

Working with the Families of Schizophrenic Patients

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As schizophrenia is a heterogeneous condition with a variety of possible causes, it is sensible to combine biological and social treatment. Neuroleptic drugs give partial protection against environmental stress, but need to be supplemented. The programme developed on the basis of research on relatives' expressed emotion begins with education about schizophrenia for patients and relatives. Family sessions in the home are run in parallel with a relatives' group, and are aimed at improving communication, teaching problem-solving skills, lowering criticism and overinvolvement, reducing social contact between patient and relatives, expanding social networks, and lowering expectations. Individual work with the patient is often undertaken alongside the family sessions, and includes social-skills training, anxiety management, and a cognitive approach to persistent psychotic symptoms. Therapists take a central role in coordinating the variety of services needed by patient and relatives.

An integrated approach only becomes possible if we are able to accept that there is no single theory that explains the origin of schizophrenia. In the past, theorists of the disorder tended to fall into distinct camps, each of which claimed to possess the only truth about the condition. That polarisation has not entirely disappeared, but it is becoming increasingly difficult to maintain as evidence accumulates for the heterogeneity of the clinical syndromes that we call schizophrenia. Every clinician is aware of the great variation in the pattern of symptoms from patient to patient. The classical subtypes represented an attempt to impose a classification on the clinical diversity, but this failed because it proved impossible to use the system reliably (World Health Organization, 1973). One of the clearest demonstrations of the heterogeneity of the condition was provided by the World Health Organization Determinants of Outcome Study (Sartorius *et al*, 1986). This cross-national epidemiological study showed that if schizophrenia was defined in a narrow way, depending on the presence of Schneider's first-rank symptoms, the incidence was remarkably uniform across the five centres. By contrast, non-Schneiderian schizophrenia showed a sixfold difference in incidence, the lowest being in Aarhus and the highest in the rural area of Chandigarh, north India (Table 1). These findings suggest that Schneiderian and non-Schneiderian schizophrenia have different aetiologies, only the latter involving a major contribution from environmental factors.

A treatment approach that is confined to only the biological or only the environmental factors in schizophrenia cannot encompass the complexity of the illness and will fail to provide the maximum possible benefit to the patient. The approach we have developed in our research unit is based on a concept of schizophrenia as a brain disease which renders the sufferer extremely sensitive to his/her social environment. We recognise that the term 'schizophrenia'

Table 1
Incidence per 100 000 of Schneiderian and non-Schneiderian schizophrenia across cultures

Centre	Schneiderian	Non-Schneiderian
Aarhus	7.3	3.8
Moscow	12.1	11.8
Nagasaki	9.5	5.8
Nottingham	14.1	4.2
Chandigarh urban	9.0	15.3
Chandigarh rural	11.4	23.5

covers a variety of conditions, in some of which biological factors are salient while in others environmental influences exert the predominant effect. Attempts have been made in research studies to segregate conditions with different aetiologies. For example, Murray *et al* (1985) found that patients with a family history of schizophrenia were less likely to have experienced obstetric and perinatal complications than those without affected family members. However, other workers have failed to replicate this finding, so that guidelines on this issue cannot be established. In their absence, each patient has to be assessed individually for the relative predominance of biological and environmental contributions to their illness.

Drug treatment

Drug treatment is the foundation on which we build our psychosocial treatment; we almost always use antipsychotic drugs in the acute phase of illness. The only exceptions are patients who have not so far been on such drugs and are admitted for assessment of their psychiatric state; if their symptoms subside within a week or so, we do not institute medication.

The decision as to whether the patient needs maintenance neuroleptic treatment is made on the basis of a number of factors. It is known that in the

West, 25% of first-onset schizophrenic patients will recover completely from the episode and remain well for at least two years (Sartorius *et al*, 1986), but is not easy to differentiate these patients from those who are likely to relapse if kept off drugs. However, we do know that living with relatives who have high Expressed Emotion (EE) is a risk factor for all schizophrenic patients, including those in a first episode (Leff & Vaughn, 1985). Consequently, if the patient lives with relatives we arrange for them to be given the Camberwell Family Interview (CFI) (Vaughn & Leff, 1976a) and assess their EE status.

In our view, neuroleptic drugs give the patient a degree of protection against environmental stress (Leff *et al*, 1983). The two main types of stress that have been measured in scientific studies are relatives' EE and life events, which have long and short time-courses respectively. Patients living in low-EE families receive valuable emotional support from their relatives, but are still vulnerable to the impact of life events unless they are maintained on neuroleptic drugs. The drugs give partial protection to patients in high-EE homes, resulting in a reduction of the relapse rate over nine months from over 90% to about 50% (Vaughn & Leff, 1976b), but patients in high-EE homes who are maintained on drugs are still vulnerable to life events. To give them further protection against relapse, it is necessary to modify the emotional atmosphere in the home. However, I would first like to emphasise the importance of providing information about the nature of schizophrenia and its drug treatment.

Every patient who is put on maintenance drugs wants to know how long these will have to be taken and why they are necessary. In the past, there was a great reluctance on the part of professionals to tell patients they had an illness called schizophrenia. This was partly because the diagnosis was thought to carry a very poor prognosis, but numerous studies have shown that this is not correct, so that it can no longer be invoked as a reason for concealment. I also used to experience this reluctance to tell patients the diagnosis, but I have changed my attitude. It is very difficult to justify to the patient the need to take medication indefinitely without an explanation of the nature of schizophrenia, and of the protection from stress that the drugs confer. Previously, we used to give all the necessary information to the relatives and leave an instructional booklet with them; we left it up to them to decide whether to share the information in the booklet with the patient. However, I no longer believe that this opting out is acceptable. My change of attitude has been reinforced by legislation in England which allows patients free access to their medical records. Since patients will inevitably see

their diagnosis recorded, I consider that it is now incumbent on the staff to educate patients about the nature of their illness. Consequently, we now have popularly written booklets on the ward about the common psychiatric illnesses, and the nurses regularly hold educational sessions which all patients are invited to attend. These have proved very popular with the patients, and the nurses consider that compliance with medication on the ward has improved since they were instituted. Education for the relatives is given in parallel with that for the patients, and forms part of the work with the family.

Family work

Selecting the families

We use the CFI to determine the EE level of the relatives, if any of these share the patient's household. All adult relatives are interviewed; this usually means parents or a spouse, and less commonly siblings or grown-up children of the patient. All high-EE households are offered further help. This does not mean that we think low-EE relatives do not need assistance, but with limited resources, we have to target the families with the greater difficulties. It is not essential to be able to measure relatives' EE. Clinical guidelines for identifying families in greatest need are (a) frequent arguments leading to verbal or physical violence; (b) families that call in the police; (c) patients on maintenance drugs who relapse more than once a year; and (d) relatives who frequently contact staff for information or reassurance.

Educating the family

We start work with the family by offering an education programme of two sessions in the home. The relatives are usually pleased that professionals have made the effort to come to them, and are bringing something they value: information. The sessions begin while the patient is still undergoing treatment in hospital, and so he/she is not included in the family sessions at this point. Instead, as described above, the patient receives a different form of education on the ward. The relatives are taught about the causes, symptoms, course, treatment, and management of schizophrenia. The information is read out from a booklet, which is written in simple language and is left with the relatives to read at their leisure. We start off by saying that there is no evidence that relatives cause schizophrenia; this helps to allay their anxiety that they will be blamed by professionals for the patient's illness. Some relatives have already had prior experience of this, and as a

consequence, are wary of us at first. We tell them that schizophrenia is an illness of the brain which makes the patient very sensitive to stress, and we outline ways in which stress may be reduced. We explain the nature of negative symptoms and their long time-course in contrast to positive symptoms. We emphasise the value of drug treatment and the need to persist with it, even when the patient appears to be well. We tell the relatives that one in four patients recover completely from an attack of schizophrenia and remain well for several years.

We allow the relatives unlimited time to ask questions, recognising that the information we give is not easy for them to absorb. Testing their knowledge before and after the education sessions has shown that they learn the name of the condition and become more optimistic (Berkowitz *et al*, 1984; 1990). There are few other changes. In fact, education continues in a less formalised way throughout our contact with the families, who tend to ask the same questions again and again until they are ready to accept the answers we give.

Improving communication

After the education programme, we include the patient in the home sessions, which are held every two weeks for an hour during the first few months. They are usually spaced out to once a month later, and may be continued for two years. We prefer to work with co-therapists, for a number of reasons. If one therapist is drawn into the emotional vortex in the family, the other can comment on the situation and re-establish control. The two therapists can make alliances with different family members and hence ensure that there is not an imbalance of power. They also have the opportunity to model good communication and the resolution of differences through calm discussion.

Not all families show disturbed communication, but in some, members interrupt each other, two people may talk at the same time, and one person may dominate the discussion to the exclusion of others, particularly the patient. We lay down some apparently simple ground rules: only one person may speak at a time, everyone should have an equal chance to speak, and communication must be made directly to the person concerned, i.e. members must not speak about someone present as though he/she were not there. This frequently happens with respect to the patient, who is referred to as 'he' or 'she'. It is remarkably easy for therapists to slip into this habit as well, thus reinforcing the patient's sense of disqualification as a person.

These rules are not easy to establish, and therapists need to be tactful but persistent in reminding family members of them. It can take months to get them regularly observed, but this is of considerable value as it tones down heightened emotion, gives every member an equal value, and helps members to listen to each other. This is an art which is often lost in high-EE families and has to be re-learned with the therapists' help. Once family members begin to listen to each other, they are usually more receptive to the therapists' comments.

Teaching problem-solving

Every family with a schizophrenic member regularly experiences problems. Low-EE relatives show a remarkable capacity to develop creative solutions which avoid confrontation and diffuse tension. High-EE relatives tend to persist with responses which provoke more friction between themselves and the patient, and often lead to a worsening of the problem they are trying to eradicate. As a result, when therapists ask high-EE families what problems they would like help with, they are usually flooded with a multiplicity of difficult issues. The first step is to help the family to focus on one problem at a time. To this end, they are asked to choose the problem they would like to deal with first. This in itself can lead to disagreements, which the therapists must help the family to resolve.

Once a problem is selected, the therapists ask each family member to give their view of it. Particular attention is focused on the patient's experience of the problem, because the family is likely to have ignored this perspective previously. It also gives the therapists the opportunity to set the patient up as the expert on the problem – after all, no one else in the family can give an account of what it is like to have schizophrenia. Then, the problem is broken down into small steps and the family members are asked to suggest possible ways of tackling each step at a time. They are guided by the therapists to select a 'low-EE' solution, e.g. buying the patient an alarm clock instead of pulling him out of bed. Then they need to reach an agreement as to when and how they will try out the solution before the therapists' next visit. The attempt is treated as an experiment so that if it fails the family will not feel that they are being held responsible for the failure. The therapists emphasise that they will ask for a report on what happened when they next come. If the family have not tried out the agreed solution, or have attempted it without success, the therapists go through with them the details of what happened, and then help them to design another experiment that is less ambitious.

Dealing with expressed emotion

Criticism

The majority of critical comments are targeted at the negative symptoms of schizophrenia, the relatives viewing the patient as being deliberately lazy or selfish. This is why we take pains to explain in the education programme that negative symptoms are an integral part of the illness. We also deal with this issue in problem-solving, since many of the daily problems are generated by the patient's apathy and inertia. We also reframe critical remarks made during sessions, to stress the positive aspect of the relatives' attitudes. In most instances, the reason they are critical is that they care about the patient's welfare and want him/her to improve.

In households with highly critical relatives, there is usually conflict between the patient and the relatives, or between the parents, if they both live with the patient. The therapists need to take firm control of a conflictual situation and prevent the arguments escalating. Therefore, they block any developing arguments and persuade the family members to discuss their differences calmly. In this process, the therapists need to convey to the antagonistic members that they are each getting some support and that their views are valued. Handling these situations is facilitated by having two therapists present.

Overinvolvement

Overinvolvement is usually of much longer standing than criticism, sometimes originating during the patient's early life in response to developmental delays or other minor abnormalities. It often takes patient work over one to two years to achieve some separation between an overinvolved pair. It is important to recognise that these relationships are symmetrical, the patient mirroring the relative's anxiety and the relative mirroring the patient's dependence. Work with the pair involves exploring their anxieties and persuading them to test out very brief trial separations. It can be useful to get the parent to agree to leave the patient alone in the home for half an hour to start with, to see if any of the anxieties are realistic. At the same time it is necessary to build up the patient's confidence in being left alone and starting to do things for him/herself.

One of the therapists' main tasks is to realign the relationships in the family. In addition to separating the overinvolved relative (almost always a parent) from the patient, it is important to strengthen the marital relationship between the parents (if both are present) and to utilise any healthy siblings in the family to encourage the patient to make peer

relationships. To this end, the therapists will often hold separate sessions with parts of the family. Thus they may see both parents without the children present, and concentrate on improving their relationship. They may need to give the parents permission to relinquish some of their responsibilities for the children and to go out together to enjoy a well-earned break. In seeing the patient and siblings separately from the parents, they are implicitly reinforcing the intergenerational boundary.

Although the eventual aim is for the patient to achieve greater independence, this does not necessarily entail moving out of the home. In fact, rather few patients in our studies have set up their own homes apart from the parental household.

Reducing contact

In the original studies of EE and the outcome of schizophrenia, we found that patients who were in low contact with high-EE relatives had a lower relapse rate than those in high contact (Brown *et al*, 1972; Vaughn & Leff, 1976b). This finding was not replicated in a number of studies, but has been repeated in a recent study in Sydney, Australia (Vaughan *et al*, 1992). The reduction of social contact has always been one of the aims of our interventions in high-EE families; we advise relatives and patients that the latter need time to themselves, particularly when the atmosphere becomes tense. We suggest to patients who have not already discussed it, that they can avoid painful confrontations by anticipating them and leaving the home to go for a walk or withdrawing to their room. We also counsel the relatives not to follow the patient if he/she adopts that strategy.

On a long-term basis, if the patient is unemployed, we help to arrange a placement in a day centre or day hospital. Of course, this has the primary aim of improving the patient's work capacity and social skills, but it also fulfils the function of separating patients and relatives for part of the day. If the relatives are unemployed or retired, we encourage them to take up leisure activities which will draw them out of the home. If the patient is willing to move out of the parental home into sheltered or independent accommodation, contact is lowered considerably, but as discussed above, this is often difficult to achieve.

Expanding social networks

If the patient and relatives have no social networks outside the household, they are inevitably thrown into each other's company for much of the time, and have no relief from the emotional tension in the

home. At the onset of the illness, families have normal-sized social networks, but as the illness progresses these shrink. The reason is partly shame and embarrassment about the patient's behaviour and having a mental illness in the family; relatives often stop seeing their friends and relatives and no longer invite them into the home. We encourage relatives to start going out again and redeveloping their social life. This can meet resistance when relatives do not feel ready to expose their problems to other people, who they fear will be unsympathetic or worse. This problem can usually be overcome by inviting family members to attend a relatives group. We run a group for relatives in parallel with the family sessions; it is open-ended and is held once a fortnight for one and a half hours. As many as 12 families can be attached to the group because usually only half that number attends each session. Once relatives can be persuaded to come, they find that other people are facing problems similar to theirs or even worse. This relieves their feelings of guilt, embarrassment and isolation. The group members often develop social relationships with each other, and so it can act as a stepping stone back into society.

We also encourage the patient to develop social contacts outside the home, but this can be very difficult if he/she had a restricted social life before falling ill and has been left with poor social skills. If this is the case, the therapists will consider referral to an appropriate professional for social-skills training. Sometimes a healthy sibling can be recruited to introduce the patient to a social group, although not all siblings are willing to play this role. Help may also be available from voluntary groups such as a church social club or a befrienders service.

Lowering expectations

Relatives often expect the patient to be cured on return from hospital, particularly if it is the first admission. We explain to them that while the positive symptoms are controlled with medication in the great majority of patients, the negative symptoms take one to two years to improve. We advise them not to put too many demands on the patient during this convalescent period, but to be pleased with small advances and to reward the patient with praise. Middle-class parents often have difficulty in modifying their aspirations for the patient. They expect him/her to return to a university course or to continue advancing in his/her career. We tell them that it is fine to have these goals in the long term, but that the immediate aims should be much more down-to-earth, such as helping the patient to get up in the morning. Unfortunately, few patients with

schizophrenia will be able to fulfil their early promise. Consequently, parents need the opportunity to grieve for their lost hopes and aspirations. They can be helped with this in sessions with the therapists that do not include the patient. Alternatively, the relatives group is an appropriate setting for working through grief, as most members will have faced similar losses.

Working with the individual patient

Working with families does not preclude work with the individual patient. Indeed, as mentioned above, the therapists holding family sessions may choose to see the patient alone at times, partly to emphasise his/her independence of the parents. In addition, the therapists may judge the patient to be in need of specialist help from other professionals.

Skills training: anxiety management

Many patients show deficits in the skills required to negotiate everyday life: social skills in particular are often impaired by schizophrenia. A behavioural approach to teaching these skills has been shown to be effective for schizophrenic patients, as long as the training situation is as close as possible to the real-life situation in which the skills are to be exercised (Wallace & Leiberman, 1985). In our programme, we refer patients to psychologists or occupational therapists for specific training in skills deficits if we consider this is warranted. However, in the research programmes run by Falloon *et al* (1982) and Hogarty *et al* (1986), skills training was given routinely to some groups of patients. By itself this was not as effective in reducing the relapse rate of schizophrenia as was work with the families, but in the study by Hogarty *et al* (1986), patients who received skills training in conjunction with family work remained entirely free of relapse for nine months.

Some patients with schizophrenia experience anxiety attacks or phobic anxiety which are identical in form to the symptoms of neurotic patients. The occasional patient will report that when the anxiety reaches a certain level, psychotic experiences occur. Some patients self-medicate their generalised or phobic anxiety with alcohol. It can be helpful for the anxiety to be treated with a behavioural approach: relaxation training and, in the case of phobias, desensitisation.

Persistent psychotic symptoms

About 10% of patients have delusions or hallucinations which persist despite medication, and this gives rise to an almost intolerable burden for patients and their families to bear. In recent years, a cognitive approach

to reducing psychotic experiences has been developed (Böker *et al*, 1989). In the case of delusions, the patient is asked to consider evidence which is inconsistent with his/her false beliefs. With hallucinations, the therapist works with the patient to identify circumstances which increase or decrease their intensity and frequency, in an attempt to increase the patient's control over them. While evidence is still lacking for the value of this approach, we have tried it with patients who are intensely disturbed by their persistent psychotic experiences, in the hope that they may thereby find some relief.

Psychoanalytic psychotherapy

Only a minute proportion of schizophrenic patients receive psychoanalytic psychotherapy in the UK, but some of these individuals have been included in our programmes. We have had no difficulties in providing our forms of care alongside individual psychotherapy. However, it is vital that the different therapists keep in close touch with each other, to ensure that their aims are not conflicting. This is particularly important with regard to medication.

Conclusion

People suffering from schizophrenia have a wide and varied range of needs: the need for maximum control over their symptoms with minimum discomfort, for a roof over their head, for financial support, for emotional support from family and friends, for an occupation which is satisfying and increases self-esteem, and for personal growth. However, the sad fact is that psychiatric services are not organised to cater to all these needs, and patients and their relatives are not in a strong position to demand satisfaction from the services or to find their way through the procedures required to mobilise help. Professionals are in a much better position to do this, partly because of their knowledge of what is available and partly because their status gives them leverage. Therefore, the therapists need to act as brokers on behalf of the patients and their families in contacting and engaging the appropriate services. This type of activity has recently been graced with the term 'case management', which has become a popular catch-phrase in the UK and the US, probably because it acknowledges the increasing power of the managerial class in the health services

of both countries. But in our view, it is essential that the therapist takes on the role of organising and managing services for schizophrenic patients, since the therapist is much more likely to be sensitive to an individual's wide range of needs than a non-clinical manager. To fulfil this role adequately, the therapist needs to take an eclectic view of schizophrenia and of the many disabilities that follow in its train. Only then can a truly integrated service be created.

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