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## Short paper

# Family therapy and clinical psychology

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The results of a survey of 111 clinical psychologists in the Republic of Ireland along with some comparable data from US and UK surveys were used to address a series of questions about the link between family therapy and clinical psychology. Family therapy was not a clearly identifiable sub-specialty within clinical psychology in Ireland. Family therapy theoretical models were used by more than a quarter of the Irish sample to conceptualize their work but by less than a tenth of US and UK respondents. In all three countries about a tenth of treatment time was devoted to the practice of family therapy. In Ireland, the use of family systems models, family assessment interviews and family therapy was more common within the child and family specialty than within the mental handicap or adult mental health clinical psychology specialties. The experience of live supervision and participation in family or couples therapy were important formative factors in the development of some clinical psychologists. Further training in systemic consultation, particularly in situations where an abuse of power has occurred, was identified in the survey as a priority area for continuing professional development. The evolving relationship between family therapy and clinical psychology is discussed in the light of these findings.

## Introduction

Within various mental health professions such as social work or psychiatry, family therapy is but one of a number of models routinely used by practitioners. Of particular interest to the field of family therapy is the degree to which professionals from different disciplines employ family therapy theories and techniques. In 1993 a national survey of clinical psychologists was conducted in the Republic of Ireland (Carr, in press). Included in the survey questionnaire were a number of items of particular relevance to family therapy and it is

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these that provide a focus for the present brief report. In some instances comparable information from surveys of clinical psychologists in the UK (Norcross, Dryden and Brust, 1992; Norcross, Brust and Dryden, 1992) and the USA (Norcross, Prochaska and Gallagher, 1989a, 1989b) is also reported.

Data from the survey and the literature allowed the following six questions about the relationship between clinical psychology and family therapy to be addressed.

- (1) Within clinical psychology, in Ireland, is there a separate sub-specialty of family therapy?
- (2) Compared with other theoretical orientations (such as psychodynamic or cognitive-behavioural models) how widespread are the use of theories of family therapy among clinical psychologists in Ireland, the UK and the USA?
- (3) Compared with other assessment procedures (such as the individual interview, behavioural observation or intellectual testing) how widespread is the use of the family interview among clinical psychologists in Ireland?
- (4) Compared with other treatment procedures (such as individual therapy or group therapy) how widespread is the use of family therapy or marital therapy among clinical psychologists in Ireland, the UK and the USA?
- (5) Are family therapy theoretical models, assessment procedures and therapy procedures more common in specific sub-specialties of clinical psychology (such as child and family mental health; adult mental health and mental handicap) in Ireland?
- (6) What role does family therapy training play in the continuing professional development of clinical psychologists in Ireland?

## Method

A total of 324 individuals listed in the Psychological Society of Ireland's (PsSI) *Directory of Psychologists* (1993) were surveyed. These included 234 who were clearly identified as clinical psychologists and 90 who were working in related clinical fields such as counselling or psychotherapy.

In the summer of 1993, questionnaires were mailed to participants with a covering letter and an SAE in the same envelope as the *Irish Psychologist* (the official newsletter of the Psychological Society of Ireland). The newsletter contained a notice describing the aims of the

survey and asking members to complete and return questionnaires promptly. The 55-item questionnaire inquired about demographic characteristics, qualifications and professional work practices and is available on request from the author.

## **Results**

### *Response rate*

Of 324 questionnaires, 142 were returned, an overall response rate of 44 per cent. Requests to return questionnaires were not sent to non-responders since this would have violated the guarantee of anonymity given to all participants.

Some 111 respondents were qualified clinical psychologists or were working as clinical psychologists. The data presented in the next section are based on the responses of this group. The remaining 31 cases omitted from the analysis were not clinical psychologists but worked in related fields such as counselling psychology.

Results from a UK survey of 993 British clinical psychologists (Norcross, Dryden and Brust, 1992; Norcross, Brust and Dryden, 1992) and a US survey of 579 North American clinical psychologists (Norcross, Prochaska and Gallagher, 1989a, 1989b) allow some comparisons across the USA, UK and Ireland to be made.

### *Irish, UK and US findings*

In the Irish survey, few psychologists had formal psychotherapy or family therapy qualifications. Six per cent had a Masters or diploma in either psychotherapy or family therapy. Two of these had a qualification in family therapy.

Only 2 per cent of the Irish sample identified family therapy as their main specialty. The majority of those surveyed (84%) were working in the specialties of child and family mental health (31%), mental handicap (30%) or adult mental health (23%).

When Irish respondents were asked which theoretical models typically guided their work, 29% said they typically used a family systems model. Family systems models were the second most commonly used non-eclectic theoretical orientation, with cognitive-behavioural models (55%) being the most popular. Humanistic approaches were used by 13% and psychodynamic by 12%. All respondents used more than one model.

The use of family systems models was far less prevalent among US (4%) and UK (6%) clinical psychologists than among their Irish (29%) counterparts. Of the non-eclectic frameworks, in the UK family systems models (6%) ranked third after cognitive-behavioural (46%) and psychodynamic (11%) models. In the USA, family systems models (6%) ranked fourth after cognitive-behavioural (29%), psychodynamic (23%) and humanistic (12%) frameworks.

When asked what percentage of assessment time was devoted to particular assessment methods, Irish respondents indicated that just over a tenth (11%) of this time was spent conducting family clinical interviews. This was the third most common option, with the individual interview (35%) and intellectual testing (20%) taking first and second place respectively. Behavioural observation (10%), neuropsychological testing (5%) and personality testing (5%) were less commonly used. Equivalent data were unavailable from the US and UK surveys.

When asked what percentage of treatment time was spent using a variety of treatment procedures, family (11%) and couples (7%) therapy were the second and third most common treatment options used by Irish respondents. Individual therapy (50%) was the most common format employed and only 6% used a group therapy format.

In the UK clinical psychologists devoted the same percentage of their treatment time to family therapy (11%) as their Irish counterparts. In the USA the proportion was a little higher, with 13% of treatment time devoted to family therapy.

Both Irish and UK respondents devoted 7% of treatment time to marital therapy but their US counterparts devoted double this amount (14%) to it.

Treatment time devoted to individual therapy in the UK was 74% and in the USA was 67%. In the UK 8% of psychologists used group therapy and in the USA 14% used this treatment format.

#### *Findings for child and family mental health, adult mental health and mental handicap sub-specialties*

The majority of the 111 Irish clinical psychologists who responded to the survey were working in one of three major specialties: child and family mental health ( $n = 34$ ), adult mental health ( $n = 26$ ) and mental handicap ( $n = 33$ ). In this section the status of these three sub-groups with respect to their use of family therapy models and

practices will be addressed. Unfortunately comparable data from the UK and USA were unavailable.

Family systems theoretical models were more commonly used within the child and family psychology specialty (50%) than in the mental handicap (12%) or adult mental health (12%) specialties ( $\chi^2 = 16.38, p < 0.001$ ). Cognitive-behavioural models were more commonly used by those in the adult mental health (69%) and mental handicap (73%) specialties than in the child and family specialty (38%) ( $\chi^2 = 9.76, p < 0.01$ ). The relationships between the other theoretical models and specialty were not statistically significant.

Respondents were asked what percentage of their assessment time they devoted to various assessment procedures. Mean percentages of time devoted to each of these procedures were computed and compared using analysis of variance. The family interview was more widely used in the child and family (19%) and mental handicap (12%) specialties as an assessment procedure than in the adult mental health specialty (3%) ( $F(2,90) = 7.17, p < 0.001$ ). The individual interview was used more commonly by psychologists in adult mental health (54%) than in the child and family (37%) and mental handicap specialties (15%) ( $F(2,90) = 13.75, p < 0.01$ ). In the mental handicap specialty (18%) behavioural observation was more commonly used than in the adult mental health (8%) or child and family specialties (5%) ( $F(2,90) = 6.13, p < 0.01$ ). Intellectual testing was also more commonly used as an assessment procedure in the mental handicap specialty (36%) compared with the child and family specialty (18%) and the adult mental health specialty (8%) ( $F(2,90) = 17.78, p < 0.001$ ).

Within each specialty there were statistically significant differences in the mean percentage of time devoted to each of the different therapeutic modalities. Family therapy was used more by psychologists in the child and family specialty (18%) compared with those in the mental handicap (8%) and adult mental health specialties (5%) ( $F(2,90) = 5.56, p < 0.01$ ). Couples therapy was used most by those in the adult mental health specialty (12%) and least by those in the mental handicap specialty (1%) with the child and family psychologists (6%) falling midway between these extremes ( $F(2,90) = 8.6, p < 0.01$ ). Individual therapy was most commonly used by those in the adult mental health specialty (63%) and less commonly by those in the child and family specialty (43%) and the mental handicap specialty (39%) ( $F(2,90) = 4.02, p < 0.05$ ).

### *Qualitative data on past and future professional development*

A number of open-ended questions were included in the questionnaire. Responses to these were clustered thematically. Two of these questions yielded material of relevance to family therapy.

A question was asked about specific events in respondents' careers that were important to their professional development. Receiving *live supervision* as part of psychotherapy training was an important emerging theme. A number of the respondents mentioned family therapy training as the context within which they had experienced live supervision. Participating in *personal growth work* was a second theme to emerge here. This included participation in either couples therapy or family therapy with family of origin as well as personal individual psychotherapy, group therapy, and membership of peer supervision groups.

In response to a question about the top three topics that respondents would like to pursue as part of continuing professional development (CPD), *systemic consultation* was an important emerging theme. This included family therapy, marital therapy, ecological approaches, ways of intervening in broader systems and interpersonal networks and ways of integrating different approaches to intervention. Specific training in *working in systems where abuse of power is the central problem* was a second theme to emerge in responses to the question about future CPD needs. Child sexual abuse and marital violence were the two main constituents of this theme and these were often mentioned within the context of new legislation that is being implemented in this area in the Republic of Ireland.

## **Discussion**

Before considering the results of the study in the light of the six questions it addressed, I will comment on the representativeness of the data and the generalizability of the findings. The sample of 111 respondents was not representative of all clinical psychologists practising in the Republic of Ireland. Psychologists who were not members of the Psychological Society of Ireland were excluded from the survey. When responders and non-responders were compared, women and basic grade clinicians were under-represented in the respondents' group (Carr, in press). The results are therefore biased in favour of clinical psychologists who are more senior male members of the Psychological Society of Ireland. The results of the USA and

UK are also biased in favour of members of the relevant national professional organizations (The American Psychological Association and the British Psychological Society). However, representativeness is less of an issue here since, unlike Ireland, most clinical psychologists in the UK and the USA are members of their national professional association (Norcross, Dryden and Brust, 1992; Norcross, Brust and Dryden, 1992; Norcross, Prochaska and Gallagher, 1989a, 1989b). Let us turn now to the implications of the survey results for the questions posed in the introduction.

The first question concerned the existence of a separate sub-specialty of family therapy within clinical psychology. In Ireland only a handful of psychologists occupy such a sub-specialty. This is not surprising, since clinical psychology training and service provision in both Ireland and the UK has traditionally been organized around the three sub-specialties of child and family mental health, adult mental health and mental handicap (Manpower Planning Advisory Group, 1990; MAS, 1989). More recently sub-specialties focusing on the elderly, patients with physical illnesses and those with neurological problems have emerged. In the UK and Ireland, it is unlikely that a large family therapy sub-specialty will emerge within clinical psychology, since in both of these countries, what purchasers of services or senior health service managers require is packages of clinical services to meet the needs of specific target populations. Common examples include abused children and their families, people with drug and alcohol-related problems or chronic psychiatric patients who are being relocated within the community. There are, of course, ample opportunities here for clinical psychologists to incorporate family therapy theory and practice into the packages of clinical services that they develop (Carpenter, 1994).

The second question concerned the prevalence of family systems theoretical models among clinical psychologists. Excluding eclectic approaches, family systems models ranked second in terms of popularity among the Irish clinical psychologists surveyed. This is in contrast to the USA and UK where psychodynamic models ranked second in popularity. These differences may reflect the important role played by the availability of training programmes with psychodynamic and systemic orientations in the three countries. Unlike the UK and the USA, psychodynamic models have never had a strong foothold in Irish clinical psychology training programmes whereas systems approaches to conceptualizing problems within the child and family specialty have been common. Also, within Ireland, continuing

professional development workshops and courses on family therapy have been more prevalent than those focusing on psychodynamically based therapies.

The third question concerned the use of family therapy assessment practices and the Irish data showed that on average about a tenth of respondents' assessment time was devoted to family assessment interviews. There is a discrepancy between the relatively large proportion of Irish respondents (29%) who endorsed family therapy theoretical models and the smaller proportion of assessment time (11%) devoted to family assessment interviews. It is probably the case that systemic models were used to conceptualize psychological problems, but that a wide range of assessment procedures, including the family interview, were used to conduct assessments.

The use of family and marital therapy treatment procedures was the central concern of the fourth question and the data showed that just over a tenth of respondents from the UK, Ireland and the USA used family therapy routinely. Twice as much treatment time was devoted to couples therapy by US respondents (14%) compared with UK and Irish respondents. The discrepancy between the high proportion of Irish respondents who adopt family systems theoretical models (29%) and the small proportions of time devoted to family (11%) and marital (7%) therapy, once again suggests that while cases are being conceptualized in systemic terms, treatment may often be offered in an individual format. In the USA and the UK, the discrepancy between theory and practice runs in the opposite direction. While an average of 5% of US and UK respondents endorsed family systems theoretical models, over 10% of their treatment time was spent on family therapy. In the UK and the USA, 7 and 14% of treatment time respectively was devoted to marital therapy. One possibility is that this therapy was being conceptualized from cognitive-behavioural or psychodynamic theoretical perspectives rather than within the context of family systems theory.

Compared with Irish and UK respondents, US clinical psychologists devoted twice as much treatment time to marital therapy. It may be that in Ireland and the UK, services for distressed couples are frequently offered, not by clinical psychologists, but by counsellors and therapists from other disciplines, whereas in the USA, work with distressed couples may constitute a greater part of clinical psychologists' responsibilities. Indeed, work with couples and families generally has been identified as a major growth area in the USA for clinical psychologists (Norcross, Alford and DeMichele, 1992).

The fifth question addressed the link between family therapy and specific sub-specialties of clinical psychology. The Irish data show that family systems models, the family assessment interview and family therapy as a treatment modality were most commonly used by those working in child and family psychology. These findings are in part explained by the fact that family systems conceptual models have typically informed the training of clinical psychologists within this sub-specialty. Furthermore, continuing professional development opportunities, including workshops and short courses, in family therapy in Ireland have largely been organized by clinicians and trainers from various disciplines who work or were trained within the child and family mental health specialty. The central role played by professionals within the child and family mental health field in the development of family therapy in Ireland has parallels in the UK, the USA and elsewhere (Broderick and Schrader, 1991).

A second important link was that found between couples therapy and the adult mental health specialty. This probably reflects the increasing acknowledgement by clinical psychologists within this specialty of the recursive relationship between adult mental health problems and patterns of marital interaction (Duck, 1988). Family therapy, however, is not commonly used by practitioners in the adult mental health specialty. This may reflect clinical psychologists' failure to acknowledge the association between adult mental health problems and broader patterns of family interaction outside of the marital relationship.

The final question addressed in this study was the actual and potential role of family therapy training in the continuing professional development of clinical psychologists in Ireland. The results of the qualitative analysis showed that the experience of live supervision and participation in family or couples therapy were important formative factors for some clinical psychologists. It is noteworthy that these *experiential* aspects of family therapy rather than particular *books* or *didactic courses* were identified as critical factors in the professional development of psychologists. For clinical psychologists to incorporate family therapy into their practice, it would seem that increased emphasis on experiential rather than didactic learning opportunities are indicated. Further training in systemic consultation generally and in working with networks where there has been an abuse of power were identified as priority areas for future CPD in clinical psychology in Ireland. These areas reflect the increasing demands that are placed on clinical psychologists in Ireland to work with child abuse cases,

marital violence and complex multi-problem cases where there is multi-agency involvement (Department of Health, 1994). Similar trends are occurring in the UK (MAS, 1989; Manpower Planning Advisory Group, 1990) and to some degree in the USA (Lappin and Van Deusen, 1994).

Overall the results of the study underline the important relationship between family therapy and clinical psychology and the potential for deepening this alliance.

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