Family Intervention in First Episode Psychosis

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Introduction

Among all medical disorders, schizophrenia is one of the most costly and most severe, creating nearly continuous disability for a lifetime in the great majority of cases. It is a devastating disorder for families, who often assume major care-taking and psychological burdens secondary to the functional deficits that this and other psychotic disorders impose. The functional disability that is particularly devastating in schizophrenia appears to be secondary to the negative symptoms that usually begin prior to the psychotic symptoms, often persist despite treatment and usually get worse with time and with each subsequent episode. These deficit symptoms are often the most burdensome for family members, because they usually do not identify them as part of the disorder but they nevertheless find themselves supporting the affected member to compensate for those deficits. The reactions many family members have to the emerging symptoms often become one of the stressors that have a negative influence on those symptoms, longer-term outcomes and degree of disability. This chapter describes the interaction of family and biological processes and a powerful treatment method that has been shown to reverse these negative processes and help family members become irreplaceable and remarkably effective contributors to the treatment and rehabilitation process.

Mutually reinforcing biological and social processes

The prodromal and early psychosis phases

Studies of first episode psychosis, document that the average time between onset of psychotic symptoms and the initiation of treatment is one to two years, depending on the study. Frequency and severity of recurrence may be increased by exposure to periods of untreated psychosis and decreased by effective treatment. The earlier one provides treatment, the more effective is that treatment, the better the prognosis, and the less the functional deficit, perhaps preventing the persistent residual deficits common in these disorders. Early identification of those with active symptoms allows initiation of state-of-the-art treatment that can continue for as long as the person remains vulnerable.

While the scientific evidence is increasingly strong that the major psychotic disorders are based in genetic or developmental defects involving brain function, there is also abundant evidence that the final development of psychotic symptoms is the result of psychosocial stress.
stress-diathesis or stress-vulnerability model provides a widely accepted, empirically supported and useful framework for describing the relationships among provoking agents (stressors), vulnerability and symptom formation (diathesis), and outcome. Therefore, a genetically or developmentally vulnerable person with a low tolerance for stress may experience a first episode of psychotic illness following exposure to excessive internally or externally generated stimulation. This principle underlies the Biosocial Hypothesis (see box).

Major psychotic disorders are the result of the continual interaction of specific biologic disorders of the brain with specific psychosocial and other environmental factors.

Psychosocial factors are usually the proximal causes of relapse in established cases and in the initial psychotic episode. The treatment described here is based on a simple and now plausible theory: the first episode occurs in a biologically vulnerable individual in an already evolving disorder in which the types of proximal causes of the first episode are the same as those in later relapses. Those include major stresses imposed by role transitions and other life events, social isolation, family expressed emotion, conflict and exasperation, separation from family of origin, and stigma. A review of pertinent literature supports this biosocial causal theory, yielding an interactive, feedback-based model for the final stages of onset, as compared to a simpler linear-causal model. Therefore, treatments that prevent relapse by counteracting those proximal causes can ameliorate the first episode, prevent subsequent relapse, and reduce the vulnerability to developing deficit symptoms.

**Expressed emotion (EE)**

High levels of criticism and emotional over-involvement are strongly predictive of exacerbation or relapse of symptoms. In an extensive meta-analysis, Bebbington and Kuipers cite the overwhelming evidence from 25 studies representing 1346 patients in 12 different countries for a predictive relationship between high levels of expressed emotion and relapse of schizophrenia and bipolar disorder. Inclusive reciprocal models have been proposed to increase the accuracy of the construct. For example, Strachan et al., and Goldstein et al., found that expressed emotion among key relatives is a reflection of transactional processes between the patient and family, supporting the conclusion that family functioning is affected by aspects of the illness, as well as the converse.

Attribution—relatives' beliefs about the causes of illness-related behavior—is also associated with expressed emotion. Relatives described as critical or hostile misperceive the patient as somehow responsible for unpleasant, symptomatic behavior, whereas more accepting relatives see identical behaviors as characteristic of the illness itself. This is an especially acute risk in the prodromal phase and in the first episode, during which symptoms and deficits often develop slowly, appearing to reflect personality or behavioral faults. An individual who is cognitively impaired, denying illness, paranoid, angry, hostile, affectively labile, socially withdrawn or anhedonic will be much less available to receive the support needed to function at an optimal level. If family members confronted by such symptoms in a loved one have little formal knowledge of the illness, they are likely to respond with increased involvement, emotional intensity or criticism. One of the few prospectively validated predictors of the onset of schizophrenic psychosis in vulnerable adolescents is negative affective style, an analog of EE.

**Stigma**

Stigma is often associated with withdrawal of social support, demoralization, and loss of self-esteem, and can have far-reaching effects on daily functioning, particularly at work or school. Link and colleagues observed that stigma had a strong continuing negative impact on well-being, even
though proper diagnoses and treatment improved symptoms and levels of functioning over time. Stigma affects the family as well. Effects include withdrawal and isolation on the part of family members, which in turn are associated with a decrease in social network size and emotional support, increased burden, diminished quality of life, and exacerbations of medical disorders. Self-imposed stigma tends to reduce the likelihood that early signs will be addressed and treatment sought and accepted, especially during the first episode.

**Communication deviance**
Communication deviance, a measure of distracted or vague conversational style, has been consistently associated with schizophrenia. It, along with family negative affective style, are the two predictive factors in the onset of schizophrenic psychosis in disturbed, but non-psychotic, adolescents.

Studies have demonstrated that communication deviance is correlated with cognitive dysfunction in relatives, which is of the same type as in patients with schizophrenia, but of lower severity. This suggests that some family members have difficulty holding a focus of attention, with important implications for treatment design. A child with subtle cognitive deficiencies may learn to converse in a communication milieu that is less able to compensate and correct. These difficulties are not personality defects; rather they are manifestations of the schizophrenic diathesis playing itself out in the interpersonal as well as in the neurological domain.

**Social isolation**
Research on several severe and chronic illnesses indicates that access to social contact and support prevents the deterioration of patients and improves the course of their illnesses. Family members of the most severely ill patients are isolated, preoccupied with, and burdened by, the patient. Social support buffers the impact of adverse life events, and is one of the key factors predicting medication compliance, behavior toward treatment in general, schizophrenic relapse, and quality of life. Availability of social support to the family is associated with subjective burden experienced by relatives. Brown et al. showed that 90% of the families with high expressed emotion were small in size and socially isolated. Social network size decreases with number of episodes, is lower than normal prior to onset and decreases during the first episode.

**Life events prior to onset**
Disruption of social networks leads to destabilization and relapse. Steinberg and Durrell found that the vast majority (nearly 80%) of first episodes in an Australian sample occurred after separation from home and family—on entering college or the military. Life events have been shown to be associated with, or predictive of, relapse in schizophrenia. For young adults and adolescents the most potent events tend to be those that involve loss of supportive social ties, especially separation from, or death of, family members, romantic/marital losses for women, and occupational disruptions for men.

**Effects on the family of psychosis**
Because there is so much evidence that family members of patients with established psychotic disorders share subclinical forms of similar deficits and abnormalities, treatment for early stages of psychosis must be designed to compensate for some of those difficulties. Those deficits lead to diminished coping ability, which is required in abundance in order to provide a therapeutic influence on the affected family member. Psychotic disorders exact an enormous toll on family members, in anxiety, anger, confusion, stigma, rejection, and exacerbation of medical disorders. Most families undergo organizational changes, including alienation of siblings, exacerbation or initiation of marital conflict, severe disagreement regarding support versus behavior control, even divorce. Almost every family undergoes a degree of demoralization and self-blame, which may be inadvertently reinforced by some
clinicians. During the prodromal phase, family members are mystified by the often dramatic emotional, cognitive, and behavior changes that they are seeing, and react in a wide variety of ways, from anger to denial to profound anxiety and worry. The result is a slow-moving crisis that cannot be guided or resolved from within the family.

A model of reciprocal causation

For the genetically or developmentally vulnerable person, subclinical cognitive deficits, effects of the psychosis on the family, family expressed emotion and exasperation, and characteristic coping styles combine to contribute to illness-generated stresses that induce a spiraling and deteriorating process that ends in a major psychosis. The proximal causes described above are potential targets for psychosocial treatment. The psychoeducational multifamily group model assumes that these stress factors can be countered or ameliorated by family and social-network intervention.

Outcomes of family intervention

Established and first episode cases

The family psychoeducational model defines schizophrenia as a brain disorder sensitive to the social environment. Thus, this form of treatment is bimodal, influencing both the disease, through medication, and the social environment, through techniques that deliberately reduce stimulation, rate of change, and complexity to tolerable levels. The approach achieves these goals by providing education, training, and support to family members and others, who in turn provide support, protection, and guidance to the patient.

The efficacy of family intervention, variously termed family ‘psychoeducation’, ‘family behavioral management’, or ‘family work’ (but not family therapy) is remarkable. Outcome studies by Goldstein, Leff, Falloon, Hogarty, Tarrier, Schooler, and Randolph report a reduction in annual relapse rates for medicated, non-institutionalized patients of as much as 40%, using a variety of educational, supportive, and behavioral techniques. The average relapse rates in these studies are 40% for individual treatment without family involvement, and under 15% for family approaches. This effect equals the reduction in relapse in medicated versus unmedicated patients in most drug maintenance studies. In over 20 controlled clinical trials, the track record for symptomatic, relapse, and functional superiority of family over non-family based routine treatment is clear: it is effective, in nearly any country, population, socioeconomic environment, class, gender or ethnic group, when applied in schizophrenia. Psychoeducational multiple family groups (PMFGs) reduce relapse to even lower frequencies and enhance vocational and social rehabilitation outcomes, especially regarding competitive employment.

In a study in which 69% of the cases were having their first episode, there were no relapses among the first episode group in the cohort that received family crisis therapy during the six months of the trial, significantly lower than in the cohort without family involvement. A long-term follow-up disclosed remarkably good outcomes in the period from three to six years after intervention. In two studies of differential effects in schizophrenia of single- (SFT) and multi-family group (MFG) forms of the same psychoeducational treatment method, better outcomes were observed for multifamily groups among those having their first hospitalization.

Psychoeducational multi-family group treatment

First episode psychosis

The psychoeducation multi-family group treatment model described here is designed to assist families directly in coping with major burdens and reducing stresses during the prodromal and psychotic phases of these disorders. This approach:
1. allays anxiety and exasperation
2. replaces confusion with knowledge, direct guidance, problem solving and coping skill training
3. reverses social withdrawal and rejection by participation in a multi-family group that counteracts stigma and demoralization
4. reduces anger by providing a more scientific and socially acceptable explanation for symptoms and functional disability.

In short, it relieves the burdens of coping while more fully engaging the family in the treatment and rehabilitation process, and compensating—non-pejoratively—for the expected subclinical symptoms that many relatives can be expected to manifest. The goal of intervention is to provide optimal treatment as early as possible for those who are experiencing a first episode of psychosis.

These groups address expressed emotion, social isolation, stigmatization, and burden directly by education, training, and modeling. Much of the effectiveness of the groups results from increasing the size and density of the social network, by reducing the experience of being stigmatized, by providing a forum for mutual aid, and by providing an opportunity to hear similar experiences and find workable solutions.

Five to seven families meet with two clinicians on a biweekly basis for one to three years. Unless psychotic, the patients also attend the group, although the decision to attend is based upon the patient’s mental status and susceptibility to stimulation. Each session lasts for 1.5 to 2 hours. The multi-family group intervention is described briefly here and in detail elsewhere.32

The intervention model consists of four treatment stages roughly corresponding to the phases of an episode of schizophrenia, from the acute phase through the recuperative and rehabilitation phases. These stages are:

1. Engagement
2. Education
3. Re-entry
4. Social and vocational rehabilitation.33

**Engagement**

Contact with the family and with the newly admitted individual is initiated within 48 hours of hospital admission or the onset of psychosis. The aim is to establish rapport and to gain consent to include the family in the ongoing treatment process. The clinician emphasizes that the goal is to collaborate with the family in helping their relative recover and avoid further deterioration or relapse. The family is asked to join with the clinician in establishing a working alliance or partnership, the purpose of which is to provide the best post-hospital environment for recovery. Initial contacts with the patient are deliberately brief and non-stressful. The young person is included in at least one of the joining sessions and is excluded from at least one. If the patient is actively psychotic, they are not included in these sessions, but only engaged in a patient-clinician format. This phase is typically three to seven single-family sessions for the multiple family group version, but more may be required until a sufficient number of families is engaged.

**Education**

Once the family is engaged and while the patient is still being stabilized, the family is invited to a workshop conducted by the clinicians who will lead the group. These 6 hour sessions are conducted in a formal, classroom-like atmosphere, involving five or six cases. Biological, psychological, and social information about psychotic disorders and their management is presented with videotapes, slide presentations, lectures, discussion, and question-and-answer periods. Information about how clinicians, patient, and family will work together is presented. The families are introduced to guidelines for management of the disorder and the underlying vulnerability to stress and information overload. Patients attend these workshops if clinically stable, willing, interested, and seemingly able to tolerate the social and informational stress.

The clinicians tailor education and information-sharing to each patient and family’s unique
and evolving experience, as assessed during the engagement process. Psychosis is defined as a reversible, treatable condition, like diabetes. The genetic or developmental vulnerability is presented as an unusual sensitivity to sensory stimulation, prolonged stress and strenuous demands, rapid change, complexity, social disruption, illicit drugs and alcohol, and negative emotional experience. As for blame and assigning fault, the clinicians take an important position: neither the patient nor the family caused the sensitivity. Whatever the underlying biological cause might be, it is part of the person’s physical personhood, with both advantages and disadvantages. Families are explicitly urged not to blame themselves for this vulnerability.

Families receive rather specific guidelines to use in relating to, and attempting to help, their relative with the illness. Table 23.1 presents the guidelines that are specific to the early phases of psychosis.

**Re-entry**
Following the workshop, the families and patients meet with the clinicians every 2 weeks in the mul-

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**Table 23.1 Guidelines for families. Ways to hasten recovery and to prevent a recurrence**

<table>
<thead>
<tr>
<th>Believe in your power to affect the outcome. You can</th>
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<tbody>
<tr>
<td><strong>Make forward steps cautiously, one step at a time</strong></td>
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<tr>
<td>Go slowly. Allow time for recovery. Recovery takes time. Rest is important. Things will get better in their own time. Build yourself up for the next life steps. Anticipate life stresses.</td>
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<tr>
<td><strong>Consider using medication to protect your future</strong></td>
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<tr>
<td>A little goes a long way. The medication is working and is necessary even if you feel fine. Work with your doctor to find the right medication and the right dose. Have patience, it takes time. Take medications as they are prescribed. Take only medications that are prescribed.</td>
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<tr>
<td><strong>Try to reduce your responsibilities and stresses, at least for the next 6 months or so</strong></td>
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<td>Take it easy. Use a personal yardstick. Compare this month to last month rather than last year or next year.</td>
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<td><strong>Use the symptoms as indicators</strong></td>
</tr>
<tr>
<td>If they reappear, slow down, simplify and look for support and help, quickly. Learn and use your early warning signs and changes in symptoms. Consult with your family clinician or psychiatrist.</td>
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<th>Create a Protective Environment</th>
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<tr>
<td><strong>Keep it cool</strong></td>
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<tr>
<td>Enthusiasm is normal. Tone it down. Disagreement is normal. Tone it down too.</td>
</tr>
<tr>
<td><strong>Give each other space</strong></td>
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<tr>
<td>Time out is important for everyone. It’s okay to reach out. It’s okay to say ‘no’.</td>
</tr>
<tr>
<td><strong>Set limits</strong></td>
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<tr>
<td>Everyone needs to know what the rules are. A few good rules keep things clear.</td>
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<tr>
<td><strong>Ignore what you can’t change</strong></td>
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<tr>
<td>Let some things slide. Don’t ignore violence or concerns about suicide.</td>
</tr>
<tr>
<td><strong>Keep it simple</strong></td>
</tr>
<tr>
<td>Say what you have to say clearly, calmly, and positively.</td>
</tr>
<tr>
<td><strong>Carry on business as usual</strong></td>
</tr>
<tr>
<td>Re-establish family routines as quickly as possible. Stay in touch with family and friends.</td>
</tr>
<tr>
<td><strong>Solve problems step-by-step</strong></td>
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Multiple family group format. The goal of this stage of treatment is to develop and implement strategies to cope with the vicissitudes of a person recovering from acute psychosis. Treatment compliance, stress reduction, buffering and avoiding life events, avoiding street drugs and/or alcohol, lowering of expectations during the period of negative symptoms, and a temporary increase in tolerance for these symptoms are major topics. Two special techniques are introduced to support to the families’ efforts to follow the guidelines introduced in the earlier workshop: formal problem solving and communications skills training.34

Social and vocational rehabilitation

Approximately one year following initiation of treatment most patients begin to show signs of returning to spontaneity and active engagement with those around them. Negative symptoms are diminishing and the patient can now be challenged more intensively. The focus of this phase deals with his/her relationship to the wider world, addressing specifically three areas of functioning in which there are commonly deficits: social skills, academic challenges and the ability to get and maintain employment.

Each family receives education that takes into account the specific features of the symptom constellation of their ill family member during the initial engagement process; this continues during the multifamily group process as well. The pace of reentry is guided by clinical status, the subsidence of negative symptoms, and the continued remission of positive symptoms. Careful, forward progress is the watchword. In particular, full use is made of precipitants as a guide to situations and factors that may be destabilizing for the specific individual with a psychosis or prodromal symptoms and signs. Temporarily reducing expectations might be suggested around those specific areas. The approach emphasizes fostering patient-to-patient relationships and friendships.

Conclusions

Family psychoeducation and multi-family groups have shown remarkable outcomes in first episode cases in several studies and multi-family groups appear to have a specific efficacy in earlier phases. Empirical evidence and our experience suggest strongly that family-oriented, supportive and psychoeducational treatment is acceptable to families and in clinical trials appears to meet many of their needs. There is theoretical support for the likely efficacy of these methods, with their strategy of stress-avoidance, protection, and buffering, while the multi-family group format adds an inherent element of social support and network expansion.

References


