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FAMILY WORK FOR SCHIZOPHRENIA

Julian LEFF, Institute of Psychiatry, Kings College London, de Crespigny Park, London SE5 8AF; ph 0044 207 794 9724

Definition: Family work tries to avert relapse in schizophrenia by helping relatives reduce high levels of negative emotion expressed to the patient such as critical comments, hostility, and over-involvement with overemotional behaviour, overprotection e.g. a mother would not let her 20 year old daughter cross the road alone when she developed schizophrenia, and lack of boundary-setting e.g. a mother allowed her son to establish a home gymnasium in her living room thus excluding her from using it.

Elements:
1. Reducing expressed emotion: Criticism and hostility can stem from ignorance about schizophrenia and are tackled initially by education about it, e.g. stating that apathy and self-neglect are caused by the illness and not by the patient being lazy or dirty. Thereafter, critical remarks are reframed as representing a caring attitude of the relative, so allowing the relative and patient to negotiate the behaviour being criticised, e.g. reframing 'He's always wearing a dirty shirt' as *'You really care about your son's appearance'*. Overinvolvement is lessened by helping the relative and patient recognise that they maintain this in a mutually reinforcing relationship e.g. asking each partner what they would feel like if the other was absent for more than a day. Relatives' guilt is alleviated by therapist statements in education sessions that relatives cannot cause schizophrenia, and direct exploration of the guilt, e.g. a mother was asked why she allowed her son to beat her - she said she'd tried to abort the pregnancy with a knitting needle and believed this had caused his illness. Joining a group of other relatives also helps. The therapist/s relieves relatives' anxiety by congratulating them on their excellent care of the patient, saying they've earned a rest, and asking them to choose and carry out enjoyable activities outside the home which involve brief trial separations, e.g. suggesting that the parents go out together for an hour to have coffee, leaving the patient at home. The therapists encourage the patient to feel competent by choosing and carrying out a small task in the relative's absence, e.g. making her bed.
2. Reducing contact with a high-expressed-emotion relative: The therapist addresses this if the patient is unemployed and has no daily activity outside home, leading to long contact (over 35 hours a week) with a high-expressed-emotion relative at home e.g. elderly parents who've retired or given up their job to care for the patient, or a homemaking partner. The therapist advises the patient to attend a day hospital, day centre or sheltered workshop, and the relative to spend more time away from home in social activities, voluntary work, or attending adult education classes. Schizophrenia impairs patients' ability to form and sustain social relationships, but the therapist tries to help them increase social activities by social skills training, e.g. encouraging eye contact and smiling during conversations, and by recruiting healthy siblings to help the patient make social contacts outside the home.

Related procedures: *Behavioral activation, community reinforcement approach, nidotherapy, reframing, social skills training*.

Application: One or two therapists run sessions with individual families or any family member/s, groups of up to 10 relatives excluding patients, and multi-family groups of up to 8 families including the patients. Antipsychotic medication is usually continued in parallel.

1st Use? Leff et al (1982)

References:

1. Vaughn C, Leff JP (1976) The influence of family and social factors on the course of psychiatric illness: a comparison of schizophrenic and depressed neurotic patients. *British Journal of Psychiatry*, 129, 125-137.
2. Leff J, Kuipers L, Berkowitz R, Eberlein-Fries R, Sturgeon D (1982) A controlled trial of social intervention in the families of schizophrenic patients. *British Journal of Psychiatry*, 141, 121-134.
3. Kuipers L, Leff J, Lam D (1992) *Family Work for Schizophrenia: A Practical Guide*. London: Gaskell. 2nd ed. 2002.
4. Leff J (2005) *Advanced Family Work for Schizophrenia*. London: Gaskell.

Case Illustration 1 (Leff, unpublished)

John age 19 developed schizophrenia and was admitted to hospital for 9 weeks. Antipsychotic medication reduced his delusions and hallucinations. He resumed living with mother and stepfather, but stayed in bed all morning and grew his hair long. His infuriated stepfather, a retired army officer, tried pulling John out of bed by his hair. Mother, an executive in a large company, gave up her job to look after John. Stepfather accused her of being too soft with John and she complained he was too hard.

As is usual, 2 therapists worked with the family in their home. They began with 2 sessions of education about schizophrenia, emphasizing that John's staying in bed was part of the illness, after which stepfather stopped criticizing him. Mother said that from John's birth she'd recognised his difference from his older brother, who now lives on his own. She felt John needed more care and protection; the therapists praised her sensitivity but said it was now actually counterproductive as it hindered John from developing friendships with his peers. One-hour sessions with mother, stepfather and John together were held every 2 weeks initially, later monthly, over a year. The therapists tried to reduce conflict between the parents, enabling them to manage John's problems together. Both parents attended a relatives-only group of up to 8 relatives meeting bi-weekly for 1.5 hours. The other group members pressed mother to return to work. She finally agreed, having developed enough confidence in stepfather's change of heart to allow him to care for John by day. He relinquished his aggressive means of getting John out of bed and, after discussion with the therapists, introduced inducements, including activities he and John could do together, e.g. constructing a barbecue in the garden. Apart from the first 2 education sessions with the parents only, the 3 family members had 15 sessions over the year, and the parents attended a relative's group together or separately 13 times in all.

Case Illustration 2: Reducing contact with a high expressed-emotion relative (Leff, unpublished)

Brian age 35 has suffered from schizophrenia for ten years. He lives with his mother and two younger stepbrothers, Mike and Joe, whose father died a few years ago. Brian's father separated from mother when Brian was aged 8 and lost contact with the family. Brian has paranoid delusions and tends to sit on the stairs to the upper floor holding a knife. Mother overprotects him and does not establish boundaries to his behaviour, e.g. she prepares special meals for him when he won't eat with the family.

He rarely goes out and his stepbrothers never ask friends home because of embarrassment about Brian. One therapist conducted 2 education sessions attended by mother, Mike and Joe. In session 1 including all 4 family members, Mike angrily announced that in the past he'd wished Brian would die. The therapist asked Mike about his relationship with Brian before he became ill. Mike gave an account of Brian teaching him to fish and how much he'd looked up to Brian. The therapist explained that protecting Brian against contact with the outside world maintained the usual stigma of schizophrenia. At family meeting 4 Mike said he'd told his friends about Brian's illness and they'd been sympathetic. They now visit the home and stay with Brian when Mike wants to go out, and Brian stopped sitting on the stairs holding a knife. Furthermore Mike now takes Brian out fishing and though Mike says little, there is a sense of companionship. By these means contact between Brian and mother has lessened considerably. The 4 family members had 6 sessions over 4 months. No relatives group was available locally.