CHAPTER 18

Collaboration with Patients and Families

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INTRODUCTION

Mental health policy, standards and vision documents in most Western countries aspire to collaborative working between users of mental health services, families and carers in the provision of mental health care and the development of services. In several Australian states 'Carers Recognition' legislation mandates that carers must be included in the assessment, planning, delivery and review of services that impact on them. There is consistent evidence that mutually respectful collaborative alliances between professionals and patients are of central importance in determining the outcome of any therapeutic strategy, regardless of specific treatment modality.[1–5] Service users, however, report disappointing levels of involvement in their own personal care and treatment, as well as in the planning and development of services.[6,7] Similarly many families and carers of service continue to report feeling excluded from decision-making, care and treatment processes[8–10] and feel blamed for the plight of their diagnosed relatives.[11]

Traditional assumptions about sickness and medical treatment derive from notions about the doctor as expert, nurses as kindly healers and the patient as needing to accept treatment and care. These concepts dictate service structure; define appropriate relationships between sufferers and professionals; and shape expectations about how health-related decisions ought to be made. However, health and welfare reform in North America, Europe and Australasia has been shaped by a discourse of consumerism that has shifted the relationship between the state, professionals and citizens. This movement based on citizen's claims to self-determination (or individual autonomy) is concerned with improving consumer participation in decision-making, challenging professional power and encouraging people to take more responsibility for their own health and well-being.[12] There are tensions between the traditional dependent relationships of the patient, and expectations for people to be consumers of health services, or actively involved in healthcare-related decisions as empowered 'users'. Although many people may be content to acquiesce to the advice of health professionals, it is increasingly accepted that at the very least people have a right to make choices about their own health and health care, and receive full information about treatments, alternatives, risks and benefits in order to inform their choices.

It may be sensible when suffering from an uncontroversial medical ailment to forgo collaborative equality

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and adopt the sick role – trusting, in ones weakness, the professionals' unclouded judgement and greater wisdom, expertise and psychological fitness (albeit at the risk of iatrogenic regressive dependency and compromised recovery). But psychiatric diagnoses are rarely aetiologically simple, frequently controversial and often the subject of conflicting therapeutic approaches.[13] The majority of mental health clients have very complex needs, which should entail the abandonment of professionally imposed, rigid formulations of care, treatment and cure or rehabilitation.[14] There is some evidence that people do not benefit from and may be harmed by the attribution of a specific diagnosis and associated treatment protocols,[15] even if the award of an identifying diagnosis provides initial relief for both sufferers and staff.

Diagnosis provides clear treatment structure and direction, but such clarity may be gained by oversimplification of the patient and family system's complex dynamics, and by discounting individuals' unique characters, temperamental strengths, aspirations and resources. Mental health patients most highly value opportunities to discuss and make sense of their symptoms, rather than passively receiving structured services and medication.[16] As Perkins and Repper[17] assert, mental health service users generally prefer 'alliance, not compliance'. Full collaboration with patients and families is based on the establishment of partnerships, or therapeutic alliances,[18] not dependence on professionals, however benign or well meaning their presentations of themselves and their service.

COMPONENTS OF COLLABORATION

Hoyt describes three factors considered essential components of effective collaboration.[19]

Alliance

Being able to sublimate one's own professional concerns within a genuine partnership; being prepared to work *with* the other person's goals, formulations, preferences, etc., not labouring *on* their symptoms or social deficits; nor aiming interventions *at* their illness (the aggressive metaphor suggests one source of the potential resistance that can be induced by subliminally authoritarian clinical styles). A meta-analytic survey of 24 separate studies identified three characteristics of effective therapeutic alliances.[20]

- The client believes in the relevance of the shared problem formulation and the effectiveness of suggested treatment options.
- The client and professional agree on both the necessary and likely short- and medium-term expectations of care.
- An affective component: a warm relationship based upon a professional ability to appear caring, sensitive and sympathetic.

The therapeutic alliance is thought to account for up to 30 per cent of variance in outcome in psychotherapy research.[5] It is among the strongest predictors of dropout in residential drug treatment,[4] and is considered essential to rehabilitation in brain injury.[21] In schizophrenia it is considered necessary to enable psychotherapy to take place[22] and is the most reliable and consistent predictor of adherence to medication advice.[23] In the treatment of depression, therapeutic alliance points directly to positive outcome regardless of the treatment provided,[2] and in bipolar disorder it has been described as a mood stabilizer.[3] There are few things that a mental health professional can do that are more useful to others than developing good working relationships with others.

Evocation of Resourcefulness

Being mindful that the person (however much apparently disabled by events or symptoms) has acquired abilities, intelligence, experience, skills and positive attributes. Nurses should attempt to mobilize and maximize these abilities, rather than risk colluding with patients' disowning their worth. To simply fulfil people's regressive needs for dependency may satisfy nurses' needs for approval, respect, etc., but may not be in service users' best long-term interests. From a nursing point of view, this factor suggests it is unhelpful to inculcate in users a sense of passivity – being subjected to treatment and control – rather than an expectation of active participation. We should establish clinical cultures wherein people feel they are *working* with staff on their problems, rather than being treated, trained and restrained.

Achievable Therapeutic Goals

Ideally *we* (the professionals) should be in search of *their* (the users') solutions. Psychiatrically defined clinical outcomes may be appropriate for drug trials, but often bear little relevance to the demands of ordinary life. For many people, complete loss of symptoms or absolute cessation of problem behaviour may be impracticable. The *solution-focused* approach to problem-solving[24] represents one practical example of effective collaborative goal-setting. Each goal should be something that matters to the individual, not simply to the treatment team. Goals should be small enough to achieve, and stated in clear, operational terms, so that the person will know when they have achieved their intention. Each goal should be checked against other aspects of the person's private life or social ecology, lest an apparently desirable gain in one area of personal functioning causes a corresponding breakdown in some other significant relationship. More recently, 'goal striving' has been incorporated into recovery-congruent 'evidence-based' packages, which include collaborative working and motivational enhancement.[25]

In mental health nursing the 'Tidal Model' incorporates elements of all the above three factors.[26] The 'Tidal

Model' advocates an essentially curious and undogmatic stance towards people's problems that privileges the user's own account of distress; personal meanings derived from their subjective experiences; and preferred solutions to their difficulties over 'off-the-shelf' psychiatric formulations. It also presupposes that people's situations are fluidly dynamic, and that problem status changes frequently – often several times in the course of a day, especially when enjoying or enduring active, collaborative care. This means that rigid or stagnant 'care plans' that conventionally remain unchanged for weeks or months are little use. The nurse–patient partnership should collaboratively review and rewrite care plans as often as understanding of the person's difficulties and potential solutions changes.

Personal illustration 18.1

Joan was diagnosed as suffering from a schizo-affective disorder and deemed by her psychiatrist and the ward staff to be deluded as she insisted that she was being poisoned by the medication she was being compelled to take. Joan distrusted electroconvulsive therapy because she believed that the anaesthetic and muscle relaxant were also poison. One nurse thought Joan's claims made sense, and that she may be suffering from unsettling side-effects. The staff discounted the idea of using a tool like LUNSERS (Liverpool University Neuroleptic Side Effect Rating Scale) as they deemed Joan too disturbed to answer the questions properly. The dissenting nurse thought that Joan's agitated, anxious restlessness may well be a form of akathisia and despite her colleagues' scorn, requested a visit from the pharmacist. He confirmed that Joan was suffering from medication side-effects and recommended a more suitable prescription.

Personal illustration 18.2

Mrs Chidgey was a middle-aged lady from a superficially jolly and supportive farming family who regularly if infrequently broke down and was well known to staff as a 'relapsing paranoid schizophrenic'. One of the symptoms of her illness was her belief – identified by staff as a recurrent delusion – that her husband and daughter (aged 19) slept together whenever Mrs Chidgey was away. This lady's illness had for many years been only partly effectively treated by neuroleptic medication of various kinds until the family moved and came under the clinical responsibility of a clinical team that advocated family-based approaches to all clinical referrals. After a few sessions of therapy, it transpired that members of the family often shared the parents' large bed when either spouse was alone, and especially when mum was in hospital and the family felt distressed. To the rest of the family, it had never been a secret, nor even an issue, but had never previously been clinically broached.

Collaboration is an integral part of a *therapeutic alliance*. Zetzel[27] coined this term, analogous with nursing's more customary *therapeutic relationship*, 5 years after Carl Rogers'[28] classic account of *client-centred therapy* gave the humanistic creed its clearest clinical formulation: that empathic understanding, genuineness (congruence) and acceptance (warmth or unconditional positive regard) are not only essential components of caring, but also sufficient conditions of care and treatment for people to begin to recover or change.[29] Rogers' connection between *acceptance* and *change* is echoed by recent strategies for working with seriously personality-disordered people. Marsha Linehan[30] identifies 'acceptance versus change' as one of the key paradoxical tensions or *dialectics* that professional staff need to maintain in their work with damaged personalities. Linehan uses the term 'validation' to refer to the professional's deeply held conviction that a patient's pathological, self-damaging or aggressively sabotaging behaviour should be responded to by understanding it as making sense from within the person's current situation, emotional status and belief system. Last century, the psychologist George Kelly[31] insisted that humans are essentially personal scientists, who attempt to create hypotheses or constructs that make sense of their experience, and behave accordingly. Following Kelly's insights, systemic family therapy teams have long embraced the idea that people's apparently pathological behaviours could be interpreted as 'attempted solutions' to underlying psychological, interpersonal or socioeconomic problems.[32]

Personal illustration 18.3

Mrs Smith was referred to the Day Hospital diagnosed as suffering from an obsessional–compulsive disorder. In the words of her psychiatrist, she 'exhibited trichotillomania'. Mrs Smith spent hours each day trying to achieve absolute symmetry by plucking single hairs from two almost perfectly circular bald patches she had created above her forehead. Despite his wife's obvious distress, Mr Smith would leave home each day for work, and Mrs Smith's mother would usually come around to help her daughter settle her anxiety by measuring the diameter of the bald patches. Sympathetic and curious nurses at the Day Hospital soon learnt that Mrs Smith had felt lonely and unloved for many years; was terrified of going out alone; and felt unable to discuss her feelings with her rather taciturn husband. Her hair-pulling, far from worrying or annoying her husband seemed to have gained some pity, perhaps confirming his sense of masculine superiority and role of provider. It also led to a rare agreement between Mr Smith and his mother-in-law, and re-established a strong supportive bond between daughter and mother, who would otherwise have also been at home alone.

Reflection

- Consider the different people whom one needs to consult and collaborate with in planning care for a person. What roles and responsibilities do these people have in the person's care and recovery? How might differences of opinion be resolved?
- What factors contribute to a good working alliance? Consider an occasion when you were involved in a genuine collaboration: what was going on for you, the other person(s) and between you that made this event collaborative?

IT'S NOT ALL IN THE MIND

Psychiatric custom and practice tends to locate the source of difficulties primarily within the patient. In attempting to accurately attribute the causes of illness behaviour, traditional psychiatric formulations may overstate personal, individual, internally located factors (such as genetic defect, constitutional weakness, personality type or organic pathology) and underestimate the significance of situational, objective, externally located causes (such as social deprivation, economic difficulty, interpersonal abuse or cultural alienation). There is for example compelling evidence that many people diagnosed with schizophrenia have a history of childhood abuse and adult trauma which has continuing residual and often profound impacts on people's lives.[33] Preoccupation with speculative biogenetic explanations obstructs the exploration of psychosocial factors that contribute to people's well-being.

Collaborative nursing can help to correct this imbalance by not discounting a person's own perceptions and understanding of their circumstances and by deeply validating their struggles to cope with life's very real pressures and stresses. Professionals can resist imposing their own clinical priorities and problem definitions, but instead work with clients to identify and prioritize their own, often more mundane, needs and aspirations. By practical collaboration and liaison with other professionals and agencies, nurses can help people with important practicalities such as benefits, accommodation difficulties, neighbourhood disputes, etc. The psychologist David Smail employs this kind of argument to substantiate a rigorous critique of specific models of psychotherapy. Smail[34,35] claims that people need effective, practical assistance to deal with the very real difficulties they encounter in life. Whenever psychotherapeutic care seems effective, it is because individuals indirectly obtain three important resources:

- comfort
- clarification
- encouragement.

Comfort refers to the therapist offering support and personal validation – aspects of what Hoyt[19] refers to as 'alliance'; Linehan[30] believes vital to effective helping; and Rogers[28] calls 'unconditional positive regard' and warmth – two of the 'necessary and sufficient conditions for change.' In nursing terms, a collaborative relationship requires the nurse to care *about* as well as *for* the person. This is not always easy to maintain, and certainly cannot be achieved simply by reciting a nursing creed of moral imperatives to be kind at all times. It requires the nurse to confront his or her own emotional needs, and clarify reactions and responses to patients and clinical interaction through deep personal reflection and supervision.

Clarification refers to some explanation of how the person's problems originated and developed. Such explanatory theories of psychopathology or life difficulties exist but differ in every school of psychotherapy, regardless of effectiveness. People need a story about their life that makes sense, and especially a narrative thread that could suggest a pathway out of their current difficulties. Some highly collaborative forms of therapy for psychosis based on narrative exploration and reconstruction exploit this insight, which lends itself readily to conversational application by mental health nurses.[36]

Encouragement refers to the ongoing support, confrontation, guidance and reinforcement that needs to accompany an individual's attempts to dare to be different or attempt another way of behaving, either specifically or in general, once problem maintenance factors and potential solutions have become clearer. Equally, encouragement may be needed to help people tolerate or cope with socioeconomic circumstances that remain stubbornly immune to practical efforts to improve them.

COLLABORATIVE CONVERSATIONS: BEING USEFUL WHEN PEOPLE WANT TO TALK

Peter Hulme[37] has outlined a useful framework for developing collaboration within a normalizing conversational approach to mental health nursing. Hulme criticizes the potentially oppressive rigidity of many conventional psychiatric formulations and expands Smail's notions about the importance of 'clarification', 'solidarity' and 'encouragement'. Both mental health professionals and distressed people in need of care often become too psychologically inflexible and rigid. Psychiatric beliefs, behaviours and attitudes are sometimes just as obstinate and unhelpful as so-called delusions, compulsions or depressions. Hulme uses the phrase 'collaborative conversation' to describe the context in which fixed beliefs, habits and feelings on both sides can begin to be dissolved away and replaced with more expansive possibilities (Table 18.1). There are three elements of such *collaborative conversations*:

- reflection, not drowning
- relativism, not dogmatism
- relatedness, not disowning.

TABLE 18.1 Elements of Collaborative Conversation

Rogers' 'necessary and sufficient conditions for change'[29]	Smail's 'components of psychotherapy'[35]	Hulme's 'aims of collaborative conversation'[37]
Unconditional positive regard and warmth 'A non-possessive caring acceptance of the client, irrespective of how offensive the person's behaviour might be. Unconditional positive regard helps to create a climate that encourages trust.' 'Conditional regard implies enforced control and compliance dictated by someone else' 'Non-possessive warmth springs from an attitude of friendliness, is liberating and non-demanding'[56]	*Comfort (or solidarity)* 'The comfort to be derived from sharing your deepest fears & most shameful secrets with a 'valued other' who listens patiently is one of the most potently therapeutic experiences to be had.' 'Comfort does not cure anything. The provision of therapeutic comfort is not unlike administering short-acting tranquillizers – it works, is addictive, but it will have to be withdrawn sooner or later.'[35]	*Reflection (not drowning)* 'When we are drowning in our experiences we are unable to separate ourselves from them. They govern us completely.' 'Reflection is the capacity to separate consciousness from its contents. We can step back, inspect and think about our experiences. We become capable of changing our relationship with them and altering their meanings for us.'[3]
Genuineness (congruence) 'The degree to which we are freely and deeply ourselves and are able to relate to people in a sincere and undefensive manner.' Genuineness encourages client self-disclosure, whilst appropriate therapist disclosure enhances genuineness.'[56] Genuineness entails meaning what you say & do. It does not necessarily entail revealing all that you think. Paul Halmos wrote about being 'a vessel of honesty floating on a sea of concern.'[57]	*Clarification* 'The point of establishing how you got to be the way you are is to disabuse yourself of mistaken explanations, not the least of which is that you are responsible for it.' 'People are often mystified about the causes of their suffering, and an important aspect of their coming to understand what they can and cannot do about their predicament is to be demystified'[35]	*Relativism (not dogmatism)* 'Dogmatism is to beliefs what drowning is to experiences.' 'In the absence of doubt there is little incentive to change one's mind about anything: we do not hesitate to put our beliefs into immediate action when the situation seems to demand it.' 'The antidote to dogmatism is relativism ... We acknowledge that we have no monopoly on the truth, that we understand & experience the world at best imperfectly from a particular viewpoint or perspective.'[37]
Empathy 'The ability to step into the inner world of another person and out again.' Empathy is trying to understand another's thoughts, feelings, behaviours and personal meanings from their own internal reference frame.' 'For empathy we have to respond in such a way that the other person feels understood, or that understanding is being striven for.' 'Empathy is a transient thing. We can lose it very quickly.' 'Literally it means "getting alongside"'[56]	*Encouragement* 'Nothing will ever change the need for human solidarity, whatever form it comes in.' 'The courage needed for a tiny powerless organism to take a chance on the nature of its reality must be colossal, and can only be acquired through a process of encouragement, in which loving recognition of the uniqueness of the baby's perspective is central to the nurture and instruction offered.'[35]	*Relatedness (not disowning)* 'When we disown aspects of our experience they do not necessarily cease to influence what we feel think & do. We disown experiences that would otherwise engulf us. We disown conclusions that conflict with cherished beliefs.' 'Relatedness is the capacity to consciously acknowledge and relate to what we are experiencing. Without the capacity to own and reflect we remain helpless victims of our own inner life.'[37]

Reflection, Not Drowning

Rather than experience themselves 'drowning' in overwhelming difficulties, people need to be able to separate themselves temporarily from their lives; to separate their consciousness from chaotic experience; and learn to *reflect* upon their situation. Collaborative conversation aims to help people feel a sense of rescue, so that the absolute (and usually apparently awful) nature of truth and reality can be considered more calmly and other possible meanings and perspectives explored. Distressed people can be aided to achieve this by experiencing the reflective calm of their potential rescuer. Sometimes, especially when faced with chaotic acting-out or threatened violence, it may be necessary for professional nurses to 'act-as-if' and non-verbally feign such confident detachment, while verbally acknowledging the apparently extreme mess that their dependent partner is experiencing.

Relativism, Not Dogmatism

It helps if both nurse and patient cease to rely upon deeply engrained certainties or 'dogmatism', and challenge their own beliefs or assumptions about themselves and

their world. Nurses can help people generate alternative explanations and even point out unusual beliefs that might initially uncomfortably challenge previously unshakeable world-views. Paradoxically, the emerging possibility of doubt can be a step towards greater autonomy, freeing people from the usually unhelpful rigidity that has previously characterized their personalities. The development of such doubt and the consequent *relativism* helps dissolve unhelpful beliefs in the same way as reflection helps us to cope with difficult experiences.

Relatedness, Not Disowning

People often blame others for their difficulties long after any original damage may have been done to them. They deny any destructive, defective or negative attitudes on their own part; or simply refuse to face up to consequences, connections or causes. People need help to discern and accept the connections, patterns or relationships between external events and their internal feelings and thoughts. They also need to learn how their subsequent behaviours are interpreted or construed by others and how these constructs then determine reciprocal behavioural responses that may in turn generate further hurt and misunderstanding, or elicit other negative emotional reactions. This *relatedness* is the undermining challenge to 'disowning', and brings denied problems or solutions back into focus, and thence into possible reconstruction and resolution.

Reflection

Consider someone who may have an experienced a prolonged low mood (perhaps yourself, a family member or someone you know).

- How did the person's relationships contribute to the perpetuation and resolution of the low mood?
- How did the person relate to others differently during the period of low mood and subsequently?
- How did the person's thinking about the world change?

BETTER THAN COLD WAR: THERAPEUTIC COMMUNITIES AS COLLABORATIVE ENVIRONMENTS

A common emphasis in psychiatric nursing is to identify and locate problems *inside* people, rather than within relationships (*between* people) or between people and real life (*around* people). This emphasis can create obstacles to progress and personal growth, if that includes coming to terms with *relatedness* and the reciprocal effects of emotion, thinking and behaviour within relationships. Shared clinical environments, whether residential units or day centres, can usefully provide opportunities for socially reinforced learning, provided that people are allowed some scope for expressing their difficulties and supported in receiving feedback from others about their behaviour. Patients can be helped to collaborate with each other's efforts to gain personal control and work towards recovery, rather than simply accept treatment passively from the professionals. This is after all what goes on informally and often surreptitiously within the subcultures of dormitory and smoking room. Nurses sometimes feel excluded from this community, and mistrust it, or feel unable to incorporate its potential benefits into the formal matrix of care.[38]

Outside of conventional psychiatric service organization, with its emphasis on one-to-one nurse–patient or psychotherapeutic relationships, perhaps the best example of shared collaborative responsibility is found within the various *therapeutic community* models of treatment. This model of recovery-based mental health care grew from the military hospitals caring for soldiers damaged by the stress of the Second World War. Hierarchies of patients and professionals were abandoned and replaced by a communal, democratic model of organization, planning, decision-making and problem-solving. In most models of therapeutic community practice, staff as far as possible abandon their clinical authority (although they do not entirely abdicate it, but rather hold it in abeyance) until forceful prescriptive interventions are essential to prevent serious harm. Staff and patients alike are expected to both support and confront people with observations and interpretations of ordinary, everyday acted-out behaviour, so that social, interpersonal and intra-psychic learning is maximized and opportunities to avoid the implications of dysfunctional or damaging personal traits all but disappear. Responsibility for all aspects of day-to-day functioning are shared, and the community becomes in effect a sociopsychological clinical laboratory for clarification of problems and a testing ground for more constructive behaviour.[39] This model of care thrived during the 1960s and 1970s, but shrank considerably during the 1980s and 1990s as the political climate in the UK and overseas swung from cooperative communal, social or municipal models of progress to embrace more competitive, individualistic ideals. The use of so-called 'community meetings' on some clinical units represents a vestigial survival of therapeutic community practice. Unfortunately, modern management procedures, confused treatment ideologies and rigid clinical hierarchies often mean that these meetings are shorn of their full democratic status. Instead of being a forum for dynamic problem-solving and collective decision-making, the community meeting's purpose often seems more a symbolic means of enforcing staff authority than an exercise in therapeutic liberalism. It has become a mechanism for staff announcements, ordering meals and complaining about food and apportioning blame or punishment for overnight acting-out. Recently, however, the drive to develop effective methods of helping people with severely disordered personalities has brought therapeutic

community philosophy and practices back into political favour. The same principles could reinvigorate community-based acute and rehabilitation units.[40]

THE SICK SELF AND OTHERS: COLLABORATING WITH FAMILIES

Personal illustration 18.4

An on-call nurse in a community mental health centre received a 'demanding' phone call from an angry father 'You'd better get round here now and sort my daughter out – she's gone mental'. The nurse was refused permission to talk to the daughter herself. After their GP was contacted and made a referral, the family were offered a daytime appointment but instead turned up at the community mental health clinic (CMHC) that evening when only the Crisis Team remained on duty. The daughter, a 17-year-old schoolgirl, seemed distraught, and collapsed when told that the family should keep the appointment they had been offered. A nurse from the team took the girl, Lisa, away and spoke to her alone for over an hour, while a colleague interviewed her parents.

Lisa was a bright highly achieving A-level student but confessed to being 'totally at the end' and unable to stay at home 'It's doing my head in'. She'd been thinking about suicide, and yesterday had cut her arms superficially and packed a case to leave home – thus prompting the phone call to the CMHC from her father. Lisa described an atmosphere of constant hostility between her father and mother, with father bearing the brunt of mother's frequent violent rages, supposedly to stop her beating her own daughter. She was unable to identify a just reason for this rage, except that mum had had a 'terrible childhood – full of sexual abuse and that'. Dad had begged her never to leave home, as 'that would kill your mother' and he himself would be broken hearted. Lisa felt that she had to stay at home to prevent real harm coming to either parent, but at the same time dreaded staying for her own psychological and physical health.

When working with families collaboration becomes even more problematic, multidimensional and full of potential pitfalls. Even when working individually, in an ecological sense, nurses are usually, and often unaware of, working with the front-end of at least one family – a complex human system of friends and relatives. Families of people needing psychiatric services are rarely harmonious collectives. Behind each individual referral, there is usually a long history of grief and worry, emotional and social difficulties, pain and disappointment or conflict and recriminations. How can nurses collaborate with every part of an internally conflicted system?

If working collaboratively with an individual is easier said than done, families present even more complex and potentially painful difficulties. It is often helpful to work with a partner or co-worker, for various reasons:

- A single worker can be overwhelmed and drown in the emotional complexity or intensity of any family's intricate social system. A supportive partner will help share the emotional burden, clarify confused affective responses and enable improved objectivity, as well as increasing the intellectual resource available for identifying potential solutions, strategies, etc.
- Two people can more easily operate with the complex balance of shifting pairs, pacts and alliances between individual members, by being able to support opposing factions at the same time, facilitate stronger alliances and other means of prospering equilibrium and negotiation.
- Two workers who have a good relationship can help model or demonstrate (either explicitly or covertly) better ways of functioning by their unafraid discussion and resolution of disagreements or uncertainties.

It helps to have a clear objective structure or cognitive framework of family functions, in order to help clarify the multifarious behaviours and patterns of interaction that might otherwise simply bewilder the most well-intentioned workers. A clear map of family functioning will help to provide a normative overview when trying to identify areas that may be causing difficulties, or exploring potential routes to improved functioning.

Although various models of healthy family functioning have been developed, tried and tested, none has achieved general acceptance, and all may be subject to cultural or theoretical bias. Nevertheless, the need for a practical conceptual model persists and the McMaster model of family functioning[41] has proved its worth over nearly three decades. The model proposes six broad areas of function: communication, affective responsiveness, emotional involvement, problem-solving, behaviour control and allocation of roles and responsibilities. The model can be used with any family as a shared lens to scrutinize behaviour and enhance insight, or a tool to explore tunnels of unawareness and construct new pathways to change. Such a model can also be used as a professional tool to attribute pathology or reach a sociopsychiatric diagnosis. Then obviously the goal of collaboration will have been submerged, as so often, beneath the expediency of objective pseudo-science and the arrogance or security of assumed expertise.

Communication: how the family exchanges information. Everybody may be in the family's network or perhaps someone or others are excluded; pairs and sub-groups may exist. The model distinguishes between practical, *instrumental* material – news, plans, ideas, proposals, etc., and emotional or *affective* matters. Families often communicate much better about cool, factual issues, while having difficulty with more highly charged emotional stuff.

The model further distinguishes between *clear* and unclear or *masked* communication, and *direct* or *indirect* messages. The *clear/masked* continuum enables a collaborative study of the overall clarity of communication in general, or of specific messages or channels. Is the message clear (both to sender and intended receiver) or is it muddled, vague, disguised? The *direct/indirect* scale invites consideration of whether messages are sent to the person they are intended for or are ostensibly about. Alternatively, perhaps there is excessive secrecy, collusion or triangular, third-party deflection?

Affective responsiveness: how wide is the family's range of permitted, established or recognized emotions? How well or poorly does the family as a whole or individuals within it respond to the whole spectrum of human emotions? Perhaps there are blind-spots or prohibitions; prescribed or obligatory feelings; frozen or stagnated emotional states; flat, grey emotional landscapes; separation and allocation of feelings to various individuals as guardians or keepers. Some families are all right with joy and awful at anger; some cannot handle shame or disgust; others insist on pride and refuse to permit guilt (and vice versa). Joy, calm contentment, surprise; sadness, anger, fear, disgust; love (and lust); guilt, shame, pride, embarrassment, envy and jealousy: each and every one may be present, absent, exaggerated or denied, a potential source of conflict in the family's emotional repertoire. Sometimes, emotions seem to have been parcelled out: one member has the job of facing sadness and despairing at life, whereas another is the family's eternal optimist; yet another is critically angry with both, enabling a lucky fourth to carry the burden of calm serenity.

Affective involvement: how integrated, warm and balanced is the family's emotional interest in the activities, interests, and aspirations of its members? The McMaster system distinguishes six levels of this dimension:

- *Lack of involvement*: the family seems detached, disengaged and isolated from each other, sharing a living space and perhaps a history but apparently little else.
- *Involved but without feelings*: apparently emotionally indifferent, showing little interest until it is demanded or extorted by acting-out or other means.
- *Narcissistic involvement*: members may feel that others in the family may only be interested in them for what they themselves may attain as a result.
- *Empathic involvement:* the most effective level, and an ideal to be aimed for, where members feel emotional investment in what something means for the others.
- *Over-involvement:* Over-intrusive, over-protective, overly enthusiastic behaviour: obviously all subjectively judged, but inferred by the statements, behaviour or revelations of those involved.
- *Symbiotic involvement:* sometimes referred to as *fusion*, there seems to be no personal boundary, or at least a very blurred one between individuals. People respond as one, claiming to know how the other is feeling, even better than they do themselves, and often reply for each other.

Problem-solving: a problem is any issue from within or outside the family that seems to threaten or compromise the healthy functioning of any member, or the whole system. Good problem-solving may require shared or well-led expertise at all stages of dealing with problems:

- *Identification of the problem*: Who sees it? How clearly? Is it a projection or displacement of other difficulties? Are emotional difficulties redefined as operational ones, or vice versa?
- *Communication*: Is it discussed with appropriate people both within and outside the family? Who decides, and how? What discussions and debate occur?
- *Generating alternative solutions*: Does the family grasp at the first idea for an action plan? Is it the same as usual? Is there any consideration of ideas from others, or always the same person?
- *Deciding on a suitable action*: Were other ideas seriously considered? Is there a single authority, or flexibility in decision-making, or pseudo-democracy? Do they rush to act, act chaotically with no coordination, procrastinate? Are any of these options appropriate?
- *Action:* Does the family do what it decided to do? Does it do anything at all, or get stuck in a frozen cycle of decision-making or denial? Does each individual play their part, or is there sabotage? Do some members feel disabled from participating in active solutions? Are they?
- *Monitoring and evaluation*: Does the family keep a check on the problem and whether it's being resolved or not? Or do they forget all about it until the next time something similar occurs? If they perform this function, how is it managed?

Behaviour control: what patterns have the family adopted for responding to actions in various situations: danger; expressing emotions, desires or biological needs; socializing within and outside the family. This dimension includes not only adult authority over children, but also how the adults conduct themselves in relation to the children, each other and the world. What standards have evolved? How much flexibility is there?

The McMaster system recognizes four broad styles of behaviour control:[41]

- Rigid control is characterized by strict authority, with tightly defined (even if unclear) standards and little scope for adaptation to circumstances (including maturational change).
- Flexible control allows for age-appropriate negotiation, and change according to context or development.
- Laissez-faire control describes those families where authority is absent or abdicated in favour of free choice, regardless of risk, judgement or maturity.

- Chaotic control is attributed to families that apparently randomly veer from the rigid to laissez-faire ends of the spectrum.

Roles: how do individuals within the family carry out specific desirable (or problematic) functions? Are vital roles achieved and is there a sense of security and confidence in the people fulfilling essential functions? What other roles seem to be being performed (or not)? Who decides on the nature or desirability of these jobs? How is their achievement or ongoing desirability monitored?

Vital roles include providing essential food, warmth and shelter; nurturing and sustaining development; preserving the family security and boundaries. Other roles can develop that may be useful or not, destructive or creative, subversive or caring. These roles may include sacrificing ones of well-being to keep the peace, or becoming ill to deflect attention from some other denied conflict.

Families that manage their own problems and seem to require little outside help demonstrate clear, direct communication patterns. When members of healthy families need to express their feelings, or achieve a particular task, they generally seem to understand what role they and others have in the situation, and speak directly to involved relatives in a lucid, unambiguous manner.[42] After years of traumatic stress, families with difficulties often manifest the opposite characteristics – they have fragile, permeable or impenetrable personal boundaries; show limited abilities to deal responsively with each other's emotions; and can tolerate only a restricted range or intensity of feelings. Fractured, unclear or indirect communications characterize their interactions. People make faulty assumptions about the meaning of other people's behaviour. They impute thoughts, feelings or motives that mismatch each other's beliefs about themselves, and then react to each other on the basis of these erroneous assumptions, thus establishing self-fulfilling spirals of distorted attitudes and interactions which over time become deeply engrained. The 'bow-tie' method of graphically depicting communication circularities is a simple heuristic devise that can sometimes dramatically clarify apparently bafflingly complex family interactions[43] (see Figure 18.1). Nurses can help families to consider each other's thoughts and behaviour differently, and identify new possibilities for tolerance, shared feelings or problem-solving, by helping them to clarify vague or mismanaged communications between individuals.

Nurse: So Lisa, when you see Mum being so wild with Dad, what do you think, or how do you feel?

Lisa: I feel angry with her, frightened for him, and I feel so stuck, I want to die.

Nurse: And what do you actually do then, when you feel all that?

Lisa: I usually go to my room, and cry.

Nurse: How does Lisa's withdrawal and tears affect you, Mrs. Jones?

Mrs Jones: I feel guilty, of course I do, but it seems unfair as well – I get even angrier with John.

Nurse: And what do you do when you feel guilty?

Mrs Jones: I try to talk with Lisa about my frustration and tell her I'm sorry, but I always end up going off at her again.

Nurse: What's that like, Lisa?

Lisa: I'm sure she wants me dead, or different, but I can only be me.

Nurse: Mr Jones – do you think that your wife wants Lisa dead or different?

Mr Jones: I know she doesn't, but it must seem that way to Lisa.

Nurse: A diagram of how this works out between you might make it clearer to me. Would you mind if we

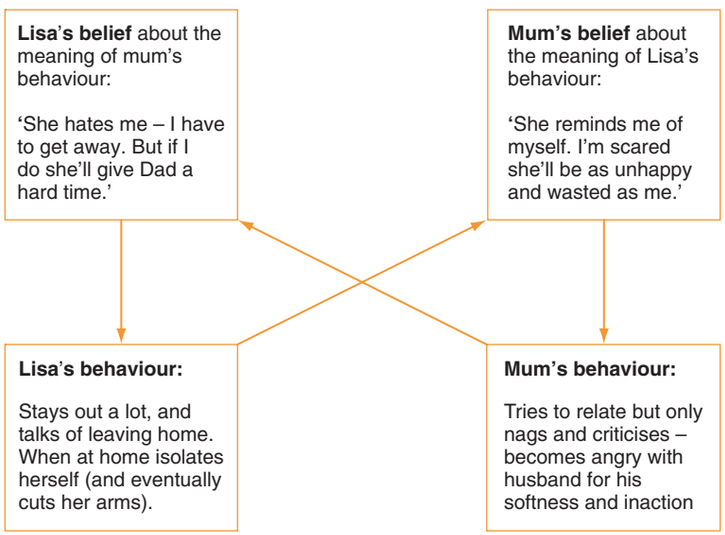

Figure 18.1 A's belief about B governs A's behaviour, which justifies B's belief about A, which governs B's behaviour, which justifies A's belief, which …

sketched it on paper? So, Lisa how does mum's nagging affect you again?

Lisa: I think she hates me, and I want to get away – but I worry about dad [See Figure 18.1].

Nurse: That's really very sad. How can you help each other with this fear that Mrs Jones is no good, and Lisa could become like her?

Reflection

Reflect on how your own family functions. Consider how your family communicates with each other, how feelings are expressed and controlled, how problems are solved, behaviour moderated and the allocation of roles and responsibilities.

Family Education

'Family interventions' have been developed that aim to reduce the stress/distress of families, improve their coping and teach them about illness and its management. This kind of broad psycho-educational approach with families is almost considered a universal component of any integrated care package in schizophrenia and has been highly formalized in terms of training for health professionals. These programmes emphasize medication compliance strategies, educating people about relevant psychiatric diagnoses, enhancing people's preferred coping methods, teaching and applying problem-solving techniques and altering family communication patterns. Well-crafted packages have been found to contribute to a reduced the frequency of relapse, reduce hospital admissions and improved social functioning.[44] Kuipers[45] concludes that it is important to '… replace the stress, anxiety and criticism in some families with calmer, more tolerant, more effective reappraisal and problem-solving, while trying to improve carer's coping and self-esteem'. The most important elements of successful programmes relate to improving communication between family members, reducing stress and reducing over-involvement.[46]

Reflection

Spend time with a family exploring their viewpoints regarding what is happening, habitual patterns of dealing with problems and their ideas about what might help improve the well-being of their family.

On giants' Shoulders: Paying One's Clinical Dues

Many collaborative strategies for working with families pre-date the development of 'psychosocial intervention packages'. Early pioneers stressed the necessity of making good relationships not only with the family as a whole, but also with each individual member. Salvador Minuchin[47] described the processes of 'joining' and 'accommodation' that professionals need to negotiate successfully when engaging with families. 'Joining' a family involves accepting its unique organization and blending with its cultural style. Nurses should adjust their own self-presentation (or 'accommodate') to achieve effective joining. Maintaining a formal, stereotyped, professional image is less important than gaining the families trust and being allowed to experience their pain, pleasure and possibilities at first hand. Nurses should consciously allow spontaneous, natural imitation of communication (or 'mimesis') to help facilitate accommodation, and follow (or 'track') family conversational threads and themes, rather than stick doggedly to pre-set questioning or interview formats. Minuchin also felt it essential to maintain 'balance' within the therapeutic system, so that whenever he supported one member over a particular issue, he would seek an early opportunity to ally with other members who might have felt their point of view disregarded. Nurses can adapt such techniques within their unique professional matrix to therapeutically transform the kind of social, conversational or more formal, organizational role-bound interactions that many have with patients and their relatives.

Jay Haley[48] outlined a structure for conducting first and subsequent meetings with families. He emphasized the importance of beginning the session with a '*social phase*' during which the professional can make contact and engage with each member in turn by being genuinely interested in positive aspects of their life and personality, separate from any discussion of the family's problems. This phase is followed by a '*problem*' stage in which each family member is invited to contribute their perspective on the family's difficulties and his or her preferred outcomes. Nurses need to be respectful of each person's contributions, and firm enough to conduct the session by facilitating other family members' listening while each person speaks. During the third '*interaction*' stage the family is encouraged to talk together to share observations on a specific issue, understand each other's perspectives or behaviour and start to identify shared viewpoints or resolutions. Nurses need to be ready to intervene during this stage to maintain balance, prevent 'scape-goating' or other damaging interactions and ensure that family members continue to listen to their relatives. During the final '*goal-setting*' stage, nurse and family collaborate to identify, clarify and plan behavioural tasks and contracts involving all relevant family members in constructive change or support. Haley's framework offers nurses a structure to make more productive use of family meetings in both residential and sessional environments.

Collaborative Conflict

Even with very careful attention to joint engagement, professionals can develop distorted perceptions of family

processes, determined not only by their clinical orientation, therapeutic belief system and working practices but their own personality development and family experiences. Any unexplored or disowned aspects of self, personality rigidity, or prejudicial narrowness in professional education or cultural background may predispose a clinician to non-collaborative practice of one kind or another. Similarly, defensive interpersonal behaviours may stimulate emotional reactions in either nurses or clients, and unmet emotional needs may result in parataxic or projective distortion of working relationships. Regular personal supervision and staff sensitivity or support meetings are necessary if nurses are to avoid being disabled by unresolved needs or negativity.

Just as families (and individuals) are often internally riven with conflict, so also the history of working clinically with families demonstrates considerable theoretical and methodological dispute. Some forms of family therapy have been accused of 'blaming' families for the plight of a sick member, whereas family management practitioners have been indicted for unnecessarily pathologizing vulnerable members and hypocritically deceiving relatives.[49] The diagnosis of schizophrenia has been an especial focus of disagreement[50] and fraught with mixed messages and paradoxes. For example, families and health professionals have campaigned to reduce the sense of blame that has often been apportioned to or felt by families in relation to schizophrenia. However, high 'expressed emotion' of relatives (a combination of criticism, hostility and overprotectiveness) has consistently been found to be psychonoxious to relatives diagnosed with schizoprenia.[51] Furthermore, many people who are diagnosed with schizophrenia have suffered various forms of abuse, sometimes at the hands of family members.[33] It is reasonable that families and individuals experience mixed emotions and exhibit complex dynamics in keeping with their complex and multifaceted histories. Good family work requires the facilitation of conditions whereby families feel safe enough to ask questions and search for answers that make sense to them.[46]

As mentioned above, a useful concept deriving from early family therapy theory involves construing all family members' apparently pathological or unhelpful behaviours as 'attempted solutions' to perceived or underlying problems. The strangeness of a young schizophrenic may be interpreted as the result of efforts to escape the stifling conformity of a rigidly judgemental family culture,[52] or simply but stubbornly create a different culture more suited to the individual's emerging personality. Violent tantrums, bizarre behaviour, withdrawal or suicidal acts may all serve the purpose of detouring conflict – focusing attention and concern onto an apparently disturbed individual and away from unexpressed or unresolved conflict between other family members[43] Equally, a family's displays of strongly judgemental criticism or hostility may reveal evidence of ambivalent grief or frustrated weariness, developed after years of ineffectual care and concern for a sick relative. Their well-meaning efforts may have been reacted to by resentment or rejection. They may have failed to dissuade an unwell relative from reckless deviance, unhappily odd preoccupations or dangerously careless behaviours. The family may desperately want to persuade the unwell member to conform to social or behavioural codes they sincerely believe to be better for their relative's welfare.[53]

All kinds of interpretation can fit the complex dynamics of a family in crisis. They are not mutually exclusive or contradictory. However, it is precisely this kind of difference in perspectives that has resulted in recrimination between clinicians from different schools of professional family work. *Family therapy* theories construe families as complex organic systems. Diagnosed pathology in an individual may be understood as the result of chronic pressure or conflict within the whole family system revealing itself by breakdown of the most vulnerable family member. *Family management* theories view the situation from the other end, and assume *a priori* the existence of disease in one individual. The unwell family member's relatives experience chronic stress, anxiety, frustration or grief. This in turn induces weariness, compassion fatigue or unhelpful responses such as excessive criticism, hostility or emotional over-involvement.[54] Bennun[55] provides a brief exploration of issues around these dichotomous approaches. In both cases, however, therapeutic progress is made by helping the family to change some aspect of its structure or function, either because the family itself is seen as the primary unit of pathology or because it has become less than optimally beneficial for all its members and ineffectively supportive as a caring network.

Whatever psycho-pathological perspective a clinical team works from, nurses should work to ensure that families experience a user-friendly service. Nurses can establish more informal, responsive relationships with both patients and relatives and avoid the arrogant dogmatism and technical excesses that have bedevilled various schools of family work. Nurses can use their relationships with both diagnosed individual and family relatives to work towards helping family members collaborate more with each other. Alternatively, there is a risk that nurses who remain unmindful of or insensitive to significant family dynamics may develop relationships with either diagnosed patients or family carers that mimic the debilitating effects of high expressed emotion. They may themselves become hostile critics, over-involved and emotionally invasive, or ally with one part of the family against another.

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