Family work, creativity and wellbeing

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by Tony Gillam

This article discusses the connections between family work, creativity and wellbeing. It explores, firstly, how family life is central to the wellbeing of service users and carers and how working with families enhances the wellbeing of mental health practitioners. Secondly, it highlights what can be learnt about creative practice from family therapy research, how this can help us identify the characteristics of creative mental health care in practice and how more creative mental health practice – including family interventions – might benefit services users and carers.

The importance of relatives, carers and family life

Family life is an important aspect of our wellbeing yet wellbeing is itself an ill-defined concept. Wellbeing has been described as "a complex, confusing and contested field (with) competing and contradictory definitions" (McNaught, 2011, p.7-8). The term is used imprecisely in various contexts (for example in the phrases *physical and emotional wellbeing*, *mental wellbeing*, *health and wellbeing*,) and often used in conjunction with, or as a synonym for, health and/or happiness. In its ubiquity it risks meaninglessness hence, in my new book *Creativity, Wellbeing and Mental Health Practice* I have gone to some lengths to explore the meaning of wellbeing in order to help understand the links between creativity, wellbeing and mental health practice (Gillam, 2018).

In my research into wellbeing and mental health nursing most of the literature reviewed concerned not physical but psychosocial wellbeing (including mental, psychological, social, emotional, individual and organisational wellbeing.) I make a distinction between the psychosocial wellbeing of service users (as a service delivery issue) and the psychosocial wellbeing of mental health nurses (MHNs) themselves. I describe these two types of wellbeing as psychosocial wellbeing *for* MHNs and the psychosocial wellbeing *of* MHNs.

When considering psychosocial wellbeing *for* MHNs, I identified several subthemes which suggest new roles or new interpretations of the role of the MHN. These subthemes are:

- facilitating flourishing

- the importance of relatives, carers and family life
- general health and psychological wellbeing
- recovery and wellbeing.

Family intervention as a means of facilitating flourishing

The findings of my research strongly suggest that MHNs need to move beyond focusing on symptom reduction or amelioration towards positively promoting resilience. Along with an appreciation of the impact of poverty, social exclusion and inequality, this also calls for skills in supporting the welfare of children and families, for greater use of solution-focused approaches and self-management resources and for an ability to identify and mobilise strengths in the community to bolster resilience (Blakeman & Ford, 2012; Ruddick, 2013). Family interventions are a very effective and efficient way of supporting children and families, promoting the use of the families own resources and skills to solve problems, achieve goals and manage difficulties. They are also an excellent way of bolstering resilience and focusing on – and mobilising – service users' and carers' own strengths.

In order to facilitate flourishing, MHNs need to work not only with individuals but with families and communities. While Ruddick (2013) calls for MHNs to have skills in supporting children and families, the importance of relatives, carers and family life emerges as a subtheme in itself. Several authors stress the value of assessing the wellbeing of families and carers and developing therapeutic relationships with the relatives of service users (Jormfeldt, 2014; Saarijarvi et al., 1998; Minardi, Heath, Neno, 2007; McGuinness & McGuinness, 2014). A structured approach to providing family interventions, such as that provided by behavioural family therapy, enables nurses and other mental health practitioners to systematically assess the strengths and needs of families, carers and service users and, through active and purposeful engagement, to develop therapeutic relationships with families.

How family work can enhance the wellbeing of mental health practitioners

If family work is an important means of promoting the psychosocial wellbeing of service users and carers how might it impact on MHNs themselves? This, I argue, relates to the psychosocial wellbeing *of* MHNs – if MHNs are to address effectively the psychosocial wellbeing of service users they may need to attend to their *own* psychosocial wellbeing. Within this, two subthemes are critical to the discussion: occupational stress/satisfying professional practice and individual/organisational wellbeing.

Much of the literature I reviewed explored the quest for satisfying professional practice in the face of considerable occupational stress. Several papers highlight evidence that MHNs experience higher levels of stress and burnout compared with both other nursing specialties and other mental health disciplines. Cole, Scott and Skelton-Robinson (2000) find organisational factors a greater source of stress than service user-related factors. Stressful organisational factors identified include lack of role definition and lack of support. Seeing the provision of family intervention as a key part of the job could help MHNs to be clearer about their role whilst, at the same time, receiving support from a network of family-work trained colleagues and supervisors. This, in turn, could increase the wellbeing of nurses, knowing they are engaged in satisfying professional practice, and bolstering the self-esteem of MHNs by providing greater clarity about what their particular contribution is to care.

Learning about creative practice from family therapy research

Family work can provide MHNs and other mental health practitioners with an opportunity to be more creative in their day-to-day work. I argue that being able to be creative and to regard mental health practice as a creative activity in itself are important to the wellbeing of mental health workers (Gillam, 2018). Health care professionals often want to be more creative in their work but have anxieties about this. Happily, in developing a model of creative mental health care and trying to identify the characteristics of creative mental health care in practice, family therapy research is able to provide some helpful ideas.

An illuminating study into therapists' perceptions of the role of creativity in family therapy and couples therapy was conducted by Carson, Becker, Vance and Forth (2003). This surveyed 142 marriage (or couples) therapists and family therapists in 36 states in the US. While these therapists may represent a somewhat different group to MHNs, Carson et al's findings provide another rich perspective, highly relevant to our understanding of creative mental health practice. They argue that creative thinking in family work often leads to real and lasting breakthroughs and that creative energy promotes families' own problem-solving efforts, imagination, flexibility and playfulness. The study explored:

- the meaning and role of creativity in couples and family work
- the characteristics of a creative family therapist
- interventions believed to yield the most novel and helpful experiences
- barriers to creative practice.

The meaning and role of creativity in family work

Carson et al. (2003) found an important part of creativity in family therapy was "the ability to apply traditional treatment modalities in novel ways" (p.102). The respondents in their study mentioned the centrality of taking risks with clients and of improvising. My book explores the impact that risk-aversion has in mental health nursing (Gillam, 2018). Risk-taking is an important factor affecting organisational creativity (Ekvall, 1996). Stickley and Felton (2006) express concern that a risk-averse climate inhibits recovery and autonomy while MacCulloch (2009) identifies the burden of complex risk as a major stress for community MHNs. Carson et al. helpfully clarify that risk-taking in family therapy does not mean engaging in dangerous activities but responding intuitively to a client in a session.

Further examples of creative work in Carson et al's (2003) study were the ideas of being "in the moment", of "thinking on one's feet" and of "connecting with the intuitive and creative parts of our clients and ourselves as therapists" (p102-3). "Thinking on one's feet" links with improvisation (which, in itself, involves risk-taking on the part of the practitioner.)

Characteristics or qualities of creative family therapists

The respondents in Carson et al's (2003) study identified three qualities of a creative family therapist (which could, perhaps, equally serve more generally as characteristics of a creative mental health practitioner). These are:

- flexibility
- risk-taking
- humour.

While few would argue with the value of flexibility in clinical practice, we have already acknowledged that a willingness to take risks can be challenging in a risk-averse climate. The use of humour is also potentially controversial. Many might recognise that a sense of humour can be a valuable asset to any mental health practitioner, helping them to maintain a sense of balance and perspective in the face of often difficult situations and painful emotions. Yet, using humour in clinical practice is a more contentious area, since, as Carson et al. recognise, the concerns and difficulties of service users are hardly something of which to make light. Using humour as a therapeutic tool, then, is risky but we cannot be creative without being playful. As Weston (2007) observes, "creativity can require a certain kind of playfulness (...) but it does not mean just letting go" (p.3). Playfulness is part of creativity but

it must be combined with discipline; to qualify as part of creative mental health care, the use of humour must be ethical and effective (Cropley, 2001).

Creative interventions

The list of creative techniques and interventions generated by respondents in Carson et al's (2003) study is interesting because many of them involve attempts to use techniques derived from the creative arts. These include role play, role reversal and psychodrama, drawing, collages, art therapy, stories, poems, films, songs, letter writing and narrative therapy. This suggests that the therapists surveyed strongly associated creativity with the arts. Andreasen and Ramchandran (2012) highlight the general tendency among lay people to associate creativity more with the arts than with the sciences while Schmid (2005) reminds us that connecting creativity solely with the arts may diminish its significant role in other activities. I would argue the association limits the possible meaning of creative mental health practice hence, in my book, I deal with applying concepts of creativity and incorporating creative arts as two distinct areas (Gillam, 2018).

Barriers to creative practice

The fourth aspect Carson et al. (2003) investigated was perceived barriers to creative family therapy. As suggested above, these barriers – if they apply to family and marital therapists – are likely to apply just as much to mental health practitioners in general. The obstacles identified by the respondents were:

- time constraints – finding time to contemplate, learn and implement creative techniques and interventions;
- client resistance – a reluctance to take part in more creative tasks;
- managed care – duration and methods of therapy prescribed or mandated;
- personal limitations of the therapist – lack of confidence, inhibition.

Commenting on this, Carson et al. point out that if the therapist is inhibited about trying out a more creative approach, whether due to time or other constraints or their own self-doubt, then this is likely to lead to reluctance on the part of the client. Those of us who practice and supervise family work are familiar with the impact of therapists' inhibition on family engagement. The moral seems to be that, if we are convinced of the benefits of a more creative approach to mental health care, as practitioners we have to act as positive role

models and offer creativity in such a way that it is likely to be embraced.

Conclusion

It is beyond the scope of this article to fully develop the model of creative mental health care alluded to but, hopefully, it has provided some insights into the connections between family work, creativity and wellbeing. Family life is central to the wellbeing of service users and carers and, indeed, to us all, and family work has the potential to enhance the wellbeing of practitioners through providing more opportunities for satisfying professional practice. Valuable lessons can be learnt about creative practice from family therapy research which can help us identify the characteristics of creative mental health care in practice. Family work can simultaneously facilitate flourishing in families and provide mental health practitioners with an opportunity to be more creative in their day-to-day work. Such everyday creativity is essential to the wellbeing of practitioners, services users and carers.

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For more resources and discussion visit*:* https://tonygillam.blogspot.co.uk/

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