Case Study: A Structural Model for Schizophrenia and Family Collaboration

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Abstract

This single case study describes a structural therapy perspective applied to a family and examines interaction patterns within the clinical setting and the home; the therapeutic view examines contextual variables that affect an individual diagnosed with schizophrenia, his family, and his recovery. The therapeutic experience of one client diagnosed with schizophrenia and his family is presented. The client's symptoms were tracked using a pre- and posttest from the Sixteen Personality Factor Questionnaire (16 PF) assessment tool over the 15-week treatment period. There was a significant change from pretest to posttest for the following factors: warmth, emotional stability, dominance, liveliness, rule consciousness, vigilance, openness to change, self-reliance, self-control, and tension.

Keywords

stepchildren, schizophrenia, 16 PF, structural family therapy

1 Theoretical and Research Basis for Treatment

Schizophrenia is a debilitating mental disorder affecting 1 in every 100 persons (Nasrallah & Smeltzer, 2002; Seeman, 2009). Families change their entire lifestyle to care for the special needs of the family member diagnosed with schizophrenia (Awad & Voruganti, 2008; Gwynneth, 1994; Seeman, 2009). At onset of the illness, patients and their families feel trapped and powerless in life patterns over which they believe they no longer have control (C. Anderson, Reiss, & Hogarty, 1986). Four out of every 10 persons with schizophrenia will attempt suicide, and 10% to 13% of all individuals with schizophrenia will complete the act (Hobson & Leonard, 2001; Rice, 2006).

Research conducted by Mueser and Gingerich (1994) showed that two thirds of individuals diagnosed with schizophrenia return to live with their families after their first hospitalization. Returning home can be especially challenging for family members who may experience shame and guilt, as schizophrenia can run in families (Dubovsky, 1988). With its genetic component, mothers have been incorrectly identified and labeled as a primary variable in the onset of schizophrenia in their children (Gwynneth, 1994). Although genetic research has been ongoing, the exact nature of the genetic interaction is unclear and lacks a specific recessive or dominant pattern associated with a target gene (Tarrant & Jones, 1999).

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Families often break up because of the stress and frustration of coping with a family member with schizophrenia and the guilt and shame associated with its onset (Schultz & Andreasen, 1999). Professional clinicians working in the field of mental illness have the greatest contact and potential for influencing the family of a stepchild with schizophrenia. Yet, they are the least prepared, academically and experientially, to reduce strain and use family strengths and abilities for addressing specific family and adolescent needs (Drapalski et al., 2008; Torrey, 1995). Most graduate counselor education programs teach a broader scope of information on the diagnosis and treatment of schizophrenia, with very limited material regarding adolescents suffering from this disorder. In addition, when graduate students complete their beginning clinical work on campus, they have little experience working with stepchildren who have been diagnosed with schizophrenia. This is due to the lack of resources available to meet the multiple needs of this population at the university level.

Numerous researchers have explored the specific topic of schizophrenia as it relates to family therapy and stepchildren (Crane, 1996; Goldenberg & Goldenberg, 2008), diagnosis (American Psychiatric Association, 2000; Frangou & Byrne, 2000; Tarrant, & Jones, 1999), definition (Frangou & Byrne, 2000; Iancu, Dannon, Ziv, & Lepkifker, 2002), etiology (Nasrallah & Smeltzer, 2002), quality of life (R. Anderson & Lewis, 2000), and treatment (Beck & Rector, 2000; Bower, 2001; Razali, Hasanah, Khan, & Subramaniam, 2000; Srinivasan, Rajkumar, & Padmavathi, 2001). Limited research has been conducted exploring the specific impact that family members in therapy have on the improvement of the adolescent client diagnosed with schizophrenia (Leff, Sharpley, Chisholm, Bell, & Gamble, 2001; Teschinsky, 2000; Wuerker, 2000).

Hall and Docherty (2000) looked at the link between parent coping styles and schizophrenic patient behavior, involving in-depth interviews with 24 adult individuals with schizophrenia and their parents. He reported that assertive parents who have aggressive offspring may be critical as a reaction to their offspring's behavior. Others (Woo, Goldstein, & Nuechterlein, 2004) argued that patients diagnosed with schizophrenia, who have relatives with high expressed emotion, have been found to recount more negative and stressful memories of their relatives than patients with low expressed emotion relatives. They propose that this stress might then precipitate the emergence of overt clinical psychiatric symptoms.

Goldstein and Miklowitz (1995) examined two generations of studies (psychoeducational family treatment and more complex experimental designs) investigating the efficacy of family therapy approaches in the treatment of schizophrenic disorders. The first generation compared clinical effectiveness of psychoeducational family therapy with medication to medication alone and contended that family intervention plus medication is superior over medication alone in delaying psychotic relapse. The second generation of studies used more detailed experimental designs that diminished the differences between the comparison conditions and experimental treatment, and predicted that the effectiveness of family therapy as an adjunct to medication in schizophrenia is related to treatment setting and type, and format of the family intervention.

Goldenberg and Goldenberg (2008) explored the importance of family therapy and working with stepchildren diagnosed with schizophrenia. They present the views of Salvador Minuchin who identified symptomatic behavior as a reaction to a family under stress and unable to accommodate to changing circumstances, as in the case of a stepchild with schizophrenia. In this view, all family members are equally symptomatic despite efforts by the family to locate the problem as residing in one family member. Change calls for the therapist to understand the family context in which the dysfunctional transactions transpire and then to attempt with family members as a group to change that existing context to permit new interactional possibilities to emerge.

Much of the family psychoeducation approach was derived from structural family therapy with emphasis on joining the therapist's style and agenda to that of the family, and enhancing

the boundaries within the family (McFarlane, Dixon, Lukens, & Lucksted, 2003). The authors report that boundaries are necessary to create barriers to stimulation because of the sensitivity to stimulation and cognitive disability, which are biological foundations of schizophrenia.

Structural family therapy was developed by Salvador Minuchin during the 1960s and continues to evolve in response to challenges mounting from within the systemic field and practitioners ever mindful of the need for regular feedback from family members. Structural family therapy is primarily a way of thinking about and operating in three related areas: (a) the family, (b) the presenting problem, and (c) the process of change (Munuchin, Lee, & Simon, 1996). The goal of therapy is the restructuring of the family's system of transactional rules, such that the interactional reality of the family becomes more flexible, with an expanded availability of alternative ways of dealing with each other. Such restructuralization enables the system to mobilize its underused resources and to improve its ability to cope with stress and conflict (Vetere, 2001).

The family presented in this study was picked at random and does not represent the stereotypic, dominant mother/passive father family that has been presented in the literature for decades. Although this case study only reflects the author's views and experiences in working therapeutically with one family, it is hoped that it will help professional clinicians become more knowledgeable and skillful in addressing the unique needs of this client population through a holistic approach.

Advantages of using the single case study here is that it brings to the reader an understanding of complex issue of implementing structural family therapy with a family and his or her son diagnosed with schizophrenia. This approach will extend the research experience and add strength to what is already known, as research has not addressed the step-by-step application of the structural family therapy in the clinical setting.

2 Case Introduction

Paul is a 17-year-old White boy, who presented for treatment of schizophrenia. He came to our specialized outpatient treatment clinic at the urging of his psychiatrist and his parents who were concerned about his behavior. Paul reported previous inpatient treatment at a local psychiatric hospital in the Midwest, at the age of 16. He reported that his symptoms were increasingly debilitating and negatively impacting his personal relationship with his parents, particularly his stepfather. He had been diagnosed with undifferentiated schizophrenia (295.90), and his global assessment of relational functioning was 60.

3 Presenting Complaints

Paul's self-reported symptoms were also observed by his parents and are consistent with a diagnosis of schizophrenia. He experienced lack of pleasure and interest throughout each day, and severe difficulty empathizing with other people's feelings. He had periods of withdrawal and isolation in his room during the week, right after school, and the majority of the day during the weekends. He also reported ongoing suspiciousness and distorted perceptions. Paul's symptoms have been consistent and have encompassed his daily life for years. For example, he was preoccupied with oversleeping and running late to school, and feeling severely stressed that he would start hearing voices again that tell him to hurt himself. He reported that he had struggled with delusions since his sophomore year of high school.

Paul reported difficulty in forming meaningful relationships with parents and peers. Due to his medication, he had a low libido and had no interest in a romantic relationship. He also described

feeling powerless over handling his own affairs and had difficulty trusting that his parents would not commit him to a hospital again. He had difficulty expressing his feelings and would act out as a bid for attention.

4 History

The client's family is composed of mother (Sue), 35 years old; stepfather (Jack), 48 years old; and Paul, 18 years old. On the telephone, the mother reported that Paul is very aggressive, throws things, and yells for no apparent motive. Historically, Paul grew up as an only child in a family with his mother and stepfather, in a middle-class, rural community. He excelled in school and participated in sports and Boy Scouts until he began hearing voices at age 13. He refused to attend school reporting that he was concerned that his teachers were "out to get him" and that there was a plot to discredit him around his peers. He stopped bathing, brushing his teeth, and failed to show any emotional expressions when around his parents. He became impulsive and took action without thinking about the consequences. He reports being arrested for hitting a pizza delivery boy on the head with a frying pan because voices instructed him to steal the delivery boy's pizzas and his car. After this incident, Paul was committed by his parents to a psychiatric hospital for 6 weeks and monitored on the antipsychotic medication Risperdal 75 mg. After returning home, he experienced diminished ability to experience pleasure, which resulted in him becoming more defiant and distant. The ensuing negative impact on his relationship with his parents was significant.

Paul's mother reported that her son thinks she needs therapy, not he; that it is his life and he can do what he wants alone, without the help of doctors; that doctors do not understand or help; that it is not his fault; and that others or circumstances are to blame. His stepfather related that Paul's ambition is to be a rock star and that he is very self-centered and puts a lot of demands on his mother. As a child, Paul was very demanding in getting his needs met, and Paul's mother would sacrifice her own needs for the needs of her son. Mother dedicated the majority of her time to Paul as a way to keep him close and safe. The stepfather reported that he resents his wife for babying her son and sees her as "incapable of letting her son grow up." Paul's stepfather disengaged by isolating himself at home physically and emotionally and avoiding interaction with both Paul and his mother, due to feelings of frustration and powerlessness.

Many of the symptoms described in this case study are consistent with *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association; 2000) criteria. Paul demonstrates at least two *characteristic symptoms*, including delusions (e.g., his beliefs about his teachers) and negative symptoms (e.g., poor personal hygiene and flat facial expression). He experienced clear impairments in social and academic functioning at the time of the diagnosis; he was no longer able to care for himself or to go to school. Duration criteria of the diagnosis were met because these difficulties lasted longer than 6 months. In addition, other diagnoses were ruled out (e.g., mood disorders, substance abuse, and developmental disorders).

5 Assessment

Clinical Interview

A structured clinical interview from the *DSM-IV-TR* was conducted with the client, and his parents designed to provide detailed coverage of Axis I disorders, shown as a valid and reliable measure of mental health disorders (Zanarini, Skodol, Bender, et al., 2000). Treatment phase consisted of 4 months of once weekly family therapy for 15 sessions.

Table 1. Sixteen Personality Factor Questionnaire Pretest Sten Scores

Factor descriptor	Pretest sten score
A: Warmth	6
B: Reasoning	8
C: Emotional stability	5
E: Dominance	8
F: Liveliness	10
G: Rule consciousness	7
H: Social boldness	9
I: Sensitivity	3
L: Vigilance	6
M: Abstractedness	4
N: Privateness	7
O: Apprehension	6
Q1: Openness to change	4
Q2: Self-reliance	2
Q3: Perfectionism	4
Q4: Tension	9
EX: Extraversion	7
AX: Anxiety	7
TM: Tough mindedness	9
IN: Independence	7
SC: Self-control	2

Sixteen Personality Factor Questionnaire (16 PF)

The 16 PF (5th ed.) is a 185 question comprehensive measure of 16 personality factors and 5 global factors found to be effective in a variety of settings in which an in-depth assessment of the whole person is needed. The primary and global levels of the 16 PF traits combine to provide a comprehensive, in-depth understanding of an individual's personality. The 16 PF is based on a large amount of research both in the construction of the instrument and in the examination of its reliability and validity. Test–retest reliability coefficients over short periods tend to range from .60 to .85 (Hood & Johnson, 2007).

Separate-sex and combined-sex norms are offered for high school juniors and seniors. Scores are provided in terms of "stens" standard scores with a mean of 5.5 and a standard deviation of 2.0. Scores below 4 (10th percentile) are deemed low and scores above 7 (90th percentile) are considered high. Because the scales are bipolar, both high and low scores can be interpreted as reflecting a particular characteristic. Three different validity scales have been developed: one to identify random responding, one to discover faking-good responses, and a third to predict attempts to give a bad impression. Additional adaptations and computer-generated interpretations of the 16 PF have been published and endorsed for use in marriage counseling with adolescents and mental illness (Cattell & Schuerger, 2003). Following the initial interview, Paul completed the pretest 16 PF in 48 min (Table 1; Russell & Karol, 1994).

6 Case Conceptualization

An inspection of the 16 PF reveals that Paul has high free-floating anxiety (tension) with a score of 9 coupled with marked impulsivity and immaturity, as indicated by a liveliness (F) score of 10. In addition to the high anxiety, other indicators were unusual: self-control (SC)

was 2, vigilance (L) was 9, and rule consciousness (G) was 2. He is a highly dominant and aggressive person as well as a high risk taker. Particularly troublesome was his low score of 2 on affiliation (Q2). Someone who requires a lot of interaction with others to gratify his dependency needs often does not work out well in individual therapy. In addition, low Q2 scores generally imply poor follow through. We must also be sensitive about his marked impulsivity (liveliness = 10) and the aggressiveness (dominance = 8) that he demonstrates. These suggest that he might be prone to act out his conflicts in critical situations when under stress, clearly not a good characteristic in someone involved in a group setting with family members.

I concluded, therefore, that Paul was conceptualized as developmentally delayed, struggling to regain his natural progression into independent, autonomous adolescence. I guessed that he might have a chance at improvement, provided that he was willing to actively participate in family therapy. My experience with many clients over the years is that adolescent males who have low sensitivity (3) and abstractedness (4) as well as high social boldness (9) tend to avoid seeking professional help for their problems because they consider such measures as revealing weakness in their self, which is alien to their values and their attempts to appear competent. There was enough ego strength, having a positive understanding about who Paul is and what are his capabilities, as reflected in his emotional stability score of 5 and intelligence to make him an effective group participant. He was a young adolescent with marked intellectual skills and was following a strategic path to successful achievement (reasoning = 8). Family therapy would need to move in the direction of teaching him and his family intervention strategies, including open communication between family members, concentration on stresses and problems, and clear and concise restructuring of boundaries to help Paul develop more effective life-coping mechanisms, particularly with regard to greater self-control and restraint.

7 Course of Treatment and Assessment of Progress

Paul, his mother, and stepfather participated in once weekly family therapy sessions for 4 months, for a total of 15 sessions. All sessions incorporated a structural family therapy perspective and lasted 60 min. The initial objective of therapy was to establish a safe space for family members as well as to develop a positive therapeutic alliance. The therapeutic relationship was designed to provide Paul with a safe place to experiment with new interpersonal behaviors around his parents and to explore his view of self, others, and the world. His ability to feel safe and secure in the therapeutic relationship provided an alternative to the earlier feelings of alienation and powerlessness. First, the therapist role was to present family problems into a subject context. Second, educate family members on the therapy model and rationale for treatment. Third, point out dysfunctional family thinking, behavior, and member triangulation. Fourth, observe who accepts responsibility for problems and/or solutions and who is powerful and powerless. Fifth, redirect the power and shape competent behavior of the weaker members. Sixth, engage family members in communicating feelings and set healthy boundaries. Finally, activate and monitor the family process of teamwork. The following excerpts can only offer a flavor of the complexity of the family work that took place.

The first session consisted of the initial assessment, including a genogram of the family and education, and observing family patterns of behavior. This session ended with Paul completing the 16 PF pretest. During the family interview, one of the first things that took place was joining in the therapeutic relationship. The family therapist matched the posture, tone of voice, actions, and interactions of family members, while following and tracking their interactions with each other as appropriate. Following joining and accommodating, the most central piece in the operational behavior of the structuralist therapist was the enactment. The primary purpose of enactment

is to observe certain behaviors so that certain sequences become clear to the therapist for problem identification.

The family therapist placed the family's presenting problem into a subjective context that identified the inner experiences of Paul and his family within the context to shape member competency. This way, any changes that take place in the context will affect the subjective experiences of the family system and the individuals in the system. The next three sessions focused on education during which the therapist explained the strategic family therapy model and the rationale for treatment. The family therapy model was discussed in terms of the family's most common irrational beliefs, interpretations, and behaviors. Shortly into the interaction with this family, certain patterns emerged. One thing that was observed was the level of enmeshment occurring within the family system between the mother and Paul.

The therapist provided the client and his family opportunities to interact to observe firsthand the family system and its dynamics. There was enmeshment between mother and son with stepfather fairly disengaged at the working phase. There was also an emotional coalition: mother and son against stepfather. Soon that enmeshment intensified to the point where there was conflict between mother and son; the coalition was damaged, and at that point, the stepfather was drawn in to intervene, leading to parental tension that diverted them around the conflict regarding their son. Often the son tried to distract his parents by interrupting and challenging the mother. With mother being somewhat incompetent in handling son, stepfather would then become overcompetent and overly responsible regarding the problem.

The parents became so focused on the problems of Paul that they lost track of what was really going on in the family system. The spousal subsystem was buried, not a system in which stepfather and mother, husband and wife could spend time together or could talk to each other about other important issues. Person-to-person contact in the spousal subsystem was minimized and limited, and the parents did not see many options. The parental subsystem was activated in the session but would become detoured around the son's schizophrenia, causing the parental subsystem to crack and become useless in making important decisions.

As a result, stepfather was drawn in and given executive power during the following three sessions. This left mother looking incompetent in her role as mother and even less so in her role as spouse. Having joined the family and having observed the interaction sequences, the therapist then elected to have mother and son talk to each other, predicting (in the therapist's head) that father would interrupt and try to set son straight. Having the interaction go as normally as it would in the beginning, the next time around the family therapist blocked father and had him simply observe to show mother's competence. This is one of the key components of structural family therapy called shaping competence according to capability, rather than focusing on incompetence. It continued long enough to show stepfather and to prove to mother and son that they can accomplish something together.

During Session 8 through 10, stepfather and mother were prompted to engage to activate the parental subsystem as preparation for activating the spousal subsystem. Conducting spatial restructuring was the focus of these sessions. The family therapist began to influence the particular pattern by exploring alternative pathways and building flexibility within the family system; the therapist began to focus on a particular theme. Spatial restructuring was initiated by asking stepfather to move closer to mother, and the therapist instructed the son to be close to him so the therapist had some control over engaging him. The therapist was also able to tone down the son's anxiety as mother and father started to talk and, when necessary, support the son when he did not interfere with the parent interaction.

The therapist invited Paul verbally to watch as father and mother were involved in the engagement process. Predictably, there was conflict and disagreement, and an inability to arrive at a productive level of interaction in the parental dyad. As expected, the son would interrupt. At that

point, the therapist swiftly intervened, blocking the son and inviting him once again to watch and listen as father and mother engage. After a few minutes, the therapist challenged the hierarchy and challenged the members of the spousal subsystem to become aware of the interactions taking place within the session. Paul was invited to self-disclose what he observed during the parent interaction and share ideas on how his parents could strengthen their communication. He reported clear boundary issues that were interfering with his parent's ability to work as a team such as parents using *you* statements instead of *I* statements.

The focus of these sessions was to challenge family power. The family therapist asked a series of questions while promoting a sense of intensity to bring the experience to bear right there in the therapy room; using repetition, focusing, and changing affect to intensify the experience so that the members of the system could hear it, see it, and feel it. It is critical that family challenging never take place before the therapeutic alliance has been established. Having convinced himself that he had established trust with stepfather, during the next three sessions the therapist proceeded to challenge the father on the way he talked at his wife and Paul.

The mother was challenged to assume more power, more character, and more of a sense of emotional honesty and ownership. It became obvious, when the therapist backed off, that mother became much more competent in her tone of voice and posturing, whereas father toned down verbally, allowing for a more productive interaction. The therapist took the occasion to do a little bit of cognitive restructuring, reframing, and a little teaching. The son was asked to accept more responsibility for his behavior, to be more involved with his peers, and to trust that his parents could handle certain things in their lives. He was able to share with his stepfather the feelings underlying his anger, including feelings of rejection, disappointment, hurt, loneliness, and feeling unloved. Father also shared his underlying feelings, including love for his son and past fears that Paul's anger and impulsive behavior would drive a wedge between him and his wife as well as interfere with Paul's success in school and life.

During the last two sessions, the goal was to activate and monitor the team process. This one helped carve out new pathways and realign less useful ways of performing tasks in the family. The parents and Paul were challenged to throw out some ideas to help reactivate the family system and shared that it would be good for their son to observe them working as a team at first and then engaging with them as a cooperative member of the team. The stepfather was identified as a key member of the household team and encouraged to initiate spousal interaction by going out of the home alone or simply initiating open interaction with Paul and his mother while respecting each other's boundaries. The family was encouraged to continue to experience new insight and perspective on how best to work with their son, through supporting the family system they had now had experienced as a team.

Assessment of Progress

Paul completed the posttest in 45 min the week following the 15 family therapy sessions. Stem score differences between the 16 PF pre- and posttest are reported in Table 2.

There was a significant change from pretest to posttest for the following personality factors: warmth, emotional stability, dominance, liveliness, rule consciousness, vigilance, openness to change, self-reliance, self-control, and tension. This was supported in the sessions with therapist observation and family member self-disclosures and behavior. Paul became more comfortable and less stressed in situations in which the close relationships he was seeking were less accessible. Paul still felt that his emotional needs were not being satisfied, but he reported that he was going to bed feeling better about how his day had turned out. He had also taken more responsibility for starting school tasks and completing them. He was less critical of his parents and was sharing his views with his parents in a more humorous manner. In addition, he was acting more

Table 2. Sixteen Personality Factor Questionnaire Pre- and Posttest Sten Score Differences

Factor	Pretest sten score	Posttest sten score	Difference
A: Warmth	6	7	+1
B: Reasoning	8	8	0
C: Emotional stability	5	7	+2
E: Dominance	8	7	−1
F: Liveliness	10	9	−1
G: Rule consciousness	7	8	+1
H: Social boldness	9	9	0
I: Sensitivity	3	3	0
L: Vigilance	6	5	−1
M: Abstractedness	4	4	0
N: Privateness	7	7	0
O: Apprehension	6	6	0
Q1: Openness to change	4	5	1
Q2: Self-reliance	2	3	1
Q3: Perfectionism	4	4	0
Q4: Tension	9	7	−2
EX: Extraversion	7	7	0
AX: Anxiety	7	7	0
TM: Tough mindedness	9	9	0
IN: Independence	7	7	0
SC: Self-control	2	3	+1

mature by using "I statements" when expressing his needs with his parents. Although he still had difficulty following strict rules, he was starting to ask questions about the benefits and consequences of following specific rules that would impact his perception of personal freedom. His trust toward his parents was improving in regard to his past fear that he would have no say over future mental health decisions. He was reassured by both parents that he would be involved in all decisions regarding his mental health care and recovery.

8 Complicating Factors

The most complicating factor in Paul's treatment was his ambivalence in taking his medication. This is a common barrier for many adolescents diagnosed with schizophrenia disorders, particularly undifferentiated schizophrenia, and often results in premature treatment termination. Despite clear impairment caused by his disorder, Paul was reluctant in taking his medication. Without switching to Risperdal Consta IM every 14 days, it is unclear whether Paul would have had the treatment adherence that he demonstrated.

9 Follow-Up

The client did complete follow-up measures at the local Community Alliance day program and Work Force Development to help him select a low stress job on graduation from high school.

10 Treatment Implications of the Case

Over the 4-month family therapy period, Paul significantly increased his ability to communicate more effectively with his parents without getting guarded and defensive. He was able to accept

influence from both his parents during weekly family meetings. Paul used more repair attempts in place of bids for attention. An area that Paul struggled with was practicing empathic responses with his parents, due to his long history of emotional disengagements to avoid rejection. Paul was willing to look at ways that he increases and decreases his emotional bank account and ways to avoid being emotionally bankrupt around his relationships.

11 Recommendations to Clinicians and Students

Working with families in a therapeutic setting is within the scope of practice for licensed marriage and family therapists, psychiatrists, psychologists, professional counselors, and social workers. This case study illustrates that stepadolescents diagnosed with schizophrenia are often able to lead rewarding and productive lives, usually with the help of pharmacological and family therapy, as well as social support, despite continued symptoms and impairments from the illness. The professional and the family system share the roles and responsibilities in the following ways:

1. Provide a relaxing therapeutic environment with gentle, straightforward questioning to promote a trusting relationship as soon as possible.
2. Provide educational material for family members in which information is provided and questions are answered with the schizophrenic family member present.
3. Expect the client to be suspicious of professionals who, in the past, may have initiated the process for commitment to a psychiatric facility.
4. During the initial interview of the client and the family, elicit a thorough history of possible precipitating events, including infection, trauma, and exposure to toxins and other substances.
5. When appropriate, offer all family members education about blended families, stepparenting, mental illness, family support crisis intervention, and problem-solving skills training.
6. Employ the most appropriate family systems approach to meet the diverse needs of the stepchildren and family. Select a family therapy that assesses the level of disengagement between the client and family member.
7. Developing reliable and practical goals in cooperation with the stepchildren and family will help the family unit become more successful in coping with unforeseen crises.
8. Be aware of the deep emotions that affect blended families of schizophrenic stepchildren and reassure family members that these feelings are normal.
9. If the client is on medication, work closely with the patient's physician (psychiatrist) to help in the monitoring of pharmacotherapy.
10. Stay actively involved with family members, friends, and extended social network to measure the social outcomes, quality of living, recreation, diet, volunteer, and/or employment success to reduce relapse episodes.

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Bio

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