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Research article

Brief Solution-Focused Therapy in schizophrenia: A preliminary study of family characteristics and psychopathology

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ABSTRACT

Family therapy for schizophrenia has been demonstrated to be effective and is recommended by international clinical guidelines. Reviews of family therapy research conclude that interventions may prevent relapse of the disease, when symptoms are already reduced under psychotropic medication, by reducing family factors associated with relapse. The purpose of this study was to examine the effectiveness of Brief Solution Focused Therapy (BSFT) in patients with schizophrenia focusing on the impact of change in family characteristics such as cohesion, conflict, organization, and control on patients' psychopathology measured with BPRS. Thirty patients diagnosed with schizophrenia were randomly assigned to the control or intervention group. The intervention group received treatment according to the BSFT model, whereas the control group received the standard care for schizophrenia. The BSFT is a future–oriented psychotherapy model which encourages clients to focus on ''change-talking'' instead of ''problem-talking'' and on instances where a successful solution has been achieved. The intervention consisted of 5 sessions delivered in 3 months. The main outcomes were patient-rated family characteristics measured by the Family Environment Scale (FES), and psychiatrist-rated symptom severity measured with the Brief Psychiatric Rating Scale (BPRS). The two groups did not differ in terms of age, sex, number of relapses, previous hospital admissions, and BPRS score at baseline. At the end of treatment compared to baseline there was a reduction of the BPRS score in the intervention group ($p<0.001$) whereas no statistically significant changes were noticed in the control group after 3 months. Also, following treatment, patients in the intervention group displayed reduced scores on the Conflict FES scale ($p=0.001$) accompanied by increased scores on the Cohesion ($p=0.004$), Expressiveness ($p=0.004$), and Active Recreational subscales ($p=0.001$) according to patient's perspective. These preliminary findings suggest that BSFT in patients with schizophrenia appears to be effective in altering the global properties of the whole family system, specifically cohesion, conflict, organization, and control which, in turn, have an impact on reducing patient psychopathology.

KEYWORDS: Brief solution-focused family therapy, schizophrenia, family intervention.

Introduction

Schizophrenia is a severe mental disorder with a significant impact on patient's level of functioning and a severe burden on their families. It is estimated that 50–80% of patients with schizophrenia in Western countries are in close contact with their relatives.[1]

Previous literature has revealed that families of patients with schizophrenia may share common characteristics, mainly conflict, and aggression among its members.[2,3] The parents have difficulty agreeing as a couple[4] and expressing conflicting messages to the patient.[5] The core of "expressed emotion", criticism, hostility, and

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emotional involvement,[6–8] create a negative, stressful emotional climate, which may precipitate clinical relapses.[9,10] It is well established that the quality of the family environment is an important factor that affects patient symptomatology.[11–14] Conflictual family environments are strongly related to greater symptom severity,[15,16] while the way the patients perceive their family environment and poor quality of relationships may lead to increases in symptom severity, and/or hospitalization.[17,18]

Treatment of schizophrenia, in addition to psychotropic medications and psychosocial interventions, also includes family therapy programs. There is evidence that family psychoeducational programs,[19] behavioral family interventions,[20] family crisis intervention models,[21,22] and systemic family therapy, may help to prevent clinical relapses in patients whose psychopathology is already partially remitted through pharmacotherapy.[23] However, few studies in the past have examined the perception of patients with schizophrenia of their family environment and its characteristics.[24] Under a systemic point of view, intervening in a patient's perception of the family characteristics and relationships can alter the way the patient relates to the family, the way that family members relate to the patient, the characteristics of the family as a whole, the behavior of the patient and finally on symptom severity.

Brief Solution Focused Therapy (BSFT) is a systemic approach that has been developed in the 1980s by Steve de Shazer and Insoo Kim Berg. It is a brief therapeutic approach according to which, language is the means to understanding and shaping reality.[25] If someone changes his/her language from ''problem-talking'' to ''change-talking'', the reality will also change.[26] While it is very important to set a realistic goal, it is also important for the therapist to have a good description of what kind of life the patients can expect after they reach their goal".[27]

Therapists hold a positive, respectful, and hopeful stance and usually give feedback, such as compliments and homework suggestions, which focus on directing clients towards "those aspects of their experiences and situations that are most useful in finding solutions and reaching their goals".[27] BSFT encourages clients to continue with other therapies that are helpful, for example, to continue to take the prescribed medication or to stay in group therapy or even to start family therapy.[28] Additionally, it encourages people to highlight instances of success in the past and future and encourages them to focus on a solution and creating change.

To our knowledge, studies examining the effect of BSFT on psychopathology and family characteristics of patients with schizophrenia based on patients' own perceptions are very limited and include very small samples. A case report as well as a larger (more patients) study of patients with schizophrenia, found some effectiveness in terms of distress levels, and also in encouraging patients to seek information regarding their illness, to seek social support, and eventually in enhancing their capacity to cope with the illness.[26,29]

The main objective of the present study is to assess the effectiveness of BSFT on (1) improving global family characteristics, i.e., level of conflicts, family cohesion, organization, independence, and control, and (2) reducing psychopathology measured with the Brief Psychiatric Rating Scale in patients with schizophrenia. The primary hypothesis is that BSFT will significantly impact patients' perceptions of the global properties of their family, the way they relate with other family members, and, eventually, symptom severity.

Material and Method

Sixty-one patients were invited to participate in the study. The majority of patients had been hospitalized at the Psychiatric Clinic of the University Hospital of Heraklion – Crete, with a diagnosis of schizophrenia. Eligible patients had to be in a stable mental state during the last trimester, i.e., no relapse or hospitalization and no major changes in pharmacological treatment (as confirmed by the treating psychiatrist), in order to be able to evaluate the additional effect of the BSFT intervention on pharmacotherapy. Also, they had to be under regular psychiatric care, speak Greek fluently, and demonstrate adequate reading comprehension capacity to complete the research tools and consent to participate in the study. Thirty patients agreed to participate in the study and were randomly assigned to the Intervention and Control groups. The study protocol was approved by the University Hospital Research Ethics Committee and all patients provided written consent. Their clinical and sociodemographic characteristics are presented in table 1.

The Family Environment Scale (FES)[30] was used to assess the global properties of the family system as the patient perceives them and is a widely used instrument in the field of family environment research.[31–33] This self-report instrument consists of 90 true or false statements that measure 10 family functioning characteristics (Cohesion, Expressiveness, Conflict, Independence, Achievement Orientation, Intellectual-Cultural Orientation, Active-Recreational Orientation, Moral-Religious Emphasis, and Organization and Control.[34] Conceptually these characteristics relate to three global dimensions: (1) Relationships (the degree to which family members are perceived to be involved with each other and how openly positive and negative feelings are expressed), (2)

Table 1. Clinical and sociodemographic characteristics by study group.

	Intervention Group	Control Group
Sex		
Women	8 (46.7%)	4 (26.7%)
Men	7 (52.3%)	11 (73.3%)
Age (mean [SD] in years)	46.8 (6.9)	47.7 (8.4)
Marital Status		
Single	12 (80%)	11 (73.3%)
Married	2 (13.4%)	2 (13.4%)
Divorced	1 (6.3%)	2 (13.4%)
Illness duration (mean [SD] in years)	20.13	21.9
Educational level		
Primary	3 (20%)	7 (46.6%)
Secondary	6 (40%)	7 (46.6%)
University	6 (40%)	1 (6.3%)
Hospitalizations		
0–1	3 (20%)	1 (6.3%)
2–5	9 (60%)	7 (46.6%)
6–10	3 (20%)	7 (46.6%)
Current status		
Inpatient	7 (46.6%)	7 (46.6%)
Outpatient	8 (53.4%)	8 (53.4%)
Medication		
Per os	8 (53.4%)	6 (40%)
Per os & Depot	7 (46.6%)	9 (60%)
History of suicide attempts	2 (13.4%)	3 (20%)

Personal Growth (the family of origin's goal orientation or ways the family of origin encourages or inhibits an individual's personal growth), and (3) System Maintenance dimensions (the degree to which the family emphasizes clear organization, control, structure, rules, and procedures in running family life).

Schizophrenia symptom severity (positive, negative, and affective symptoms) was assessed using the Brief Psychiatric Rating Scale (BPRS).[35] The BPRS consists of 18 symptom constructs, rated by a mental health professional during a 20–30-minute interview on a 1-(not present) to 7-point (extremely severe). Both scales were completed for all patients twice: first, before the intervention for the intervention group and upon enrollment in the study for the control group (Time 1), and again immediately following the intervention (Time 2).

Following their psychiatrist's referral, the patients were informed about the purpose of the study and they signed a consent form for their participation. The control group received the usual medical treatment, namely a visit to their psychiatrist once monthly or bimonthly, primarily focused on the assessment of their pharmaceutical treatment. Patients in the intervention group received the systemic intervention consisting of 5 sessions over three months (one every fifteen days), in addition to the usual medical care. The pharmaceutical treatment for both groups was administered by psychiatrists who did not participate in the research project in any way. There were no dropouts within the intervention group or the control group (see figure 1).

Intervention model

The first session: According to BSFT, in the first session special attention was paid to defining the therapeutic goal which had to be limited and clear,[27] described in detail and in behavioral terms, be realistic and useful for the patient, and focus on the presence or the development of something rather than on the absence of something. In order to define the goal, six kinds of questions are asked.

- Questions about pre-session change (ex: "between the time I called you and today, what is it that is a little bit better?")
- Miracle questions (it gives a patient the opportunity to describe what he/she wants from therapy (e.g., "suppose that you are asleep and a miracle happens that solves the problem which brought you here (pause). When you wake up you don't know that the miracle has happened… (pause). What would be different telling you that a miracle has taken place?")
- Expanding the exceptions (e.g., "what part of the miracle is already happening?")

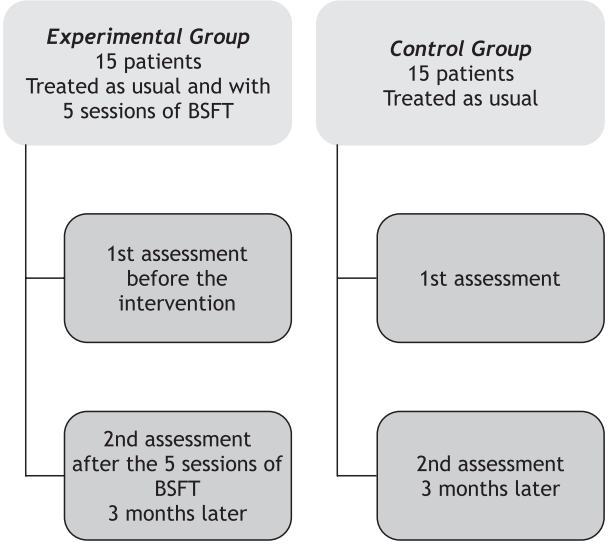

Figure 1. Experimental design.

- Scaling Questions (patients are asked to place themselves on a scale where 0 is the least desired condition, and 10 is the most desired outcome)
- Identifying the change (patients are asked how will they and their environment know that a one-point change will have occurred)
- Coping questions are made when a patient has difficulty shifting into a solution-building context, e.g., "Given all that you say is happening in your life, what do you do to just make it through each day?").

By asking these kinds of questions the therapist keeps the focus on effective solutions so the patient begins to identify them.

Subsequent sessions: at the end of each session, the next session is scheduled, giving patients the chance to choose to wait 2 or 3 weeks. Each session usually begins with the question "What is better?", to assess their current state and plan the next steps. At the end of each session the therapist praises everyone and provides further encouragement with phrases such as 'Do more of what is working already' or 'It is time to try something different' helps to maintain change after the session.

Data analysis

Preliminary analyses compared the two groups on demographic and clinical characteristics using ANOVAs for continuous variables and the chi-square test of independence for categorical variables. The first research question was assessed through two-way mixed ANOVAs on each of the 10 FES subscale scores and BPRS scores with the group as a between-subjects variable and time (Time 1, Time 2) as the within-subjects variable. The significance level was set at $\alpha=0.05/11=0.0045$ (Bonferroni-adjusted for 11 tests). The second research question evaluates the association (linear and/or quadratic) between change in BPRS score (Time 2 minus Time 1) and corresponding changes on each of the FES subscale scores (intervention group only). Additional analyses assessed the association (linear and/or quadratic) between family characteristics at Time 1 and intervention-related change in psychosis symptoms.

Results

Preliminary analyses

The two groups were comparable in age ($p=0.7$), illness duration ($p=0.6$), sex ($p=0.2$), marital status ($p=0.8$), number of hospital admissions ($p=0.2$), and the BPRS score at baseline ($p=0.15$). Moreover, none of the intervention and control group patients required hospitalization or attempted suicide during the project or required a substantial change in the type or dose of the psychotropic medication.

Impact of intervention

Significant interactions between Time and Group were found on 4 FES subscales: cohesion/expressiveness ($F[1,28]=11.28$, $p=0.002$), conflict ($F[1,28]=38.60$, $p<0.001$), organization ($F[1,28]=10.52$, $p=0.003$), and control ($F[1,28]=9.34$, $p=0.005$) and on BPRS score ($F[1,28]=93.11$, $p<0.001$). As shown in table 2, posthoc comparisons (at Bonferroni-adjusted $a=0.05/11=0.004$) confirmed that the two groups did not differ at Time 1 ($p>0.2$) with the exception of a marginally significant trend for higher scores in the Intervention group on the Conflict ($p=0.075$) and Active-Recreational Orientation subscales ($p=0.03$). Corresponding comparisons between groups at Time 2 revealed that the Intervention Group scored higher than the Control Group on Cohesion ($p=0.004$) and Active Recreational Dimension ($p=0.001$) and lower on the Conflict FES subscale ($p=0.001$) and BPRS ($p<0.001$).

Importantly, the Intervention Group scored lower at post- as compared to pre-intervention in the Conflict subscale ($p<0.001$; Cohen's $d=3.0$), whereas considerable, marginally significant changes were also found in the Cohesion ($p=0.01$; Cohen's $d= 0.8$), Active Recreational Dimension ($p=0.05$; Cohen's $d=0.44$), organization ($p=0.01$; Cohen's $d=0.63$), and Control subscales ($p=0.015$; Cohen's $d=0.5$). In addition, the Intervention Group scored lower on the BPRS ($p<0.001$; Cohen's $d= 3.3$) after the 5 sessions. In contrast in the control group, during the same time interval, FES and BPRS scores did not change at a statistically significant level ($p>0.09$ in all cases).

Predictors of response to intervention

Correlational analyses failed to reveal significant associations between the degree of reduction in BPRS score and clinical (illness duration, number of relapses prior to intervention) or family function characteristics ($r<0.32$, $p>0.2$). There was, however, a large-size, negative correlation between Intellectual Cultural Orientation subscale scores at Time 1 and the magnitude of symptom reduction between Time 1 and Time 2 ($r=-0.611$, $p=0.015$) and a modest-size positive correlation between the Conflict subscale score at Time 1 and BPRS reduction ($r=0.413$).

Discussion

This preliminary study investigated the efficacy of BSFT in patients with schizophrenia combined with medication, a topic that has received little systematic research.[36] The main finding of the study suggests

Table 2. Scores of the Intervention and Control groups on BPRS and each of the 10 FES subscales at Time 1 and Time 2

	Time 1		Time2		P values			
Group	1. Intervention	2. Control	3. Intervention	4. Control	1 vs 2	3 vs 4	2 vs 4	1 vs 3
BPRS	55.3 (10.8)	61.4 (11.9)	28.8 (4.5)	62.7 (9.9)	0.1	<0.001	0.4	<0.001
Cohesion	34.2 (17.6)	29.8 (19.7)	47.0 (16.5)	27.3 (18.2)	0.5	0.004	0.09	0.01
Expressiveness	35.7 (9.6)	34.7 (13.4)	35.5 (10.2)	34.2 (13.1)	0.8	0.7	0.6	0.9
Conflict	63.5 (13.5)	53.9 (14.9)	39.5 (4.8)	53.9 (13.9)	0.075	0.001	0.9	<0.001
Independence	25.5 (20.4)	33.0 (13.7)	30.1 (21.5)	31.9 (13.8)	0.3	0.08	0.1	0.1
Achievement Orientation	45.3 (16.0)	46.0 (13.9)	48.2 (13.7)	45.5 (14.4)	0.8	0.07	0.7	0.2
Intellectual-Cultural Orient.	40.5 (16.4)	31.7 (11.0)	43.2 (15.7)	31.6 (11.4)	0.1	0.027	0.9	0.1
Active-Recreational Orient.	38.5 (12.9)	29.4 (8.4)	43.8 (11.9)	29.4 (8.4)	0.03	0.001	0.9	0.05
Moral-Religious Emphasis	52.3 (12.2)	51.4 (13.8)	53.4 (12.8)	51.0 (13.4)	0.8	0.6	0.3	0.4
Organization	51.7 (11.8)	53.6 (10.8)	58.0 (9.9)	52.9 (11.3)	0.7	0.2	0.1	0.01
Control	64.5 (12.9)	61.9 (10.2)	59.5 (9.6)	62.7 (9.5)	0.6	0.3	0.1	0.015

Abbreviations; FES: Family Environment Scale; BPRS: Brief Psychiatric Rating Scale. Note: Values are means (SD). Significant posthoc tests ($p<0.004$) are shown in bold

that BSFT can have a positive impact on serious mental health illnesses[37,38] such as schizophrenia, at least in patients who are stable under psychotropic medication. To our knowledge, the significance of intervening in family characteristics via BSFT has been shown in one other study[39] which also used the FES.[31] Five patients with schizophrenia and their families each received five BSFT therapeutic sessions in combination with psychotropic medication, while patients and their families in the control group underwent standard psychiatric care. Following the intervention, significant changes were found in expressiveness, active-recreational orientation, and moral-religious emphasis. The efficacy of BSFT has also been shown in a case-study reporting reduction of depressive and anxious symptomatology to subclinical levels, in a patient diagnosed with paranoid schizophrenia. Failing to observe changes in either symptom severity or patient-rated family function characteristics over time, in the present study, in the control group of patients receiving standard care, i.e., psychotropic medication and regular visits to their psychiatrist lends further support to the specificity of the effects of BSFT.

A secondary finding of the present study is that the reduction in symptom severity (observed solely in the intervention group) was paralleled by concomitant changes in self-rated family function characteristics. Thus, the reduction of "conflict" and improvement of self-rated cohesion in the family following BSFT, were related to the reduction of psychopathology at the patient level. The small sample size and the lack of additional longitudinal measurements on the key study variables (FES subscales and BPRS) render any inferences regarding causality untenable. One possibility is that the systemic intervention directly impacted several patient-reported family function characteristics, mitigating psychopathological processes (and symptom severity). This notion is consistent with previous reports that patients with schizophrenia, who experience high levels of criticism from relatives, experience more severe positive symptoms.[18,40] Moreover, the risk of relapse for patients with schizophrenia who live in highly expressed emotion environments (criticism is one of the three characteristics of expressed emotion)[41] is more than double compared to patients who live in low-expressed emotion environments.[42] It is also well established that Global Properties of the family system, i.e., conflict and cohesion, are related to the onset and/or relapse of patients with schizophrenia.[8] Specifically, patients who report poor levels of cohesion in their family have greater symptomatology,[43] whereas patients who report greater levels of family cohesion feel less distressed,[14] and high levels of family cohesion seem to protect against psychosis.[44] Within the systemic framework, however, bidirectional causality may also take place, whereby a reduction in psychiatric symptoms can further change patient perception regarding their family characteristics.

Regardless of the direction of effects that took place during the intervention period, the associations found between global family properties and BPRS score suggest that patients who benefited most from the intervention were those who experienced greater family dysfunction at baseline (as indicated by higher self-rated conflict and lower intellectual cultural orientation). An important component of the BSFT therapeutic method

is that the patients with schizophrenia were encouraged to express themselves and talk more about solutions for their difficulties than for the difficulties per se. Any problems resulting from the illness ''were externalized'', giving patients the opportunity to use available resources and better manage such problems. This is consistent with bidirectional causality between psychopathology and functionality in several aspects of family life. On the other hand, the control group receiving standard care, did not experience changes in family environment characteristics or symptom severity. This is an indirect indication that any changes in the intervention group were due to the BSFT sessions which when added to medication and social treatment modalities, can further reduce the psychopathology score and improve the family climate.

Finally, we did not observe any significant changes in the BPRS score in the control group between baseline and follow-up. Possible explanations are the very short follow-up period (3 months) and the fact that all participants were psychiatrically stable and regularly followed up by their physicians for at least one 3 months prior to inclusion in the study.

A crucial limitation concerns the small size of the two groups, which renders the generalization of the results problematic and limits the statistical power of the univariate analyses performed (especially in view of the need to apply a rigorous correction for multiple comparisons). A second limitation is that we did not assess the mid/long-term impact of BSFT on key study outcomes Also since all participants in the intervention group were stable in terms of symptomatology, and without a clinical relapse before their inclusion in the study. Our study findings may not apply to unstable or hospitalized patients. Finally, changes in family characteristics are solely based on patient self-rating, rather than ratings by a family member or independent observed. However, from a theoretical point of view, a system (family) has very distinct characteristics and qualities from each of its members. Thus, the validity of a group family score obtained by averaging the scores across participants is questionable. Nevertheless, patients' different views on family functioning appear to aid the therapist to enhance the dialogue in the family context. Future research is needed in order to address these limitations.

In conclusion, the results of this preliminary study indicate that BSFT, when applied to patients with schizophrenia may improve their family characteristics, specifically cohesion, conflict, organization, and control. As a result, BSFT appears to have a favorable impact on the symptom severity of patients with schizophrenia.

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Ερευνητική εργασία

Σύντομη Εστιασμένη στη Λύση Θεραπεία στη σχιζοφρένεια: Μια προκαταρκτική μελέτη των οικογενειακών χαρακτηριστικών και της ψυχοπαθολογίας

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ΠΕΡΙΛΗΨΗ

Η οικογενειακή θεραπεία έχει βρεθεί να είναι αποτελεσματική στην αντιμετώπιση της σχιζοφρένειας και συμπεριλαμβάνεται στις διεθνείς κατευθυντήριες οδηγίες ως θεραπεία εκλογής. Ανασκοπήσεις ερευνών καταλήγουν ότι η οικογενειακή θεραπεία μπορεί να συμβάλει στη μείωση των υποτροπών της νόσου, όταν τα συμπτώματα είναι σε ύφεση υπό φαρμακευτική αγωγή, με τη μείωση οικογενειακών παραγόντων που συνδέονται με την υποτροπή. Ο σκοπός της παρούσας μελέτης ήταν να εξεταστεί η αποτελεσματικότητα της Σύντομης, Εστιασμένης στη Λύση, Θεραπείας (BSFT) σε ασθενείς με σχιζοφρένεια, εστιάζοντας στην επίδραση αλλαγών σε οικογενειακά χαρακτηριστικά, όπως η συνοχή, οι συγκρούσεις, η οργάνωση και ο έλεγχος, στη βαρύτητα της ψυχοπαθολογίας. Μελετήθηκαν 30 ασθενείς με σχιζοφρένεια, οι οποίοι κατανεμήθηκαν τυχαία στην ομάδα παρέμβασης και στην ομάδα ελέγχου. Η ομάδα παρέμβασης δέχθηκε τη BSFT ενώ η ομάδα ελέγχου συνέχισε με τη συνήθη θεραπεία. Η BSFT είναι μια ψυχοθεραπευτική προσέγγιση που εστιάζει στο μέλλον, ενθαρρύνει τους ασθενείς να «μιλούν για αλλαγή» αντί να «μιλούν για το πρόβλημα» και επίσης για στιγμές που έχουν καταφέρει μια επιτυχή λύση. Πραγματοποιήθηκαν 5 συνεδρίες σε διάστημα 3 μηνών. Τα οικογενειακά χαρακτηριστικά, σύμφωνα με τους ασθενείς, αξιολογήθηκαν με τη Family Environment Scale (FES) και η ψυχοπαθολογία με το εργαλείο Brief Psychiatric Rating Scale (BPRS). Οι δύο ομάδες δεν διέφεραν στην ηλικία, το φύλο, τον αριθμό των υποτροπών, τον αριθμό νοσηλειών και στη βαθμολογία στην κλίμακα BPRS κατά την έναρξη της μελέτης. Στο τέλος της παρέμβασης, συγκριτικά με το σημείο έναρξης, παρατηρήθηκε μείωση της βαθμολογίας στην κλίμακα BPRS ($p<0,001$), ενώ στην ομάδα ελέγχου δεν παρατηρήθηκαν στατιστικά σημαντικές αλλαγές συγκριτικά με την έναρξη της μελέτης. Επίσης, μετά την παρέμβαση, στην ομάδα παρέμβασης, και συγκριτικά με την έναρξη και την ομάδα ελέγχου, σημειώθηκε μείωση του επιπέδου συγκρούσεων ($p=0,001$), και αύξηση της συνοχής και της εκφραστικότητας ($p=0,004$) καθώς και του προσανατολισμού στη δράση ($p=0,001$) σύμφωνα με την εκτίμηση των ασθενών. Παράλληλα, αυτά τα προκαταρκτικά ευρήματα συνιστούν ότι η BSFT μπορεί να συμβάλει στην αλλαγή των ιδιοτήτων του οικογενειακού συστήματος και συγκεκριμένα της συνοχής, των συγκρούσεων, της οργάνωσης και του ελέγχου, και εν τέλει στη μείωση της ψυχοπαθολογίας του ασθενούς.

ΛΕΞΕΙΣ ΕΥΡΕΤΗΡΙΟΥ: Σύντομη εστιασμένη στη λύση θεραπεία, σχιζοφρένεια, οικογενειακή θεραπεία.

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