Introduction to family interventions

Aim
The aim of this chapter is to start to explore the history and development of family interventions, with related evidence for mental health practice.

Learning outcomes
By the end of this chapter you will be able to:

- identify the historical work surrounding family work
- articulate the effects of family blaming
- describe the emergent theme of expressed emotion
- detail some key factors related to legislation and the need for family-orientated therapy.

Introduction
It would not be unreasonable to expect that any person experiencing serious mental health difficulties would receive care and support from family members, and that being at home in a familiar environment would be the ideal place to receive this care and support. Unfortunately this is not always the case, and in reality many people experiencing mental illness are treated in hospitals.

It is generally accepted that family members, and carers, often feel unable to help. They can feel stressed through being with their relative 24 hours a day, often witnessing behaviours and symptoms which are difficult to understand. They experience a variety of emotions and distress because they are with their relative, largely without a break. This includes general stress, anxiety and a fear of what may happen, and frequently guilt. Alongside these emotions the family member may experience financial difficulties, as going out to work may not be possible with the constraints of providing supervision and care. There are often restrictions on
The involvement of family in the care of mental illness has been somewhat curtailed. Although the family has traditionally cared for mentally unwell members of society for many years, the transition from family-based care to institutional care became the norm. As it became evident that people experiencing mental health symptoms needed treatment, the early treatment of mental illness subjected the sufferer to an ‘asylum’ with little thought to the family members. In the early years, there was the view that mental illness was caused by the family, and the notion of family blaming (Johnstone 1999).

For many years people suffering from mental illness were isolated from society and placed in large institutions. Alongside this isolation was the combined prejudiced view of society. It is well documented that people with a diagnosis of schizophrenia (in particular) experience discrimination and stigmatization (Sayce 2000). While attempts to reduce this are ongoing, it is an added burden for both the sufferer and family members.

At the beginning of the twentieth century a small French town of Ainay-le-Château became a setting that did not isolate individuals with mental illness but rather welcomed them with open arms. In this rural town ‘mentally ill men’ were welcomed as part of the family (family colony). These men (lodgers) lived everyday lives with ordinary families (foster parents), and even held down jobs. This setting provided invaluable social insights into the effects of family involvement and has been documented as part of a four-year ethnographic study by Denise Jodelet (1991). This particular study highlights the importance of ‘family’ involvement, and the benefits that support and care can provide.

In 1948 Henry Richardson explored the importance of family care in the recovery from both physical and mental health difficulties. His book Patients have Families is well regarded as a significant step forward and is seen as a contributing factor to the development of systemic family therapy. Systemic family therapy is very effective and is supported by evidence. This approach is based on the idea that the problem lies within the whole family and not one single individual. We highlight this but acknowledge that this is a very different approach to family interventions.

The most significant piece of work that can be regarded as paving the way forward for family interventions was carried out in the 1950s. George Brown (a medical sociologist) and colleagues began to study the outcomes of relocating long-term mentally ill people into community settings (Brown et al. 1958). The results focused on the environment that patients were discharged to. Interestingly patients who were discharged to family homes fared far worse (in terms of relapse and readmission to hospital) compared to those who lived on their own or in a supportive
residential setting. Those who were discharged to hostels, where there was little warmth and support, experienced the worst outcomes. Further work carried out in the 1960s and 1970s (Brown et al. 1962; Brown et al. 1972) led to the development of the now very familiar term expressed emotion, which we discuss further in Chapters 2 and 3.

The significance of social inclusion gathered pace in the 1980s with increasing recognition by the government. The advent of ‘community care’ was outlined in what was referred to as the Griffiths Report (Griffiths 1988), which emphasized the benefits of maintaining individuals in their own homes. In 1989 came the publication of the White Paper Caring for People: Community Care in the Next Decade and Beyond (Department of Health and Department of Social Security 1989). This was added to in 1990 by the National Health Service and Community Care Act (Great Britain 1990).

The introduction of the National Service Frameworks in the 1990s included a framework for mental health. Within this framework is recognition that carers’ needs should be met (Department of Health 1999). This was further enforced in 2004 with the publication of the Carers (Equal Opportunities) Act (Department of Health 2004a). Further to this came the National Institute of Clinical Excellence (NICE) guideline recommending that family interventions be offered to all families where a family member has experienced schizophrenia (NICE 2002).

**Family interventions**

From the development of expressed emotion came the recognition that work needed to be carried out with family members that would ultimately reduce their stress, increase understanding and, importantly, benefit the individual experiencing the symptoms of mental illness. Work by Leff et al. (1982) was significant and seen as a vital piece of research in kick-starting a whole wave of studies which attempted to determine how effective interventions with families could be. The studies have strengthened the evidence base for family interventions and outlined the effectiveness of this approach. When you also add the potential financial savings to services (as high as 27 per cent: Tarrier et al. 1991) it only strengthens the need for family interventions to be offered as part of everyday practice.

However, despite the need for family interventions, they are certainly not offered in many mental health services. There are a few notable exceptions: in Bath (Smith and Velleman 2002), Somerset (Stanbridge et al. 2003) and the work of the Meriden family programme in the West Midlands (www.meridenfamilyprogramme.com).

There has been a considerable push to develop training courses across Britain and this is leading to a significant number of trained therapists, yet despite this training professionals are not carrying out family interventions. Why is this? It may be that services do not recognize the benefits or do not have the available resources. It may be that family members do not want this intervention. It may be that therapists feel they do not have the support to carry out the work.

Whatever the reasons, the benefits cannot be ignored and mental health services need to look at the barriers to the implementation of family interventions. This is addressed further in Chapter 22.
What constitutes a family?

‘What constitutes a family?’ is a question that is often asked. In our experience colleagues have sometimes stated that they cannot carry out any family work because the service user does not have a family. Colleagues often state that the service user has only a partner and there are no other family members. We hear experienced staff say that they would like to carry out family work, but family members are always out at work, or are not available when the service user is visited. It would be ideal if every service user had a mother, a father, a brother and a sister who were willing to engage in family work – in reality this is not the case. This is often one of the difficulties in starting family interventions, as it is perceived that any family work can be offered only if there are several family members involved, and that they are all available at the same time. If we broaden our view and look more widely, and actually ascertain who the service user spends time with over the course of a week, we can include those who spend a significant amount of time with the service user. This could include grandparents, aunts, uncles and people who are not actually related. Carers are often included in family intervention work, as they spend a large amount of time with the service user. A significant amount of time could be regarded as a minimum of 35 hours per week (5 hours per day) though we are not prescriptive in this. We feel that regular contact and awareness of the service user’s illness are significant.

Summary

- Family members experience a range of emotions as a result of witnessing often difficult behaviours from their relative.
- An individual with mental illness should be treated in a familiar environment, if at all possible.
- Family interventions are beneficial to both the family members and the individual experiencing mental health difficulties.
- Family interventions are cost effective.
- Any person who has significant contact with the service user can be considered as a ‘family member’.

Questions

1. Who carried out the research in the French family colony?
2. Geographically, which areas carry out family interventions?
3. When was the National Health Service and Community Care Act first published?
4. What is ‘family blaming’?
5. Why are family interventions not routinely offered?
2

The evidence for family interventions

Aim

The aim of this chapter is to detail relevant influences and evidence that underpin the development of family intervention in clinical practice.

Learning outcomes

By the end of this chapter you will be able to:

- understand the evidence base for family interventions
- establish the impact that different styles of communication have on participants in family intervention
- detail the drivers for the use of family intervention
- describe the importance of family members undertaking family intervention
- articulate a rationale for the use of family intervention in practice
- start to explore whether family intervention is truly evidence based.

Introduction

Before we start to explore the evidence for family interventions, we briefly review what sort of evidence we feel is influential in relation to the area. Rather than just relying on laboratory-type evidence, we felt the need to focus on practice-related evidence where possible. This would enable us to explore the engagement in a praxis construct. This would involve the competing demands on practitioners to complete not only the basic administrative and team-related work, but also the demand of family members and service users. Addressing these demands can create a sense of overwhelming dread, perhaps due to another way of working. We choose to look at it as a model that can influence everyday practice, rather than seeing it as something to be feared.

Evidence-based practice and whether family interventions are evidence based are not necessarily definitively answered in this chapter. We would like you to be able to
think about this question, and then ask yourself the question, are family interventions evidence based, and if so in what way, using the information we have provided?

Restricting the evidence to this small section would be a form of reductionism in approach, and we prefer to thread the information throughout the book so as to add to the sense of praxis. Not that we fail to offer information for the support that it is, but ultimately we need to address the questions below (and those in subsequent chapters) to see if family interventions could be so described.

For family interventions to be viewed as evidence-based practice they would need to address the following:

- Is family intervention based on best available evidence?
- This evidence will need to have a research base.
- Research would need to be of such a quality to have addressed the issues of rigour and reliability and be systematic and controlled.

To partially address the question you may want to look at databases such as the Cochrane and Campbell centres for information. You could also consider the drivers from government and the evidence it uses to support the need; another area could be the National Institute for Health and Clinical Excellence (NICE). Whichever you look to, you may be swayed by the need to adhere to the gold standards of evidence (meta-analysis, randomized controlled study, systematic reviews), yet for practitioner research, frequently this information seems distanced from the practicalities of the work to be undertaken. More often case study and experiential accounts seem more grounded and applicable to skills development. Ultimately what you find important in addressing whether family interventions are evidence based or not is, on a superficial level, down to what you and your service are willing to accept as evidence.

If you are trying to present a case for introducing family interventions, you will need to consider all of the above and not be exclusive. We offer some thoughts as to why family interventions should be used in all services, with mentally ill people at the centre.

There is a high level of confidence concerning the utility of family interventions, especially when considering the evidence base presented by Pilling et al. (2002) and Pharoah et al. (2010).

Pilling et al. (2002) completed a meta-analysis involving 1467 patients, in 18 family intervention trials. They concluded that although improvements were made, some decline over time occurred. They cast doubt over some of the information they used as there were differing methods of intervention and differing groups of clients. With this in mind they still suggested that family interventions ‘had clear preventative effects on the outcomes of psychotic relapse and readmission’ (Pilling et al. 2002: 763), and that family intervention should be offered to families of people with a diagnosis of schizophrenia.

Pilling et al. (2002) identified some important markers for why family interventions should be used. The evidence they examined is summarized into themes in Table 2.1.

The Pharoah et al. (2010) Cochrane Collaboration concluded that family intervention could reduce the frequency of relapse and the need for hospitalization. The information was of interest for people with schizophrenia, clinicians and policy
They did suggest some caution over the findings as much of the evidence they reviewed had poor methodological quality.

To move on, there is a need to look at the historical perspectives that have influenced the development of family interventions. It is fine that we have such eminent and authoritative evidence, but conceptualizing the information needs more detail. The issue of relapse has probably become a marker for success or failure in the eyes of lay people and professionals.

There is clear evidence that family members do have a role in the identification and relapse of mental illness (studies by Brown et al. 1962; Goldstein and Doane 1982; UCLA projects by Goldstein 1987). This role needs to be understood from a variety of perspectives in order to find a positive way forward and avoid an age-old default of blaming the family for all the problems that a service user presents with.

Throughout the book the theme of expressed emotion and stress vulnerability will be detailed and linked to different aspects of education and therapy. The fact that a great deal of research has gone into the issue of expressed emotion cannot be ignored and should be discussed as a factor in why we need family interventions. To say that this is the main factor in relapse would be naive and exploration of affective style and communication deviance will be discussed in later chapters.

We need to accept that prior to a service user coming to the attention of a mental health service, there have been many life experiences and attempts by the individual and their family to remediate problems, solve dilemmas and make sense of something that seems to make no sense. The manner in which this is done varies according to the problems and the family members.

They have generally adapted styles of coping and communication to address the difficulties they perceived. This may have led to the development of new behaviours and risk taking by the family in order to resolve conflict or attempt to make sense of bizarre and frightening allegations. Unfortunately many families conclude (with or without the help of services) that they are to blame for the illness, and find it difficult to relinquish this blame. Blame and ultimately labels can be attached to families and even individual members. All too commonly families can feel rounded on and that their actions are scrutinized by people who have nothing to do with their family. This can lead to polarizing views and inharmonious relationships with service providers.

The introduction of mental health services may inadvertently introduce a paradox that leaves relatives confused and at time paralysed, ultimately reinforcing

| Table 2.1 Why family interventions should be used |
|----------------|---------------------------------------------|
| Category        | Outcome                                    |
| Relapse         | Reduction in relapse rates                  |
| Readmission to hospital | Reduction in readmission                  |
| Suicide         | No increase in the rates for those involved in family interventions |
| Compliance with treatment | No real difference with other treatments |
| Burden          | Reduced level of burden                    |
| Compliance with medication | Improved compliance with medication regime |
the blame. Sometimes a little bit of knowledge from pre-registration courses can lead to poor conclusions, and well-meaning throwaway statements can lead to long-lasting conflicts and upset. The paradox often comes from well-meaning service providers who through a limited knowledge of the influence that a family have on illness suggest that the family are not to blame for the service user’s illness yet if they changed the way they all behaved to the service user, they could have averted a relapse.

Herein lies the initial reason for why family intervention needs to be explored in this book. We hope to increase the body of information available for all levels of service provider in order to help them to avoid creating damaging conflicts before therapy has even started.

**Expressed emotion**

Although expressed emotion is discussed in detail in other sections, we need to look at the components at this point in order to offer a cogent argument for why we need family interventions. If we accept the details suggested by Vaughn and Leff (1976) that expressed emotion has three distinct components, hostility, criticism and emotional overinvolvement, and that families can fall into categories of high expressed emotion (exhibiting many factors related to the components) and low expressed emotion (exhibiting few if any factors related to the components), then we can start to see a tangible thread for help that may need to be given to support the family. It is generally accepted that families who are viewed as having high expressed emotion have a higher relapse rate than the low expressed emotion families and that as the amount of contact time increases with such families, so does the chance of relapse (Kavanagh 1992).

Acceptance that expressed emotion is an important theme in family work must not be lost and the addressing of it can become the rationale for family interventions.

**Compounding influences**

Mental health workers with many years’ experience see trends come and go. If we are not careful, family interventions may be seen as a trend and this would be unfortunate. The development of the opinion that families had a role in the development of mental health emerged from the work of Bateson et al. (1956) and the discussion of ‘double-bind’ (where one message conflicts and invalidates a subsequent one). An example of this could be seen in a parent’s interaction with a child. A mother says that she loves her child while showing disapproval. The child is unable to comment upon this due to the dependency on her.

Although anecdotally discredited as unresearchable by Abeles (1976), the work of Koopmans (1997) argues for the theory to be revisited due to the narrow focus of past attempts to understand the influence on children who developed schizophrenia.

Family relationships were further explored, especially ones where ‘strife’ existed. Lidz and Fleck (1985) identified competition and hostility in families and looked at situations where the ideas of one parent were not addressed by a passive other. The importance of these studies is in the fact that the factors highlighted started before the
birth of the service user. Therefore they could not have been a consequence of the behaviour of the service user.

This unfortunately raises the issue of blame again, but care is needed by mental health workers. Blind acceptance of such ideas could lead to altered practice and scapegoating of families or family members. Our understanding of the factors identified gives us the opportunity to focus on tangible themes for therapeutic interventions. Just because the family worked in this way does not mean that they have done anything deliberate in order to cause harm to the service user. The fact that families have been identified as significant was highlighted only through the development of the illness. Many families with this pattern of behaviour have probably never come to the attention of mental health services.

**Drivers**

The move of mental health services from hospital to community has gathered pace since the mid-1990s. The involvement of mental health workers and family members has become more commonplace yet limited help is offered. Predominantly help is singled out for the service user and the family are left to deal with the aftermath.

Over recent years the government has made moves for families to be both recognized and included in the decision-making process. The advent of the carer’s assessment (Department of Health 1999) and the highlighting of what constitutes a good carer’s assessment (Department of Health 2007) raised the profile and rights of the family. Hand in hand with the increased rights is the demand for better services and a say in the way care is provided. Organizations such as Rethink (a UK charity) are at the forefront of moves to make services more transparent and collaborative. Implementation of guidelines published by the National Institute for Health and Clinical Excellence (2002, 2009) cover a range of treatments and services. Family interventions have become part of the guidance for working with people who experience schizophrenia (NICE 2002, 2009). NICE guidelines at this point argued that family interventions should be offered to 100 per cent of families where a family member has experienced an episode of schizophrenia.

More recently NICE has developed a shared learning database with the Meriden Family Programme whose aim is to help services implement family interventions so service users and their families receive evidence-based care and support. The access to online information is an important part of this but only one part.

**Service user and family involvement**

It is laudable that we promote the importance of the family, but we must not lose sight of the service user in all this. At some time in the future the service user may become so unwell that hospitalization may be considered. The family will need to know their rights and in particular the ‘nearest relative’. This person can apply for a service user to be detained or discharged under a section of the Mental Health Act (Department of Health 1983). Such decisions are never easy and families can feel disempowered at times with the merry-go-round of doctors and mental health professionals offering
advice. What is clear is that families need an impartial advocate to support them. More importantly they need to have the knowledge to help them make sensitive decisions and not become scapegoated for their opinions.

The families have a pivotal role at crisis times and their inclusion is imperative. For family interventions, it is at times like this when the family see the gaps in their knowledge and the need for family interventions is raised. Commonly referrals for family interventions are made when a service user has been admitted to hospital. Families are generally more receptive to support when their relative is (or has been) in hospital, and the important message that family interventions need to convey is often better received at these times.

It is in these situations where knowledge of working with families and the understanding of issues such as expressed emotion and stress vulnerability are paramount. Understanding the crisis that has potentially precipitated admission to hospital and the need for both tact and diplomacy both go without saying, but appreciation of the events and the understanding that the family placed on them is vital. Care is needed not to overinquire yet you need to exude a level of interest. It is at these times that it becomes clear what could potentially be the families’ opinion about mental illness and their immediate needs become identifiable.

At times families develop a tolerance of abnormal behaviour and accommodate this. What seems unacceptable to the outside eye may not be to those exposed to the thoughts and behaviours for a prolonged period. Care is needed not to demean the coping strategies and isolate families with their attempts to cope. Although risks need to be taken to accommodate some adaptive strategies, preservation of the relationship is important. After all it is important that the interests of the service do not detract from the lifestyle that the service user and their family may want.

The preservation of the family relationships is an aim of family interventions as well as working together with the service user and family to improve their functioning on all levels. This functioning will need to encompass social skills, problem solving and education about the illness (to name but a few). If this aim is made transparent and the relation with service providers made collaborative the quality of life of the family and service user may improve. The improvement of quality of life issues will need to be measured and this may involve the use of a standardized tool such as the Manchester Short Assessment of Quality of Life (Mansa) (Priebe et al. 1999) in order to identify and quantify elements of life that may need improvement. The baseline measurement made at the outset can influence any joint programme of care and act as a future measure for improvement or deterioration.

Another important factor is the overt design that the family intervention takes. The main crux lies in the domain of the service user and the family members engaging in treatment and having a say about what this may look like. Engaging in treatment and understanding principles such as normalization will allow them to make choices and take risks on their terms. The risk taking may include tolerating a level of illness that the service user and family accept, and could involve the notion that the service user may not be symptom free.

The level and form of symptoms will be discussed in later chapters but will be established by the family worker being knowledgeable about various forms of assessment scales and having positive interpersonal skills. The family worker will need to
understand key skills of discourse including counselling-type skills in order to develop **core skills** (see Box 2.1).

<table>
<thead>
<tr>
<th>Box 2.1 Core Skills needed for family workers</th>
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<tr>
<td>Carl Rogers (1951) advocated the following core interpersonal skills:</td>
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<tr>
<td>• showing acceptance</td>
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<tr>
<td>• being genuine</td>
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<tr>
<td>• having some form of empathic understanding</td>
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<tr>
<td>• having a level of congruence</td>
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<tr>
<td>• having unconditional positive regard</td>
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<tr>
<td>• listening and responding.</td>
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These core skills may help the flow of interchanges of communication and help the worker to deal with elements of resistance. Showing understanding and being genuine may seem to be basic skills; however, being able to demonstrate these attributes needs constant attention and vigilance. The complicating factor in this is that the worker needs to use the skills in conjunction with assessment scales while trying to maintain a flow that addresses the concerns and agenda set at the outset (this will be discussed further in later chapters). It would also set precedence for the underpinning style of interchange.

The introduction of family interventions may be the first time that the service user and the family have had exposure to mental health workers. There is anecdotal evidence that getting it right first time may improve the prognosis for the service user. This is an underpinning ideology for the introduction of **Early Intervention Teams**.

**Summary**

- Blame is an issue that can be felt by family members who have been insensitively worked with.
- Expressed emotion is a possible factor for relapse.
- Expressed emotion is affected in high expressed emotion families by increased contact.
- The issue of double-bind should not be automatically ignored.
- NICE guidelines argue that family interventions should be offered to 100 per cent of families where a member experiences schizophrenia.
- Care is needed not to scapegoat families for the illness and to blame them for coping strategies.
- Accept that families do not necessarily work as family workers do and may have skewed views of mental illness and coping strategies.
- The use of core skills will enable workers to ease the process of communication but there is a need to accommodate the style to ensure that assessment is addressed.
Questions
1 Name three components of expressed emotion.
2 What is a double-bind?
3 What rights does the nearest relative have in relation to the Mental Health Act 1983?
4 Improving functioning will need the exploration of which factors?
5 What factors do family interventions try to address at the outset?