Family work for schizophrenia: practical application


Objective: To review the evidence for the efficacy, efficiency and effectiveness of family work for schizophrenia.

Method: The review is based on the relevant literature but is not intended to be exhaustive, except in the area of practical application.

Results: The effectiveness of family work has been established by a series of randomized controlled trials. Relatives groups are efficient in terms of staff time, and multiple family groups may be more efficacious than sessions with single families. However, a substantial proportion of relatives refuse to attend a group and need sessions in the home. Family work skills can be acquired by clinicians working in ordinary settings, although few studies have addressed this question. Problems have been encountered regularly by trained community workers trying to practise their newly acquired skills.

Conclusion: Difficulties in implementation may be remedied by adopting a systemic approach and including the managers of the service in the initial training sessions.

Introduction

Family therapy began in the 1950s with families caring for a schizophrenic member. The approach was that the family was pathogenic and responsible for driving the patient mad. The theoretical basis was provided by concepts such as the double-bind, marital schism and skew, communication deviance and scapegoating of one family member. After initial enthusiasm, interest in family therapy for schizophrenia waned, largely in response to disappointing results, and the focus shifted to behavioural and neurotic disturbances in children and to adult neuroses.

As interest in family therapy for schizophrenia was declining, the research on Expressed Emotion (EE) and schizophrenia began to appear in print. Between the 1960s and the present, dozens of studies in many different cultures and languages have replicated the association between relatives EE and the course of schizophrenia (1). The confirmation of the protective effects of maintenance antipsychotics and low social contact for patients in high EE homes (2, 3) opened a window of opportunity for intervention.

The efficacy of family interventions

From 1978 onwards there have been over a dozen controlled trials of family interventions for schizophrenia. These randomized controlled trials have mainly taken the form of antipsychotics alone versus antipsychotics plus family intervention. These studies can be considered as first-generation research, attempting to establish the efficacy of family interventions when added to maintenance antipsychotic medication. Studies of this nature have been reviewed by the Cochrane Collaboration, which concluded that family interventions reduced the relapse rate by one-half over the first year (4). They did not review data on a longer-term follow-up, presumably because only a few trials continued beyond 1 year. However, of the four trials which included a 2-year follow-up, three found that the relapse rate was significantly reduced by the addition of family interventions (5–7). The Cochrane reviewers also noted that later studies produced smaller effects than the earlier studies.
raising the question of the transferability of the expertise of the pioneers. I will address this issue later in this review. Most of the trials included measures of social performance as well as clinical outcome, but only Falloon et al. (5) were able to demonstrate an improvement in this area in response to family intervention. It seems that social disabilities may require a longer time period of intervention before they begin to ameliorate. Alternatively, programmes may have to include a more formal behavioural component, which characterized Falloon’s intervention, in order to produce gains in social performance.

This raises the question of what are the essential elements in a programme of family intervention? Very little work has been carried out on this issue. It is evident from the trial by Tarrier and colleagues (8) and from our most recent study that education alone makes no impact on the patients’ risk of relapse, but that is not sufficient reason to drop it from a programme. A few sessions of education are a very good way of engaging families, as they offer information which families are keen to obtain and do not pose a threat to family members in the way that other aspects of an intervention do. In order to determine what the other essential components are it would be necessary to conduct a series of trials in which one or other component of the intervention package was omitted. This represents a massive investment of time and effort, which so far no research group has been willing to undertake.

It should be noted that the term ‘family therapy’ is no longer acceptable for these types of intervention. Carers rightly resent the implication that they are pathogenic or pathological and need treatment, while the assumption of the therapists of the 1950s and 1960s, that is not sufficient reason to drop it from a programme. A few sessions of education are a very good way of engaging families, as they offer information which families are keen to obtain and do not pose a threat to family members in the way that other aspects of an intervention do. In order to determine what the other essential components are it would be necessary to conduct a series of trials in which one or other component of the intervention package was omitted. This represents a massive investment of time and effort, which so far no research group has been willing to undertake.

Studies of efficiency
The second generation of studies is concerned with the issue of efficiency; namely, which is the best method of delivering family work? The number of such studies is much smaller than the first-generation trials. The second trial my group conducted was of this nature. We compared family sessions, which included the patient and were given in the home, with a relatives group, which excluded patients and was held in a community facility (9). We found that if relatives attended the group they and the patients did as well as those receiving family sessions. However, nearly half the relatives invited to the group refused to attend, and patients in these homes had a poor outcome. This led us to recommend that all suitable families are offered sessions in the home to start with, and once they have engaged with the therapists, the relatives should be encouraged to attend a group. This combination of approaches is obviously more efficient than family sessions alone, which require the therapists to travel to the home and to spend more time on the work. However, it needs to be recognized that there will always be relatives who do not attend a group, despite the greatest efforts of the therapists, and these families have to be visited at home.

Another second-generation study was carried out by McFarlane and colleagues in the United States (10). They instituted multiple family groups to which all family members, including the patients, were invited. Each group consisted of six families and two co-leaders. Families were randomly assigned to a multiple family group or to be seen as a single family by a clinician. Each clinician was assigned nine families. The relapse rates over 1 year were 15.7% for patients treated in multiple family groups and 28.1% for those treated as a single family. Over 2 years the relapse rates were 28.1% and 41.6%, respectively. The additional benefit from multiple family groups was on the borderline of significance (P=0.06). These results suggest that multiple family groups may be more efficient than family sessions, but this research needs to be repeated by other teams before being accepted as generalizable, since no other centre has been running groups of this nature.

Another study which belongs in this group is a trial of behavioural family intervention for young patients conducted by Linszen and his team in Holland. Whereas most of the other trials selected patients at high risk of relapse by virtue of living in high EE households, Linszen and colleagues (11) included all patients, regardless of whether they lived with high or low EE relatives. It was found that there was no difference in relapse rates between patients living with high EE relatives who received individual care and educational sessions for the relatives and those assigned to a full course of behavioural family sessions. However, the relapse rates over 1 year were unusually low, 18% and 13%, respectively, suggesting a high quality of individual care. Patients in low EE homes actually did worse when they received the family intervention than when they were given individual care only; the relapse rates were 13% and zero. This is a useful warning not to interfere when
families are coping well. The focus on improving communication skills was interpreted by the low EE relatives as implying defects in their intrafamilial relationships, which at times created stress in the sessions. Furthermore, some relatives remarked spontaneously that the focus on these tasks interfered with their need to deal with the painful feelings aroused by the breakdown of their young offspring and the residual defects that became apparent. Linszen and colleagues emphasize the need to attend to affective issues related to loss and mourning. While behavioural family interventions tend to marginalize emotional issues, they are central to other family approaches, particularly those of Leff’s and McFarlane’s groups, who pay particular attention to the needs of parents to do grief work around the losses they have experienced through their son’s or daughter’s illness.

While it is important not to stress low EE relatives unnecessarily, most clinical teams do not have the expertise to identify the EE level of relatives by applying the Camberwell Family Interview. However, there are a few simple guidelines enabling clinicians to identify a high EE household (12), as follows: families in which there are frequent outbreaks of verbal and physical violence; families which call in the police because of conflict; patients who are known to be compliant with their medication, who are living with their families and who relapse more than once a year; relatives who constantly contact the staff with what are seen as unreasonable demands.

Studies of effectiveness

The third generation of studies are concerned with effectiveness. The question is whether the skills and techniques developed by the initiators of family work can be acquired by clinicians working in routine services. Central to this issue is the provision of high-quality training programmes which operate on a national scale. The Thorn Initiative in the United Kingdom was established for this purpose, with two national training centres in London and Manchester. Trainees are generally community-based mental health workers who are seconded to the programme for 1 day a week over the course of 9 months. The training begins with didactic teaching, which is followed by practice through role-plays. Thereafter trainees are required to take on families in order to put their knowledge into practice, and their clinical work is closely supervised in groups with their peers (13). There are few studies of the effectiveness of community mental health workers trained in this way.

The earliest study on this topic was by Brooker and colleagues (14), who compared family intervention delivered by community psychiatric nurses (CPNs) with routine care. The patients were not randomized to the different treatments, which weakens the findings of this study. The CPNs were trained in behavioural family work, but otherwise were part of the staff of ordinary clinical services. Patients and relatives who received family work from the CPNs had better outcomes than those in routine care. In particular, patients experienced a reduction in non-psychotic symptoms and an improvement in social functioning, while relatives’ mental health improved and their satisfaction with services grew.

The randomized trial conducted by Randolph and colleagues (15) in Los Angeles was of family work delivered within the context of an ordinary clinical service rather than by research personnel. The therapists were two psychologists and one nurse, who were trained by Robert Liberman and another experienced trainer, Gayla Blackwell. Using the same criteria for symptomatic exacerbation as in the original Falloon study (5), the researchers found a highly significant difference between the two treatment groups. Symptomatic exacerbation occurred in 55% of the customary care group compared with 14% of the group receiving family work. Hence, the clinical workers achieved as great a reduction in the patients’ relapse rate as was recorded in the earlier research-based trials. Our own team has recently completed a trial of this nature (16). The therapists were community mental health workers who were trained in family work by a CPN who had been trained by Robert Liberman and another experienced trainer, Gayla Blackwell. Using the same criteria for symptomatic exacerbation as in the original Falloon study (5), the researchers found a highly significant difference between the two treatment groups. Symptomatic exacerbation occurred in 55% of the customary care group compared with 14% of the group receiving family work. Hence, the clinical workers achieved as great a reduction in the patients’ relapse rate as was recorded in the earlier research-based trials. Our own team has recently completed a trial of this nature (16). The therapists were community mental health workers who were trained in family work by a CPN who had been trained by another CPN, trained by the originators of family work (Kuipers, Leff and Lam). Thus the therapists were third-generation trainees. They proved to be as skilful at reducing EE as the originators had been. However, although the experimental patients in this trial had a lower relapse rate than the control patients the difference was not significant. This was due partly to non-compliance with medication by some of the experimental patients, who relapsed shortly after discontinuing their drugs. Family work, even when effective in reducing high EE to low EE, is not a substitute for medication. As a result of this experience we now recommend that family work training includes a module on medication management.

Problems of implementation

Even when community mental health workers are trained in family work to a high level of skill, this is no guarantee that the work will be performed. A few surveys have been conducted of the experiences of
community workers when they have tried to implement the skills they have acquired through training in family work. The first of these was in Australia by Kavanagh and his colleagues (17). They administered a questionnaire to trainees which included an enquiry about the number of families that they had worked with for a minimum of three sessions since completing the course and the difficulties they had experienced with this work. There were questions about the availability of supervision for family work, and a list of possible problems which they may have encountered when trying to implement family interventions in their place of work. The top-ranking problem with implementation was difficulty in integrating family work with the existing case-load or other responsibilities at work. The second most severe difficulty concerned allowance of time from the service to do the interventions. Both these problems stem from a lack of understanding by the managers of community services that the trained workers need to be relieved of some of their regular clinical responsibilities in order to practise the family work. One London trainee reported to me that her manager had told her that if she wanted to do family work she would have to do it in her own time. It is obviously irrational to invest money in training community workers in specific skills and then to deny them the time with which to put them into practice; yet this example of irrationality in managing human resources is far from unique. The Australian study was repeated with 21 former trainees from the Manchester Thorn Initiative (Butterworth et al., submitted), including the use of the same questionnaire. Nearly half the trainees had worked with three or more families in the 6–18 months since completing the course, but three trainees had worked with only a single family and another three had done no family work. When asked about the main difficulties or challenges in using the approach, the majority of trained workers cited a lack of support by managers and/or colleagues. The same two problems were given the top rank of difficulty, as in the Australian study, namely allowance of time and difficulty in integrating family work with the case-load. The next two in order of severity were lack of support by managers and non-availability of time in lieu or overtime for appointments. This last problem is a major practical issue, since in order to hold sessions with all family members, some of whom may be working, it is often necessary to arrange appointments outside of the 9–5 day.

A third survey was conducted by Fadden (18) of 86 therapists trained in Behavioural Family Therapy (sic). The majority of the therapists were nurses and nearly 80% worked in community services, the remainder being located in in-patient units. They were asked to complete a questionnaire which was modelled closely on Kavanagh’s. Completed questionnaires were received from 59 subjects, a response rate of 70%. The subjects were surveyed between 1.5 and 3.5 years after being trained. However, the highest mean number of families seen per staff member (2.4) was in the group who had completed the training 18 months previously. It was noteworthy that a small group of seven therapists saw 40% of the families. As with the other surveys, among the most common difficulties encountered in implementing the family work were integration with the case-load and allowance of time from the service to perform the intervention. Surprisingly, the top-ranked problem was availability of appropriate clients. Fadden noted that there were plenty of suitable families available and considered that the root of the problem lay with the therapists’ views of what constituted an appropriate family to work with. She found that staff members who were most successful in putting their training into practice were able to use a large number of creative strategies to overcome difficulties encountered. They were also more willing to see families in their own time, to work outside the 9–5 day, to be proactive in engaging families and to see families with a co-therapist. Fadden concluded that it was necessary to attempt to change the systems in which the trainees worked in order to overcome the resistance to incorporating family work into routine practice.

It has become clear from these three surveys that the implementation of family work requires a full understanding by the service managers of the demands it makes on the time of the trained workers. The work is also emotionally demanding and if the trained personnel are to take full advantage of their new skills, they need the enthusiastic backing of their managers, as well as support from their colleagues. If they face practical problems in the work situation as well as the inherent difficulties of the task, they are likely to give up and waste their training. Solutions to these problems have been proposed by several of the researchers in the field.

McFarlane’s group (10) adopted the principle established by Fairweather (19), that effective dissemination is achieved through working simultaneously with clinical and administrative personnel. Their programme began with a 1-day orientation which included both administrators and senior clinicians. All the modern interventions with families are based on forming an alliance with family members in which they are treated as equal partners. McFarlane’s group applied this approach to establishing relations with local administrators, who were included in decision-making from the beginning, consulted about problems related to the
conduct of the project at their own and other sites, and invited to participate in training sessions. The same strategy was then used to maintain a collegial relationship with new supervisors, providing a model for their relationships with their trainees and the administrators of the services in which they were providing training. This principle was also enunciated by Leff and Gamble (13), who recommended that low EE attitudes should characterize relationships throughout the system of training and implementation.

To conclude, there is now unequivocal evidence that working with families to ameliorate the emotional atmosphere in the home significantly reduces the risk of relapse for people with schizophrenia. However, it is also clear that family work is not a substitute for maintenance antipsychotic medication, but that the two interventions augment each other. The particular components of family work that are responsible for its success have yet to be identified, although it is evident that education alone is ineffective. The most efficient method of delivery of family work also requires clarification. Although groups of relatives or multiple family groups undoubtedly represent an efficient use of professional time, some relatives will refuse to participate and need to be visited at home.

It has become increasingly clear over recent years that providing training programmes in family work for staff is not sufficient to guarantee its integration into routine clinical services. It is necessary to involve the whole system of managers and clinicians in educational activities that familiarize them with the rationale for the work and give them a feel for its nature and a respect for the skills acquired by the trainees. Only a systemic approach of this nature will involve the whole system of managers and clinicians in educational activities that familiarize them with the rationale for the work and give them a feel for its nature and a respect for the skills acquired by the trainees. Only a systemic approach of this nature will.

References