Article abstract : ' Family interventions for psychosis: developing family work skills step by step ' by Annie Higgs. Following research as part of an MSc in Mental Health Practice at Bath University. 2007.

When offering an integrated model of family work (Smith et al, 2007) a person centred relationship (Rogers, 1951) and structures are used skilfully to enhance and complement each other and hold hope for change

Data analysis of 6 interviews with carers, who had been offered an integrated model of family work, highlights how family workers used skills (Devane and colleagues, 1998) that join personal qualities and structure.

This begins to inform practice, training and supervision to develop workers' skills and qualitative outcomes for carers and could inform service development if coupled with managerial support at all levels.

A simple framework for anyone wishing to develop practice is offered to capture family work skills in a stepped way, reflecting a recovery focussed family work model.

Key words:
Family work/interventions for psychosis
Family workers' skills and structures
Training
Working alliance with carers
Recovery

by Annie Higgs
Independent Mental Health Practitioner, Supervisor and Trainer
a.m.higgs@tintock.com
UK

Title

' Family interventions for psychosis: developing family work skills step by step ' by Annie Higgs.

This article relates to my research undertaken as part of the MSc in Mental Health Practice at the University of Bath.

1. The aims of the research were to

- explore what carers value about the relationship with workers offering family interventions, how this is developed and what impact this has on their role as a carer.
- inform my own practice, and that of others through supervision and local training programmes for family work.
- disseminate findings; potentially informing service development in the local NHS Mental Health Trust.

2. Key points from the literature

The literature demonstrated a change over time of outcomes used to measure the effectiveness of family interventions and differing hypotheses tested; application to practice of the knowledge gained with regard to the components of family work and a change in working relationships with families.

The effectiveness of family interventions is widely researched and recommended in clinical guidelines (NCCMH, 2014). Outcomes used to measure the effectiveness of family work traditionally, focussed on rates of hospitalisation and relapse. (Lam, 1991, Mari & Streiner, 1994).

Such outcomes do not reflect contemporary mental health services promoting short hospital admissions (DH, 2000). With the inherent difficulty in defining relapse, there is a need to broaden outcomes used to gauge the effectiveness of family interventions (Mari & Streiner, 1994) and an established need to develop outcomes relevant to carers (DH, 2004, Glynn, 2006).

Contemporary mental health services need to work in partnership with carers and service users to meet their needs (Askey et al, 2009), as part of the Care Programme Approach (CPA) (DH, 1999a). For many carers this has not been the case (Glynn et al, 2006) despite numerous recommendations and guidance that family interventions be available to those with a diagnosis of psychosis (DH 1999b, 2000, 2004, NCCMH, 2014).

Service development and evaluation needs to involve those who use services (DH, 2004, Glynn, 2006) particularly given the expectation that carers should take on more responsibility for caring, as service users are spending less time in hospital (Brooker, 1991, DH, 2000).

Carers need to be heard, impart information, deal with emotions generated by the experience of caring, identify coping patterns and balance the needs of

themselves and the service user (Grunebaum and Friedman, 1988, Askey et al, 2009).

Mental Health Professionals can be trained to deliver family interventions (Brooker et al, 1994, Gamble, Midence and Leff, 1994). Effective components have been identified as the structures used, as well as the positive relationship between carers and family workers (Lam.1991). The most effective components are not yet clarified (Askey et al, 2007). Family work includes managing emotions, communicating positively, problem solving and enhancing coping (Askey et al, 2009) in order to reduce stress (Barrowclough and Tarrier, 1997).

The terms 'working relationship' and 'working alliance' are used interchangeably here to describe a person centred relationship: genuineness, acceptance and empathic understanding (Rogers, 1951). Provision of stability and structure requires meetings to be structured; transparency about regular contact; a present day focus; boundary setting; understanding of the illness; assessment of strengths and needs and direct communication (Lam, 1991).

Despite recommendations and support for family interventions there are many barriers to offering them as part of the CPA (Smith and Velleman, 2002, Askey et al, 2009). If complemented with managerial support at all levels, training and supervision can contribute to changing culture and practice for service development by enabling staff to meet carers needs.

One tool used to assess the skills of family workers in training is the 'Schizophrenia Family Work Skills Checklist' (SFWC) designed by Devane and colleagues in 1998. This can be used as a baseline of skills and to evaluate skill development.

Little is written about carer experience of the working relationship with those who offer family interventions for psychosis. The qualities and experience of this is poorly understood and, therefore became the focus of my research (Higgs, 2007).

3. Methodology

As a family worker, supervisor and trainer I was interested in the experience of carers who had been offered family work. Six carers who had received family work in the locality were selected according to criteria relevant to the research question. (Willig, 2001). This is a realistic number of participants for this analysis methodology given the depth of data analysis (Smith, 2006). These participants were expected to have met with family workers at least ten times following an initial assessment process, as recommended by clinical guidelines (NCCMH, 2014).

Potential participants were recruited via local Thorn Course graduates (Baguley, 2000), who had graduated within a specified 2 year period, to use the integrated model of family work (Smith et al, 2007).

Carers were given written information by their family worker, so that they could make an informed decision about participation. The letter detailed the research purpose, its methodology and ethical issues, such as confidentiality, and an assurance that refusal to take part would not impact on service provision (Banister et al, 1995). A return slip was included which carers used to contact me.

Anyone in the very early stages of caring who might be shocked by this experience (Mohr et al, 2000), or anyone coping with an acute relapse of psychosis or for whom the family workers felt that participation in the research would be detrimental to their health, were not included.

The identities of workers and carers were made anonymous, thus protecting individuals and focussing on the process of family work, rather than individual personalities involved (Willig, 2001).

Tapes and transcripts are identified numerically and stored safely.

A personal log was was reflected on with regard to my thoughts, emotions and behaviour during the research process to reduce the likelihood of these impacting on data collection or analysis (Banister et al, 1995).

Data consisted of transcriptions of the interview between the carer and myself. This was systematically analysed, identifying themes, within cases and across cases, which captured the essence of the research question and built to create a general understanding of phenomena (Willig, 2001).

Data was analysed at a semantic level, keeping with what a participant had said, themes were identified within the surface meanings of the data. I generated initial codes. colour coded relevant contextual data, collated data for each code, searched for themes in the codes, and code combinations to form overarching themes. Finally I wrote up my analysis (Braun and Clarke, 2006).

4. Findings

Carers identified person-centred characteristics within their relationship with family workers (Rogers, 1951). They identified structural components of family work, which included workers using agendas and a co-worker in meetings (Smith et al, 2007).

Participants attributed these structural components to the family workers' qualities and skills. They considered personal qualities, together with the skills, knowledge and experience of the family workers, as more important than worker ages, gender and/or the length of time they had known the family workers.

Participants said family workers enabled clear communication, offered people quality time to reflect, comprehend, perceive meaning of, and explore how to deal with their experience and that of others. This occurred in an atmosphere of neutrality and reduced stress. As a consequence of this, shared

understanding was developed, caring and hope was engendered, and the needs of the service user and carers were identified. Acceptance of what could not be changed and adjustment to emotions generated by their experience was also described.
Carers felt able to access support to make changes, addressing relevant sensitive issues for their relative as well as for themselves, improving links to the CPA (DH, 1999a).

Participants were able to acknowledge their own needs as well as those of their relative; connections were rekindled within the family, on a personal level, and with the wider community as one might see in a recovery process (Carver et al, 1989, Drage et al, 2004, Ralph, 2000, Glynn et al, 2006).

Prior to family work, carers said that they had endured negative experiences of engaging services early in their caring experience, had felt distanced from the CPA and found it difficult to access support for wider issues (Askey et al, 2009).

5. Implications

These findings have implications for skill development in family work which is the focus of this article.

Positive attitudes towards working with carers are necessary as an essential element to meeting carer needs. Integrating a positive working relationship with the structures of family work, enables each to complement the another. The strengths and subjective knowledge of the family joined with the family workers experience and knowledge. Thus, the holistic needs of the service use and carers can be assessed within the CPA process (DH, 1999a) to focus on recovery and holding hope for change (Smith et al, 2007).

Carers need to be heard and develop joint understanding (Askey et al, 2009). The intention of the worker is to join the family, working in collaboration, with respect for those involved to build empathic understanding (Hatfield, 1987). Meetings were held as a whole family following a period of assessment on an individual basis (Barrowclough and Tarrier, 1997)

Findings indicated that family intervention had offered a positive experience to all interviewed, facilitating acceptance or enabling change. Participants made re-connections personally and interpersonally, integrated the experience of caring and thus moved forward towards an improved quality of life (Smith et al, 2007).

They provided evidence that carers are able to identify outcomes of family work for themselves, which included giving, as well as receiving, information; developing clear communication and joint understanding; developing coping and engagement with the CPA (DH, 1999a) and moving beyond illness management to recovery (Askey et al, 2009).

Themes identified missed opportunities and barriers to working with carers collaboratively as found by Askey and colleagues (2009). These were identified as a lack of awareness of family work and mental health issues, missed opportunities to

engage families within the CPA process (DH, 1999a) and the negative impact of other demands existing on workers delivering family interventions. These reflect research findings of family interventions not being offered early on when required to undertake a caring role (Campbell, 2004), failing to work collaboratively with carers (Riesser and Schorske, 1994) and family workers facing conflicting demands for their time from their caseloads (Bailey et al, 2003).

Services need to be developed to reflect equity of timely access to family work and take account of the carer literature to meet the needs of service users and carers. Training and supervision can support this with appropriate managerial support. (Askey et al, 2009).

6. Reframing the family work skills checklist

The SFWC is one tool used to assess the skills of family workers and has inter-rater reliability (Devane et al, 1998). This is used on the local Thorn Course (Baguley, 2000) and other psychosocial courses, to assess the skills of students on the family work module. It can be found in its original order in appendix 8 of 'An Integrated Approach to Family Work for Psychosis' by Smith and colleagues (2007).

Many of the skills found in this checklist are transferable to individual or group work and the detail in the original SFWC can help practitioners to articulate their skills sets, reflect on these, using it as a base measure of skills that can be developed in supervision or training (Smith et al, 2007). The skills checklist can also help workers to better understand their purpose and interventions offered when working with carers as a lone worker (Smith, Higgs and Gregory, in press).

It is also important to offer the SFWC within a context of a positive working relationship, holding hope for change and the structure of family work moving beyond managing psychosis towards recovery for everyone involved (Lam, 1991, Glynn et al, 2006). This is depicted in figure 1.

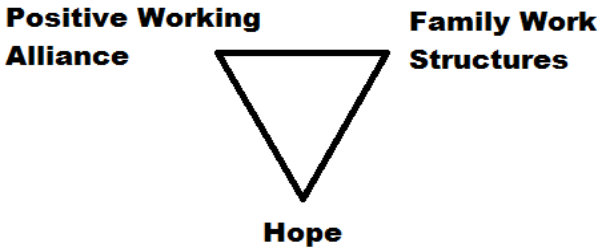

Figure 1.

There are 17 skills identified by the SFWC, each with at least 3 descriptors and it can, therefore, seem overwhelming to some novice family workers.

In an effort to 'digest' the checklist into 3 bite-sized chunks it is depicted here in steps (see figure 2), to reflect findings in the broader literature as well as practice based experience (Higgs, 2007).

That is not to say that any of the skills are any more important than others, or that the skills checklist cannot also be viewed in its entirety. It clusters the skills to reflect some of the processes that occur in family work, thus presenting the information it holds in a different way to aid learning. Novice

workers (Benner,1984) can be mindful of the skills in these bite-sized chunks depending on the context of the family meeting.

It may be necessary to use the skills clustered as steps 1-3, in a different order to that depicted in figure 2. For example. if engaging a family at a time of crisis the skills of problem solving, depicted here as step 3, may be particularly relevant in early meetings. The skills used will of course depend on the needs of the family. Nevertheless, once the crisis has passed, the skills highlighted as relevant to steps 1 and 2 will need to feature more to make the most of meeting as a family. Thus information exchange and joint understanding are enabled.

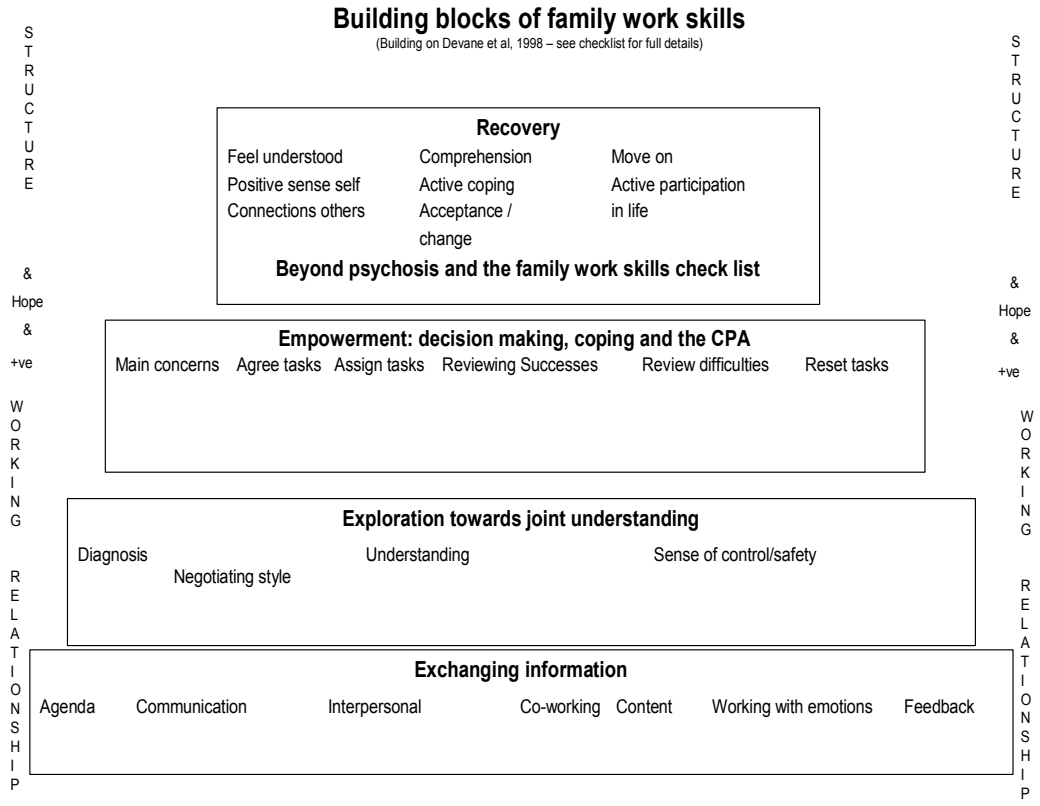

Figure 2.

Family work skills are developed as part of the process of family work that evolves over time (Brooker et al, 1994). This is not a linear process and use in practice, together with reflection on this in supervision, is required to learn, consolidate and hone skills (Smith et al, 2007).

Particular skills are described here as being more useful in early family meetings to set the scene for family discussions. This helps to develop an environment that is safe, which can then facilitate information exchange and joint understanding, enabling changes to be made.

Each of the steps will be discussed in detail to illuminate the criteria used by Devane and colleagues (1998) within each component of the SFWC.

Step 1: Exchanging information.

Exchanging information
Agenda Communication Interpersonal Co-working Content Handling emotions Feedback

2. Communication.
3. Co working skills
4. Working with emotions.
5. Content.
6. Feedback.
7. Interpersonal

1) Items for the agenda should be requested from the family, as well as being offered by the workers, to develop a collaborative approach. Negotiating to prioritise the agenda ensures time is given to the most pressing items and fosters working in partnership. All items can be noted so that they can be revisited in later meetings. Adherence to the agenda gives structure and direction to meetings.

2) Clear communication facilitates information exchange. It benefits from using ground rules including taking turns to speak, addressing each other directly rather than talking about the person (Smith et al, 2007). Active listening is required (Stickley and Freshwater, 2006) throughout family meetings and discussion is framed in a way that promotes managing emotions, understanding and promoting recovery. Reframing also facilitates change (Smith,et al, 2007).

3) Interpersonal skill reflects components of a person-centred approach such as genuineness and warmth. Respect for all those involved is necessary.
These skills can be the most familiar to trainee family workers, having experience of working with groups or individuals.

4) Having two family workers has benefits, enabling structures and skills to be used within a working relationship, holding hope for change.
Planning meetings and documenting discussion are key skill to co-working and facilitates clear communication, understanding and helps capture varying perspectives and large amounts of information.
It supports the use of ground rules and agendas that have been negotiated, helps seek feedback, the pacing of meetings and keeping to time.
Co-working creates opportunities for alliances with participants in the meeting, especially quieter members.
It helps to handle emotions by identifying and acknowledging them as they come up and reduces the risk of staff burnout (Smith et al, 2007).

5) Content skills encourage discussion and asking questions about the impact of illness for the person and their carers. This develops collaboration and exploration, tailoring the intervention to the family's needs.

6) Working with emotions is often the skill least evident amongst workers commencing training regarding family work (Devane et al, 1998). It includes acknowledging emotions and can reflect caring and emotional sensitivity. It may require reframing or normalising experience to reduce others feeling blamed or criticised.
It is key to the integrated model of family work and when offered in early meetings helps engagement and creates a foundation for problem solving. Without addressing emotional issues, problem solving is likely to be less productive and creative as emotions, such as anger or sadness, can block these processes (Smith et al, 2007).

7) Checking for feedback improves understanding between everyone. This identifies concepts, perspectives, opinion or knowledge about issues and or experience of the meeting overall. This is also traditionally less familiar to those training as family workers (Brooker et al, 1994).

Step 2 : Building on early skills of understanding and negotiating

Exploration towards joint understanding			
Diagnosis	Understanding	Control	Negotiating style

Carers described developing understanding and a sense of shared perspectives through the process of family work (Higgs, 2007). Building on the atmosphere engendered from using 'step one' skills, it highlights the need to use the skills defined by Devane and colleagues (1998) relating to:

1. Diagnosis
2. Understanding
3. Sense of control / safety within the meeting
4. Negotiating style

1) Discussing diagnosis may be a new experience for some families due to psychosis being emergent or simply because there has not already been the opportunity to discuss this as a group. This may be a sensitive issue and highly relevant to understanding and coping.

2) 'Understanding' includes being sensitive to what is said, reflecting emotions, rephrasing and summarising to acknowledge and validate each person's feelings. It demonstrates attunement and builds an 'empathic bridge' (Gilbert and Leahy, 2007). Workers who are sensitive to the person's distress, are compassionate and caring and able to reflect feelings, and can aid guided discovery.

Understanding and collaboration in developing the steps for change, encourages ownership and facilitates change (Gilbert, 2007).
Clarification develops through paraphrasing and summarising, to jointly understand and develop a formulation of the impact of thoughts, feelings and behaviour for the person in the here and now. (Gilbert and Leahy, 2007).

3) Living with psychosis and/or the process of change can be stressful. This can alter communication and negotiation between family members and can result in a sense of chaos. A sense of control in family meetings is supported by the family workers using an agenda and ground rules. This facilitates members to focus on issues in depth, at a suitable pace.
The co-working model is key here to ensuring a general focus; using the skills and structures of family work as required.

4) A negotiating style is required to get agreement on common issues within the family group. To gain consensus can take intense negotiations.
This is very different from undertaking individual work in front of the family i.e. all participants view the service user as 'the problem'. The latter could easily cause discomfort for all involved and is not family work.
It is key to agree joint needs and goals (Smith et al, 2007).
The co-working model is key here to supporting negotiations as both workers can be mindful of varying perspectives on issues.

Step 3 :Joint problem solving

Empowerment: decision making, coping and the CPA
Main concerns Agree tasks Successes Review difficulties Reset tasks

Carers discussed being able to work on mutually agreed targets using a framework, for specific issues to be acknowledged and addressed (Higgs, 2007). This highlights the skills defined by Devane and colleagues (1998) relevant to:

- Main concerns
- Agreeing tasks
- Assigning tasks
- Reviewing success
- Reviewing difficulties
- Resetting tasks

These key technical skills for the family worker are known collectively as a problem solving framework (Falloon, 1984). Whilst it may be required that family workers use problem solving on first meeting the family, ideally it follows a process of assessment to discover what participants hope to achieve, their strengths, resources and capacity to do so.

After the exchange of information from a period of assessment family workers may formulate a list of strengths, problems and needs that can be discussed with the family. Together the needs are prioritised. To meet each need,

common goals are agreed so that these can be the focus of the family interventions. Having two family workers facilitates problem solving, to achieve goals (Smith et al, 2007).

1). Agreement on the priority concern requires negotiation. Familiarity with problem solving is aided by understanding and exploring the group experience, family members being supported whilst working on one issue at a time.
2). Clarity of goals focuses on one issue at a time and is more positively framed than being problem led.
All possible solutions should be considered and documented so as not to be lost.
Once the pros and cons of solutions have been considered, modifying the seemingly outlandish solutions can be considered to promote creativity.
The process allows the best solution to be agreed by all present.

3). Being very specific about what is realistically achievable clarifies goals of family work, the detail of the plan, what challenges might be faced and setting a date to review the task set all make it more likely to be successful. Thus, a pathway forward is developed through using this structured approach.

4). Viewing progress in small steps is encouraged. Reviewing what has gone well reflects achievements and successes to boost confidence, a sense of empowerment, hope for change and identifies positive coping whilst building resilience.

5). Reviewing difficulties is intended to increase the chances of successfully achieving goals that need to be reset. The discussion allows for learning, in order to best reset the task. Being specific allows the plan to be fine-tuned.
It is important not to attribute failure to any person. Absolving blame is key to reducing shame and maintaining motivation. Alongside exploring other options maximises the opportunity to make change. Reframing skills may be required to support the latter.
Getting everyone's perspective improves understanding. (Smith et al, 2007).

Beyond managing psychosis: Changing outcomes for carers from family work towards recovery.

Recovery
Feel understood Comprehension Move on
Positive sense self Active coping Active participation in life
Connections others Acceptance /change

Carers highlighted the need to 'go beyond' illness management (Higgs, 2007).
This includes having hope, understanding and acceptance, an active participation in life, active coping, a positive sense of self, and having purpose. The process is complex and requires support from, and partnership with, others (Ralph, 2000) and will include being valued by family workers (Hatfield, 1997).

Deegan (1996) highlights a locus of control as important to recovery and the family worker has a role in facilitating this feeling of empowerment. Empowerment can be developed through information sharing and involvement in decision making (Hatfield, 1997), increased coping and engaging with the usual care process (Smith and Birchwood, 1988). Empowerment reflects the underpinning philosophy of the change process, supporting self-efficacy. Expressing empathy, developing discrepancy, avoiding arguments and rolling with resistance are also key to this (Miller and Rollnick, 1991).
Having an active participation in life with some form of transformation, as well as coping with the experience of psychosis, are identified within the recovery literature (Glover, 2001, Glynn, 2006, Spaniol and Zipple, 1994).

Conclusion

Carers who participated in my research did not differentiate personal qualities from the structure of family work. They described interventions building on strengths, with genuineness, empathy, and respect. Family workers were said to deliver the care process, engaging, assessing, offering and evaluating interventions, with hope for change. (DH, 1999a). This research has strengthened my belief that family work skills, integrated with a person centred approach, are more than the sum of their parts (Smith et al, 2007).

Service development remains necessary to meet the needs of service users and carers despite a plethora of research, policy, law and guidance across decades. In order to implement recent policy (DH, 2011) training and supervision can support service development, with the appropriate managerial support at all levels (Askey et al, 2009).

For workers offering family work for psychosis the SFWC has been broken into bite-sized chunks, to be developed as a whole, in an endeavour to improve practice, supervision and/or training in developing the skills defined by Devane and colleagues (1998).

More needs to be written about, and inculcated to practice, regarding the subjective perspective of recovering from living with a person who experiences psychosis (Askey et al, 2009, Glynn et al, 2006) and the skill sets for staff that might support this (Smith, Higgs & Gregory, in press).

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