

# Family therapy and neuro-rehabilitation: Forging a link

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*Family therapy—otherwise known as systemic therapy—is based on a holistic understanding of the impact of illness or injury on the family. The overall aim of family therapy is to draw on family strengths and highlight examples of positive coping in the face of adversity.*

*Family therapy is often delivered in a high-tech ‘open’ clinic setting, in contrast to the majority of rehabilitation efforts which take place behind closed doors, either in acute medical settings, rehabilitation establishments or in the family home. In neuro-rehabilitation there are further difficulties relating to the actual injuries themselves; particularly the impact of reduced mobility, and poor memory and concentration. Together, this can make family therapy a challenging approach.*

*Yet in spite of its challenging nature, there is a growing exploration of links between rehabilitation and family therapy services, particularly in the UK. This new development is based on a belief that rehabilitation should involve a model for supporting families that is flexibly applied, with extra support for the injured party to allow their full participation. This paper outlines the issues and makes the claim for special interest groups to develop the initiative further.*

*Key words: family, therapy, counselling, rehabilitation, neuro-rehabilitation, neurological*

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The process of rehabilitation for neurological patients often places special demands on the family, particularly as the patient is rarely fully ‘recovered’ when discharged home. In particular, out-of-hours support in the community can fall solely on family and carers, who may themselves be struggling to accept and adjust to a very new situation.

Clinical observations suggest that adjustment to traumatic and acquired brain injury tends to be more demanding for spouses because the person who returns home from hospital can pose specific difficulties (Serio et al, 1995). Researchers have confirmed not only this but that the level of strain can depend on the localization and extent of the injury, and the specific disease type Palmer and Glass, 2003; Edmonds et al, 2007). Rolland (1994) has developed these ideas into an integrative model, arguing that the way chronic illness affects the family depends on a number of factors such as the psychosocial dimensions (onset, course or progression, outcome, incapacitation, level of uncertainty), time-related stages or factors (crisis or diagnosis, chronic, terminal, also aspects

of transition and adaptation), and key family life-cycle issues (e.g. if children are involved, whether they are living at home or close by). The process of family adaptation in life-threatening illness or injury has been likened to ‘navigating uncharted territory’ (Steele, 2005). In particular, difficulties related to communication and problem-solving are commonplace (Blais and Boisvert, 2005), and this signals a potential role for family therapists in neuro-rehabilitation services. A key task for any therapist is to map out the incidence of predisposing vulnerability factors and heightened risk.

## FAMILY THERAPY

Over the course of the last 50 or so years since its inception, the field of family therapy has undergone many changes, as seen most recently in the growth of the narrative movement (White and Epston, 1990), and post-Milan thinking (Jones, 1993; Jones and Asen, 2000). Both of these movements have attempted to bridge the gap between professional, privileged or ‘expert’ knowledge on the one hand, and variations based on the grounds

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of gender, cultural, ethnic or grassroots initiatives on the other. While these developments have sometimes taken practice away from the clinic setting, there appears to be a long-standing reluctance to extend family therapy into the community, perhaps for reasons previously noted (Cottrell, 1994). Hence, the practice of family therapy is still dominated by one-way mirrors, ear-bugs, etc, in 'high-tech' clinic settings. Appointments typically take place on a monthly basis (partly to co-ordinate attendance by all members), and the most usual referral route is via Child and Adolescent Services although there are examples of 'across the lifespan' clinics. Therapy training is via a post-qualification (masters level) course, of 4 years duration (part-time), and open to all health and social care professionals who routinely work with families in the course of their job. Incidentally, most training places are taken up by nurses, social workers, psychologists and psychiatrists and it is quite rare to find specialist rehabilitation staff who have completed this formal training. The reasons for this pattern of uptake are unclear, however, as a trainee it is relatively rare to see neuro-rehabilitation patients in clinic, perhaps for reasons related to engaging with the families and the occurrence of fatigue and relapses, or because of difficulties with wheelchair access.

This article proposes that, in spite of these challenges, family therapy can make a positive contribution to existing neuro-rehabilitative services if the initiative is taken forward by committed individuals and if techniques are flexibly adapted for the client group (e.g. with written summaries and extra one-to-one support for the patient). An analysis and discussion of the progress made in adopting family therapy approaches to the field of neuro-rehabilitation will be presented.

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## MAIN RESEARCH FINDINGS

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### Impact of brain injury on the family

Some of the early studies conducted in the field show the startling results of what happens in the absence of family-orientated brain injury rehabilitation; namely, that during the period of 2–7 years after injury, one can expect the percentage of relatives who report medium to high subjective burden to steadily increase (studies conducted in Glasgow suggest this rate may steadily rise to 89% (Brooks et al, 1987)). However, despite some suggestions that people with brain injuries are vulnerable to increased rates of separation (Webster et al, 1999), new research tracking 120 people 30–96 months after their injury indicates that this rate may be no higher than for a generic population (Kreutzer et al, 2007). These researchers found that people

who were most likely to remain married were: those who were married longer before the injury, victims of non-violent injuries, older people, and those with less severe injuries (controlling for gender, ethnicity, educational level, time elapsed since injury, and post-injury employment status).

### Factors affecting family adjustment

In their critical review of psychological and marital adjustment, Blais and Boisvert (2005) suggest that much of the variance in the data can be understood when findings are interpreted according to the following factors: severity of injury; stage in the recovery process; and relationship to the injured person (e.g. spouse vs parent). It would appear that while these distinctions have the potential to clarify matters, the most consistent finding appears to be the third of these variables—that spouses uniformly show greater distress than parents, who may be considered to be resorting back to old familiar protective roles, particularly for young adults. In contrast to this, spouses are challenged by a particular set of problems, largely owing to increased responsibilities within the family and the loss of intimacy with their loved one, as well as cognitive-behavioural sequelae such as an increased level of mood swings in the injured partner (Woods et al, 2005).

### Family functioning and rehabilitation outcomes

While clinicians have long suspected that engaging with the family is crucial to successful rehabilitation, researchers have also been keen to confirm this. Case study evidence was demonstrated in a paper describing the exceptional recovery of a patient with encephalomyelitis (in minimally conscious state) by MacNiven et al (p.531, 2003):

**'The role of Kate's family and friends in her emotional recovery must not be underestimated. In the context of a highly supportive and understanding family, Kate was given chance to adjust. Without this support, it is unlikely that Kate could have recovered to the extent that she has'.**

A larger study has provided further evidence of the relationship between family functioning and rehabilitation outcome (Sander et al, 2002). The study showed that chronic brain-injured patients assessed as having healthy family functioning on admission achieved higher rates of success in rehabilitation. Unfortunately this particular study did not assess family functioning again at discharge. However, in general it would appear that, as with other chronic conditions such as cancer and heart disease, family support plays a critical role in recovery processes after brain injury.

### Critical components of family interventions

Blais and Boisvert (2005) highlight evidence in support of therapy that focuses on communication skills and acceptance within the family. In particular, a case is put forward for family approaches to involve problem solving with cognitive restructuring, and the 'low use of avoidant coping skills and magical thinking' (p.1231). Studies by Koscuilek and colleagues (e.g. 1997) have informed the debate with the finding that indicators of hope within the family are the presence of schemas of manageability (feeling in control) and meaningfulness (feeling life has a purpose). Koscuilek (1997) offers the following by way of conclusion: that interventions based on positive reappraisal and family tension management are indicated in neuro-rehabilitation. Other studies highlight the area of empathy skills and insight—as significant predictors of relationship satisfaction—to be targeted in couple and family work (BurrIDGE et al, 2007; Yeates et al, 2007). In summary, family therapy interventions applied to a brain injury population need to address issues related to intimacy, communication, problem-solving and positive reappraisal.

## MODELS OF FAMILY INTERVENTION

### Key features of models

Clinicians have become increasingly aware that optimum outcomes in rehabilitation can only be achieved if good working relations are maintained with carers and the family. Attempts to involve the family have therefore generally been subsumed under the banner of 'working collaboratively with families' (Sohlberg and Mateer, 2001). Models of family intervention in brain injury tend to cover one or more areas of potential need for information and/or support and/or counselling (Miller, 1993; Sander, 2005). It would

appear that information alone, whether delivered in written or workshop format, is helpful and necessary but not sufficient for clinical and statistical changes to be observed in carers' strain levels and ability to cope (Sinnakaruppan et al, 2005; Morris, 2001).

### Specific therapy models

In terms of specific therapy models, Smith and Godfrey (1995) in New Zealand were among the first to describe family interventions based on cognitive-behavioural approaches, whereas in the United States, Padrone (1999) adopted an individual psychotherapeutic approach sensitive to the unique impact that brain injury can have on different family members (depending on variables such as the stage in the patient's life cycle and pre-existing relationships within the family).

A more comprehensive programme has been developed in Virginia (USA), described by Kreutzer et al (2002). These authors propose five levels of intervention: family therapy, marital therapy, individual therapy, group therapy, and bibliotherapy. Furthermore, the interventions are all underpinned and informed by what Kreutzer et al (2002) call the 'Brain Injury Family Intervention Curriculum' (Table 1).

In many ways, the above programme extends earlier ideas proposed by Muir et al (1990) who delineated six categories of intervention: patient-family education, family counselling, family therapy, behavioural family training (c.f. Cognitive Behaviour Therapy), respite care, and family support groups. Taken together, there could be any number of levels of intervention to consider.

## SERVICE EXAMPLES

### Examples in the UK

Within the UK, psycho-educational and other support groups are by far the most common family intervention in neuro-rehabilitation. The Aylesbury Community Head Injury Service, for example, has pioneered this approach, not only developing a comprehensive series of workshops for relatives but also employing a designated family worker who offers individual and couple counselling (Tyerman and Booth, 2001; Tyerman and Barton, 2007). In terms of access to family therapy, the author knows of a number of practitioners who either take a systemic approach to their work in community neuro-rehabilitation or refer to clinics with wheelchair access and without referral criteria that exclude neurological clients (e.g. the Horbury and Wakefield Family Therapy Team). Within the Royal Hospital for Neuro-disability where the author currently works, systemic approaches are being implemented in a multi-family group (MFG) format (c.f. Charles et al, 2007).

**Table 1.**  
**Brain Injury Family Intervention Curriculum**

1. Understand the typical consequences of brain injury
2. Recognize ambivalent feelings and develop strategies for positive coping
3. Recognize the brain injury happens to the whole family
4. Recognize the detrimental affects of guilt and the need to care for one's self
5. Appreciate the natural limits of rehabilitation
6. Help to extend improvement well beyond the first 6 months
7. Avoid giving inconsistent or contradictory advice
8. Understand the differences between physical and emotional recovery
9. Manage stress more effectively
10. Learn effective ways to judge success
11. Avoid working on too many things at one time
12. Expand support systems
13. Recognize and address gaps in the system of care
14. Encourage communication and asking questions
15. Politely address disagreements
16. Resolve conflicting advice and information.

p.353, Kreutzer et al (2002)

Unfortunately, the majority of these UK initiatives have not yet been formally documented in the literature (Oddy and Herbert, 2003).

### Examples outside the UK

Examples of family therapy practice in brain injury are being demonstrated in other countries, in Belgium for example (Laroi, 2003). However, it is difficult to determine the wider availability of family interventions from this type of case study analysis\*. Other than the programme developed in Virginia, there is one further example of the systematic application of family counselling to a brain injury population in Australia (Perlesz and O'Loughlan, 1998). Interestingly, this intervention showed reduced distress and conflict in recipients, coupled with improved cohesion and adaptation within the family. These gains were all maintained when follow-up took place 12 and 24 months later. However, there was a return to the original pre-intervention high levels of anger and marital dissatisfaction.

### Barriers to service provision

The development of family therapy approaches within brain injury may have been hindered because professionals have to acquire concurrent competencies in both neuro-rehabilitation and family therapy fields (Laroi, 2003). This situation has led some to argue that in actuality what is required is a whole new profession (Johnson and McGowan, 1997).

## ADAPTING FAMILY THERAPY MODELS

In a recent randomized controlled trial of antidepressants vs systemic couple therapy for depression, the latter showed a 'significant advantage' with no extra cost and was also found to be more acceptable to recipients (Leff et al, 2000). The therapists in this case (Jones and Asen, 2000) describe the component parts of their therapy as: hypothesizing (e.g. anticipating difficulties before the patient arrived), joining and engagement, circular interviewing (e.g. asking one person to guess what another thinks and feels, in the presence of that other person), enactment (e.g. blocking unhelpful transactions), focusing on strengths, problem-solving, challenging, family life-space techniques (e.g. drawing a family tree or 'genogram'), reframing (e.g. finding a positive interpretation of events), inter-session tasks (i.e. homework), and special issues (e.g. non-couple sessions may be interspersed with couple sessions). It is proposed that all these general systemic strategies can be used when working with families in neuro-rehabilitation, provided allowances are made for possible

\*There may be other service examples in non-English professional and peer-review journals that the author is not aware of.

cognitive difficulties on the part of the injured relative (e.g. extra time for the person to articulate their difficulties, some protective blocking of unhelpful or attacking verbal exchanges, written summaries provided and optional individual sessions to review and prepare for couple or family appointments).

Family therapy models may require further adaptations for use in community or rehabilitation settings. Vetere and Dallos (2003) advocate the use of a 'consultant in the room' to assist the therapist as the team would in clinic, and this has been found to be invaluable by the author. An example of this flexible approach used by the author in a community neuro-rehabilitation setting is given in *Table 2*.

### Therapy approaches

As the case example serves to illustrate, a wide range of specific techniques or questions can be beneficial in rehabilitation efforts, from structural interventions through to systemic, reflexive, and narrative questions. A helpful example of a structural intervention is the technique of enactment, which aims to challenge coalitions and redefine role relations (Minuchin, 1977), particularly pertinent to brain injury work and problems of dependency, or to situations where children become parents and spouses become carers. The use of simple circular questions can also highlight subtle differences of opinion within the family, thereby fostering empathy (Stratton et al, 1990), particularly if used in a gender-sensitive way (Jones, 1993). Certain types of reflexive questions can also be useful adjuncts to therapy, for example those questions that focus on desired futures and longer-term goals (Tomm, 1987). However, complex questioning and interventive interviewing may be too elaborate for family consultations, especially those involving the injured individual. A similar cautionary note

**Table 2.**  
**Example of a therapy approach**

A mother of three was about to separate from her husband when, on the day before filing for a divorce, she was involved in a head-on crash with a drunk-driver. Consequently, the lady suffered a stroke as a result of damage to the carotid artery, leaving her with very limited speech and weakness down one side of her body. The family suffered greatly in this case: the husband was showing signs of a severe stress reaction, the eldest child dropped out of university, and the other two children developed alcohol and behavioural problems; unsurprisingly, talk of divorce was put on hold. Appointments using the 'consultant in the room' approach took place in the family home, 1 year after the original incident, and consisted of appointments with the client and husband—who initially acted as an interpreter but who also needed support himself—interspersed with sessions with the patient alone. The intervention comprised a number of family therapy techniques (hypothesizing, joining / engagement, circular interviewing, enactment, focusing on strengths, problem-solving, challenging). In addition, the narrative technique of identifying so-called 'unique outcomes' (i.e. occasions which dis-confirm the norm), in this instance reflecting on how the couple were able to visit the accident site when previously they had avoided it. The therapist and 'consultant in the room' model also helped to manage the intense emotions that conversations necessarily provoked.

applies to the use of paradoxical intention (Selvini et al, 1978), whereby the therapist gives instructions to the family to continue in their maladaptive coping in the hope they will resist. This strategy is likely to be counterproductive if insensitive to the realities of the situation faced. Finally narrative therapy, which uses ideas and questions related to externalization, 'landscape of consciousness', and 'landscape of action' (e.g. 'What has happened in your life to help prepare you for this situation?'), can be useful approaches for reviewing family strengths and mobilizing family efforts to counter adversity (White and Epston, 1990; Payne, 2006).

### SPECIAL INTEREST GROUPS

In the course of researching this topic, and attempting on occasions clumsily, to practise systemic therapy in opportune moments with neurological patients, the author soon realized that there were other practitioners working in similar conditions, also sometimes without access to appropriate services and adequate resources. Additional impetus came from the National Service Framework for Long-term Conditions, launched in March 2005, which lists care for the family as one of the 11 quality requirements. Therefore, in response to the need for networking and sharing ideas, a satellite workshop for psychologists was set-up (funded and supported by the British Psychology Society), and the first inaugural meeting was held in March 2007 at the University of York. At the same time, a new multi-disciplinary listserv was launched with the intention of being a focal point for information on best practice, new research, funding, with details about conference and training events (to join go to <http://www.jiscmail.ac.uk/lists/tbifamilies.html>). Early feedback from participants indicates that this has been a very helpful resource.

### CONCLUSIONS

Given the pressure and strain that family members of people with head injuries are under, family therapy in the community and at other opportune moments can be vitally important. By addressing issues that arise in the course of caring for an intimate other, such as those related to intimacy, communication, problem-solving and positive reappraisal, family therapists can make a significant contribution to neuro-rehabilitation services. A variety of family therapy techniques, from structural therapy through to narrative therapy may be flexibly employed, with sensitivity paid to the physical and cognitive difficulties of the patient. A new and emerging network of professionals interested in this developing area of neuro-rehabilitation illustrates the potential for furthering practice, research and services for families and clients. **IJTR**

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## KEY POINTS

- The process of rehabilitation for brain-injured patients can put their family under pressure and strain, particularly as the patient is rarely fully recovered when discharged home.
- There are a variety of family therapy models and approaches to support both family and client after injury - examples of which are outlined in this article. These models may often require adaptations for use in community or rehabilitation settings.
- Family therapy interventions applied to a brain injury population need to address issues related to intimacy, communication, problem-solving and positive reappraisal.
- A new and emerging network of professionals interested in this developing area of neuro-rehabilitation illustrates the potential for furthering practice, research and services for families and clients.

## COMMENTARY

This article makes a much-needed argument for the ‘forging of links’ between the fields of family therapy and rehabilitation in brain injury. We agree with the author that a range of family therapy models can be beneficial in assisting families. These models need to be applied flexibly and informed by specialist knowledge about brain injury sequelae. Such knowledge includes the impact of trauma and complex grief and loss issues for the individual and family (Lezak, 1986), cognitive, behavioural and emotional changes, models of family adaptation to brain injury (Perlesz et al, 1992) and family outcome literature. These considerations avoid the risk of pathologizing family difficulties that commonly follow brain injury.

Important advances have been outlined in family-based interventions in various countries. There remain, however, systemic constraints to family work becoming integral to brain injury rehabilitation. These constraints include rehabilitation systems that are largely person-centered rather than

family-centered (which can polarize family members). They also include the need for models of care which enable ‘intermittent input over the long-term’ in recognition of the life-long impacts of brain injury, particularly at transitional points of the family life cycle. Finally, the need for training in family therapy, without assuming staff are necessarily equipped through their primary disciplines to work confidently and effectively with families, should be recognized.

The field of family therapy has long moved past its early focus on family deficits that were seen to cause or maintain family problems, to a field that is underpinned by principles of respect and strengths-based approaches. With its unique focus on family dynamics and relationships, family therapy offers a useful resource in assisting families to deal with the interpersonal consequences of brain injury and provide support in making the necessary adjustments over time. It is important to distinguish ‘family-centered practice’ from ‘family therapy’ and to acknowledge

that both have a useful place in brain injury settings.

Family-sensitive practice as conceptualized at The Bouverie Centre involves a high level of commitment to working collaboratively with families from the onset and at all points of treatment; retaining a compassionate attitude; valuing the experience of family members; seeking to maximize family involvement in all decision-making; avoiding participating in blaming dynamics between family members and with the service network; and maintaining expectation that change can and will occur (Furlong et al, 1991). Ideally, the field could move towards trained family therapists being integrated into neuro-rehabilitation settings (inpatient and community) as well as all workers being trained and confident in family-inclusive practice. This is in recognition that all workers, in acute, rehabilitation, and community integration settings, play a crucial role in supporting families to adjust to brain injury. Where organizations are not able to employ a trained fam-

ily therapist, we would argue that training in family-inclusive practice is essential. Family work is complex and workers often feel they lack the confidence and skills required to work effectively with families, particularly in dealing with the emotional aftermath of brain injury. The issues raised in this article are well worth further discussion and implementation.

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