psychosomatic family' as a necessary condition for the development of the eating disorder. The evidence for the psychosomatic family is weak and more recent findings have indicated that families in which an eating disorder sufferer is present are heterogenous group. This heterogeneity is not only with respect to socio-demographic characteristics but also in terms of the nature of the relationships within the family and the emotional climate and patterns of interactions (Eisler 1995).

Regardless of whether the family has an impact on the aetiology of the eating disorder, the major impact of an eating disorder, on family life, cannot be denied. " As time goes on food, eating behaviours and the concerns that they give rise to begin to permeate the entire family fabric, every relationship in the family, influencing daily family routines, coping and problem solving behaviours."(Eisler, 2002, p. 292). Due to the monumental <https://assignbuster.com/contributions-of-systemic-ideas-to-psychological-therapeutic-practice/>

impact of the disorder on the entire family, an intervention that includes the entire family seems logical.

The most important facet of systemic therapy is that the family is seen as resource. It is important to explore with the family where things have got stuck and to help them to re-discover some of the resources that they have as a family so that they can become 'unstuck' and start looking for new solutions to the problems (Eisler, 2002).

As mentioned previously there is a growing body of evidence for the effectiveness of systemic family therapy in the treatment of anorexia, in particular adolescent anorexia nervosa. The initial studies were uncontrolled follow up studies. The first study of family therapy with patients with a diagnosis of anorexia nervosa was conducted by Minuchin and colleagues (1975). Their study involved 53 anorexic patients, just over half of whom started receiving inpatient treatment in conjunction with family therapy. Some patients were also seen individually. The results were extremely positive, the researchers reported a recovery rate of 86%, however the study has been heavily criticised for its methodological weaknesses (the evaluations were conducted by members of the clinical team, there was no comparison treatment and the length of follow-up varied from 18 months to 7 years ) (Eisler, 2002).

A similar study conducted by Martin (1985) showed positive results comparable to that of Minuchin and colleagues' study. The research was a five year follow up of 25 adolescent anorexia nervosa patients (mean age 14.9 years), with a short duration of illness (8.1 months). At the end of the

treatment period there had been significant improvements, although only 23% would have met the Morgan/Russel criteria for good outcome, 45% for intermediate outcome and 32% poor outcome. The results at follow-up were 80% having good outcome, 4% intermediate and the remaining patients either still in treatment (12%) or relapsed (4%).

Two other studies (Dare, 1983; Mayer, 1994) used family therapy as the only treatment intervention and found that 90% of patients had made significant improvements or were recovered at follow up. However, both of these studies were small (12 and 11 patients).

A third larger study, conducted by Stierlin & weber, (1987, 1989), took place with families seen at the Heidelberg Centre over a period of 10 years and adds to the evidence that adolescents and probably also young adults, do well in family therapy (Eisler, 2002).

To date there has not been very many randomized clinical trials in anorexia nervosa and the few that there is having been relatively small. Russell and colleagues (1987), compared family therapy and individual therapy and found that adolescent patients with a short duration faired significantly better with family therapy than the control treatment (individual therapy). The findings were however, inconclusive for those with duration of illness of more than three years who mostly had a poor outcome. Eisler (1997), conducted a five-year follow up of this study and showed that in the adolescent subgroup who had a short history of illness, those who received family therapy continued to do well with 90% having a good outcome. In comparison while those that had received the individual therapy also

improved, nearly half still had significant eating disorder symptoms. This finding suggests that the benefits of family therapy can still be detected, 5 years after the end of treatment (Eisler, 2002).

Several other important studies have compared different types of family therapy. Two such studies were Eisler et al (2000), and LeGrange and colleagues (1992). Both researchers compared Conjoint Family Therapy (CFT) and Separated Family Therapy (SFT) in which the adolescent was seen on their own and the parents were seen in a separate session with the same therapist. Overall, the results of both studies showed improvements in both the CFT group and the SFT group. The study by Eisler and colleagues, suggested that on individual psychological measures and measures of family functioning there was significantly more change in the CFT group.

Similarly, a study by Robin et al (1999), also investigated the differences between two forms of family therapy. Researchers compared conjoint family therapy, which they described as behavioural family systems therapy – BFST, with ego-orientated individual therapy – EOIT. The EOIT consisted of individual therapy for the patient on a weekly basis, combined with fortnightly meetings with the parents. Robin and colleagues, (1999) found that by the end of treatment, both the BFST (similar to the Eisler, CFT group) and the EOIT group patients had significantly improved, with 67% reaching target weight by the end of treatment. A one year follow up found that 75% had reached their target weight. The research found that BFST led to significantly greater weight gain than EOIT both at the end of treatment and at follow-up (Robin et al. 1999). Both groups produced comparably large improvements in eating attitudes, depression and self-reported eating-

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related family conflict. Furthermore a decrease in maternal negative communication and an increase in positive communication was found in the BFST group but not the EOIT group.

In summary, the overall consistent findings of these studies is that adolescents with anorexia appear to respond better to systemic family therapy, and often without the need for inpatient treatment (Eisler, 2002). Conclusions about the comparisons between different kinds of family therapy have to be examined more carefully. This is mainly due to the small size and small number of comparative studies (Eisler, 2002). It seems apparent that those treatments which encourage the parents to take an active role in tackling the adolescents anorexia are the most effective. According to Eisler, 2002, these therapies may have some advantages by over involving the parents in a way that is supportive and understanding of the adolescent, but encourages them to step back from the eating problem. Furthermore it has been suggested that not involving the parents in the treatment at all, leads to the worst outcome and may considerably delay recovery of the patient. However it should be noted that seeing whole families in which there are high levels of hostility or criticism, may be disadvantageous to the individual with anorexia. According to Szmuckler and colleagues, 1985, such families may be difficult to engage with and this may be even more salient when the whole family is seen together. During family sessions feelings of guilt and blame may be increased as a consequence of criticisms or confrontations brought up during the family therapy session (Squire-Dehouck, 1993).

## **SCHIZOPHRENIA**

Providing family intervention therapy for individuals with schizophrenia is widely accepted as being beneficial to the both to the individual with schizophrenia and their families. Both the NICE (2003) and PORT (Lehman et al., 1998) guidelines recommend some kind of ‘ family work’ or ‘ family intervention’ for schizophrenia (Bertrando, 2006). It’s efficacy with treating individuals with Schizophrenia could also be considered one of systemic family therapies major contributions to clinical practice. Although there is considerable variability in the format of systemic-family based interventions, they tend to share a common set of assumptions. Firstly schizophrenia is regarded as an illness; secondly, the family environment is not implicated in the etiology of the illness. Third, support is provided and families are enlisted as therapeutic agents and lastly the interventions are part of a treatment package used in conjunction with routine drug treatment and outpatient clinical management (Lam, 1991; Dixon & Lehman, 1995). The elements of family interventions most frequently used in differing combinations are psycho-education, behavioural problem solving, family support, and crisis management (Dixon & Lehman, 1995). It is clear that effective family treatments involve at least some conjoint family meetings which include symptomatic and non-symptomatic family members. Emphasis is placed on blame reduction, the positive role which family members can play in the rehabilitation on the person experiencing difficulties and the degree to which family intervention will alleviate the family’s burden of care (Carr, 2000). One helpful aspect of systemic -family intervention is that it provides family members with an ‘ explanation’ or ‘ framing’ of the condition which provides “ a rationale for reducing family stress, increasing family support and active

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coping and arranging for the person with schizophrenia to adhere to the prescribed medication regime” (Carr, 2000; 284).

Initially a study by Brown (1972) found that people with schizophrenia from families that expressed high levels of criticism, hostility, or, over-involvement have more frequent relapses than individuals with similar problems from families that tended to be less expressive of their emotions. There are now several interventions available to families involving education, support and management to reduce expressed emotion etc. (Pharoah et al, 2006). The aim of such family interventions is to reduce stress within the families and subsequently by doing so reduce the levels of relapse. Interventions are proposed to accompany drug treatments rather than to be used as an alternative (Pharoah et al, 2006).

A review by Mari, (1996), found that family interventions in Schizophrenia significantly reduced hospital admissions at one year follow up. Further to this, the most recent review carried out by Pharoah and colleagues, (2006) lends support to Mari’s, (1996) original finding and up to date evidence suggests that family intervention does statistically and significantly reduce hospital admissions at one year (Pharoah et al, 2006). In addition, at 18 month follow up, family intervention was still found to significantly reduce levels of admission to hospital. A study lending support to this hypothesis, reported that total number of days spent in hospital at 3 months was significantly lower for individuals that had received family interventions. Another study by Xiong (1994) cited by Pharoah (2006), favoured family intervention. The authors reported that 33 individuals receiving family intervention , spent on average 7. 9 days in hospital by the end of 1 year

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follow up period, compared to 28 controls who spent on average 24 days in hospital.

In terms of effect of family intervention on the families or relatives of the individual with schizophrenia, a study by Bloch, (1995), pointed that family's ability to cope with the illness was not clearly increased by family intervention. However, the study did report that the families understanding of the patients' needs were statistically increased by family intervention. In contrast Szmuckler, (2003), reported on continuous measures of coping by the carers and found ambiguous results with no benefit been shown for those in intervention group compared to controls. However studies have proven that family intervention decreases significantly the levels of criticism and hostility compared to groups not receiving family therapy (Tarrier, 1988). Increased understanding of an individual's difficulties with schizophrenia, coupled with decreased levels of hostility and criticism towards that person, can be viewed a significant and important contribution of systemic therapy to dealing with this condition.

There is also evidence to suggest that family intervention is favourable when compared to standard care. A study by Chen, (2002; cited in Pharoah, 2006), reported that at the end of 1 year follow up, family therapy intervention did significantly reduce relapse rates of patients. Zhao, (2000), found that at 2 year follow up rates were again significantly lower in the family intervention groups. Furthermore studies looking at relapse rates at 3 year follow up also favoured family therapy (cited in Pharoah, 2006).

In their review, Pharoah and colleagues, (2006), concluded that people receiving family therapy may relapse less than standard care groups. However it is noted by the authors that unpublished and inaccessible smaller negative studies that could not be included in the current review, and may weaken the overall findings (Pharoah, 2006). But at the moment the best available evidence suggests that approximate number of families needed to be given Family Intervention in order to avoid the relapse of 1 patient at the end of 1 year, is 8. The impression of better overall global improvement in family intervention groups is supported by several other studies (Xiang, 1994; Ran, 2003; cited in Pharoah, 2006).

Family intervention was not shown to either hinder or promote the completion of one year of therapy , however findings do suggest that family therapy does promote compliance of individuals with schizophrenia and medication (Pharoah, 2006). The authors propose that it can be speculated that this is the reason that family Intervention has its main effect. Hogart, (1997), suggests that although compliance with medication was indeed improved by family