How brain injury rehabilitation may benefit from knowledge on the development of theory in family therapy

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CITATION
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Abstract
This paper considers how family therapy theory can inform work with families and clients with brain injury.

Keywords
family therapy; acquired brain injury; rehabilitation; review

Introduction
This paper was written as part of the foundation course in systemic and family therapy. It summarises the opportunities the course offered to review my own practice in the light of growing disquiet at unimaginative accounts of how we should educate or support families to live with brain injury, and instead offered an invitation to look again at what may be gained from taking a stance of curiosity to consider what may be learnt from working with families who find their own ways of negotiating life post injury.

A brief history of modernity
To place in context the development of both family therapy and parallel developments in brain injury, I will briefly summarise the early development of family theory. Family therapy emerged in the context of a
prevailing empirical paradigm in which we, as observers, all experience the world in the same way and gain evidence that accumulates to knowledge of the world that can be verified by multiple experiences. In the history of family therapy, the development of structural schools arose within this model. This therapy focused on observing ‘invisible’ demands that organise how a family interacts (Minuchin, 1974), with the aim of then altering these demands so that families with a ‘problem’ symptom would eventually come to resemble the more normative family structure.

In this model, supporting families adjusting to illness in one family member became a process of exploring how one event had altered the rules governing family organisation in terms of subsystems, boundaries, hierarchies and alliances (Hayes, 1991), and providing challenges, education and prescriptions that encouraged and restored functional structure in the face of illness-based stressors (Woods, 1994). In brain injury services in the 1980s, this was reflected in a particular focus on helping members re-establish or re-distribute role obligations (e.g., where a father has previously worked full time, but will now have full time parenting responsibilities), and to redefine generational boundaries in the light of potentially altered abilities and relationships between members, (e.g., to support the parental sub-system to present a ‘united front’ on discipline in response to children testing parental boundaries as they grew aware that they could ‘out-think’ dad at times; Laroi, 2000).

Within this ‘expert’-based approach there was a danger the needs of individuals became valued only in so far as they contributed to the running of a functional family unit, and no recognition that observation of families who successfully negotiate life after brain injury by adopting less conventional family structures and responsibilities could actually inform our view of what represents a normal family.

Responses to these limitations of a strictly structural approach to families were generated by looking to ideas from philosophy that challenged this empirically based account of reality. Later family theorists referenced the ideas of Kant who saw that observers may do more than stumble over the truth as it lies in walt, and that instead the act of making an observation at a particular time and point in space may influence reality as it is perceived and interpreted as “objects must conform to our knowledge” (1781).

**Early systemic theory**

Bateson drawing on not only these ideas but also from work on cybernetics and ‘general systems theory’ (von Bertalanffy, 1968) in the 1960s began applying these constructivist thoughts to the family structure, exploring ideas of the family as a system that has a regulatory function (e.g., Bateson, Jackson & Haley, 1956). In family theory, a system became “a group of elements in interaction with one another over time, such that their recursive patterns of interaction form a stable context for individual and mutual functioning” operating in an open unit “which interacts with other individuals, groups and context” (Jones, 1993, p.2).

Thinking about this school in relation to families adjusting to brain injury, problems could be hypothesised to occur when other family members experience change as highly traumatic, leading to a wish to bring the early adjustment and recovery period to as quick a resolution as possible. This may however lead to attempts to over-adapt to compensate for change in the injured family member, thus preventing a more shared and ‘helpful’ version of homeostasis being reached. At worst this leaves families stuck in rigid styles of responding, e.g., showing ‘protectiveness’, which may have been helpful in the very early stages of life post injury, but which may become less helpful as recovery occurs and circumstances change. Use of family therapy models based on strategic and early Milan schools may be beneficial in this scenario, to allow therapists to observe family communication in action, to seek out points of shared meaning, and to open discussion on potential helpful and unhelpful solutions. This then allows rehabilitation to be framed to support families who wish to work towards goals associated with generating more flexible coping responses, that will continue to allow members to grow and change as the family life cycle and relationships with the injury develop.

Problems however remain within these early versions of systemic theory and practice, with a key limitation of the original Milan style family therapy being that it is still carried out with a defined family unit, with less active focus on working out with the family to incorporate influences of other systems (see Carr, 2000). As the area of brain injury eloquently illustrates, as well as challenges within the family, when one member has a ‘diagnosed’ condition, forces outside of the family may also begin to exert pressures due to the family being labelled as different and stigmatised in ways that will affect access to material and social resources. The implicit assumption within constructivist accounts that all views are equal, has also been strongly criticised within feminist literature for ignoring the power imbalance which can
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occur within families and therefore within the therapy setting. In brain injury there is therefore a challenge to contemplate how the altered perceptual, communication and cognitive experiences of the individual with brain injury may be shared with and understood by family members, rather than allowing their views to become less valid because they arise from 'faulty' observing systems.

**The lure of post-modernity**

More recent attempts to think systemically about all families as systems within a wider network of overlapping communities and structures who are important in so far as they co-construct realities, has led to development of post-modern positions within family theory. Lynn Hoffman (1993) describes her own journey to “cast in my lot with social construction theory”, a theory placing “far more emphasis on the intersubjective value of language, family, and culture, and much less on the operations of the nervous system as it feels its way along” (p.88). Evolving from the constructivist position’s acknowledgment of the importance of observers in ‘interpreting’ reality, social construction goes a step further than constructivism and describes itself, creating very specific challenges with society offering ‘lenses’ which are overlapping communities and structures who are important in so far as they co-construct realities, has led to development of post-modern positions within family theory. Lynn Hoffman (1993) describes her own journey to “cast in my lot with social construction theory”, a theory placing “far more emphasis on the intersubjective value of language, family, and culture, and much less on the operations of the nervous system as it feels its way along” (p.88). Evolving from the constructivist position’s acknowledgment of the importance of observers in ‘interpreting’ reality, social construction goes a step further than constructivism and describes itself, creating very specific challenges with society offering ‘lenses’ which are incongruent with the families prevailing cultural discourses about cognitive disability, or to simply ensure that all members’ stories are given their due focus and attention to reflect some of the prevailing cultural contexts, which may be applying pressures on the family in day-to-day life. Anderson therefore developed the concept of a reflecting team, whose role it is to observe the family in interaction, so that they can then later hold a conversation in the presence of the family about what they noticed themselves feeling or noticing as the family story unfolded. There is an instant appeal to think that this experience may be helpful in families adjusting to brain injury, to positively interpret member’s attempts to support each other, to emphasise how the family’s story may highlight prevailing cultural discourses about cognitive disability, or to simply ensure that all members’ stories are given their due focus and attention to emphasise that each has their own relationship with the injury.

**The dilemma of family and brain**

To consider then the potential of a systemic position to add something new to past research on the benefits of education, couple work and parenting intervention after brain injury (e.g., Brooks, 1984; Rosenthal & Young, 1988; Miller, 1993; Gosling & Oddy, 1998), it is worth briefly considering recent...
literature emerging on family discourse after brain injury. Yeates, Henwood, Gracey and Evans (2007) have used qualitative discourse analysis to explore how the very common problem of lack of awareness of disability because of brain injury, is managed by families. They found a number of common themes in discourse, one of which was lack of ‘insight’ which correlates highly with family distress (Livingston & Brooks, 1988). Analysing conversations of families where this was a problem, they found the families often had a construction of the person as “vulnerable and needing protection”, and that actually it may be that the individuals awareness of these schema led to them making focused attempts to “orientate their families to their success” by making concerted efforts to describe only the positives of their situation.

Families saw such accounts of successes as ‘proving’ lack of awareness and therefore vulnerability, leading to escalating attempts to protect (the hermeneutic circle). In contrast, in families where challenges of brain injury were met more successfully, families were seen to construct accounts of problem behaviours which were shared and which emphasised continuity. For instance, for Dave with “a tendency to tuck in other peoples jumper labels while queuing in the supermarket” family conversations emphasised this as a evidence of a long standing personality trait, with his wife commenting “he was always been a very tidy person he didn’t like a mess”.

Within such accounts, there is a role for a systemic approach to offer the possibility that such accounts are constructions bound by a particular time and context, and therefore that alternative accounts of injury and disability may be equally possible. A focus on the experiences of family members, the authoring of a new account to accommodate rather than actively invalidate and exclude (Sabat & Harre, 1992) any new cognitive-communication style of the individual with the brain injury, and the opportunity to acknowledge shared stressors using adjunctive techniques like a family life cycle model, all hold potential promise to help improve practice with families. The family life cycle model also allows acknowledgment of the influence of other systems on the family, for instance in post-concussion syndrome where tensions may be caused by conflicting accounts held by the individual, the family, medical/legal experts and the employers about the validity of symptoms (due to the absence of structural brain change). Systematic work to bring representatives of these communities together to develop a coherent account regardless of the ambiguous ‘facts’ may offer the best chance of finding a way out of disability caused by conflict around causality.

Conclusions/reflections
In writing this essay, I observed a shift in my own position with regards to the ‘facts’ of brain injury, and the presumed inevitability of enduring family stress and distress in the face of significant changes in one family member. Whilst it would feel impossible to ignore the striking changes that severe brain injury brings, and the life altering impact that changes in memory, communication skills and executive abilities can potentially have, a systemic approach offers hope that for families there may be something better than simply being told to remediate or compensate for such obstacles. Instead, adding a constructionist lens may offer a means to augment more traditional approaches to family work after brain injury, to shift focus beyond the brain and look to the accounts of families to help us view brain injury as a construct that we all have different relationships with. This may ultimately offer a more optimistic account of human life and acceptance than a positivist medical model of calamity and inevitability.

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References


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**RESEARCH REPORTS**

**Risk factors and escalators in 52 suspected suicides**

Ron Siddle, Jane Mathieson & Rachel Brown

**Abstract**

This paper presents an audit of biographical data from 52 suspected suicides registered in Cumbria in 2008. The aim of the audit is to improve understanding of the contextual and personal factors associated with suicide. We found that causal pathways were complex and multifactorial. In order to identify idiosyncratic risk factors, individual suicide risk assessments should consider the interplay of these multiple factors.

**Keywords**

suicide; psychological autopsy; qualitative data; clinical audit

**Introduction**

Psychological autopsy involves structured interviewing of relatives of people who die through suicide and other key informants. The review of life histories of people who die through suicide has been given relatively little attention and few studies have utilised the qualitative information that can be collated from notes made by general practitioners and other health professionals, coroners, and other witnesses whose statements constitute coroners’ investigations (Valle et al., 2008).

The aim of this study was to improve understanding of the contextual and individual factors associated with completed suicide including proximal factors that may constitute ‘triggers’ for suicide.