Module:
Mental Health in the Community

Week 4
Psychosocial approaches to care in the community

Topic 2
Psychological approaches II: Beyond the individual to couple, family, and group work – Part 2 of 2

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Lecture transcript

Slide 3

Strategic family therapy has a strong affinity with structural family therapy, but emphasises more interactional dynamics and power struggles, and regards the difficulties as resulting from a family's need to change and reorganise at key transitional stages. According to Haley, who's one of the main proponents of strategic family therapy, difficulties arise in a family when there are incongruent and confused hierarchies. According to Haley, symptomatic members get triangulated in cross-generational interactions that actually reinforce and contribute to the confusing hierarchies. Now, strategic family therapists adopted a functionalist viewpoint, which is the notion that dysfunctional families need the symptomatic behaviour as a stabilising device in order to relieve stress, and this is at the core of the approach.

Slide 4

For example, the identified patient becomes essential in order to maintain primary stability, and for the other members of the system to avoid confronting their own problems, and this is called conflict detouring. At the same time, strategic therapists also recognise the possibility that the identified patient uses the symptom as a strategy to control the other members of the group - and this is called to incongruous hierarchy - and that would be a way to feel loved, to feel protected, or even to dominate the other members of the group. So if we think about families, what a strategic family therapist says is that, at times, parents may lose their superior position in relation to the helplessness of the symptomatic child, who in turn gains power and control.

Slide 5

Now the important thing is that strategic family therapists view the problems as attempted solutions. There is a focus on the developmental strategies that can change the need for the symptom and that can help the family redistribute power in a much more balanced way. Therapists become the experts and focus primarily on hierarchy and power struggles, through directive and paradoxical tasks, while overlooking the family structure, which was instead emphasised by structural therapists.

Slide 6

During the 1970s, some scientists criticised previous approaches for being too mechanical, and emphasised instead the importance of exploration of meanings, beliefs, and family stories. Now, in addition to understanding family structures, the Milan followers (which are typically believed to

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be second order cybernetics) argued that it is crucial to study communication. It is in fact through communication that family relationships are defined and therefore the family structure. Now, according to this model, prejudices - or beliefs - are located within the communicating systems, and the importance of values, background, attitudes, and culture in the creation of a negotiation of meaning is actually stressed.

Now, the Milan approach embodies the idea that we discussed at the beginning of this lecture, that argues that the family is the maker of meaning, and that families tell themselves stories which organise their experience. Now, whereas first order cybernetics adopted a functionalist view of problems (in which symptoms are believed to preserve stability), second order cybernetics challenged this view and argued that, actually, the function of a symptom was not to be discovered, and that a functional view existed only in the eye of the observer.

Slide 7

So the Milan Group did not regard their clients as phenomena out there, but rather as a therapeutic system that consisted of the family plus the therapists. They used the therapeutic encounters to create new meanings that would lead to new patterns of thought and behaviour. Now, the Milan Group focused on overcoming the 'tyranny of linguistics', which they believed keeps therapists and clients thinking in an intrapsychic, linear manner. So they sought to create a different language which allowed them to understand families in different ways, and that allowed a family to find new language that was open to difference, and that was open to alternative meanings and points of view. The rationale behind this process was to free the family and the therapeutic system from entrenched meanings that led to systems becoming stuck.

Slide 8

The Milan Group argued that mental phenomena reflect social phenomena and that what is called a 'mental problem' is really a problem in social interaction, so therapies should be directed at patterns and interactions instead of at the intrapsychic dynamics of the individual. Problems were reframed in social terms rather than being rooted within individuals.

Slide 9

An example of this was discussed by Checchin and colleagues (1994), and they related the encounter with an adolescent boy who was brought to therapy apparently because of his violent behaviour and his antisocial behaviour. Now, Checchin and colleagues spoke of the fact that the initial discussion between the members of the team was mainly negative towards the boy's behaviour, and they reflected on the fact that the team had allowed themselves to become trapped in a negative loop in which the family had also been trapped.

Slide 10

However when the problem was reframed in a more positive and social light, it was actually possible to rewrite a story that, instead of blaming the adolescent for his reported violence and antisocial behaviour, connected all of the family members. So what the Milan team managed to do was to develop a new meaning that connected the boy with the family's attempt to keep the memories of his grandfathers alive. in this way, the difficulties the family had presented with were reframed, and moved from an individual level to a much more relational level, a level in which the family's way of relating to each other and to the deceased grandfather had become unhelpful to the family members. Part of the prescription, in this family's case, was for the boy to find a way to help his relatives to stop, or at least to deal with, their worries about him. The problem was re-framed in social and relational terms, which helped, removing the blame and the guilt from the boy's behaviour.

Slide 11

Although it can be argued that all family therapists are systemic, in that they consider the person

in a larger context of which he is simultaneously a part, yet distinct, and in that they view the symptom of an individual member as rooted in the family as a whole, the Milan School can be regarded as the most systemic. In fact, to maximise the systemic approach, associates work interactively in teams from behind a one-way mirror, and this is a technique which is called the Greek Chorus. It offers inputs whose aims are to support, confuse, challenge, and confront the family, while remaining at a distance and therefore maintaining an objective stance.

Slide 12

The shift from the first to the second phase of systemic therapy saw a movement from an emphasis on pattern and processes to an increasing awareness of the social and cultural context that shapes both families' and therapists' beliefs. Now in the third phase there is a growing realisation that the development of problems is fundamentally shaped by culture and language, which actually define power. This phase is a definite move towards social constructionist theory, to the point that some clinicians such as White and Epston even argue that this is the end of family therapy. Now therapists become much more aware that the 'reality' that they observe is a construction, and that everything an individual experiences is influenced by dominant discourses in society. So, as we already mentioned at the beginning of this lecture, our understanding of our identity, gender, family roles, expectations, is shaped by dominant discourses and ideologies in society.

Now, social constructionism argued that these meanings are co-constructed in interactions that are shaped through language. So rather than focusing on an individual's experiences, or on the structure of the family, or on their relational context, the third phase of systemic therapy views problems as almost stretched across social context. There is an emphasis on the strategic use of language and how language defines power. So for example, doctors, scientists, or politicians might actually use technical jargon to keep power differences and to boost their own status. But also, a sophisticated use of language has often been an indicator of status in society.

Now what the third phase argues is that even our own inner dialogue is constructed of verbal dialogues and images from our culture. Hence, language becomes strategic and used to initiate change. So for example, Anderson and Goolishian argue that the problem is not within the family's dynamics or structure, but rather in the way the discussion about these problems have become saturated. These discussions, as we have already seen, can lock families into becoming stuck in one way of seeing their actions and experiences. Hence part of the therapist's goal is to enable families to construct alternative narratives.

Slide 13

Influential approaches of this phase are narrative therapy and feminist perspectives. Let's look at narrative therapy in a bit more detail. Now narrative therapy has often been associated with attention for issues of stigma, gender, sexuality, and racism, amongst others. The characteristic element is that narrative therapy looks at how these issues, not only from an individual or family perspective, but also from a community perspective, is specifically this multilayered element that allows the narrative approach to explore and encourage multiple perspectives on viewing a situation. Now the argument put forward is that there is a dominant psychobiological paradigm that locates problems within individuals, and that ends up leaving individuals feeling helpless and unable to challenge or address problematic experiences.

Slide 14

For example, if we think about someone who says that they feel depressed. As we have already discussed, an intrapsychic way of thinking about it would be that this is a condition which is internal to the person, and over which they have very little or no control at all. Now, a narrative approach would not directly challenge this view. Instead, it would focus on the overarching framework, which may be problematic because people may end up feeling that they have little room for agency. Now what can happen is that, if people identify with narratives that are saturated, their attention will focus and it would be skewed towards noticing information that will reinforce their view. Now from

a narrative perspective, the problem is not the problem as such, but is the identification of the individual with a problem-saturated narrative.

Slide 15

So, what do we do about it then? Well, the first step in narrative therapy is really to explore this dominant story that the person has about their life and about their problems - so basically just explore what has brought individuals to therapy. Now, the intention in doing this is to develop a map of the problematic descriptions without accepting that this is the full or the only story that the person has. Now, very often when we feel stressed or we face a problem we might feel as if this is all-engulfing, and we might actually struggle to think of different perspectives. But the reality is that no problem is all-engulfing. Now, we all see different things from our problem, and there will be times when our problem is more under control or when it feels less overwhelming, but often we can't actually notice these exceptions because the problem-saturated description tends to minimise any different experience. So in mapping the influence of the dominant narrative, the therapist's purpose is also to begin to notice, and have questions for the client, about exceptions. Now in doing this, it is really crucial to pay attention to the client's experiences because of the danger that the person might feel invalidated. Though exploration of instances in which the person challenged or stood up to their problems, the individual might develop a bit of a sense of personal agency, which might eventually allow them to feel and behave differently.

Slide 16

Now, a key technique is externalisation, so, having a problem, rather than being the problem: presenting with symptoms of depression, rather than being depressed. People are encouraged to resist the problem by seeing it as external to them, something that has entered their lives as an unwelcome visitor. Now, both individuals and family members are encouraged and positively challenged to consider ways in which they can actually work together and trick and resist the problem. Now, a very nice example of externalising is the clinical case of Sneaky Poo, a real life case of a boy who struggled with encopresis. Michael White, who worked with the boy, used the term 'sneaky poo' to personify it as an entity which was external to the child, and this allowed the psychologist to kind of almost recruit the child in order to fight the problem together.

Slide 17

Let's think about this for the client who, for example, experiences panic attacks. Now, the person might come to you and say that they experience a panic attack every time they leave the house, and they might experience fear about doing anything at all outside the house. Now, the first step in a narrative approach might be to really reframe the problem as the client being tricked and being bullied by the fear, or by the panic. Then the problem becomes externalised. So rather than talking about the client as a fearful person, the therapist might be able to explore the impact that fear has in her life, and how fear is able to trick and bully her. Now, this would understandably lead to very different conversations from the one that we would have if we spoke about the client as being fearful, and might actually encourage questions, such as, different times in which the fear was or wasn't able to trick the person into staying at home. The conversation might open up possibilities about the client being able to stand up to fear, and how this experience might be, which then in turn might enable the client to develop a different understanding of these exceptions. You can imagine that this approach would enable the client to reframe the problem from a linguistic point of view and to use language as a vehicle of change.

Slide 18

In this phase there is really an acknowledgment that pathology is inevitable, because it actually reflects the pathology within society - so for example, the discrimination that women and ethnic minorities face. Families are seen as a mirror of society, a microcosm which reproduce rather than create these difficulties.

Slide 19

As discussed, newer approaches highlight the integration of several theories and several models as clinicians borrow concepts and techniques across theoretical boundaries. Now, an example of this is attachment narrative therapy, which combines attachment, narrative, and systemic theories and techniques. This approach combines systemic principles, which view difficulties as belonging to the family, with ideas of how these difficulties are fuelled by underlying attachment dynamics. Now this is in turn explored through family members' narratives: so how a family member understands and explains the problems and how these explanations are connected to, and in turn shape, the attachment patterns.

We've already spoken about attachment and the relevant secure-insecure attachment style in Module 1. We've also covered the principle of systemic therapy, and the underlying socio-cultural background, and their understanding of how psychological distress develops. We have also spoken about the narrative idea of problem-saturated conversations. Attachment narrative theory combines all of these elements to understand how difficulties might develop.

Slide 20

So, for example, in an individual presenting with eating disorders, the model would conceptualise these difficulties as originating from an insecure attachment style, and there is a lot of research that suggests that eating disorders are linked to insecure attachment styles. They will also look at dysfunctional family dynamics. They might look at disturbances in the relationship between the child and the primary caregiver. They will look at a failure to develop autonomy from a parental figure. They will look at boundaries, enmeshed boundaries. But also they will look at the nature of narratives in individuals presenting with eating disorders and in families of individuals presenting with eating disorders.

Slide 21

So things that therapists of ANT might look at is difficulties in discussing or expressing emotional states, they might look at lack of coherence in narratives, which again is typical of insecure attachment styles, and they might also look at the difficulty in adopting alternative narratives, or the difficulties in considering the possibility that others might see things differently; and they combine all of this in a newer approach.

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