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Family centred brief solution-focused therapy with chronic schizophrenia: a pilot study

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The purpose of the study was to pilot a family centred brief solution-focused therapy model (BSFT) with families and clients diagnosed with schizophrenia. A control group of clients and their families received traditional outpatient therapy, while an experimental group of clients and their families were treated with a BSFT model. All participants were pre-tested and then post-tested with the Family Environment Scale after five therapy sessions over a ten-week period. Significant differences between the groups were found on expressiveness, active-recreational orientation, moral-religious emphasis and family incongruence. The participation of families and clients with schizophrenia in family centred brief solution-focused therapy produced encouraging results and demonstrated the need for expanded studies using BSFT with other chronically mentally ill clients and their families.

Introduction

Schizophrenia continues to be one of the most prevalent and pervasive psychiatric disorders confronting mental health agencies. Conventional strategies used in outpatient treatment of schizophrenia

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focus primarily on the individual client rather than on the family unit despite the fact that families of individuals with schizophrenia are involved in critical care-taking roles (Baker, 1989). Although there is abundant documentation describing the burden of mental illness on families (Lefley, 1987a, 1987b, 1989; Eakes, 1995, Hainesworth *et al.*, 1995), most interventions dismiss the family and primarily provide individual aftercare services centred around the administration and/or monitoring of psychotropic medications and day treatment or psychosocial programmes designed to increase socialization skills.

However, there have been successful family-focused programmes developed to assist families of individuals with severe and persistent mental disorders. The psychoeducational approach (Anderson *et al.*, 1986), the multiple family group treatment (McFarlane *et al.*, 1995), the behavioural family interventions approach (Faloon *et al.*, 1984), and the family crises therapy model (Goldstein *et al.*, 1978) are examples of programmes that involve the families of patients being treated for schizophrenia.

Over the last decade, brief solution-focused therapy (BSFT) has emerged as a model in clinical practice (de Shazer *et al.*, 1986; de Shazer, 1988; O'Hanlon and Weiner-Davis, 1989; Walter and Peller, 1992). Although identified as working primarily with individuals, the approach was developed from a systemic perspective and does invite involvement of families (Berg, 1994) and other involved systems, such as schools (Metcalf, 1995). Furthermore, the idea of externalization of the problem (White and Epston, 1990) has been incorporated into the BSFT approach.

Although BSFT has not been developed to work specifically with schizophrenic individuals and their families, it appears that the concepts and approach are compatible with psychoeducational and behavioural models that focus on families. The approaches emphasize a systemic perspective, encourage family involvement, and focus on managing the presenting condition. BSFT does not formally teach the family. However, it presumes family competency, orients the family towards a future when they will manage the problem, and builds on family strengths by highlighting previous successes in coping with and managing the presenting difficulties. It therefore appears that BSFT can be used as part of the overall intervention for individuals and families dealing with a schizophrenic disorder. While there is anecdotal support for the effectiveness of brief solution-focused therapy in offering rapid

improvement in chronic family problems (de Shazer, 1994), to date there has been no published empirical testing of the approach with families of chronically mentally ill patients.

In order to test the above supposition and address the lack of data on the use of brief therapy models with chronic mental illness, a pilot study was developed in a community mental health centre to investigate the impact of a BSFT model on both individual psychopathology and the social climate of families dealing with schizophrenia. Because of a small client sample in the pilot phase of the study, only family data are reported here. Specifically, the research question guiding the family part of the study was: Are the pre-test–post-test interactive effects of Family Environment Scale scores significantly different for an experimental group of families with a member diagnosed as having schizophrenia who received BSFT treatment and a similar control group of families who received traditional treatment?

Methodology

A pre-test–post-test quasi-experimental design was used to investigate the impact of BSFT on the social climate of families with a member having a schizophrenia diagnosis. The Family Environment Scale (Moos and Moos, 1994) was chosen for use in the study because it provides information on family members' perceptions of the social climate within the family on a wide variety of dimensions that schizophrenia could be expected to affect. The following ten dimensions are measured by the scale: cohesion, expressiveness, conflict, independence, achievement orientation, intellectual-cultural orientation, active-recreational orientation, moral-religious emphasis, organization, and control. Moreover, family incongruence scores, which reveal the level of disagreement regarding the social climate among family members, can be obtained from the above dimensions. Acceptable reliability and validity measures have been established for the FES (Moos and Moos, 1994).

Sample

A purposive sample of ten clients with a diagnosis of schizophrenia receiving outpatient services at a community mental health centre and members of their families was recruited for the study. Criteria

for inclusion were: (1) a schizophrenia diagnosis; (2) all participants were aged 18 or over and were able to give informed consent to involvement in the research, and (3) family participants were individuals indentified by the clients as immediate family members with whom they had weekly contact.

All aftercare clients of five nurse therapists were invited to participate in the research. The study was described in detail to the families who volunteered and informed consent was obtained from all family members. Two psychiatric nurses agreed to meet clients and families with the BSFT team. The first five families under their care to volunteer were assigned to the experimental group. The other three nurses agreed to continue with traditional aftercare services. The first five families under their care to volunteer were assigned to the control group. The experimental group was initially composed of five patients and nine family members. Although all clients and family members gave informed consent to participate, one client with a diagnosis of paranoid schizophrenia refused to complete the pre-test and dropped out of family therapy after attending only one of the five scheduled BSFT sessions. His parents, however, continued to participate in his absence. One other client, also with a paranoid schizophrenia diagnosis, refused to complete the data collection instruments, yet willingly participated in five BSFT sessions with his mother. The control group consisted of five clients and one member of each client family. All clients in the study were currently receiving psychotropic medicines and had been previously hospitalized. Descriptive data on the clients in the experimental and control groups are provided in Table 1.

The mean age of the fathers in the experimental group was 69 years. Two were retired, one was employed full time, and one

TABLE 1 *Descriptive data on experimental and control clients*

	Experimental	Control
Sex	Males = 5	Males = 5
Race	Black = 2 White = 3	Black = 4 White = 1
Age	Range 21–40 Mean = 31.4	Range 33–50 Mean = 40
Years in school	Mean = 12.2	Mean = 10.75
Marital status	Single = 4 Married = 1	Single = 3 Married = 2
Employment status	Unemployed = 5	Unemployed = 5
Hospitalizations	Mean = 7.4	Mean = 4.6

worked part time. All had completed high school and three had received post-secondary education. The average age of the mothers was 64 years. One mother was employed full time, two were employed part time, and two were not employed outside the home. All but one of the mothers had completed high school; three had received college degrees. All five of the family members in the control group were female significant others. Three were mothers of the clients, one was a daughter, and one was the wife of a client. These women ranged in age from 30 to 60, with an average age of 49. Two of the women lived with the mentally ill family member. One of the women worked part-time; the others were unemployed. Two had received less than a high school education, two had graduated from high school, and one was educated beyond high school.

Procedures

Clients and family members in the experimental and control groups were pre-tested using the Family Environment Scale (FES) (Moos and Moos, 1994). Once baseline data were collected, clients in the control group continued to meet individually every other week with a psychiatric nurse for traditional follow-up therapy consisting of twenty-minute medical checks with the clients. Immediately following the every other week individual medical checks, experimental group patients and family members participated in five BSFT sessions with a team comprised of the researchers and a psychiatric nurse being supervised in BSFT.

All BSFT sessions were conducted according to the following protocol: (1) the team greeted the clients and family members before each session and then observed the session behind the one-way mirror; (2) consultation to the primary therapist was provided through phone-ins, walk-ins, and scheduled intermissions during the therapy session; (3) following the procedure described by Anderson (1991), the team changed places with the family near the end of the session and commented on its strengths and resources while being observed by the family; (4) the team and family resumed their original positions and the therapist asked the family members to comment on what they had heard the team say, and (5) the session was ended with the team, therapist, client and family members exchanging goodbyes.

At the conclusion of the five sessions of either BSFT with the clients and family members in the experimental group or tradi-

tional medical therapy with the control group, the clients and their family members were post-tested with the FES. All clients and family members received a US$10 reward after completing the post-test.

Results

In order to ascertain whether the control and experimental groups were experiencing similar social climates prior to the treatment, mean scores on the FES scales for clients and family members in each group were computed and subjected to t-test analyses. No significant differences were found between the two groups.

Likewise, ANOVA procedures were used to test for interaction effects between the aggregate pre-test and post-test mean scores of the experimental and control groups for each FES scale (see Table 2). Significant differences with one degree of freedom were found for the following scales: expressiveness; active-recreational orientation; moral-religious emphasis, and incongruence. On the expressiveness and active-recreational orientation scale, the experimental group scores on the post-test increased, while the control group scores decreased. The moral-religious emphasis score remained the same for the experimental group, but increased for the control

TABLE 2 *ANOVA results comparing pre- and post-test FES scores of experimental (N = 12) and control groups (N = 10)*

	Experimental				Control					
	Pre-test		Post-test		Pre-test		Post-test			
Scale	Mean	SD	Mean	SD	Mean	SD	Mean	SD	F	P
Cohesion	6.67	1.99	6.33	2.10	6.20	2.20	5.60	2.84	0.16	0.695
Expressiveness	4.08	2.23	4.92	1.38	5.40	1.26	4.40	2.07	6.36	0.020
Conflict	2.67	2.19	1.92	1.31	2.60	2.49	2.40	2.22	0.38	0.542
Independence	6.83	1.70	6.92	1.44	7.10	1.79	6.00	2.67	1.78	0.197
Achievement orientation	6.25	1.48	6.67	0.79	6.30	2.11	6.50	0.97	0.09	0.766
Intellectual-cultural orientation	4.92	2.23	5.58	2.15	4.60	2.22	4.10	2.33	3.44	0.078
Active-recreational orientation	4.00	2.45	4.92	1.78	3.80	1.81	3.20	2.10	5.09	0.035
Moral-religious emphasis	6.50	1.98	6.50	1.88	6.60	1.26	7.60	1.17	5.45	0.030
Organization	5.92	2.31	6.50	1.78	5.30	2.41	5.80	1.93	0.02	0.878
Control	4.08	1.51	4.25	1.36	4.20	1.93	4.46	1.71	0.00	0.957
Incongruence	20.59	3.36	11.84	1.17	19.00	10.79	23.80	10.40	9.35	0.018

group. The incongruence scale increased for the control group on the post-test, but decreased for the experimental group.

In summary, the data showed that subsequent to family centred BSFT, the expressiveness and active-recreational orientation scores increased. The increased scores indicate a healthy change towards more expressiveness and participation in social and recreational activities by the family members. The moral-religious emphasis scores of the experimental group remained the same on the pre-test and the post-test. The increase in the post-test scores of the control group indicated that after two months of traditional follow-up therapy they placed more emphasis on religious issues and values. The decrease in scores on the incongruence scale demonstrated that the experimental group increased their agreement on the social climate dimensions tested by the scale, while the control group decreased their agreement with the same issues.

Discussion

This study was designed as a preliminary investigation of the efficacy of a family centred BSFT approach in treating clients with schizophrenia and their family members. The data provides preliminary information on the potential impact the use of BSFT combined with psychotropic medication may have in the treatment of serious mental illnesses.

There were no statistically significant differences between pre-test scores of the experimental and control group on the FES. Any interactive effects between the scores of the two groups on the pre-test and post-test may therefore be attributed to BSFT and/or other variables not accounted for in the parameters of the study. For example, the presence of the family members interacting with the client, the therapist and the team may be the operative factor for change rather than the type of therapy itself. The following discussion regarding each of the significant FES scales reflects the interaction of the solution-focused therapy, as well as the participation of the family and the therapy team.

Expressiveness

The clients in the control group were treated by nurse therapists individually within the traditional medical model. Such interaction is framed within a hierarchical relationship, where the therapist is a

diagnostician and problem-solver. The communication loop is therefore formal, and information is passed from the client to the therapist for evaluation and action. Family members in the experimental group, however, were encouraged to express ideas, feelings and concerns openly to each other both formally and informally. The therapist and the team created interactions about solutions rather than focusing on what was wrong with medication. Problems resulting from the presence of schizophrenia were externalized allowing the family to view the illness as one of many contributing factors over which they could exercise some control. Once problems were defined in these terms, they no longer appeared to create distance between clients and family members. This collaborative relationship between the therapist, team, client and family members may account partially for the increase in expressiveness within the experimental group.

Active-recreational orientation

The traditional treatment approach separates the individual from the family and at least subtly encourages both the client and the family members to see the illness as disabling. The competency-based model used with the experimental group in this project viewed the client as capable, albeit with some limitations, but in no way totally disabled. The team members personally engaged with the clients and the family members before and after the sessions, as if the occasions were quasi social events. Through this modelling and practice, the family's confidence in their ability to be successful in the social venue was strengthened. Indeed, the experimental group families often reported going out to eat and socialize with each other after the sessions.

Moral-religious emphasis

Clients in the control group were treated under a traditional model with emphasis on medication as the healing agent. As a result, they may have felt somewhat impotent. They transferred their power and responsibility to entities outside of themselves, who in the persons of physicians, nurses and psychotherapists are perceived to have a higher order of knowledge and authority. The increase on the moral-religious emphasis scale in this group may reflect a perceived lack of control, a sense of not being able to fight the effect of the

illness, and a discouragement that warrants putting faith and hope in another dimension. The experimental group members, on the other hand, were extolled to believe in their own ability to handle the problems associated with schizophrenia. They found, at least minimally, that during the five sessions of BSFT they had some control over the illness. The balance between the clients' own power, the families' power and the healing effects of psychotropic medications was thus maintained. This balance is reflected in their scores on the moral-religious emphasis scale which neither increased nor decreased.

Incongruence

Control families experiencing the traditional medical approach to schizophrenia had little or no time to work through the effects of the illness on the clients or on other members of the clients' families. The experimental group in solution-oriented sessions were helped to question stereotypes of helplessness, hopelessness and incompetence. The process allowed clients and members of their families to acknowledge the very real limitations imposed by the illness, but also allowed everyone to appreciate each other's strengths and commitment towards overcoming the illness. The struggles that evolved in the sessions were not always comfortable, but they consistently revealed conflicts about the mental illness and its consequences on all family members. Ultimately, through this process, the clients and family members acquired more knowledge about each other and their family situation. This mutual knowledge was reflected in the decrease of incongruence in the families' perceptions of their social climate.

Non-significant dimensions

While the pilot study revealed significant differences on the FES scales listed above, no statistically significant differences were found on the cohesion, conflict, independence, achievement orientation, intellectual-cultural orientation, organization, and control scales. The degree of similarity between families in the experimental and control groups on all but the independence and intellectual-cultural orientation factors is sufficiently high to suggest that BSFT made little or no impact on these areas of family interaction. These dimensions may be more resistant to change or may not be directly

affected by the theoretical and applied constructs used in BSFT. Externalization, future focus, scaling, competence and exceptions may be less effective in creating change on some dimensions and more effective on others. Furthermore, given the suppositions that deeply ingrained family patterns influence the development of mental illness or that interactional changes occur gradually with the onset of a severe illness, it could not realistically be expected that all dimensions of family interaction would be affected by five BSFT sessions.

Case example

JW was a 38-year-old single white male with a schizophrenia diagnosis. After several hospitalizations over the preceding three years, he was residing in a group home and was receiving regular outpatient services. JW expressed extreme anxiety about his parents' well-being, especially after home visits. His parents were retired and were experiencing medical problems. Frequently, JW telephoned his parents asking for reassurance about their health. The parents were afraid to provide critical information about their own medical issues, believing that such information would intensify JW's symptoms. However, the parents' reluctance to answer their son's concerns only increased his anxiety and suspiciousness, which in turn led to more frequent telephone calls.

In session one, the BSFT focus was to search for exceptions to the pattern of JW becoming more anxious in response to his parents' attempts to avoid sharing potentially upsetting information. The family was directed to explore the times when they were able to talk about issues without experiencing anxiety. Within this context, the illness was also externalized with comments indicating that they had 'pushed the illness away' or had 'gotten on top of the illness' rather than letting the illness 'get in the way' or 'step in' between them and 'confuse' the communication. At the conclusion of the session, the family was asked to notice the times when they took control of the illness and were able successfully to talk to each other about serious family issues.

In the second session, the family reported a few instances where they 'controlled' the illness rather than it 'controlling' them. Using 'externalizing talk', the family explored specifically what each member did to contribute to this 'marvellous accomplishment' and how they would make it continue. JW was asked to describe what it

would be like for him in the future when communication between himself and his parents was the way he wanted it. After elaborating on a future when conversations were going well, the family was again given the observation task of watching for times when communication was going well.

In the third session, JW and his father reported excellent conversations during the previous two weeks. JW was able to ask his father about a failed business venture that had been 'haunting' him for years. He was relieved at his father's answers and proud that he was able to finally separate himself from the ruminations that had been 'forever' in his head.

Between the third and fourth sessions, the mother required a brief period of hospitalization. The father was able to tell JW what was going on medically with his mother. A situation which would have previously led the client to intense anxiety and the father to less willingness to confide in his son was handled with neither of these results. The client experienced connectedness, confidence and trust from the father and the father felt greatly relieved, and supported by the son.

In the fifth session, the family reported significantly less anxiety and a level of personal communication that was gratifying to each of them. As a family, they had attended a wedding reception at which the parents received many positive comments from friends on how enjoyable it was to see and talk to their son. JW reported that he was not only communicating better with his family, but he had also resolved some social issues at the group home. Even though the experimental phase of the pilot study was complete after the fifth session, the family requested that they continue with the BSFT team.

The above case exemplifies some of the BSFT interventions used with the experimental group families. During the first session, exceptions were elicited and externalization of the illness initiated. Observational tasks, positive in nature, were given to the family. They were asked to notice how family members controlled the affects of the illness rather than focusing on times when the symptoms of the illness controlled their behaviour. Building on exceptions and externalization, future orientations were taken by asking the families to visualize times during which they were in charge of the illness. The team always commented on the family's strengths, successes and co-operation with each other to defeat the illness. Ultimately, a working alliance was established with the family to manage and cope with the schizophrenia.

Issues and recommendations

The study was encumbered by many obstacles endemic to research with outpatient client populations. Occupational demands, transportation to and from the clinic, acute episodes of the chronic illness, and some resistance to new treatment models from non-participating clinic staff impacted on the size and composition of the sample. The scheduling of clients, families, therapists and team members also created more barriers than were expected at the onset of the study. Organizing schedules in many instances encumbered time out of proportion to the hours actually spent in therapy. Further research with BSFT and chronic illness must account for the above issues and will require larger samples and longer time spans. Six months or more of BSFT with chronically mentally ill clients and their families will fall well within a brief time framework, when therapy with such a population is expected to extend over many years or to be never-ending. The effects of BSFT, the family interaction in the therapy, the composition and impact of the team on the process, the training and experience of the therapists, and client/family demographics should all be isolated in future research. Each of the above may have affected the results of this study individually, or as a group. The pilot aspect of the research did not allow for an analysis of these variables, nor for short- and long-term follow-up of the clients and their families. In addition, multiple family and psychopathology measures should be utilized to gain a more comprehensive understanding of the impact of BSFT as an intervention tool for families living with chronic schizophrenia.

While some benefits of using BSFT in a team concept with schizophrenia were enunicated in this study, the mental health system must also account for the number of therapists and time spent with each family. The traditional one-therapist–one-client paradigm is more cost-effective if the outcome, i.e., families and patients managing more effectively in the community, is obtained. However, the limited data from the study suggest that a BSFT approach in conjunction with traditional medical treatment should be investigated more thoroughly.

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Erratum

In the paper by Snyder, M. (1996) Our 'other history': poetry as a meta-metaphor for narrative therapy (*Journal of Family Therapy*, **18**: 337–359), an unpublished paper by Peggy Penn was incorrectly attributed to Peggy Papp. The correct reference should be as follows:

Penn, P. (1993) *Aesthetic Experiences in the Conversations of Therapy* (unpublished).

The author, Maryhelen Snyder and the responsible editor, John Carpenter, apologize most sincerely.