Original Article

Culturally Relevant Family Therapy Practice with Parents of Children and Adolescents

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ABSTRACT

Background: India is diverse in culture, with multiple aspects that may not match with the Western societal picture. Hence, it has often been seen that therapists encounter unique aspects of therapy that is faced during actual practice, which is never written in any textbook or research papers. Substantial information is present through both outcome (efficacy and effectiveness) studies and process research, but it has very little impact of actual Marital and Family Therapy (MFT) practice. This paper throws light into "how" and "what" of family therapy with parents of children/adolescents having psychiatric disorders. **Materials and Methods:** Focused group discussion was conducted with practicing family therapists and mental health professionals working in Psychiatric Tertiary Hospital (National Institute of Mental Health and Neurosciences, Bengaluru, Karnataka, India). Qualitative analysis was done to disseminate process issues in therapy. **Results:** Aspects that are vital for families having children and adolescent with psychiatric disorders include: Academic decline and loss of parental control as main reasons for seeking help, integration of models is noted to be beneficial, therapeutic alliance, intake sessions, conjoint sessions and individual sessions are important, cultural issues like gender of therapist, their cultural belief model, therapist's cultural competence need to be taken into consideration. **Conclusions:** Challenges and way-outs to overcome these has been mentioned and implications discussed

Key words: *Adolescent, children, family therapy*

INTRODUCTION

The prevalence rate of mental illness is 12.5% in 0–16 years of age in India. Psychiatric morbidity in 4–16 years of children is 12.0%. Frequent diagnoses include enuresis, specific phobia, and hyperkinetic disorders, stuttering, and oppositional defiant disorder.[1]

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Over involvement, inconsistent disciplining, problematic intra-familial relations, and anomalous family situations are reported to be significantly higher in the conduct disorder group than in the control group in India,[2] family factors associated with conduct problems are inadequate parental supervision/control, parental

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mental disorder, and intra-familial discord among adults.[3] Marital discord is important contributory and maintaining factor for conduct disorder.[4] Families show high academic expectations of children as well as of achieving things in life which parents could not. Usually, children are brought for therapy on issues of disobedience and poor academic performance. The underlying issues are seen in parents in the form of high expectations from children, rigid beliefs on what is best for the child, and inconsistent parenting practices.[5] Thus, focusing on the family pathology helps in reducing children/adolescents' problems and emerging toward healthier family systems. The whole family as a unit can be the therapist's focal point; thereby bringing in systemic changes. Factors such as family conflict, negative parenting behaviors, disturbances in family organization, and marital conflict among parents are related to offspring's aggression.[6] Research also shows that marital turmoil produces childhood disorders through (a) disruption of attachment bonds, (b) modeling, (c) altered discipline practices, and (d) stress models.[7]

Current researches on systemic family-based interventions are focusing on garnering empirical evidence. Various meta-analytical studies and follow-up studies have reviewed the efficacy of various approaches of family intervention and their effectiveness. The process of therapy has also been studied and focus has also been given on parental psychopathology.

Various meta-analysis and randomized clinical trial studies on anorexia nervosa show family treatment is advantageous over individual treatment in improving weight gain, resumption of menstruation, and reduction of cognitive distortions.[8] Maudsley method of family-based treatment is showing probable efficaciousness.[9] Conjoint sessions were superior over separated family sessions in relative weight gain.[10] Brief Strategic Family Therapy (BSFT) efficacy was found suitable mostly among children and adolescents with behavioral problems and drug abuse.[11] BSFT was found more effective in lowering days of drug use, engaging, retaining family members as compared to community treatment[12] in retaining severe cases;[11] improved reports of family functioning,[12] reduction in adverse effects from family,[13] and could be flexibly modified to incorporate novel approaches in working with difficult-to-engage families.[14] Consistent parenting for behavioral problems and dealing with parent anxiety have been found efficacious.[15,16] Family therapy was found to be effective with depression as compared to individual work. The scores also showed differences in anxiety reduction between the family therapy cases and the child psychotherapy cases.[17]

India is diverse in culture, with multiple aspects that may not match with the Western societal picture such as the presence of extended social systems, adolescents "launching out," and concept of marital dyad.[18] Hence, it has often been seen that therapists encounter unique aspects of therapy[19,20] that is faced during actual practice. Substantial information is present through both outcome (efficacy and effectiveness) studies and process research, but it has very little impact of actual MFT practice.[21] During supervision discussions, and peer discussions these introspections and valid aspects come out. It may also be a good learning to hear a different way of approaching family dynamics and problems. However, it has been seen that such kind of rich knowledge and experience of therapy processes and therapists introspection that help in guiding day-to-day practice of therapy – not just the "what" but also the "how" of therapy is understood only through qualitative dissemination of therapy details.

MATERIALS AND METHODS

The current paper aims to bring in qualitative aspects of family therapy practice specific to families of children and adolescents having psychosocial problems. The knowledge sharing and introspections by clinicians of National Institute of Mental Health and Neurosciences (NIMHANS) provide useful insights and directions for culture-specific practice.

The paper disseminates contents and processes of two focused group discussions (FGDs) conducted as a part of a PhD thesis "Psychosocial therapeutic intervention with parents of children and adolescents referred to family psychiatry centre" undertaken by the author. FGD is a well-known qualitative research tool.[22] The ethical clearance has been approved by the Institute Review Board, NIMHANS, Deemed University, Bengaluru, Karnataka, India.

The content of the session was audio-recorded and transcribed verbatim. The researcher coded the contents as well as the dynamics of the sessions, for example, which issues generated more debates, where there were more consensuses or vice versa, etc., The data were analyzed through thematic analysis.

Details of the participants

One FGD was conducted with therapists who are exclusively working in the field of Family Therapy, in total six members currently involved in conducting sessions, FT teaching, and supervision. The other FGD was conducted with Psychiatric Social Workers from Department of Psychiatric Social Work. In total, there were 11 participants.

All participants of both these groups had M.Phil in Behavioural Sciences (Psychiatric Social work - 13 and Clinical psychology - 4) as their minimum qualification and currently pursuing PhD. During their M.Phil training, apart from other therapies, these clinicians have undergone mandatory 3 months of exclusive Family therapy training which consisted of 90–150 h (approximately) of conducting therapy sessions with families; and over 600 h of teaching and training in family and marital therapy (through classes, case presentations, each session discussion with supervisors and skill building sessions).

RESULTS AND DISCUSSION

The interview was guided through semi-structured interview guide. Probes were used as per need.

The broader questions included:
- What kind of diagnoses and family pathology have you come across in families with children and adolescents?
- What were the therapeutic processes/dynamics that evolved as important in your sessions?
- What cultural aspects became important?
- What were the challenges and how was it overcome?

Reasons for seeking therapy by parents of children and adolescents

Parents' inability to manage the child's "symptoms" was the main problem, i.e., when the child and/or adolescent to do not obey them and aggression occur. When there is academic problem such as school–dropout, absenteeism, parents seek therapeutic help. Diagnoses include conduct disorder (mostly reported), evolving personality disorders (second most reported), other disruptive disorders, obsessive-compulsive disorders (OCDs), addiction, dissociative disorders, eating disorders, depression, schizophrenia, mental retardation with behavioral problems, and also nil psychiatry. Nil psychiatry categories include excessive use of electronic mediums such as mobile phone and Internet, romantic relationship especially for the girl child, sexual contacts, and generic adolescent transition issues where parents are confused about their parenting. Such a finding is similar to studies pointing out prevalence rates of mental illness in children.[1] Problems related to communication and role taking, power struggles between members of the family and extended social systems, inconsistency in parenting, marital discord/disharmony in parents were family factors. Family conflict, negative parenting behaviors, disturbances in family organization, and marital conflict among parents are related to offspring's aggression.[6]

An integration of models

Most therapists differed on their viewpoints on which "one model" works. Everyone unanimously upheld structural approach - but equally emphasized that they moved on to other models at a later stage.

Structural work must begin early for this specific group. Excerpt 1: "There will be power struggle (especially in externalizing spectrum), you want to empower parents to handle it first … there must be a structure set in a way that communication can be helpful." While emotion-focused work was essential for adolescents, some weighed behavioral work as equally helpful. Excerpt: "We need to have a holistic approach. It cannot be too compartmentalized." Another says "No black and white structure of what to do is possible. A combination of the models is the key."

Therapists value "helping the families" as the primary goal irrespective of models. Psychoeducation, explanatory sessions such as discussing family life cycle changes, adolescent stage, and its needs help immensely, though they are relatively simple "common factors such as personal hope and resourcefulness and the therapeutic relationship contribute more to change than technique or model. Family therapy is a best practice approach for all therapists where systemic wisdom helps to decide what to do with whom when."[23]

Therapy process and therapeutic alliance

Therapeutic alliance

Clear and collaborative stance about the therapist's role and nature of therapy provides this alliance which needs to be done in the first session itself. A study examined therapeutic alliance in 100 cases of adolescents seeking therapy. It was found that therapeutic alliance with both parents and adolescents in FT predicted a decline in drug use and externalizing behaviors.[24] Drop out and therapeutic alliance is also correlated in another study.[25] Therapists' cultural sensitivity and empathy help seal the therapeutic bond. A recent meta-analysis showed that there are no significant associations between similar or discordant client-therapist background and therapeutic alliance or outcome.[26,27] Therapist's cultural sensitivity, warmth and empathy, therapist's competence and client-therapist congruence rather showed significant results.[28] One-way to tide over cross-cultural impasses is to be culturally competent – knowledge about other's culture, have self-awareness about own culture and development of relational skills for cross-cultural interventions.[29]

The first contact, i.e., intake session built rapport and was considered the most important session.

One member shared "Always try to give them back something in every session. They must benefit." As one participant mentioned "it sets the stage for the therapist and family therapy."

Individual/conjoint sessions

Individual sessions grounded in systemic perspective aid the process of building rapport with a child or adolescent. The adolescent may be excluded later in some sessions addressing couple's or parenting issues.

Regarding cultural issues in therapy

Gender and patriarchy

The gender of adolescent and/or the key person with whom there is conflict and therapist's gender plays a vital role. In a study, 600 adolescent substance abusers and their therapists were grouped according to matches and mismatches on both gender and race and the alliance were rated. It was found that gender-matched dyads reported higher alliances and were more likely to complete treatment.[30]

In another example father coming from very traditional gendered family evoked negative feelings of "not being taken seriously" in a female therapist. She reports "it was so subtle … but I realized what happens with his wife regarding power, is played out with me as well in therapy … it was not as explicit as other cultural factors!" She reports that when a male therapist was added as co-therapist, the same ideas were accepted better by the father.

A study found that family members respond differentially to male and female therapist behaviors and vice versa.[31] Recent meta-analyses, however, reported that there were no associations between matched or discordant client–therapist backgrounds and the quality of the therapeutic relationship and therapy outcomes.[27] Factors such as therapist's warmth and empathy, therapist's competence, therapist's cultural sensitivity, and therapist/client congruence in values have been found to be more important for therapeutic outcomes than the social locations of clients and therapists.

Cultural beliefs of illness model and therapy

Some families have a belief about illness model which may not fit the explanatory model provided by the therapist. Participant reports "the family believed that their inability to do religious rituals has led to child's symptoms and hence only performing the rituals can cure this (OCD)." Another reports, "A father of a family with high education, would not accept anything short of a medical model – and totally ignored the psycho-social perspective."

Moreover, other family members' notions about therapy influence outcomes and readiness also. As one member puts it "how the supportive network believes about therapy is important. Drop out can be there if sustaining social networks have no faith in therapy."

Therapist's background and cultural notions

Sometimes therapist's background and cultural notions color their therapy. One therapist expressed that countertransference occurred seeing the sheer helplessness the woman who belonged to a specific religious group which is highly male dominated. She reports that her ideologies about gender equality entered into her ability to connect effectively.

Road blocks and way-outs

Not letting go off the "scapegoat"

Deep underlying discords in the couple subsystem get masked by scapegoating the child/adolescent. The homeostatic force can out-rightly reject the idea of change in every member, i.e., the whole system. One member points out how a father erupted in sessions overthrowing the therapist's authority to bring back session's focus on the child. This led to an untimely dropout.

Side stepping active change

Parents also revolve endlessly in a cycle of blaming each other/external factors for the child's problem and upholds him as a "sick child." This can be interpreted as the system resisting change.

Multidisciplinary approach as a Boon

In general, Child and Adolescent Psychiatry team (NIMHANS) begins with the same systemic framework of treating parents along with child. Therefore, when the referral is made to family therapy, the therapist work becomes easy. If such support is present from the referral source, then being able to implement family therapy becomes feasible.

Strategizing change process

How to intervene needs thorough assessment and strategizing. Sometimes, working with only willing members can bring systemic changes, which will impact the resistant person too. Changing the focus away from child was also beneficial. Using therapeutic alliance and hierarchy, discussions about family strengths and using child as the strength of the family are some strategies. Initiating therapy with a less threatening model to foster small, achievable changes or a model that is suited to family needs is best.

Implication

The results and discussion reveal minute areas of therapy practice that is applicable in all models of Family therapy. These aspects being difficult to measure may not get priority in evidence-based findings. They

mostly talk of comparisons of models with specific diagnostic group. However, here, we find that actual practice often moves beyond the rigid walls of models, towards a more "helping" stance bringing in systemic changes. These nuances of therapy become important on a day-to-day basis when therapists conduct session. The findings may help beginning therapists to be more reflective of their sessions, more aware of such processes and also find confidence in their practice through experiences of others. These aspects may often be put due importance in supervision discussions and consultative processes. The findings may also help in tailoring culturally sensitive practice.

Limitation

The study is a qualitative analysis of experiences and introspections. Therefore, it cannot be generalized. This is particularly relevant only in the context of a multidisciplinary team working in a tertiary psychiatry hospital set up in South India. Therapist's experiences may differ in other therapeutic formats such as private clinics, nursing homes, and rehabilitation center, or in other parts of the country.

The study is also limited to the teaching and learning processes offered in the institution and discussions are guided by that. Finally, some of the contents mentioned will require more evidence gathering and further research to uphold it as significant therapeutic indicators.

CONCLUSIONS

The article aimed to provide a thematic presentation of clinician's experiences in dealing with Families of children and adolescents referred for Family therapy. Further research areas– both qualitative and quantitative needs to be framed around each theme to muster more empirical support.

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Conflicts of interest

There are no conflicts of interest.

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