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Family therapy, system theory and suicidal behaviour

(First published in the Norwegian journal *Suicidologi* 1999, no. 2.)

Family therapy has a relatively brief history in therapeutic childcare. In the 1920s the problem child was brought alone to the therapist. Eventually therapists spoke with parents about the child, and later to the parents about how they ought to behave with their children. Next all family members had their own therapist, which was the practice during the 1950s. In the 1960s the child would be in therapy while parents would go to joint sessions. Only about 30 years ago were family members brought together with the therapist, and family therapy started to take form.

The background behind this development is the recognition that any ailment bothering one family member will impact the other family members. Changes brought about for one family member will necessarily lead to secondary changes for the others.

What is system theory?

This concept was based on recent theory models from the natural sciences. Bateson, the anthropologist, was inspired by cybernetics (the theory of controlling and self-controlling systems) deriving from technology, and system theory from biology (Bertalanffy 1956). He (Bateson 1973) described the family as a system which can be compared to a steam engine with a valve. When steam pressure increases the forces act on the valve so it allows steam to escape, and when the pressure decreases the valve closes the system again. We thus have a continuous interplay with feedback (or information exchange) between the steam pressure and the valve. Applied to the human system the model grows more complex, and factors such as persons, events and attitudes come into play. Information (in its widest sense) that is exchanged between the factors controls their mutual relationships. The sender and the receiver of the information are equally important for this process. We cannot use our common cause/effect thinking. We must consider individual factors now as cause, now as effect in a continuous interplay. Applied to the family the rules for what kind of information is to be exchanged between family members can be said to determine which of their inherent possibilities for behaviour individual family members may exhibit. These rules also influence how any given behaviour is perceived. The aim of cybernetics is to maintain equilibrium (think of the steam engine again). A symptom may thus be an attempt to maintain the equilibrium of a system where the balance is threatened. A case in point may be how the unruly child draws attention away from the parental conflict, thus contributing to keeping the family together. This way of viewing the family has gained wide acceptance, and system theory permeates most of family therapy activities. The family is the natural starting point for therapy when the wish is to change symptom behaviour in children.

Developments in the 1990s

Much has taken place since Bateson's ideas gained full acceptance. Many have been influenced by post-modernist thinking: Everything has become so complicated that we cannot see the forest for the trees. We nevertheless understand important events and emotions in our lives in such a way that they give as much meaning as possible for us. New events or information may shift the pattern so that we suddenly perceive the events of the past in a new light: We may create a different and new history of ourselves, or of our family. A new narrative is the catchword family therapists have borrowed from literary science. A post-modernist would say that nobody can rightly claim that one narrative is wrong and another correct. All understandings are basically constructions. Based on this thinking, concepts such as constructivism and narrative therapy techniques have become popular (Hoffman 1985). All these new concepts have been created inside the framework of system theory. A common feature is that the traditional understanding that one event is the cause of another (linear thinking) is rejected and replaced by circular or systemic understanding.

Linear and circular understanding

We shall examine more closely the difference between linear and circular thinking. In our region of the world we have the tradition to consider cause and effect – we divide our experiences into sequences having a beginning and an end. "Father criticises mother. Mother becomes hurt." This is linear thinking. The idea that father causes mother hurt easily leads to the idea that father intends to hurt mother, and a moral assessment thus easily taints family interactions. If we remove our customary "full stops", we would perhaps see that when mother is depressed, the child grows unruly, and when the child is restless father criticises mother ... and so on. The therapist has a circular way of thinking, shifting his or her focus from individuals to relations and patterns of acting. This in itself leads to less moralism, shifting the concern to the effect of actions rather than the intent.

Family therapy

Currently family therapy is a central element in child psychiatry. However, our society is permeated by linear cause-effect thinking, not least when it comes to suicide and suicide attempts. Families with difficult children encounter this all the time: What did the parents do wrong? Most parents ask themselves this question with great sincerity: Where did I fail? For some, accepting an offer of family therapy may appear to be confirmation of guilt. A sense of guilt is virtually always present when a loved one is suffering: Love and guilt are like light and shadow. When good wishes do not suffice, guilt easily follows, irrespective of what the parents have done. Needless to say, all parents have done many things that might deserve criticism (if they say that they are beyond reproach THAT at least is worthy of reproach). However, in family therapy cause or guilt is not on the agenda. We are looking for matters that may cause change where the family wants change, whether this is aberrant behaviour, self-harm or any illness. Those with the greatest vitality are best suited for participating in change processes, not "the guilty". If a family is under such stress and strain that a child's

essential needs cannot be satisfied, therapy is not enough. Then other support schemes must be applied, within or outside the family.

Family therapy and suicidal behaviour among children and young people

When it comes to suicidal behaviour we know that the picture is so complex that ONE explanation will never be correct. Hence ONE treatment is rarely sufficient. We know that the natural sense of guilt can be strong, almost beyond tolerance, and is easily mixed with anxiety or anger. An offer for family therapy may initially reinforce such emotions. Nevertheless, all who are involved in suicide issues concerning children and young persons agree on one thing: Family life must be involved one way or another (King et al. 1997). *The family needs help and support for their own part, and even more if they are to be supportive of their child.* Conflict levels will often be high in families where there is a looming suicide. What we do in actual practice should be undertaken on the basis of discussions between the family and the assistance services. We who serve as helpers cannot in truth claim that THIS will be helpful, but THAT will not. Treatment must be adapted to family needs and wishes. However, professional helpers must collate experience from research, from other experienced therapists and from their own experience, and base their recommendations on these experiences. Professional expertise, for example regarding psychiatric ailments and suicide, must be included as an important element of the system. As persons giving treatment we are also part of a system, and the information we dispense may influence a family's perception of their own narrative.

What does treatment research offer?

As suicides and suicide attempts are rare it has not been easy to prove that one treatment is better than another. There is broad agreement that children cope best if families participate in the follow-up. This usually takes place with the family present, but occasionally the child must receive additional treatment alone or the school might be drawn in (Spirito 1997). Treatment will also depend on whether the family wishes assistance to change family interaction patterns. Even though only some family members are concerned with the problem, possible solutions will be best if everybody in the family gets to have their say.

The family approach that in research appears to show the best documentation of effects, is family therapy according to psycho-educational principles (Brent 1997a; Brent et al. 1993), often combined with assistance for any mental illnesses (Brent et al. 1997b; Spirito 1997). The principle is that the therapist seeks to share his or her professional knowledge about suicide attempts and the mental illness underlying the suicide attempts with all the family members, making the therapist and the family partners in a cooperative effort. Special conflicts and problems, which the family also would like to have assistance with, are also focused on.

Clinical example:

For a long period of time Liv, 15 years old, has been quiet and introspective, terrified of being inadequate. Her mother has become very protective, while her father has set clear demands on her, leading to objections from her mother. This has made Liv even more guilt ridden. Her parents rarely raise their voices, but Liv easily senses when even the smallest word is out of tune in the house. One day, for no discernible reason, Liv swallowed a large number of pills with suicide in mind because – as she wrote – she only made life worse for those she loved. However, she was not seriously harmed, and was soon taken under treatment for depression. Her condition improved as the depression lightened, but at home Liv felt that the discord was more or less palpable. Her doctor suggested family therapy. In family therapy each person was asked to state what he or she would have wanted to be different. Liv wanted happier parents as she felt they were growing increasingly silent together. Her mother was walking on tiptoes, afraid that she would say something that would make Liv suicidal. She wanted this to be different. Liv's father sensed that the mother blamed him for Liv's problems. He wanted to have all the accusations on the table so they could get things over. All three of them were surprised by each other's perspectives. Initially they were given information about depression, including the possibility of relapses (the psycho-educational approach). Liv wanted to be responsible for saying if she became depressed again. Warning signs were discussed and they agreed that each would contact the other if they felt that Liv did not alert them when she ought to. This lifted some of the anxiety from the mother. The parents were told to speak together at least twice a week, and register their anxiety for Liv on a scale of 0 to 10. At the next meeting Liv's mother stated that she was surprised that her husband was at least as anxious as she was. It had been good for them to speak about this together. The topic for this session was: Who feels accused by whom? The mother has always felt guilty because she was away from Liv for four weeks when she was two years old. The father stated that he felt paralyzed because everything he did was perceived as "nagging" and would hurt Liv. Finally, Liv put her foot down – almost – because all of them wanted to have the "blame" for her self-harm. She wanted that for herself. She could stand nagging, even if she did not always like it. It was just fine that parents are different. However, she felt guilty for ruining the relationship between her parents. After some sessions many things had changed. Both parents were much more active. They were different, hence there might be discord, but they insisted on the right to be slightly grumpy, and did not think Liv should meddle. They spoke together more. Some months later the whole family was able to make jokes about the time when they were all fighting for guilt. (They had obtained a new narrative about themselves.) All of them had allowed themselves greater space in which to act, and discord was no longer a catastrophe. Regardless what the future might bring they had a much better repertoire for countering new difficulties.

Conclusion

Families should always be involved when young persons have harmed themselves. Educating the family is important. A family therapy approach to reducing the conflict level should often be combined with individual approaches to the young person.

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Berit Grøholt is a child psychiatrist and has worked for many years as medical director at the Department of Child and Youth Psychiatry, Akershus County Hospital. Her research focus has been suicide and suicide attempts by persons less than 20 years of age. Now she has a scholarship from the Norwegian Research Council to do a follow-up study.