

## 2 Engaging the family

The intervention is a package composed of a variety of types of work with the family. The three basic components are:

- (a) an education programme;
- (b) family sessions in the home;
- (c) a relatives' group.

The intervention begins with the education programme; then family sessions are arranged. Additionally, relatives may be invited to attend a group, which can be run in parallel with the family sessions.

It is very likely that a family will be reluctant to engage in treatment sessions. There may be a history of unhelpful previous professional contact, actual or perceived. Relatives may feel blamed for the illness and worry that treatment will pinpoint this. There is often a very real fear that any change will make things worse, not better, and that the status quo, even with all its problems, is, after all, to be preferred. Finally, and especially after many years of living with a person with schizophrenia, there may be an atmosphere of resignation, a feeling that 'nothing can be done', so that any help will be a waste of everyone's time.

### **Clinical example**

This illustrates a family's dissatisfaction with previous professional contacts and a sense of resignation. (In all the clinical examples, T stands for therapist, M and F for mother and father, H and W for husband and wife, and P for the patient.)

M. They let him out because he was malicious. That's what they told me. I mean they don't have to deal with him if they choose to. But guess where he went? He came straight home and I had to deal with it all. I rang up the ward and that girl said she was scared of him. I mean there were so many of them and they were scared. What about me? And they gave him a week's supply of drugs. This is the first time they did that since my last showdown with them. If he takes an overdose this time, I would hold the hospital responsible. I sometimes wonder if things are ever going to get any better.

We do know that people are more likely to accept help at a time of crisis, for example after an admission to hospital. If there is an adamant refusal, therapists may have to wait until a future crisis to try again.

Engaging the family is the first task: unless a family's reluctance to engage is tackled, then however skilled the intervention, it will not be taken up. Therapists must be aware that every professional contact with the family, each telephone call or chat in the corridor, is part of this engagement process and it should not be done in an offhand way.

It helps to remember that most families will have many needs, and that if they can be engaged, then these are likely to be addressed. On the therapists' part, engagement consists of offering positive, pleasant, polite contact, while sharing appropriate care and concern for the family's problems. This must be offered consistently, despite a family's negative response. They may refuse contact, avoid appointments, turn up late or not at all, or make it difficult to arrange a firm time; when a time has finally been arranged a crucial family member may miss the meeting.

There is an advantage in beginning with the education programme, since the therapists are offering something families are often desperate for – information. Furthermore, the fact that the therapists are prepared to make the effort to visit the home in order to give the family information aids the process of engagement.

The only situations in which we have found it impossible to engage a family have been when patients have been so suspicious of the therapist, or have specific paranoid ideas, that they refuse to allow access to the relative. One wife was terribly jealous of any contact her husband had, and the family felt too worried to accept a visit. These worries have to be respected and help offered later, when the ideas may be less firmly held.

### *Strategies*

The general strategy for engagement is to offer positive experiences of contact, at the pace which the family will allow. Persistence is often necessary, as refusal at first contact is common. Being flexible as to the time and place of a visit, not becoming angry when arrangements break down, and continuing to offer another meeting will often enable enough trust to be built up for the family to risk a meeting.

It may be helpful to meet informally before family work begins, so that a family feels they have some prior knowledge of who the therapists are and what they are like. Sometimes, of the two therapists (see Chapter 4), one at least will have had contact before. One may have met a patient while he or she was acutely ill in hospital, so that the

patient may be able to introduce therapist to the rest of the family. A relative, while visiting, may have been greeted by a therapist. It is important that these early, informal contacts are pleasant and reassuring. It is not going to help a family engage if there have been previous angry or hostile exchanges.

### *Families who refuse*

If the family continues to refuse contact, there may come a point when this has to be accepted, and help offered at a later stage. However, there are some strategies therapists should try first.

If neither of the therapists knows the family, they should try to get introduced informally by a trusted third party, who can be reassuring about their involvement. It can help if they have some short statements in mind as to their reason for wanting to work with the family: "We would like to see how you're all getting on now that John is coming home soon", "We want to find out how things are at the moment and see if we can help you with any problems that may arise".

Sometimes it can help to meet the family singly; a first meeting may be with one relative alone. Once this contact has been made, it is important that the therapists make it clear that they would like to meet all those who have reasonably close contact with the patient (live in the same house, visit frequently, are key persons such as parents or partners). Separate letters to all relatives stating the time and date of the next meeting have been found to be useful. It cannot be assumed that family members will pass on messages, and an individually addressed letter is likely to be received and read. It is important for therapists to convey to the family that it would be helpful for everyone to attend who is or has been involved in the caring for the patient.

The most usual family member to show reluctance to participate in meetings is the father. Again, a separate letter to him, encouraging attendance and stating the time and date of the next meeting can be helpful. Occasionally the patient will not engage. Usually this is connected to acute phases of the illness, but sometimes a patient will feel that listening to relatives' complaints will not be productive. Make it clear to the patient that everyone will have a say in a family meeting and that all problems can be aired and listened to. It is then important to stick to these rules.

For some families, despite all efforts, only part of the family system will engage. It is important for therapists to work with whoever will attend; they can become advocates and persuade other family members to join in. It is worth keeping the channels open and continuing to ask if absent family members would like to join meetings. Often, after many

months, they will. However, even if only one or two family members accept the help, it should still be offered; it is possible, though often more difficult, to effect change through part of the family system, and therapists should always be prepared to do so.

### *Maintaining families in treatment*

Once the family has come to attend the first family session, one of the main tasks for the therapists is to maintain them in treatment. Some families might have had bad experiences with help from professionals in the past and be sceptical about the present offer of help. Others might hold unrealistic expectations of therapy. Families who have tried to cope for years might feel pessimistic about the future, but have decided to find out what the therapists have to offer. Hence it is extremely important to explore the family's past experience of professional help, their expectation of therapy this time, and their pessimism. It is a delicate balance between infusing hope and conveying what realistically can be expected from therapy. Empathy, warmth and genuineness help. In addition, the therapists should convey the message that this type of family work has repeatedly been found to prevent relapses, and spell out that any change is likely to be gradual. They should also express their willingness to work with the family.

Sometimes families will not acknowledge any positive changes. Therapists are cautioned not to argue and attempt to prove their therapeutic efficacy, as these families are likely to respond by showing the therapists that they are wrong. Instead, the therapists should reiterate that changes are slow. Attempts should be made to understand why these families are frightened to admit that change has occurred.

During treatment, therapists should make clear the purpose of behavioural goals and relate them from time to time to what the family want to achieve ultimately, so that they understand the small steps involved. Regular feedback, either verbally or in writing (e.g. 'Helpful Aspects of Therapy' forms – see Appendix 2), helps to elicit from families the way in which they see the treatment is going. Another important aspect of therapy is to hold regular reviews with families to explore how they feel about treatment. Any dissatisfaction or pessimism can then be dealt with before families decide to end treatment prematurely.

### *Summary*

Families are likely to be difficult to engage in treatment. Be aware of this and be prepared to be persistent, and to continue to offer help

even if it is initially rejected. We would always try to work with part of the family and aim to engage the others in due course. Initial contact may be informal or during a crisis, but always needs to be as pleasant and helpful as possible. Reminding families that progress will be slow helps to maintain them in treatment.