

## Family interventions in schizophrenia: Issues of relevance for Asian countries

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### Abstract

A growing body of research evidence has confirmed the efficacy of family-interventions as adjuncts to antipsychotics for the treatment of schizophrenia. Much of the recent evidence for such interventions derives from Asian, principally Chinese, studies. These trials have shown that relatively simple forms of family-interventions have wide ranging benefits, and can be implemented successfully in routine clinical settings. With the accumulation of this evidence in their favour, family-interventions for schizophrenia in Asia are poised to take the next critical step, that of wider implementation and improved accessibility for potential users. However, several issues merit consideration. Family-interventions need to be based on a culturally-informed theory, which incorporates cultural variables of relevance in these countries. While the ideal format for conducting family-interventions is still to be determined, it is quite evident that for such interventions to be useful they need to be simple, inexpensive, needs-based, and tailored to suit the socio-cultural realities of mental health systems in Asian countries. The evidence also suggests that delivery by non-specialist personnel is the best way to ensure that such services reach those who stand to benefit most from these treat-

ments. However, there are several existing challenges to the process of dissemination of family-interventions. The major challenges include the achievement of a critical mass of trained professionals capable of delivering these interventions, and finding innovative solutions to make family-interventions more acceptable to families. If these hurdles are overcome, we could look forward to a genuine collaboration with families, who have always been the mainstay of care for the mentally ill in Asia.

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### INTRODUCTION

Family-based intervention programmes constitute one of the most important advances in the treatment of schizophrenia over the last four decades, or so<sup>[1]</sup>. Moreover, of all the psychosocial interventions found to be useful in schizophrenia, family treatment is the most extensively studied intervention<sup>[2]</sup>. Two recent updates of earlier Cochrane reviews on the subject have reiterated some of the findings of earlier research<sup>[3,4]</sup>. The first, based on a meta-analysis of 53 randomised-controlled trials (RCTs) demonstrated that, compared to routine care, adjunctive family-interventions reduced the frequency of relapse and risk of re-hospitalisation, while encouraging compli-

ance with treatment and improving social functioning<sup>[3]</sup>. The evidence favouring other positive outcomes such as a decrement in symptoms, reduction of caregiver burden, improvements in caregiver-coping, and cost-effectiveness was, however, either minimal or inconsistent. The second update consisted of a meta-analysis of 44 RCTs, which examined the efficacy of psychoeducation added to routine care<sup>[4]</sup>. Psychoeducation also led to a significant reduction in relapse and re-admission rates, and appeared to improve compliance with medication, although the extent of improvement was unclear. The findings further suggested the possibility that psychoeducation had a positive effect on the patient's well being and social function. Both reviews again highlighted the fact that despite the robust evidence favouring family interventions, several methodological problems continue to plague the studies constituting the evidence-base. Apart from these methodological concerns, other existing challenges in this area include determining the critical ingredients of successful family-interventions, implementing these treatments in routine clinical settings, and deciding on the modalities for wider dissemination of such treatments<sup>[1,5,6]</sup>.

Another striking fact revealed by both these reviews was that although much of the earlier research data originated from European and American studies, over the last few years there has been a phenomenal increase in studies from mainland China and Hong Kong<sup>[3,4]</sup>. Sensitivity analyses conducted as a part of these meta-analytic reviews revealed that there was no difference between the quality of Chinese and Western studies<sup>[3,4]</sup>. This suggests that cultural differences are not necessarily an impediment to implementing family-interventions, as has been occasionally found<sup>[7]</sup>. Rather, culturally-adapted (and simplified) family-interventions are as likely to be successful as the original treatments<sup>[2]</sup>. In fact, the Chinese studies have shown more robust effects favouring family-intervention<sup>[3]</sup>, and larger effect sizes than studies from Scandinavia or North America<sup>[8]</sup>, although some of these differences could be attributed to suboptimal care received by control groups in these studies<sup>[2,9]</sup>. Additionally, the Chinese studies have revealed more wide ranging benefits from family-interventions, in terms of positive effects on symptoms, treatment-adherence, social functioning, family burden, relatives' knowledge, attitudes and perception of support, and their sense of self-efficacy<sup>[3]</sup>. Given this overwhelming support for family interventions, the relative lack of similar trials from other Asian countries is somewhat disappointing. However, it is encouraging to note the recent emergence of RCTs of family-interventions from India<sup>[10]</sup>, Iran<sup>[11,12]</sup>, Pakistan<sup>[13]</sup>, Thailand<sup>[14]</sup>, and Malaysia<sup>[15]</sup>. With this accumulating evidence of the efficacy of family-interventions in Asian countries, research in this area is poised to take the next big step, that of implementation of such treatments in actual clinical settings, and efforts to make these treatments available for families in need. However, there are several issues that merit consideration at this critical juncture.

## NEED FOR STRUCTURED FAMILY-INTERVENTIONS IN FAMILY-CENTRIC ASIAN CULTURES

Unlike the West, Asian families have never been excluded from treatment of the mentally ill; rather, they have always functioned as partners in their care<sup>[16,17]</sup>. Indeed, Asian families have been the mainstay of care of the mentally ill for a number of different reasons. Some cross-cultural comparisons have suggested that there are significant differences in the social circumstances of Asian patients and their Western counterparts<sup>[17,18]</sup>. For example, while in the West only about a-third to two-thirds of persons with schizophrenia live with their families (or have regular contact with them), the proportion of patients staying with their families is much higher (over 90%) in countries like India or China<sup>[17-19]</sup>. Moreover, the close knit composition of Asian families also ensures a somewhat greater involvement of families in all aspects of the care of those with mental illness<sup>[18]</sup>. This natural preference of families to be involved in the care of their mentally ill kin is further reinforced by the woefully inadequate mental health infrastructure in most of these countries, which virtually compels families to become sole caregivers of the mentally ill<sup>[18,19]</sup>. These differences have led some authors to question the need for structured family-interventions for Asian patients with schizophrenia and their families. These critics have pointed out that the concept of formal family interventions is a foreign one, based on the notion of expressed emotions (EE), which itself is of doubtful relevance in non-Western cultures. Asian families are already more involved in care, and are generally more tolerant and supportive of the patient, which could account for the better outcome of the disorder observed in this part of the world. Finally, such detractors also contend that structured family interventions are costly, time-consuming and labour-intensive, which makes them unsuitable for Asian countries, where trained personnel and mental-health services are scarce. On the other hand, proponents of the concept argue that although the involvement of families in the patient's care is readily welcomed by professionals, they often fail to appreciate the difficult circumstances in which families get involved in such care. Consequently, professional help and support is less than forthcoming; its absence makes the caregiving experience more burdensome and distressful than it already is. To obviate the negative consequences of caregiving, mental health professionals thus need to forge a genuine collaboration and an equal partnership with families, by providing increased support and help. One way to achieve this objective could be to carry out formal family-interventions, which are culturally congruent, socially appropriate, economical and widely applicable<sup>[16-18]</sup>.

## NEED FOR A CULTURALLY-INFORMED CONCEPTUAL FRAMEWORK FOR FAMILY INTERVENTIONS

The construct of EE and its association with relapse has

played a central role in the evolution of family-interventions for schizophrenia. These interventions were originally developed to employ a number of different strategies to reduce high levels of EE, thereby preventing relapses of schizophrenia<sup>[20]</sup>. Unfortunately, the hypothesis that reduction in EE was the crucial process-variable accounting for the success of family-interventions was not borne out by subsequent research<sup>[21,22]</sup>. The use of the EE typology to identify families in need of help also proved to have distinct disadvantages in clinical and service settings<sup>[23]</sup>. Moreover, family-interventions appeared to be equally effective in both high EE and low EE families. This led to the general consensus that such treatments should not be restricted only to high EE families<sup>[9,23]</sup>. With regard to Asian families, there have always been considerable scepticism about the cross-cultural validity and transfer of the EE model; thus, explanatory theories based on reduction of EE appear to be particularly unsuitable for Asian countries<sup>[18,24]</sup>. Accordingly, alternative theories, which incorporate other elements of family-interventions as potential variables mediating the positive effects of family-interventions among Asian families, need to be examined. Such process-variables could include stress-reduction, attitudinal change among relatives leading to more adaptive appraisals, and improved coping by relatives. Other cultural processes could also be assessed to determine whether they contribute to the usefulness of family-interventions. For example, recent studies have highlighted the central role of certain cultural variables such as familism and filial obligations in the process of caregiving by families<sup>[25]</sup>. Although much of this research has been conducted among caregivers of those with dementia, such cultural constructs could well turn out to be the critical mechanisms in a culturally-informed theory of family-interventions for schizophrenia.

## WHAT SHAPE SHOULD FAMILY INTERVENTIONS TAKE IN ASIAN COUNTRIES?

A variety of family-intervention models and strategies have been developed and empirically tested in the West. Two of the major models are referred to as the behavioural family management model, and the family psychoeducational model<sup>[5,6]</sup>. The former involves education about the illness, as well as structured training in problem-solving and effective communication skills, whereas the latter places emphasis on developing a therapeutic alliance with the family, providing education and ongoing support, teaching techniques to reduce stress, and identifying and intervening early at times of relapse. These strategies have been used as a part of both group and individual treatment programmes. Another set of strategies, referred to as the family education models, consist of brief educational interventions, either led by professionals or peers, which focus on affected family members rather than patients. A subset of the family education model is

the consultation model, in which individual families meet periodically with a professional involved in the patient's treatment, to receive information, advice or support according to their needs<sup>[6,26]</sup>. Although some forms of family intervention have been studied more often than others, there is no compelling evidence to suggest the superiority of any particular approach over others<sup>[3,5,6]</sup>. While most of the Asian studies have employed the psychoeducational model of family intervention<sup>[10,27]</sup>, the efficacy of other approaches including behavioural family management<sup>[28]</sup>, family education programmes<sup>[11]</sup>, consultation models<sup>[29]</sup>, and group treatments<sup>[30,31]</sup>, has also been examined, and these strategies have also proved to be useful. Thus, there is still some uncertainty regarding the most appropriate model of family-intervention for Asian countries. Nevertheless, there is considerable consensus about the other essential features of family-interventions. The evidence clearly indicates that relatively simple and inexpensive forms of these interventions, which place emphasis on ongoing contact and medication compliance while offering emotional and practical support, are more likely to succeed in the Asian context<sup>[10,18,32]</sup>. Finally, family-interventions also have to be tailored to the background and needs of the families, to enhance their acceptability, and positively influence the readiness of families to participate in such interventions<sup>[18,23]</sup>.

## ISSUES RELATING TO DELIVERY OF FAMILY INTERVENTIONS IN ASIA

Despite the strong evidence for the efficacy of family-interventions for schizophrenia, the implementation and dissemination of these treatments has been hindered by complex organisational and attitudinal difficulties, even in countries with well-developed mental health services<sup>[1,6]</sup>. Therefore, this is expected to be an even greater challenge in Asian countries, with their resource limitations and a variety of other social, economic and cultural problems<sup>[33]</sup>. However, some encouragement can be derived from the fact that many of the Asian trials have been carried out in clinical environments more representative of usual care, both in urban and rural areas<sup>[9,27]</sup>. Moreover, they have employed relatively simple formats of family-interventions, have often relied on non-specialist professionals for service-delivery, and have turned out to be cost-effective in many instances<sup>[10,27,34]</sup>. They have thus demonstrated that structured family-interventions can be successfully conducted in "real-world" settings, even when resources for these treatments are limited<sup>[10]</sup>. Nevertheless, quite a few issues regarding training, supervision, cost and delivery of these services, still need to be resolved, and need to be the focus of future research<sup>[10,18,33]</sup>. Indeed, most researchers would agree that unless sufficient numbers of trained and motivated personnel are available to work with families, and unless families find these interventions acceptable, it is unlikely that the benefits of family-interventions will reach those families who require it the most<sup>[18,33]</sup>.

Despite these seemingly formidable potential hurdles,

it would be safe to conclude that the usefulness of family-interventions for schizophrenia among Asian populations has been amply documented. It is for the mental health-care system, and all professionals who are a part of it to use this evidence for the benefit of the suffering patients and their families. It is the responsibility of these professionals to lead the way to a future, in which these interventions could be used to forge a genuine collaboration with patients and families, in order to improve the plight of all those affected by this devastating illness.

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