

Involving the Family of Patients with Mental Illness in Treatment: A Model for Assessment

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ABSTRACT. This paper presents a model for screening families of patients with mental illness, to assess the family's need and readiness to be involved in the treatment. In an era of downsizing of resources, recognizing the importance of family involvement and incorporating it into mental health services requires the close scrutiny of issues and dilemmas related to these interventions. Using examples from the field, this paper also examines the model in practical work in the field of mental health, with attention to the incorporation of family intervention into psychiatric settings, whether hospitalization, ambulatory services, or rehabilitation. doi:10.1300/J085v18n01_02 [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2007 by The Haworth Press, Inc. All rights reserved.]

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INTRODUCTION

Family intervention is part of the current therapeutic repertoire in the field of mental health. Research indicates that family intervention prevents relapses, decreases negative symptoms, and improves the social and occupational functioning of patients with schizophrenia. Following many years of decline in the use of family therapy in the treatment of mentally ill patients, and avoidance of working with the families (MacFarlane, 2003; Marley, 1999), the psychiatric community is currently showing willingness to accept the family as a possible partner in treatment. Yet, if the family is to assume a role of an essential resource for the patient, its needs must be identified, understood, and considered. Therapeutic work with families and the importance of the family as a support for the patient raise the need to examine ways of intervention while differentiating between families according to their ability, willingness, and source of motivation to be enlisted to help the sick family member. Such a distinction will enable to identify whether *the family can join in as a partner, and to focus the appropriate therapeutic approaches*. In fact, there are practical and ethical questions regarding the use of family modalities: With whom is the work done? What is the approach to be used? What is the focus? Where does treatment take place? How much treatment is needed, if any? In an era of down-sourcing, focused thinking can be an efficient and economical tool for interaction between the needs of clients, families, and mental health care system.

In this paper, we present a sample clinical case and a tool—a flow model, which enables us to examine these questions in a systematic, differentiating manner.

The model addresses the encounter between the therapeutic team and the family when a family member is hospitalized or followed up in an ambulatory system. It focuses on the family's abilities and assesses its ability to be a partner to the treatment.

The literature on the effectiveness of family intervention shows it to be a positive factor in preventing recurrences of schizophrenic episodes. Family intervention also contributes to a decrease in negative symptoms; it has a positive effect on managing negative symptoms, and enhances successful occupational rehabilitation (Bellack et al., 2000; Dyck et al., 2000; Gerhart, 1990; MacFarlane, 2003; MacFarlane et al., 1995; MacFarlane, 2000; Marley, 1999; Stein et al., 1994; Marsh & Lefley, 2003; Melamed, 2001). There is also an indication from research

that family interventions have a positive impact on the well-being of caregivers themselves (MacFarlane, 2003).

Selecting optimal intervention is a frequent topic. Marsh and Lefley (2003) discuss compatibility resulting from identifying a family's strengths and weakness, and suggest distinguishing between family counseling, a psycho-educational process, and family therapy, each of which is appropriate for a different stage of the illness. Dixon, Adam, and Lucksted (2000) refer to the need for optimal matching of mental health therapeutic services, claiming that a diagnostic evaluation of the concrete and emotional family system, as well as an evaluation of the family's ability to receive help, may contribute to screening and to referrals to appropriate therapeutic sources.

The issue of selecting optimal intervention becomes further crucial with the brief numbers of days authorized for hospitalization, which might mean that the therapeutic process should go beyond the hospitalization period.

Family therapy during the crisis involved in hospitalization and follow-up brings the family face to face with all the inter-psycho and intra-psycho strata of the illness, at a time that family members are extremely sensitive. The illness impacts upon family equilibrium and, potentially, could act as a barrier to the family life cycle. It can, however, also be an opportunity for a show of strength.

With the disease as a factor and a presence, previous family problems could be intensified. However, not every problem must, can, and should be addressed during hospitalization, nor does every problem require treatment. Not all families need the same therapeutic intervention at the same point in the disease, and not all families can benefit from such intervention.

Difficulties in Integrating Family Therapy into the Therapeutic Repertoire in Psychiatry

Staff attitudes: A potential factor in hindering or enhancing family intervention. Despite the well-documented effectiveness of family approaches in psychiatry, mental health care professionals seldom include these methods in their professional repertoire (Amenson & Liberman, 2001; Carosso, 2000; Rubin, Cardenas, Warren, King Pike, & Wambach, 1998).

Cooperating with families toward achieving better care for the patient is neither natural nor obvious, and is not always high on the list of

priorities among the various mental health care professionals, be it an individual professional or management.

A study by Rubin et al. (1998) reveals that although social workers acknowledge the impact of biological factors, they still believe in parental responsibility for the illness, and these attitudes affect the care. Carosso (2000), writing about psychologist's attitudes toward work with the families of patients with mental illness, lists barriers to providing optimal services to patients' families, among them work overload, direct treatment of patients which does not leave time for indirect work, a large amount of administrative work that is an upshot of working with families, and vague boundaries of the various mental health professions. Hospitals and mental health centers have not yet developed adequate services for families.

Family Intervention: Therapeutic Dilemmas

Seemingly, family therapy can only yield positive results, yet in our work we often meet cases that raise questions about such generalizations. Questions such as, does every family of a person with mental illness require family therapy? Can all kinds of family intervention only advance the client? Does treating the patient always necessitate systemic work with the patient and family? Would we also work with families that do damage to the patient?

Utilizing family modalities in psychiatry also raises ethical questions regarding the target of interventions. For example: Who is defined as a client? To whom do we owe therapeutic allegiance? What is our role when various interests are involved, and the client's interest is contradictory to that of the family? Does the patient want his family members to be part of his treatment? Some patients feel that exposure is difficult on the family (e.g., ultra-orthodox Jewish families), and that it is their duty to protect the family from the hardship of caring for them and from the exposure. There are times when it is the patients' experience that the family might pack up and desert them, and they protect themselves by distancing the family from the illness. In other cases, factors related to the illness cause the patients to try and break off relations with the family.

The complexity of family relations, coupled with the complexity of the illness, require careful consideration in deciding whether family participation in caring for the patient is needed, and what kind of participation it will be.

Why Is There a Need for a New Model?

Models found in the literature use various dimensions for diagnosing families for therapeutic purposes.

The Circumplex model (Olson, Russell, & Sprenkle, 1989) proposes a structured understanding of family dynamics along all stages of its development, with the main axes being cohesion, adaptation, and familial communication. The model characterizes various family types, examines the type of balance in the family, and indicates areas of difficulty that require therapeutic intervention.

Other models are specific for diagnosing families in crisis. The Double ABCX model of adaptation and adjustment developed by McCubbin, Cauble, and Patterson (1983), attempts to evaluate the cumulative effect of stress on the family. This model measures the attributes of stress factors, the coping resources available to the family, and the way the family perceives the crisis, and using this information attempts to predict the severity of the crisis.

A later model (Bentovim & Miller, 2001) evaluates competence, strengths, and difficulties in the family. It considers family organization, history, and the attributes of the specific family (e.g., degree of identification with the family, personal autonomy in the family, and boundaries), to make systemic assessment of families as a basis for intervention.

Marsh and Lefley (2003) propose a specific focus on the families of people with mental illness. Believing that in mental health the family is part of the solution and not part of the problem, they suggest helping each family of a person with schizophrenia. Their comprehensive, process-oriented perspective focuses on internal and external factors affecting the family of the person with mental illness, and they present four levels of family intervention—from counseling to therapy—according to the stage of the illness and the level of relationship that has formed between the caregiving team and the family.

Part of the decisions regarding therapeutic directions and the optimal use of therapeutic resources in times of crisis includes an evaluation of the relationships within the family as they pertain to the crisis brought about by the illness, and an evaluation of the readiness in the family to be a therapeutic resource.

Out of our personal work experience, we have tried to conceptualize the knowledge and experience that would be helpful in deciding on therapeutic directions and optimal utilization of therapeutic resources.

We found that in time of crisis there is also a need to *assess the family as it addresses the illness, and to evaluate its readiness for a therapeutic relationship*. The model deals with families in time of a crisis due to the mental illness of one member of the family. Its purpose is to assess, within a few meetings, the state of the family of a person hospitalized with mental illness, focusing on the illness. This assessment can help the therapeutic team to decide on which families require intervention, which intervention has the potential to advance the client, and where such intervention should take place (Figure 1, Table 1).

Case Description: Danny

Danny, a hospitalized patient of about 30, had been in Israel for six years. Following psychotic outbursts, he was diagnosed as having paranoid schizophrenia. Despite treatments with atypical medication, practically, no progress was detected in his condition over the years. His mother had requested to meet the therapists and was invited to do so, despite Danny's reservations.

FIGURE 1. Flow Chart of the Model for Mapping and Screening for Family Intervention in Mental Health

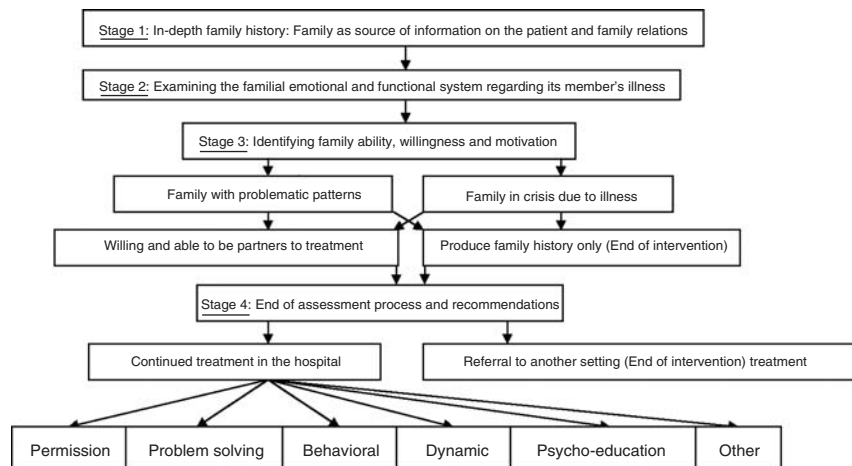


TABLE 1. Assessment Stages for Family Involvement

Goals	Sample Questions	Results
Stage 1. In-depth family history: Family as a source of information on the patient and family relations		
Acquiring in-depth history of client, illness, and family	Who are the family members? When do they see each other? What are their family activities? What happened before the illness? Were there difficulties as the illness progressed? When did they first notice a problem? How was the client in the past? How do they perceive the client now? Do they identify a problem or do they think the client is pretending/being spoiled?	Initial distinction between family as merely a source of information on history OR Partner in the therapeutic process → Further assessment
Stage 2. Examining familial, emotional, and functional system regarding the illness		
Identifying family patterns of coping and communication regarding the illness	How do you feel when there is illness in the family? Who else is partner to this difficulty? Do you think you need help? Do you have therapeutic support? What feelings does the sick person evoke in the family? What have you done with this problem so far? How did you resolve family problem?	Diagnostic distinction between families in crisis due to the illness and families with problematic patterns
Stage 3. Identifying family ability, willingness, and motivation for intervention		
Examining the family's ability to undergo a process of <i>change</i> . Assessing whether the focus of therapy is the crisis due to illness or whether there are previous family problems preventing the family from focusing on the patients.	What form does the client want family involvement to take? How much does the client want to share with his family? What in the family's opinion, will help the client? Does the family see itself involved in treatment and rehabilitation? Does the family think it needs help? Where? Is there another therapeutic relation? What is the family's relationship with the hospital? Is the family willing to be part of the process?	Information regarding willingness and <i>motivation</i> of the family to join in as partners to treating the patient Decision as to whether there are contraindications to a certain therapeutic setting

TABLE 1 (continued)

Goals	Sample Questions	Results
Stage 4. End of assessment process and recommendations		
Setting goals that will focus on an intervention based on client's needs and an understanding of the family	Does the family agree to form a relationship with a therapeutic setting in the hospital or elsewhere? What are the family's expectations from the therapy?	Decision as to type of intervention (e.g., psycho-educational, dynamic, behavioral, problem solving, permission), its focus, recommendation regarding setting

*Stage 1. In-Depth Family History:
Family as a Source of Information on Patient and Family Relations*

The mother, a single parent, told about her marriage and about the conception and birth of Danny, her sick—and only—son. She reported that throughout the pregnancy she and Danny's father had been in open and loud conflict about wanting a child. Shortly after the birth, the father abandoned the family. Mother and son live together, have no contact with the community, and rarely do things separately. The immigration to Israel, several years prior, served to further block community contact. These details gave Danny's narrative more color and a deeper systemic as well as cultural framework.

*Stage 2. Examining Familial, Emotional,
and Functional System Surrounding the Son's Illness*

The mother listed several causes, including herself, as responsible for her son's mental state. She is inundated with guilt, and is occupied with endless practical attempts to find better treatment for her son. She does not believe that Danny is capable of doing anything for himself including knowing how to be in therapy.

In our talks, she never managed to characterize her life in any other way than being the tormented mother of a tormented son. She described long years during which she did not function in any area, and says that she could not free herself emotionally or physically to work. Perhaps, due to cultural difficulties, the mother is not familiarized with rehabilitation options and does not believe that there is a possibility that Danny could adjust to a rehabilitational setting. In addition, she describes the

shame she feels because of his illness, her difficulties in being exposed as the mother of a sick son, and the fact that she does not share her difficulties with others.

A picture emerged of a family where each member is trapped alone in a system in which he or she remains injured, lonely, hurt, angry with the other, finding it difficult to emerge from this pattern of relationships.

The family was assessed as having patterns of over-involvement, trapped in system that is potentially destructive for the development of a family life cycle (Carter & McGoldrick, 1988; Duetsch, 1991). It seemed that without enabling separation between the two, the son would have difficulties in individuation and integrating into a rehabilitation program. Incidentally, both the concept of “family life cycle” and the concept of “individuation and separation” are culturally oriented concepts, rooted in the western culture thinking (Singh, 2004; Karmy, Ochana, Al-Krenawi, & Shalev, 2004) subject to cultural variation and need a special consideration.

Stage 3. Identifying Ability, Willingness, and Motivation of the Family for a Therapeutic Process

In our assessment meetings, the mother repeatedly drags the conversation toward her son’s treatment which she dismisses as “insufficient” and “inappropriate,” and tries to mediate between her son and all his therapists. When asked what she thinks would benefit her sick son, she says that only her presence can somewhat ease his pain. When asked to be an encouraging partner in her son’s social-rehabilitational activities, she dismisses this and expresses her difficulty in encouraging him to join in such activities. She also repeats her son’s objection to group housing, which they both say is “ugly, vulgar, and crude.” She expressed a desire to be treated in the department where her son was hospitalized.

The assessment revealed that although the mother was indeed motivated to be part of therapy, her motivation collided with the wishes of her sick son, and further established the over-involvement of mother and son. Each of them needed separate space to deal with their life issues.

Stage 4. End of the Assessment Process and Recommendations

In the family assessment using the model, a need was identified to provide the mother with interventive support, which would focus on “broadening” her existence as a human being beyond being the mother

of a sick son, with the hope that she will thus “give him permission” to be sick and rehabilitated (Melamed, 2001).

Because a need was identified that called for a process of separation between mother and son, it was recommended that the mother be treated away from her son’s therapeutic setting. Contact was made with a therapist in the mental health infirmary in the community who treated her, and the mother agreed to have the therapists meet and adjust their goals, so that therapy could continue in the community. In addition, the mother was referred to a family group in the hospital. This ongoing group for relatives of people with mental illness focuses on the relatives themselves, rather than focusing on the illness. At the same time, this group serves as a “community” supporting the caregivers who might have similar life experiences. The mother attended the group meetings for a few months.

While these processes were taking place with the mother, in the patient himself, after years without remission, there was a slow increase in insight about his illness and he began gradually opening toward the possibility of social rehabilitation within the community. He was referred to further treatment in the mental health infirmary in the community.

Throughout the follow-up period of two years, there was no relapse requiring a hospital admission.

Case Description: Hannah

Hannah, a young woman and mother in her thirties, has had a bi-polar illness for over 20 years. She was first hospitalized at age 16, and has been hospitalized six times since then. Between hospitalizations, she functioned both on the family level and on the occupational level—she married, gave birth, and was steadily employed. After the birth of her third child, she had a psychotic episode. Toward the end of a long hospitalization, her husband was invited for a discussion.

Stage 1. In-Depth Family History:

Family as a Source of Information on the Patient and Family Relations

In the assessment interviews, we learned about the patient’s family system, which up to then had only been known to us from the point of view of the illness. For example, we got to know the husband’s family background, a background that included sorrow and neglect. Conversely, the discussion with the family revealed that the woman’s relation with her family of origin had limited and enmeshed boundaries.

Stage 2. Examining the Familial Emotional and Functional System Regarding Its Member's Illness

During the family assessment, it was revealed that up to the time of the psychotic crisis, the couple functioned as an extension of the woman's family of origin. It was revealed during family interviews, that both partners, neither of whom had a nurturing parenting model, found it difficult to function as a couple and as parents of their young children. The sick wife was afraid to break away from her parents, and her husband, who did not have a family of his own, was drawn into his wife's family. The wife's parents were close and were eager to help and to act as parents to the couple and their children, which infringed on their independence as a couple.

When the woman became ill, her parents, out of worry, tried to continue being the main figures in her life and in the lives of her family members.

Stage 3. Identifying Family Ability, Willingness, and Motivation for a Therapeutic Process

Despite past difficulties—or perhaps due to those difficulties—the couple's relationship was assessed as being a deep and meaningful one. The man, who had married although he knew of the illness, was very worried. After the experience of his own childhood he was afraid that he would be losing the family that he had worked so hard to have, and was willing to apply himself to support his wife and help her. He expressed devotion, support, a desire to do anything needed to learn to live with the sick woman and maintain an optimal family with the illness present.

The sick woman, whose childhood was within a chaotic family, was also eager to maintain the dual frameworks of couple and family. The crisis brought about by the illness was defined as an opportunity for the couple to grow together toward independence.

Stage 4. End of Assessment Process and Recommendations

The main conclusion of the assessment process was that the couple was indeed ready for family therapy in the hospital. They chose to be treated in the hospital due to the recognition of the couple that such a treatment should be done where the wife was known as a patient and

could speak openly, directly, and safely about her medical condition. Therefore, as part of the therapeutic setting for the illness, the couple was invited to start therapy at the hospital. The therapy was aimed at teaching them to function as a couple and as parents to their children. Later on, the sessions continued, focusing on connubiality, communication, and sexuality. Throughout the long, ongoing therapy, the husband learned to replace the parents as the significant others in his wife's life, and the wife learned to become a mature partner. Both learned how to discuss their difficulties—those related to the illness and others, and together succeeded in reaching decisions regarding their children's education. For example, they were active participants in school events, and chose a nursery school for their child. At the same time, their awareness of the woman's illness increased, as did their awareness of the limitations and the special needs posed by the illness. Both partners learned to function in a realistic and honest manner, one which accepts the illness as part of their shared life.

During the couple therapy which lasted for about eighteen months, and which first took place within hospitalization and later in the outpatient clinic of the hospital, the wife's condition gradually improved. Slowly she started to function at home, and later she also found a job outside her home. Five years later, and following another birth of a child she had an outburst of her illness and was hospitalized again. The couple asked to resume again the sessions of the couple therapy. This period of therapy, which lasted about six months, helped to improve yet deepen the intimacy between them and the insight about the illness. Slowly, gradually, and with her husband beside her, the wife asked for rehabilitation, a process she was not willing to consider before, and was referred to support occupational and social services in the community. The husband was referred by the therapist to join a group of caregivers in the hospital.

DISCUSSION AND CONCLUSIONS

Family intervention is part of current mental health therapeutic practice. Therapeutic work with families, and the importance of families for supporting the patient, raise the need to examine modes of intervention while distinguishing between families according to their ability, willingness, and source of motivation to be recruited to help the ill family member. *This distinction would enable us to identify whether the family*

is able to join in as a partner to the treatment and to focus on the appropriate therapeutic approaches. Focused thinking in times of downsizing could be an effective and economical tool for integrating the needs of patients, their families, and the health care systems. Using clinical examples, we presented and demonstrated a flow model, which allows a methodical, classifying examination of these questions.

Meetings with the families in the clinic could add another dimension to understanding the patient and the nature of his or her disease, providing information beyond the patient's narrative about the family. This could contribute valuable material to the team, thus enhancing therapy. Danny could have continued relating his narrative, which included many references to his mother and to the relationship between the two of them. However, it was not until we met his mother and witnessed the interaction between them that we grasped the complexity of the relationship.

One aspect of this complexity involves the effect of immigration of the family to Israel several years earlier. Being an adult who lives with his mother can be understood as a problem in the process of separation and individuation, but it can also be a cultural variation of family life cycle. Whatever the context, initiating rehabilitation for this sick young man required that his mother give him permission to be ill and rehabilitate: Work, live, love to the best of his ability (Melamed, 2001).

Meeting the patient's family and using the model allows us to locate the family's needs—both the visible and the invisible ones—understand family dynamics, and diagnose the family's emotional position vis-à-vis the illness. A family can express worry about the condition of the ill family member, present their distress, and ask for help. At times, the worry and distress carry emotions and subtexts, such as anger, guilt, blame, all of which may not be related only to the illness.

According to the literature, the combination of family therapy and medication has the best effect on illness (Gerhart, 1990; Stein et al., 1994). The changes may be small, and the success minimal, but they are meaningful. In this paper, we attempted to provide a discerning conceptual framework for working with families. We believe that more research is needed on the various forms of family therapy in psychiatry, so that our recommendations regarding candidates for such intervention would be empirically based, as would the focus of intervention and its timing. It is important to remember that the population under discussion comprises people with mental illness, whose illness is characterized by outbursts, remission, and regression. The family's need for help from the therapeutic and rehabilitation systems is constant along this long and arduous route.

Our clinical experience shows, that since we began using the model to assess families during the psychiatric hospitalization and follow up of a family member, we have found it easier to locate, systematically, those families that could benefit from family therapy during the period of hospitalization of the family member with mental illness.

As stated, the model has been formulated and tried on families of patients with mental illness. We have not conducted any research into the matter, but possibly the target population should be broadened, and this mode of thinking applied, with appropriate modifications, to other forms of medical disease.

Focusing on family therapy in the health field in general, and particularly in the field of mental health, is relatively new. The model for including the family in medicine is gaining acceptance. Medical forums and journals contain more studies that show various aspects of this combination. In addition, medical family therapy is beginning to gain recognition as a specialization in professional associations, journals, research, study days, and conferences. Medical schools are adding family therapy training to their curricula. At the same time, the development of family intervention in medicine requires critical evaluation, one which will not make an all-encompassing recommendation, but would examine its effectiveness and appropriateness for each family and each health care system.

The real-life encounter with the family in the clinic can add new dimensions to the understanding of the client and the nature of his or her illness, above and beyond the clients' narratives regarding their families. This provides the therapeutic team with valuable information that can enhance the treatment.

Danny could have continued to relay his narrative, one that often mentioned his mother and his relationship with her. However, until we met the mother and "witnessed" this interaction, it was difficult to comprehend the complexity of the relationship, a relationship in which Danny could not have made any progress without his mother beginning a separate therapeutic path of her own.

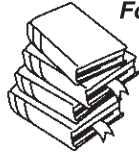
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