

The Facts Never Speak for Themselves: Schizophrenia, Substance Abuse and Family Therapy

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Everything we write
will be used against us
or against those we love.
These are the terms,
take them or leave them.
Poetry never stood a chance
of standing outside history.

Adrienne Rich, *North American Time*.

In an optimistic reflection on the legacy of Gregory Bateson published in 1983, the psychoanalyst-cum-family therapist Helm Stierlin anticipated that the then newly emerging systems paradigm, informed by concepts of co-evolution, self-regulation and the interdependence of biological and psychosocial processes, would lead to a creative relationship between biological science, family therapy, epistemology, ethics and aesthetics (Stierlin, 1983). That, of course had been the dream (or the conceit) of Bateson and his colleagues during the 1960s and seventies. In those turbulent, prosperous and heady days, family therapy in the USA emerged as the self-styled application of cybernetic and systems principles to psychotherapy. At that time, few family therapists, at least not in the USA, doubted the superiority of the systems paradigm over other ways of thinking. Stierlin's paper articulated the grounds for such confidence.

Of course, in those days, 'co-morbidity' or 'dual diagnosis' were not in the family therapy (or psychiatry) lexicon. In those days we merely assumed that such apparent complexity meant that the problem was more entrenched, multi-layered, multi-faceted or had more than one 'job' to do in the family than could be 'solved' by a single symptom. In those days, Evidence-based treatments and Managed Care in their various semantic, administrative and pedagogic manifestations (including treatment manuals) had as yet raised only faint alarms in the vast US psychotherapy scene that was forever throwing up new fads and fashions marketed by charismatic salesmen; we in Australia generally 'took a squiz' (my apologies to Brian Stagoll) but were usually cautious about buying, believing, or enlisting. And of course, in those days, many family therapy gurus told us that 'schizophrenia' was merely a mystifying word for the angst caused by communication unauthenticity and contradictions.

Mercifully, in a move that saved them from being consigned to the dustbin of history, family therapists came to acknowledge that schizophrenia is a terrifyingly 'real' disease that can blight the lives of individuals and families in ways that often are impervious to reframing the language game. Family therapists retreated from their more extreme constructivist and systemic claims and from the anarchic relativism implied by the 'punctuation of reality' thesis. Indeed, in the past two decades family therapy has never remotely looked like vindicating Stierlin's 1983 optimism.

But, in our new-found post-adolescent humility, did we surrender too much of what is creative, interesting and useful in family therapy, and which might offer something to a particularly difficult population of patients in the mental health system? This, as I understand it, is the context of Sheils and Rolfe's paper on systems-oriented family therapy models and therapy outcomes in the 'co-morbid'/dual diagnosis of schizophrenia and substance abuse.

Their paper reads like the obligatory, workmanlike literature review of a Master's thesis or funding grant proposal. Kavanagh and his colleagues, drawn to cognitive-behavioural models, summarise a related but somewhat different research literature, thereby making a direct comparison between the two papers rather difficult. Both papers conform to the spirit of academic detachment and today's dominant ideology of evidence-based approaches to clinical practice. Worthy as these characteristics might be in a university seminar or learned journal, their usefulness to a clinician struggling with a difficult patient or family is rarely as great as academic researchers and health bureaucrats would like to believe.

The late, redoubtable Professor Hans Eysenck whose 1950s behaviourist paradigm set the standard for teaching 'scientific' therapy in academic departments of psychology throughout the world to this very day, had nothing but contempt for those psychotherapists (like myself) who, knowing the difference between science and applied statistics, do not believe that comparative statistical studies of therapy models offer greater verisimilitude, understanding or insight than the ideas of our professional forebears who spent a lot of time listening to and thinking about patients.

How, for example, would the writer of a treatment manual or evidence-based protocol operationalise Jay Haley's opinion I heard at a workshop nearly 20 years ago, that 'with schizophrenia the therapist has got to be

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willing to go to the mat with the family?'; or Sal Minuchin's kindly admonition to me in 1984, 'Never make a move in a system unless you've got the power?'

But, as Sheils and Rolfe demonstrate, despite many methodological problems clinically-relevant research in this area has been done. I think McFarlane's work (McFarlane, 1995) deserves a better press than is accorded by the two papers. Sheils and Rolfe correctly note that these psycho-educational models so widely advocated in the contemporary family therapy literature on schizophrenia owe little to the specific conceptual and clinical models which are taught in most family therapy programs. Yet, some of the latter do have a degree of formal evidential support for their efficacy, as both papers show. So what are the practical, ideological and political forces which have discouraged the development of these latter models? How do Sheils and Rolfe plan to recognise and overcome such forces in the implementation of their integrated program?

Some formal research evidence and my own experience suggest to me that the enduring therapeutic elements of the psychoeducational approaches are not the family educational workshops, the communication-skills training or problem solving, multi-family discussion groups, important as they may be and which are described in great detail in treatment manuals. No, I think that the most potent therapeutic element is the sense held by the family (usually the parents, and often the main carer-parent) that the clinical team is readily available for the family, just a phone call away, backed up by regular home visits and the expeditious admission of the patient to hospital if the situation at home becomes untenable. Such empathic, non-judgmental support, *when maintained for years*, and buttressed by practical assistance in developing the patient's occupational and social skills, and by the regular review of the requisite medication, has brought hope and relief to many previously isolated, stigmatised, overburdened families. I fear that the vital importance of this element, *the long-term, sustained* availability of clinically-relevant, non-blaming support, is likely to be overlooked or minimised in manual-based treatments (and supervision). Is that what Jay Haley was getting at?

My second concern is about diagnosis. Is it schizophrenia and if so according to whose criteria? I am not playing academic games here. For example, there is a long tradition of psychiatric thought originating with Eugene Bleuler in the 1920s that disturbance in the sense of self is a central feature of the schizophrenic experience, possibly originating from the effects of formal thought disorder. Accordingly, the 1980 revised edition of America's psychiatry's diagnostic bible, the Diagnostic and Statistical Manual (DSM IIIR) stated:

The sense of self that gives the normal person a feeling of individuality, uniqueness and self-direction is disturbed in Schizophrenia. This is sometimes referred to as a loss of ego boundaries and frequently is evidenced by extreme perplexity about one's identity and the meaning of existence ... (American Psychiatric Association)

However, this part of the description of schizophrenia was deleted in the 1994 (DSM IV) edition, apparently in

pursuit of more 'objective' diagnostic criteria. While this may simplify research, when applied in clinical practice it may exclude from consideration patients in whom this feature is a central part of their subjective experience. How will clinicians schooled in the DSM IV learn how to look for or talk about such experiences with their patients? And, if they are elicited, what will be the relevance of such experiences for the clinician?

Although some prominent psychiatrists recently have revived the once-popular idea that all psychoses, including schizophrenia, are variations of one core psychotic process, most psychiatric teaching tries to discriminate between several types of psychosis, with differing outcomes ranging from self-limited to chronic. In clinical practice at any given point in time it is sometimes difficult to be too specific about what type of psychosis the patient has, and when the clinical picture is clouded by substance abuse, it is even more difficult to be sure that the diagnosis is schizophrenia. Yet I don't detect much hesitation in either Sheils and Rolfe or Kavanagh's group about their confidence that they can diagnose schizophrenia.

It doesn't get any easier when considering 'substance abuse'. Neither paper differentiates between substance use, misuse, abuse, dependence and addiction. This is not a semantic quibble. According to contemporary neurobiology research 'addiction' is looking more and more like a disease, whose causal mechanisms may involve long-term changes in the genetic code controlling the synthesis of particular brain proteins. Not so with use/misuse/abuse. A person may 'use' or 'misuse' a drug to soothe a psychically painful state such as acute grief; sometimes a drug is used to relieve boredom or as a gesture of group solidarity in a young person who fears his growing sense of social isolation; still others may 'use'/'misuse'/'abuse' drugs in a desperate attempt to shore up a terrifying fragility in the sense of self (McDougall, 1989). It is not at all clear how these patterns, motives and mechanisms of drug use are related to each other, but the differences between them are likely to be important and should be recognised in the design and implementation of treatment programs.

Furthermore, while cannabis is the drug at issue in these two papers, clinical reality confronts us with the fact that many patients use, misuse, abuse or become addicted to more than one substance at a time or serially, including alcohol, nicotine, cannabis, amphetamines, heroin and 'ecstasy', and often for different psychological and physiological reasons. Again, this problem is not addressed in either paper.

Moving from diagnostic issues to psychotherapeutic ones, consider the array of psychological concerns typically faced by patients suffering from schizophrenia. These include self-identity, gender-identity anxieties, separation-individuation problems, sexual abuse, the consequences of having a parent or a spouse who suffers from alcoholism, paranoia or depression, unresolved grief and transgenerational trauma, to name but a few. Of course, many other patients (and clinicians too) struggle with these problems, but their intensity is greatly height-

ened in psychosis and may even be a factor in inducing psychotic patients to 'do' drugs. While some of these issues are touched on by Sheils and Rolfe's review, the difficulties they cause are greatly underestimated by manualised treatment protocols.

Or consider the siblings of the patient with schizophrenia. Although formal research in this area is sparse, clinical experience indicates that siblings' needs and distress often are greatly under-estimated by parents and clinicians. Such distress often does not come to light in the standardised, programmatic approaches, yet clinical experience teaches us that they greatly influence the family environment. Only the clinician's skill and sensitivity may guide him/her to the decision to see a sibling alone without the parents or the patient. Then the youngster may need time to develop trust in the therapist and to feel that the clinician is competent to help with the mixture of concern, fear, hatred, embarrassment, shame and guilt (including survivor guilt) adolescents often feel towards a psychotic sibling. Such feelings are further amplified if the index patient has been violent at home, sexually abusive (or abused) or has attempted suicide.

So by all means let us have methodologically sound research on 'dual diagnosis' or 'co-morbidity'. Let us set up regional (and national! and international!!) treatment, training and evaluation programs informed by such research. But in boasting to government and the public of our statistical success and clinical expertise let us be

honest with ourselves and with them—do we really always know and understand who and what we are purporting to treat? Are we really that good?

More importantly, whatever the treatment model or module, let us always leave plenty of room for the empathy, intuition and skill of the well-trained clinician to get to know the particular patient and family in their particular contexts and to win their trust for the often-torrid and wearying journey that is therapy.

Clinicians are not static instruments. All treatment programs must provide the time, space and resources for clinicians to debrief with colleagues in an atmosphere of mutual support and constructive criticisms after a session with difficult patients. Most important of all, all therapists should know that to succeed as therapists they must have a rewarding life separate from the clinical context, though no evidence-based treatment manual tells us about that.

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- Stierlin, H., 1983. Family Therapy—A Science or an Art? *Family Process*, 22: 413–423.

Editors and their Sheds: Addiction

In reporting their survey of marriage and family therapists, Johnson, Sandberg and Miller found that masters level respondents read 59.4% of each issue of their favourite related professional journal, and those at doctoral level read 54.8% (*The American Journal of Family Therapy*, 27: 239–249, 1999). So the more educated you are, the less you read? What proportion of you have read the articles listed below!

- Gleeson, T. and Muir, P., 1986. The Logical Difference between Prevention and Treatment, *ANZJFT*, 7, 3: 141–145.
- Gleeson, A. 1991. Family Therapy and Substance Abuse, *ANZJFT*, 12, 2: 91–98.
- Toumbourou, J., Blyth, A., Bamberg, J., Bowes, G. and Tina Douvos, 1997. Behaviour Exchange Systems Training: The 'BEST' Approach for Parents Stressed by Adolescent Drug Problems, *ANZJFT*, 18, 2: 92–98.

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