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Towards an Integrated Approach to a Family Intervention for Co-occurring Substance Abuse and Schizophrenia

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Comorbid substance abuse and schizophrenia is a major cause for concern from clinical, economic and health care systems perspectives. Existing treatment strategies are frequently inadequate, partly due to a lack of research into the unique problems facing this dually diagnosed population. These individuals commonly place a disproportionate burden on the mental health delivery system. In addition, their families are left with the onerous task of caring for them. This paper reviews the literature on family interventions for both substance abuse and schizophrenia and postulates that a composite model of family therapy might be appropriate.

INTRODUCTION

There is a growing awareness of the unique problems facing individuals with comorbid substance abuse and mental illness. Comorbid substance abuse and schizophrenia is a major cause for concern from a clinical, economic and health care systems perspective. Individuals with a dual diagnosis frequently manifest chronic disability, social dysfunction and high service utilisation. Until recently there was little evidence that the specific treatment needs of this population were being evaluated and addressed.

The huge burden of care experienced by the families of dually diagnosed people has been largely overlooked, and family treatment approaches have not been described. The purpose of the current paper is to review the literature on family interventions for both substance abuse and schizophrenia in order to develop a better understanding of the types of family therapy that might be most appropriate for the dually diagnosed individual and his/her family.

FAMILY INTERVENTIONS FOR SUBSTANCE ABUSE

The Role of the Family

The importance of the family in the maintenance and treatment of substance abuse is well known. It is widely accepted that addiction develops within the family context, that it frequently reflects and/or promotes other family difficulties, and that it is maintained and sometimes exacerbated by family interactive processes (Stanton and Heath, 1995). Several family factors have been identified that appear to influence drug use (Glynn and Haenlein, 1988):

1. Substance abusers have strong family ties up to the age of 30 and beyond (Stanton, 1979; Stanton and Heath, 1995). More than 60% of substance abusers live with their family of origin (Stanton and Todd, 1979).
2. Roles and relationships within the family unit lack balance. One or more members overfunction to compensate for those members who are underfunctioning (Boyer, 1989).
3. Families lack clear intergenerational boundaries (Boyer, 1989; Todd and Selekman, 1990). Mothers of substance abusers are often overinvolved and overprotective whereas fathers commonly assume a distant role with minimal involvement (Glynn and Haenlein, 1988; Stanton, 1979; Textor, 1987).
4. Parental behaviours in families where there is a substance abuse problem include denial, inconsistent limit setting, overprotection and unrealistic expectations (Todd and Selekman, 1990).
5. Communication within these families is often characterised by unclear messages, vague information-giving, lack of direct talk, avoidance of eye contact, frequent interruptions and speaking for others (Glynn and Haenlein, 1988; Stanton, 1979; Textor, 1986).

Compared with other dysfunctional families, substance-abusing families exhibit:

1. a higher frequency of multigenerational substance abuse and a disposition for other addictive behaviours
2. a more dysfunctional expression of conflict
3. a predominance of death themes and premature and unexpected deaths in the substance abuser's family
4. more frequent acculturation problems and cultural differences between the parents and children (Heath and Stanton, 1991; Stanton and Heath, 1995).

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In summary, there appear to be key issues within the family system that may influence substance abuse behaviour. This provides a compelling reason to incorporate a family perspective in plans for intervention, treatment and prevention.

Family Therapy Approaches

Traditionally, substance abuse was viewed within a medical framework and the majority of research and treatment efforts were focused on the individual (Glynn and Haenlein, 1988). During the late 1960s and early 1970s it was found that individual psychotherapy for substance abuse was largely ineffective. Low recovery rates were reported and relapse often occurred (Textor, 1987). Family therapy for a variety of disorders, including substance abuse, came of age during the 1970s. Since then there has been a proliferation of family-oriented treatment approaches to substance abuse, the diversity of which is striking. Despite this level of acceptance, family therapy is practised inconsistently. The term 'family therapy' covers a conglomeration of supportive and therapeutic approaches in relation to substance abuse treatment (Gleeson, 1991; Liddle and Dakof, 1995).

The supportive approach attempts to diminish or extinguish substance abusing behaviour by supporting and/or educating other family members (Gleeson, 1991). Distinct from this supportive family therapy approach are the *mainstream family therapy approaches* (Gleeson, 1991), united by three fundamental assumptions. First, family interactional patterns are seen as relating to individual symptom development and maintenance. Second, family therapy targets and attempts to change these specific family processes. Finally, these changes are related to changes in individual symptoms (Liddle and Dakof, 1995). Some of the commonly used and better researched approaches to family therapy for substance abuse disorders include structural–strategic family therapy, behavioural family therapy, and integrative family therapy.

Most research into family therapy for substance abuse disorders reflects a strong allegiance to the structural and strategic schools of thought. These types of therapy are often combined because they were developed by many of the same practitioners and are often used interchangeably depending on the family's needs (Kaufman, 1994). *Structural family therapy* typically focuses on patterns of family interaction, including alliances and coalitions, as well as the role that solutions might have in the life of the problem (Gleeson, 1991). It attempts to restructure the family system by creating interactional change within the session and involves the therapist in becoming an active part of the family while retaining sufficient autonomy to enable restructuring (Kaufman, 1994; Stanton and Todd, 1979). Past history and insight are not considered to be important. Tasks or 'homework' assignments are often used to consolidate changes made during the sessions.

According to the *strategic* approach, symptoms are maladaptive attempts to deal with difficulties that regulate patterns of family interactions (Kaufman, 1994). The strategic approach attempts to substitute new behaviour patterns for existing destructive patterns and, unlike the structural approach, places a strong emphasis on change outside the sessions.

Structural–strategic family therapy integrates different aspects of each of these approaches, depending on the family and the family situation (Kaufman, 1994). An emphasis is placed on how the drug use maintains the family system and is maintained by it (Todd, 1991). The primary task of therapy is to address the substance abuse. The importance of concrete and realistic goals is emphasised and the therapist uses enactment within the session and homework tasks between sessions to help families move toward these goals (Todd and Selekman, 1991). Structural and strategic approaches are the most prevalent approaches to substance abuse treatment in the literature. They fit comfortably with the usual treatment milieu for substance abuse given that (1) they are directive, and (2) they are based on normative assumptions of family functioning (Gleeson, 1991).

Behavioural family therapy incorporates empirically validated procedures that are theoretically compatible with structural and strategic family therapies. Such procedures include behavioural contracts, assertion training, problem solving and communication training (Kaufman, 1994).

The integrative model of family therapy for substance abuse incorporates different elements from the structural, strategic, and behavioural schools (Piercy and Frankel, 1989; Textor, 1987). One such approach, Todd and Selekman's (1991) model of family therapy, has several key assumptions. There is an emphasis on the present and future and on positive reframing rather than insight. Improvements are seen as resulting from interpersonal changes and small alterations are seen as crucial. There is a pragmatic emphasis on simplicity and on what works. The therapy is short-term and involves therapists playing an active role. Finally, solutions are viewed as being unique to each family. Other researchers have proposed different integrative strategies all with the aim of synthesising the ingredients from a wide variety of models that have been shown to be empirically effective. Some attempts aim to integrate individual and family systems approaches.

The evidence for the comparative efficacy of these different 'schools' of family therapy is not conclusive (Stanton and Shadish, 1997). In addition to this extensive array of models of family therapy for substance abuse, several different treatment units have emerged. These include marital therapy, parent groups, conjoint family therapy, multi-family therapy, sibling oriented family therapy and one-person family therapy.

The comparative efficacy of these treatment units is still under debate. Todd (1991) proposed that family therapy for substance abuse should focus on the family of origin rather than on partners or siblings. Additionally, in a review of family treatment approaches to substance abuse, Stanton (1979) listed group treatments for parents, multiple family therapy and outpatient-oriented therapy with individual families as most promising.

Family Therapy Outcome Measures

The measures most commonly used in family therapy research for substance abuse focus on family functioning. These include the Family Adaptability and Cohesion Scales (Olson, Sprenkle and Russell, 1979), the Moos Family Evaluation Scale (Moos, Insel and Humphrey, 1974), the Parent–Adolescent Communication Inventory (Barnes and Olson, 1982), the Family Problem Assessment Scale (Kiresuk and Sherman, 1968), the Parent–Child Relationship Problems Scale (Friedman, 1989), and the Emotional/Psychological Problems Inventory (Friedman, 1989). Other measures that are frequently used focus on drug use symptomatology such as relapse rates, patterns of drug use, abstinence and problem behaviours associated with substance abuse (Liddle and Dakof, 1995).

Problems with Family Therapy

Individuals with addictive disorders form a heterogeneous and complicated group. They have been described as the hardest patients to treat, the most ungrateful, the angriest, the most sociopathic, the most dependent and the most in need of support (Frances and Miller, 1991). Two of the more salient issues in family therapy for substance abuse are engagement difficulties and confidentiality issues. Firstly, families of substance abusers are particularly difficult to engage in treatment. Several procedures have been outlined which can be used to encourage resistant families into treatment (Heath and Stanton, 1991; Stanton and Heath, 1995). Secondly, when substance abuse is viewed as a family phenomenon many of the existing regulations on confidentiality do not apply. In fact, hiding the substance abuse from the family and thereby maintaining confidentiality may even serve to exacerbate problems (Heath and Stanton, 1991; Stanton and Heath, 1995).

Despite these problems, family therapy has repeatedly been found to be an efficacious and cost-effective treatment for substance abuse. As early as 1979, Stanton concluded that 'family treatment shows considerable promise for effectively dealing with problems of drug abuse' (10). In a more recent meta-analysis and review of controlled, comparative studies of family therapy for substance abuse, Stanton and Shadish (1997) found family therapy to be superior to non-family treatment modalities and to be equally effective for both adults and adolescents. Furthermore, they concluded that family therapy attains relatively high rates of engagement and retention in treatment compared with other treatment approaches. However, the effectiveness and efficacy comparisons between different 'schools' of family therapy remain inconclusive (Stanton and Shadish, 1997).

FAMILY THERAPY AND SCHIZOPHRENIA

Over the past 30 years, there have been major advances in the pharmacological treatment of schizophrenia (Posner, Wilson, Kral, Lander and McIlwraith, 1992). The reintroduction of Clozapine and the development of novel antipsychotic medications has further enhanced the pharmacological treatments currently available. This, in conjunction with the process of deinstitutionalisation, has meant that most people with schizophrenia now remain in the community. It is widely recognised that current community care is based on a partnership between existing health services and carers, families or relatives (Burbach and Stanbridge, 1998; Chandra, Varghese, Anantharam and Channabasavanna, 1994). Despite this, however, the literature suggests that families feel unsupported, carry too great a burden of care and experience poor communication with health services (Burbach and Stanbridge, 1998). The family must cope with the stress of the patient's disruptive symptoms, practical problems such as the patient's finances, unemployment, lack of social skills and self-care, and deficits in resources, treatment facilities and information about the disorder (Abramowitz and Coursey, 1989).

The Role of the Family

The study of family pathology in relation to schizophrenia has changed dramatically over the last three decades. In the 1960s and 1970s, the family was implicated in the etiology of schizophrenia. Specifically, certain family structures and communication patterns were thought to cause, or at least maintain, schizophrenia (Laing, 1964; Lam, 1991). As late as 1989, Palazzoli, Cirillo, Selvini and Sorrentino were still confidently expressing this set of assumptions. In the 1970s, however, the focus of the mental health system moved to the construct of expressed emotion (EE) which refers to the emotional atmosphere of the family in which an individual with schizophrenia lives. The EE construct has played a significant role in the evolution of professional interventions directed at families. The EE model postulates that a caregiver's behaviour influences the outcome and course of the illness (Brown, Birley and Wing, 1972). For example, patients living in high EE families where there are high levels of criticism and emotional over-involvement are considered to be at greater risk of relapse than patients living in low EE families (Koenigsberg and Handley, 1986; Leff and Vaughn, 1985).

The utility of the EE concept has recently been criticised (Lefley, 1992) and has generated considerable debate both among family members and professionals. At least some of this controversy stems from concerns that the EE construct carries with it the original blame directed at families for causing schizophrenia (Mueser and Bellack, 1995). Additionally, the practical utility of the EE construct is limited. A lengthy training period is required for the administration of the Camberwell Family Interview (CFI) and for rating the audiotaped interviews on which the EE concept is based. Furthermore, the amount of time required to administer the CFI may limit its clinical use (Tarrier and Barrowclough, 1986). A major theoretical limitation of the EE construct is the unidirectional model of the influence of negative family affect on patient symptoms. This unidirectional model fails to consider the social context in which negative family interactions occur and the impact of the illness on the care-giving relatives (Mueser and Bellack, 1995).

Despite the increasing involvement of relatives in caring for individuals with schizophrenia, there has been surprisingly little research into the actual experience of caregiving. Furthermore, little attention has been given to how the family may be helped with the onerous task of caring (Bloch, Szmukler, Herrman, Benson and Colussa, 1995; Szmukler, Herrman, Colussa, Benson and Bloch, 1996).

Family Therapy Approaches

To our knowledge, family interventions currently used in the treatment of schizophrenia do not include the traditional family therapies mentioned earlier (such as structural, strategic and integrative family therapies) that are derived from the theoretical proposition that behaviour and/or communication within the family unit plays a key etiological role in the development of schizophrenia (Dixon and Lehman, 1995). Today, the family interventions most commonly used in the treatment of schizophrenia include psycho-education (Abramowitz and Coursey, 1989; Berkowitz, Eberlein-Fries, Kuipers and Leff, 1984; Berkowitz, Shavit and Leff, 1990), behavioural family work (Barrowclough and Tarrier, 1992; Falloon, Boyd, McGill, Ranzani, Moss and Gilderman, 1982; Tarrier, 1991) and family and/or relative support groups (Leff, Berkowitz, Shavit, Strachan, Glass and Vaughn, 1989; Leff, Berkowitz, Shavit, Strachan, Glass and Vaughn, 1990). These differently named approaches have a number of common emphases (Lam, 1991):

1. The positive aspects of the family and the family's ability to change
2. Provision of structure and stability in order to reduce stress
3. The current problems and stress that a family faces
4. Family concepts, such as 'marriage' and 'parenting', and their appropriate meaning within the family unit
5. Cognitive restructuring
6. Behavioural strategies, such as problem solving techniques
7. Improvement of communication through communication training

These family interventions also share a common set of assumptions. First, schizophrenia is regarded as an illness. Second, the family environment is not implicated in the etiology of the illness. Third, support is provided and families are listed as therapeutic agents. Finally, the family interventions are part of a treatment package that also includes routine drug treatment and outpatient clinical management (Lam, 1991).

Several differences exist between the family interventions for schizophrenia listed above. Such differences include whether they are conducted with individual families or groups of families, whether they are conducted in the home or out of the home, whether the patient is included or excluded in the intervention, the length of the intervention and the phase of the illness at the time of the intervention (Dixon and Lehman, 1995).

Family Therapy Outcome Measures

The outcome measures most often used in family therapy research for schizophrenia can be grouped into client, family and service outcome measures.

Client outcome measures

Studies focusing on family interventions for schizophrenia have largely focused on relapse as the major outcome variable (Birchwood, Smith, Cochrane, Wetton and Copestake, 1990). Lam (1991) argues that a variety of outcome measures including patients' social and role performance, the relatives' level of distress and burden, and their subjective report on the impact of an intervention, should be used in addition to relapse rates.

Impairment in social functioning is widespread in schizophrenia. This variable has also been widely used as an outcome measure as it is thought to reflect a primary impairment as well as a secondary disability (Birchwood et al., 1990). Additional client outcome measures include the Social Role Performance Scale (Brewin, Wing, Mangan, Brugha and McCarthy, 1987), the Social Functioning Scale (Birchwood et al., 1990) and the MRC Social Behaviour Scale measuring behavioural disturbance (Scazufca and Kuipers, 1996). These client outcome measures are often administered to the clients as well as to the caregiving families.

Family and service outcome measures

The predominant family outcome measures used in schizophrenia research focus on the relatives' level of distress and burden. There are several burden of care scales currently in use such as the Social and Behavioural Assessment Scale (Platt, Weyman, Hirsch et al., 1980) and the Experience of Caregiving Inventory (Szmukler et al., 1996). Service outcome measures are also frequently used in schizophrenia research, predominantly to assess the impact of the family intervention.

Problems with Family Therapy

Although family interventions for schizophrenia have been found to be effective, some problems invariably arise. The most common is treatment adherence (Tarrier, 1991). Meichenbaum and Turk (1987) have summarised factors influencing treatment adherence into five categories: characteristics of the client, characteristics of the treatment regime, features of the disease, the relationship between the health care provider and the client, and the clinical setting. The determinants of adherence in each individual family need to be assessed as they are likely to vary considerably (Tarrier, 1991). This is particularly important if the clinical potential of a family intervention is to be maximised.

The Efficacy of Family Therapy

There is now substantial evidence to support the value and efficacy of family interventions in the management of schizophrenia when used in combination with neuro-

leptic medication (for reviews see Kuipers and Bebbington, 1988; Tarrier and Barrowclough, 1990). There is evidence to suggest that such interventions reduce relapse rates, increase the level of social functioning of the individual with schizophrenia and decrease the subjective burden of the caregiver (Tarrier and Barrowclough, 1990). Furthermore, family interventions for schizophrenia have also been found to result in savings to mental health services (Tarrier, Lowson and Barrowclough, 1991).

Evidence suggests that family education may be useful as a cost-effective intervention for reducing relatives' burden and distress (Lam, 1991) and in facilitating a more receptive attitude to subsequent family interventions (Smith and Birchwood, 1987). One of the more promising findings was reported by Abramowitz and Coursey (1989) who provided an effective short term intervention with a mix of educational and problem solving approaches. This finding was supported in a review of the existing evidence for the efficacy of family interventions in the treatment of schizophrenia conducted by Dixon and Lehman (1995). They conclude that brief psychoeducation alone is inferior to other family interventions that use different combinations of engagement, support and problem-solving in addition to an education component. The review also suggests that multi-family groups may have some advantage over single-family treatment for patients with positive symptoms and families with high levels of EE.

FAMILY THERAPY AND DUAL DIAGNOSIS

Although many studies have shown that families of mentally ill individuals report enormous amounts of distress and burden associated with the mental illness (Pakenham and Dadds, 1987; Posner et al., 1992), there are few studies that have addressed the burden associated with additional substance abuse problems. In one such study, Kashner, Rader, Rodell, Beck, Rodell, Beck and Miller (1991) reported that the additional substance abuse problems contribute to family conflict, erode social support, and generate high levels of expressed emotion. These complications further disturb the vitally important caregiving network and highlight the need to provide services for the families of dually diagnosed individuals.

There are three possible approaches to consider when establishing a family intervention for dually diagnosed patients:

1. A substance abuse approach (an intervention is adapted from existing family interventions used for the treatment of substance abuse)
2. A mental health approach (a family intervention is adapted from existing family interventions used for the treatment of schizophrenia)
3. An integrated approach incorporating the most relevant and applicable aspects of both, drawing on research into the substance abuse and schizophrenia fields.

The difficulty in providing treatment using either of the first two approaches is clear. Both would involve adopting a single-problem treatment system, each with its own philosophy, conceptions, and approaches, and would pose grievous limitations in working with dually diagnosed individuals and their families.

Some problems that may arise from using a substance abuse family intervention for cases of dual diagnosis are as follows:

1. Substance abuse family interventions do not address the possible lack of insight into mental illness.
2. The requirement of abstinence is the hallmark of one influential substance abuse perspective. However, dually disordered individuals are often in denial of the substance abuse problem when they present for treatment, they are often not prepared to commit to abstinence and they are often at serious risk if they are left untreated (Ryglewicz, 1991). A more suitable approach may therefore include motivational treatment to reduce substance use and maintain engagement, prior to considering abstinence.
3. Individuals may believe in the therapeutic effect of cannabis, particularly in reducing anxiety, improving social confidence and as a modifier of the side-effects of medication.
4. Family-oriented substance abuse programs are often intense and confrontational, in effect potentially increasing Expressed Emotion.
5. Anxiety or paranoid symptoms may interfere with engagement in traditional family substance abuse treatments, particularly multi-family treatments.
6. Concentration, attention and information processing difficulties associated with the psychotic illness may limit the utility of the traditional family therapy interventions.

Several problems may also arise from using a family intervention for schizophrenia as the treatment for cases of dual diagnosis. Family interventions for mental illness:

1. do not necessarily address addictive problems associated with substance abuse in their treatment paradigm
2. do not address issues of denial that are frequently present in dually diagnosed patients
3. may not provide enough time in the engagement phase of treatment. It is generally recognised that dually diagnosed individuals require more time for the engagement and persuasion stages of treatment than is offered in traditional family interventions for schizophrenia (Ryglewicz, 1991).

TOWARDS AN INTEGRATED APPROACH

A better alternative would be to synthesise family therapies emanating from psychiatric and substance abuse perspectives to meet the needs of dually diagnosed individuals. This approach makes good sense given that both perspectives share a common view of the importance of addressing the needs of the family in any treatment approach (Hien, 1993). Despite this, there has apparently been no literature to date that has linked these two areas of family therapy.

Aspects from within the substance abuse paradigm that would appear to have some utility with families of the dually diagnosed include problem solving skills, communication training and the multi-family treatment modality. Aspects from the substance abuse field that are not appropriate for the dual diagnosis population include the confrontational nature of the programs and insistence upon abstinence. Aspects from within the schizophrenia paradigm that would appear to be of benefit with families of the dually diagnosed include psycho-education and family support groups. Positive aspects that overlap with the substance abuse programs include problem solving and communication training.

The psycho-education approach with families is used in both the substance abuse and schizophrenia fields and is becoming increasingly accepted as a modality of engagement and assessment of individuals with dual disorders (Sciacca, 1987). Psycho-education was originally used in the treatment of schizophrenia as an anxiety reducing tool for families (Ryglewicz, 1991). Applied to the field of family work with dually diagnosed patients, psycho-education can provide basic information, education, guidance and support in the same package, with a 'low-key' opportunity for engagement and further assessment of problems (Ryglewicz, 1991).

We will briefly describe the process of integrating the above ideas into a discrete family intervention package. This package has been operationalised into a manual and will shortly be piloted. In attempting to synthesise the various advantages and avoid the pitfalls of the two approaches to family intervention, the psycho-education framework is initially useful. The pace of the intervention needs to be slow to allow for the complexities of understanding the interactions between substance use and mental illness. Psycho-education concerning substance abuse needs to be carefully undertaken to avoid confrontation and the attendant increase in emotional arousal. Many families have strongly preconceived ideas about the influence of substance use; these ideas are better used as a resource for discussion than openly challenged. The emphasis early in treatment must remain on continued engagement in order to maintain treatment motivation (Miller and Rollnick, 1992).

The middle phase of intervention requires that families acquire skills to deal better with substance use and its effects. For problem-solving techniques to be effective, family members must undertake a process of exploration during which they are asked to discuss the advantages and disadvantages of ongoing substance use. This sets the scene for the generation of possible solutions. It is anticipated that many potentially useful solutions will arise including the beneficial influence of work and/or training. The benefits of occupation cannot be overstated. Much useful work can be undertaken in assisting the family in its role of supporting and encouraging such activities without increasing the stress associated with them. During this phase the concept of harm-minimisation will also be introduced.

Avoidance of potentially negative influences is central to the intervention. This principle addresses the known harmful effect of confrontation in this setting. The concept of harm minimisation would challenge the demand for abstinence, and the arousal that stems from attempting to police it.

It is important to note that a single brief intervention is likely to do little more than provide families with some of the basic techniques and basic understanding of the problem of dual diagnosis. The intervention is intended to reduce the potential negative influence of what the family have been doing in the past and improve their understanding of what might be more effective in the future. A trial period is required before review and individual modification. At this stage we intend to use a multi-family group modality to explore the usefulness of this synthesis. Combining the most pertinent elements of successful strategies to form an integrated family intervention is a necessary step towards an improved capacity to meet the needs of these families.

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