FAMILY PSYCHOEDUCATION AND SCHIZOPHRENIA: A REVIEW OF THE LITERATURE

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Family psychoeducation has emerged as a treatment of choice for schizophrenia, bipolar disorder, major depression, and other disorders. More than 30 randomized clinical trials have demonstrated reduced relapse rates, improved recovery of patients, and improved family well-being among participants. Interventions common to effective family psychoeducation programs have been developed, including empathic engagement, education, ongoing support, clinical resources during periods of crisis, social network enhancement, and problem-solving and communication skills. Application of family psychoeducation in routine settings where patients having these disorders are usually treated has been limited, reflecting attitudinal, knowledge, practical, and systemic implementation obstacles. Through consensus among patient and family advocacy organizations, clinician training, and ongoing technical consultation and supervision, this approach has been implemented in routine clinical settings.

Our purpose here, as part of the series commissioned by the American Association for Marriage and Family Therapy (AAMFT) on family interventions and therapies and the evidence for their effectiveness, is to describe family psychoeducation, the basis for its status as an evidence-based practice (EBP), and barriers to implementation. Proposed strategies for overcoming those barriers are also described. Although the focus is on results and developments since the last such review in the Journal of Marital and Family Therapy (Goldstein & Miklowitz, 1995), we start with a brief overview of this work for those who are new to it.

Family psychoeducation originated from several sources in the late 1970s. Perhaps the leading influence was the growing realization that conventional family therapy, in which family dysfunction is assumed and becomes the target of intervention for the alleviation of symptoms, proved to be at least ineffective and perhaps damaging to patient and family well-being. As efforts to develop and apply family therapy to schizophrenia and other psychotic disorders waned, awareness grew, especially among

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family members themselves and their rapidly growing advocacy organizations, that living with an illness such as schizophrenia is difficult and confusing for patients and families alike.

It became increasingly clear that, under these circumstances, a well-functioning family has to possess the available knowledge about the illness itself and coping skills specific to a particular disorder, skills that are counterintuitive and only nascent in most families. Given that perspective, the most adaptive family was increasingly seen to be the one that has access to information, with the implication that the treatment system is a crucial source of that information. As to coping skills, many families develop methods of dealing with positive (psychotic) and negative (functional and cognitive deficits, such as flattened affect, loss of energy and apathy) symptoms, functional disabilities, and the desperation of their ill relatives through painful trial and error. These successes, however, are rare. A critical need is for families to have access to each other to learn of other families’ successes and failures, and to establish a repertoire of coping strategies that are closely tailored to the disorder. Further, family members and significant others involved in the lives and care of adults with serious mental illnesses often provide emotional and instrumental support, case management functions, financial assistance, advocacy, and housing to their relative with mental illness. Doing so can be rewarding but poses considerable burdens (Adamec, 1996; Cochrane, Goering, & Rogers, 1997; Leff, 1994; McFarlane, Lukens, et al., 1995). Family members often find that access to needed resources and information is lacking (Adamec, 1996; Marsh, 1992; Marsh & Johnson, 1997).

Even with this new perspective, it took over 10 years for interest and effort in involving families in the treatment of persons with severe mental illness to be revived, and then it emerged with an entirely different ideology. Investigators began to recognize the crucial role families played in outcome after an acute episode of schizophrenia had occurred and endeavored to engage families collaboratively, sharing illness information, suggesting behaviors that promote recuperation, and teaching coping strategies that reduce the families’ sense of burden (Anderson, Hogarty, & Reiss, 1980; Falloon, Boyd, & McGill, 1984; Goldstein, Rodnick, Evans, May, & Steinberg, 1978; Leff, Kuipers, Berkowitz, Eberlein-Vries, & Sturgeon, 1982). The group of interventions that emerged became known as family psychoeducation.

The psychoeducational approach recognizes that schizophrenia is a brain disorder that is usually only partially remediable by medication, and that families can have a significant effect on their relative’s recovery. Thus, the psychoeducational approach shifted away from attempting to get families to change their “disturbed” communication patterns towards educating and persuading families that how they behave toward the patient can facilitate or impede recovery by compensating for deficits and sensitivities specific to the various psychotic disorders. For example, a family might interfere with recuperation if, in their natural enthusiasm to promote and support progress, they create unreasonable demands and expectations, but the same family could have a dramatically positive effect on recovery by gradually increasing expectations and supporting an incremental return of functioning.

Research conducted over the last decade has supported the development of evidence-based practice guidelines for addressing family-members’ needs for information, clinical guidance, and ongoing support. This research has demonstrated that meeting the needs of family members also dramatically improves patient outcomes, while improving family well-being. Several models have evolved to address the needs of family members: individual family consultation; professionally-led family psychoeducation (Anderson et al., 1980; Falloon et al., 1984), in single-family and multifamily group formats (McFarlane, 2002); various forms of more traditional family therapies (see Marsh, 2001); and a range of professionally-led models of short-term family education—sometimes referred to as therapeutic education (Amenson, 1998; Marsh, 2001). There are also family-led information and support classes or groups such as those of the National Alliance for the Mentally Ill (NAMI; Burland, 1998; Pickett-Eubanks, Cook, & Laris, 2000). Of these models, family psychoeducation has a deep enough research and dissemination base to be considered an evidence-based practice. The descriptor “psychoeducation” can be misleading; family psychoeducation includes many cognitive, behavioral, and supportive therapeutic elements, often utilizes a consultative framework, and shares key characteristics with other types of family interventions.
WHAT IS FAMILY PSYCHOEDUCATION?

A variety of family psychoeducation programs have been developed over the past two decades (Anderson, Reiss, & Hogarty, 1986; Falloon et al., 1984). These programs are professionally created and led, offered as part of a treatment plan for the consumer, and are usually diagnosis-specific. The models differ significantly in format (multiple-family, single-family, relatives only, combined), structure (involvement or exclusion of consumer), duration and intensity of treatment, and setting (hospital or clinic, home). They place variable emphasis on didactic, emotional, cognitive behavioral, clinical, rehabilitative, and systemic techniques. Most have focused first on consumer outcomes, although family understanding and well-being are assumed necessary to achieve those outcomes. All focus on family resiliency and strengths.

Although the existing models of family intervention may appear to have substantial differences, a significant consensus about critical elements of this kind of treatment emerged in 1999, under the encouragement of the leaders of the World Schizophrenia Fellowship (1998). Leff, Falloon, and McFarlane (World Schizophrenia Fellowship, 1998) developed the original consensus, which was then refined and ratified by many recognized clinical researchers working in this field. The process involved selection of the key components, developing a consensus based first on empirical evidence and then on a consensus as to what each component actually represented. The final step was further refinement based on feedback from, and iterative reworking with, nearly all of the principal psychoeducation researchers in the world. Parenthetically, this process led to convergence of concept rather than the usual process of the field splitting into competing schools. The resulting consensus regarding goals, principles and methods, i.e., elements of family intervention that are critical to achieving the empirically validated outcomes reported, was summarized as follows.

**Goals For Working With Families**
- To achieve the best possible outcome for the individual with mental illness through treatment and management that involves collaboration among professionals, families and patients.
- To alleviate suffering among the members of the family by supporting them in their efforts to foster their loved one’s recovery.

**Principles For Working With Families**
The models of treatment supported with demonstrated effectiveness required clinicians working with families to:
- Coordinate all elements of treatment and rehabilitation to ensure that everyone is working towards the same goals in a collaborative, supportive relationship.
- Pay attention to the social as well as the clinical needs of the patient.
- Provide optimum medication management.
- Listen to families and treat them as equal partners in treatment planning and delivery.
- Explore family members’ expectations of the treatment program and for the patient.
- Assess the family’s strengths and limitations in their ability to support the patient.
- Help resolve family conflict through sensitive response to emotional distress.
- Address feelings of loss.
- Provide relevant information for patient and family at appropriate times.
- Provide an explicit crisis plan and professional response.
- Help improve communication among family members.
- Provide training for the family in structured problem-solving techniques.
- Encourage the family to expand their social support networks, e.g., participation in multifamily groups and/or family support organizations such as the National Alliance for the Mentally Ill.
- Be flexible in meeting the needs of the family.
- Provide the family with easy access to a professional in case of need if the work with the family ceases.

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Evidence-Based Family Intervention Models

Several models have been developed to address the needs and concerns of families of persons with mental illness, including:

- Behavioral family management
- Family psychoeducation
- Psychoeducational multifamily groups
- Relatives groups
- Family consultation
- Professionally-led models of short-term family education (therapeutic education)

Because each model has introduced critical components of treatment that have contributed to the development of family psychoeducational models, they will be described briefly here.

Behavioral family management. The behavioral family management approach, developed by Falloon et al. (1984), is the most behavioral among the models influencing psychoeducation. It follows a sequential framework of assessment, intervention, and ongoing review, and includes a behavioral analysis of the strengths and needs of each family member and the family unit as a whole, followed by single-family treatment sessions in the home. These sessions focus on education about schizophrenia, strategies for improved communication, and the development and rehearsal of problem-solving techniques, all designed to focus on the psychosocial rehabilitation of patients and the needs of family members. The model starts from a strengths perspective, with clinicians assuming that each family member is functioning at his or her best, given the circumstances, contradictions, and challenges involved in contending with a family member with mental illness. This approach has been found effective in one major study in Los Angeles (Falloon et al., 1984) and replicated in a subsequent controlled clinical trial (Randolph et al., 1994).

Family psychoeducation. Developed by Anderson et al. (1980) almost simultaneously with family behavioral management and relatives groups, family psychoeducation is a specific, empirically-based model that includes an intensive engagement effort with family and patient, extended education about the disease and its treatment, and guidelines for recovery based on research and best clinical practice. It pursues a careful, gradual treatment process that promotes a strong stable symptomatic recovery and relapse prevention, followed by an equally careful social and vocational rehabilitation effort, and problem solving based on the needs of both family and patient. Anderson translated her long experience working with families of patients with schizophrenia into a standardized approach that emphasizes partnering with family members, extended joining effort, incorporating family and patient desires and ambitions as the core of the treatment plan, and empathic acceptance of the family’s suffering, burdens, and frustrations in caretaking. A key feature is its strong commitment to solve problems raised by family members that are properly the province of the mental health system and/or professional intervention. Much of the approach was derived from structural family therapy—an emphasis on joining the therapist’s style and agenda to that of the family and enhancing boundaries within the family. This last point had a rationale different from Minuchin’s (1974) original conception. Here, boundaries are necessary to create “barriers to stimulation”; i.e., they are helpful because of the sensitivity to stimulation and cognitive disabilities that are biological substrates of schizophrenia, not because the family is categorically enmeshed.

This approach was also heavily influenced by Hogarty and Ulrich’s (1977) finding that relapse is a major impediment to longer-term clinical and functional improvement, but that after roughly a year of remission, most patients can make significant functional gains, are more resistant to stress, and can tolerate increasing mental and physical demands. This translated into working closely with the family, making coordinated efforts to take the next steps toward improved community participation carefully, using clinical condition as the guide to what a given patient might be able to handle. A hallmark is that a considerable period of time is allowed for recovery from the last episode of psychosis—as much as a year, much as is done for heart attacks. The assumption is that psychosis is traumatic for the brain, the person having the episode, and the immediate social support system, and that it requires recuperation to allow functional recovery.
Finally, the approach uses clinical approaches in training families to assist in creating an optimal psychosocial environment for recovery, especially one that is somewhat quieter, less intense, less complex, and moves a bit slower than the world in general. This is perhaps the point on which there is the greatest contrast with family therapy: Here the family is assumed to be functional until proven otherwise, e.g., by resisting or failing to use the treatment. Its members need to adopt a special interactive style and create an unusual social environment to adapt to, and compensate for, the specific sensory and cognitive characteristics of a given disorder. This model was found to be effective in a large clinical trial in which the combination of family psychoeducation and social skills training was found to be even more effective over a 1-year (Hogarty et al., 1986), but not 2-year, course of treatment (Hogarty et al., 1991).

**Psychoeducational multifamily groups.** The psychoeducational multiple family group (PMFG) brings together aspects of family psychoeducation, family behavioral management, and multiple-family approaches. As such, it is a second-generation treatment model that incorporates the advantages of each of its sources, diminishes their negative features, and leads to a number of synergistic effects that appear to enhance efficacy. Building on the psychoeducational family approach and the family behavioral management approach, the model attempts to reflect contemporary understanding of schizophrenia and other severe mental illnesses from biological, psychological, and social perspectives. Unlike the recent origins of psychoeducation, however, multiple family group work arose nearly 3 decades ago in attempts by Laqueur, LaBurt, and Morong (1964), and Dettre, Sayer, Norton, and Lewis (1961), and others to develop psychosocial treatments for hospitalized consumers. The emphasis was more pragmatic than theoretical. Indeed, the first reported successful experience with the modality emerged serendipitously from a need to solve ward management problems. In the process, Laqueur et al. noted improved ward social functioning in inpatients who insisted on attending a group organized for visiting relatives. Dettre et al. started a multiple family group to encourage cooperation between resident psychiatrists and social workers on an acute inpatient service. They found a high level of interest in the group among patients and family members alike, as well as improvements in social functioning among patients and in family communication and morale.

Many practitioners have observed that specific characteristics of the multiple family group have remarkable effects on a number of social and clinical management problems commonly encountered in schizophrenia and other severe mental illnesses. Further, the PMFG approach is based on research showing that families attempting to cope with mental illness inevitably experience a variety of stresses that secondarily put them at risk of manifesting exasperation and discouragement as natural reactions. These responses often take the form of high expressed emotion, in which relatives are highly critical or overinvolved, a factor empirically shown to predict and, most likely, cause relapse (Hooley, Rosen, & Richters, 1995). Multifamily groups address social isolation, stigmatization, and increased financial and psychological burden directly. They achieve these by increasing the size and richness of the social support network, connecting the family to other families like themselves, providing a forum for mutual aid, providing an opportunity to hear the experiences of others who have had similar experiences and have found workable solutions, and building hope through mutual example and experience.

The general character of the approach can be summarized as consisting of three components that roughly correspond to the phases of the group. In the first phase, the content of the model follows that developed by Anderson (1983), with its emphasis on joining with each family in a single-family format, conducting a multifamily educational workshop, focusing on preventing relapse, and fostering social and vocational rehabilitation. Unlike the single-family psychoeducational approach, the format for treatment after the workshop is a multifamily group. The second phase involves moving beyond stability to gradual increases in consumers' community functioning, a process that uses PMFG-based problem solving, as in the family behavioral management model, as the primary means for accomplishing social and vocational rehabilitation. This usually occurs during the second year of the PMFG. The third phase consists of deliberate efforts to mold the group into a social network that can persist for an extended period and satisfy family and consumer needs for social contact, support, and ongoing clinical monitoring. This format is also an efficient context in which to continue psychopharmacologic treatment.
and routine case management. Expansion of the families’ social networks occurs through problem solving, direct emotional support, and out-of-group socializing, all involving members of different families in the group. In two different studies at seven simultaneously replicating sites, multifamily groups were shown to be more effective than a single-family version of a combination of family psychoeducation and behavioral family management (McFarlane, Link, Dushay, Marchal, & Crilly, 1995; McFarlane, Lukens, et al., 1995).

**Relatives groups.** This model, developed by Julian Leff and his associates in the U.K. (Leff et al., 1989; Leff, Kuipers, Berkowitz, & Sturgeon, 1985), involves helping families to enhance coping skills through a combination of in-home individual family sessions in which brief educational material is presented to the families with time allowed for questions and discussion. This is followed by a series of biweekly group interventions conducted by two professionals and designed for parents and other family members, excluding the patient. The particular goal is to structure groups that include family members designated as both high and low in expressed emotion, as a means of encouraging cross-family education and modeling. In addition, the group model targets isolation and creates a forum for focused discussion among family members. Leff and his colleagues eventually devised two different studies to assess the effectiveness of their model. In the first study, they compared patients receiving standard treatment, which involved little or no family intervention, with a family program that combined educational sessions, a relatives group, and family sessions in the home including the patient (Leff et al., 1985). In the second study, Leff et al. (1990) tested the components of the first intervention, so families were invited to attend either ongoing relatives groups, excluding the patient, or individual family sessions at home. When the data from the first and second studies were combined, the relapse rate at 2 years was 75% for those consumers who received standard treatment as compared to 40% for those whose families received any form of intervention, providing strong endorsement for the value of a family support model regardless of format.

**Family consultation.** Another approach that has been shown to be effective for some types of conditions and families is the family consultation approach, developed by Wynne and colleagues (Weber, McDaniel, & Wynne, 1987; Wynne, 1994; Wynne, McDaniel, & Weber, 1988). In this approach, individual families meet periodically with a professional consultant, often the consumer’s psychiatrist or primary practitioner. The goal is to provide information and guidance on an individual basis to address the specific concerns and problems identified by the family, without a pre-specified agenda. The sessions are scheduled as needed. Again, the model is strengths-based with an emphasis on reinforcing the natural resiliency of the family. This approach appears to be especially useful when scheduling meetings involves great inconvenience, in cases in which there are few ongoing problems or acute crises, the family is coping well with the situation or, in contrast, the family faces a crisis or emergency situation. It is a flexible model and may be particularly practical in situations in which the mental health system is fragmented or not highly professionalized. It is often the de facto approach for long-term follow-up, after the family has participated in the more structured models.

**Short-term models.** In work that focused particularly on family rather than patient outcomes, Solomon, Draine, Mannion, and Meisel (1996, 1997) compared two short-term models of family intervention, either family group education or individualized family consultation, with a waitlist control group. About half of the participants were members of family support groups such as NAMI. For the active treatments, patients were invited. The group education model was well defined and included 10 weekly sessions focusing on education and development of coping skills. To facilitate collaboration between professionals and families, the groups were co-led by a professional and a peer consultant. The families were involved in designing the psychoeducational and problem-solving agenda and could obtain as-needed professional consultation following the conclusion of the group. In contrast, the consultation sessions were individualized, conducted in person or by telephone. Improved self-efficacy, defined as confidence in one’s ability to understand and cope with the mental illness of a relative, was the only significantly improved outcome at the conclusion of the interventions. Among those who received individual consultation, self-efficacy improved regardless of prior membership in a self-help group. For
those attending the family groups, participants showed significantly increased self-efficacy only if they had never participated in a self-help group. A more recent study assessed the efficacy of the Family-to-Family Education Program, a structured 12-week program developed by the National Alliance for the Mentally Ill (Dixon, Stewart, et al., 2001). After completing the program, the participants demonstrated significantly greater family, community, and service system empowerment, and reduced displeasure and worry about the family member who had a mental illness. These benefits were sustained at 6 months. It is noteworthy that these interventions were short-term in nature and that effects on patients were not assessed. Given recent practice guidelines that emphasize duration of at least 6 months and that the core elements of coping skill training and problem solving were lacking, an extension of these models may or may not have produced improved patient outcomes.

RESEARCH OVERVIEW

In the preceding Journal of Marital and Family Therapy research review in 1995, Goldstein and Miklowitz concluded that family psychoeducation for people afflicted with schizophrenia was highly effective when compared to standard care or medication alone. Going beyond basic efficacy, they described a number of studies in progress or very recently published that addressed the question as to whether there were technical variants that were more or less effective and/or specific subpopulations of patients with schizophrenia for which a given approach was superior. They went on to note that in the U.S., where the bulk of the research had been done, there was little application in routine clinical practice. In the U.K., by contrast, there was at least one national and one major large urban initiative to implement the approach. Finally, they noted that the approach had begun to be tested in other disorders, beginning with bipolar disorder. Each of those themes is reflected in the research reviewed here, although one of them, dissemination and implementation, is in nearly the same discouraging state that it was in 1995.

However, there are newer developments that enrich the field and raise further possibilities for research. We will attempt to review those as well. In particular, there is now some initial research available and underway that attempts to determine if self-help is as effective as professionally conducted family psychoeducation, and if it is not, whether there are aspects of self-help that are superior and should be incorporated in the existing evidence-based approaches. There is some research suggesting that expanding social networks and providing social support to families and patients is another therapeutic strategy with its own margin of efficacy, especially when families, patients, and clinicians work on common issues together. Further, there is a suggestion of evidence that it is better if the patients are direct participants in the treatment, and stronger evidence that all of these approaches require 9 to 12 months to achieve the level of efficacy reported in the literature. Finally, we review studies here that demonstrate a remarkable cross-cultural and cross-national efficacy. This body of research argues that the therapeutic impact of well-organized family support for those with schizophrenia is as universal as the disorder itself.

A large number of controlled and comparative clinical trials have demonstrated markedly decreased relapse and rehospitalization rates among patients whose families received psychoeducation compared to those who received standard individual services—20% to 50% over 2 years. At least eight literature reviews have been published in the past decade, all finding a large and significant effect for this model of intervention (Baum, Shoham, Mueser, Dauto, & Stickle, 1998; Dixon, Adams, & Lucksted, 2000; Dixon & Lehman, 1995; Dixon, McFarlane, et al., 2001; Falloon, Held, Coverdale, Roncone, & Laidlaw, 1999; Goldstein & Miklowitz, 1995; Lam, 1991: McFarlane & Lukens, 1998; Penn & Mueser, 1996; Pitschel-Walz, Leucht, Baum, Kissling, & Engel, 2001). Since 1978, with the publication of Goldstein et al.'s study showing dramatic short-term effects of educational and coping skills training intervention, there has been a steady stream of rigorous validations of the positive effects of this approach on relapse in schizophrenic disorders. Overall, the relapse rate for patients provided family psychoeducation has hovered around 15% per year, compared to a consistent 30% to 40% for individual
therapy and medication or medication alone (Baucom et al., 1998). Table 1 presents the major studies and relapse outcomes, divided by the format of the treatment model tested.

It is important to note that medication is not a variable in these studies: The design of family psychoeducational approaches has medication adherence and its value in promoting recovery as a central element. Therefore, medication is provided in both the experimental and control conditions in every instance.

As a result of the compelling evidence, the Schizophrenia Patient Outcomes Research Team (PORT) project included family psychoeducation in its set of treatment recommendations. The PORT recommended that all families in contact with their relative who has mental illness be offered a family psychosocial intervention spanning at least 9 months and including education about mental illness, family support, crisis intervention, and problem-solving skills training (Lehman et al., 1998). Other best practice standards (American Psychiatric Association, 1997; Frances, Hoffman, Pass, & Andrews, 1987; Frances & Kahn, 1996) have also recommended that families receive education and support programs. In addition, an expert panel that included clinicians from various disciplines, families, patients, and researchers emphasized the importance of engaging families in the treatment and rehabilitation process (Coursey, Curtis, & Marsh, 2000a, 2000b).

Reviewing studies in which there has been no effect found for family psychoeducation is simpler than reviewing studies in which a positive effect has been demonstrated: 3 studies to date out of nearly 30 (Kottgen, Sonnichsen, Mollenhauer, & Jurth, 1984; Linszen et al., 1996; Telles et al., 1995). In the Kottgen study, the ongoing sessions were oriented toward exploring psychodynamic and dysfunctional aspects within the families participating, now considered contraindicated for nearly all families of patients with schizophrenia. In the Telles study, conducted in a Spanish-speaking immigrant sample, there was a reversed effect for family behavioral management among those from a less acculturated subgroup, and no effect for those from the more acculturated subgroup. Other recent studies in Spain have demonstrated the same robust effects as the prior studies in English-speaking countries, suggesting that it was the sample’s immigrant status that may have negated the effects of family intervention, not a difference between languages or cultures. In the Linszen et al. study, the control group received

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<th>Table 1: Relapse in Major Outcome Trials of Family Psychoeducation</th>
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<td><strong>Duration of treatment (mos.)</strong></td>
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<tr>
<td>Falloon et al. (1984)</td>
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<td>Hogarty et al. (1991)</td>
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<td>Randolph et al. (1994)</td>
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<td>McFarlane, Link et al. (1995)</td>
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<td>Schooler et al. (1997)</td>
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<td>N and means</td>
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Note. MF = multifamily format; SF = single family format.
individual therapy that was well designed and also achieved low relapse rates comparable to those in the family intervention sample (15% to 16% in both conditions). This study also utilized family intervention only during an inpatient admission and not during outpatient treatment. Finally, a study of personal therapy by Hogarty et al. (1997) produced mixed results. In patients living with family, personal therapy had lower relapse rates than family or supportive therapy, but personal adjustment was better in family psychoeducation.

Thus, the nonconfirming studies tend to validate the effectiveness of the studies in which an effect was found—by suggesting that the core elements in fact make a difference, that some patients and families may require cultural and/or contextually specific adaptations of the approach, that longer-term participation by families is required to achieve outcomes, and that other methods may also achieve comparable short-term effects. The Linszen et al. (1996) study illustrates a key finding: Programs lasting longer than 3 months had more robust effects. In fact, consistent efficacy has been demonstrated only in those studies in which intervention was provided on an ongoing basis, lasted at least 6 months, and incorporated problem solving, coping skills training, expanded social support, and communication skills training. As will be explored further in the section on differences in models, it has become clear that education alone has at least short-term salutary effects for family members (Dixon, Stewart, et al., 2001), but other studies have found that there is no lasting effect on patient clinical or functional outcomes (Abramowitz & Coursey, 1989). Further, given the long-term course of illness of schizophrenia, it has appeared to many observers that even the shorter-term positive effects for family members of the education-only models will erode under the influence of the persistent deficits, symptoms, and burdens. Thus, the critical elements include those that involve changes in behavior and ongoing training in diagnosis-specific and clinically oriented coping skills training. Increasingly, as the focus of intervention has shifted to functional aspects, especially employment, the patient has been included in these skills training and behavioral interventions. In the multifamily group approaches, there is another element added—ongoing social support and social network expansion for family members and the patient.

The consensus of previous reviews is that the various approaches, if they include the key elements and continue for a minimum duration, are equally effective. Although not a rigorous criterion, there is nevertheless a remarkable consistency of effects on relapse rates, with minimum reductions of about 50% of the control groups’ rates. The differences simply increase with time, so that at 24 months the family-based conditions are well below 50% of the relapse rates in the control groups, approaching 75% in some studies. Baucom et al. (1998) found that in 11 of the most rigorously designed and conducted studies, with an average study duration of 19.7 months, the overall average relapse rate for family intervention was about 27% and for the control groups it was 64%; a reduction of about 58% of the standard or routine treatment rate. These differences in outcome are some of the most substantial and consistent empirical effects achieved by any treatment in the mental health domain.

Three studies have directly compared single- and multifamily formats or approaches, one small sample trial in the U.K. (Leff et al., 1989) and two community-based studies in the U.S. (McFarlane, Link, et al., 1995; McFarlane, Lukens, et al., 1995). Across the three studies, relapse rates for 24 months were 40.3% in the single-family conditions and 24.8% in the multifamily conditions. Table 2 provides the comparison of actual relapse rates and a mean rate for each format.

One of the U.S. studies was a large, multisite effectiveness study conducted in state- or city-operated clinics and hospitals, in which multifamily groups had lower relapse rates in five of the six sites (McFarlane, Lukens, et al., 1995). Given the reduced cost of MFGs, there is a strong bias in the literature and in fiscally hard-pressed mental health centers to adopt the MFG format as the more cost-effective alternative. This study also identified a subgroup for which the single-family format was more effective—families with low expressed emotion and patients with unusually good response to medication during the index hospitalization (McFarlane, 2002). In addition, first-episode cases did substantially better in the MFGs than in the single-family format (McFarlane, 2002).

Recent reports have only added to the strong validation of the effects on relapse, particularly because these later studies have been conducted in a variety of international and cultural contexts.
Table 2
Relapse Outcomes in Single- and Multifamily Formats

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<th>Duration of treatment</th>
<th>% Relapsed during study</th>
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<td></td>
<td>n (mos.)</td>
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<tr>
<td>Leff et al. (1990)</td>
<td>23 (24)</td>
<td>33</td>
</tr>
<tr>
<td>McFarlane, Link, et al. (1995)</td>
<td>34 (48)</td>
<td>83</td>
</tr>
<tr>
<td>N and means</td>
<td>229 (27.6)</td>
<td>48.7</td>
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</table>

Note. MF = multifamily format; SF = single family format.

Reductions in relapse for family intervention, compared to the control conditions, have been demonstrated in China (Ling et al., 1999; Zhang, Wang, Li, & Phillips, 1994; Zhao, Shen, & Shi, 1999; Zhao et al., 2000), Spain (Montero, Gomez Beneyto, Ruiz, Puche, & Adam, 1992; Muela Martinez & Godoy Garcia, 2001; Tomaras et al., 2000), Scandinavia (Rund et al., 1994), and Britain (Barrowclough et al., 2001). That these effects are additive to, but not substitutive for, antipsychotic medication was illustrated in a recent German study (Wiedemann et al., 2001). The investigators found that behavioral family management did not compensate for the increased risk of relapse posed by targeted drug treatment, in which the patient did not use medication unless experiencing prodromal signs or symptoms of relapse. However, the universality of this approach seems to have been demonstrated in contexts different enough that further generalization in other cultures and countries appears to be likely to succeed, especially if the necessary adaptations are made. For instance, a new model is being developed specifically for Asian Americans, designed to fit this population’s different value orientations and cultural characteristics (Bae & Kung, 2000). Another variant is being tested that integrates ethnic minority families with a member with mental illness into the larger community (Connery & Brekke).

In addition, these and other studies, many reported in the past 3 years, have demonstrated significant effects on other areas of functioning. These studies and findings address a frequent criticism of the clinical trials: that relapse is only one dimension of outcome and course of illness. Many consumers and their family members are more concerned about the functional aspects of the illness, especially housing, employment, social relationships, dating and marriage, and general morale than about remission, which tends to be somewhat abstract as a goal. Several of the previously mentioned models, particularly the American versions—those of Falloon et al. (1984), Anderson et al. (1986), and McFarlane (2002)—have used remission (the absence of relapse) as both a primary target of intervention but also as a necessary first step toward rehabilitative goals and recovery. In addition, these models all include major components designed to achieve functional recovery, and the studies have documented progress in those same domains. More recently, several investigators, including our research team, have shifted focus to targeting these more human aspects of illness and life. Other effects have been shown for:

- Improved family-member well-being (Cuypers, 1999; Falloon & Pederson, 1985; McFarlane, Dushay, Staatsy, Deakins, & Link, 1996; Shi, Zhao, Xu, & Sen, 2000; Solomon, Draine, & Mannion, 1996; Wang et al., 1999; Zhao et al., 1999)
- Increased patient participation in vocational rehabilitation (Falloon et al., 1985)
- Substantially increased employment rates (McFarlane et al., 1996; McFarlane et al., 2000; McFarlane, Lukens, et al., 1995)
- Decreased psychiatric symptoms, including deficit syndrome (Dyck et al., 2000; Falloon et al., 1985; McFarlane, Lukens, et al., 1995; Zhao et al., 2000)
- Improved social functioning (Montero et al., 2001)
- Decreased family medical illnesses and medical care utilization (Dyck et al., 2002)
- Reduced costs of care (Cardin, McGill, & Falloon, 1985; McFarlane, Lutkens, et al., 1995; Rund et al., 1994; Tarrier, Lowson, & Barrowclough, 1991).

**Mediating Effects**

From a theoretical standpoint, this broad spectrum of effects is mediated either by (a) a broad spectrum of numerous intervention components, or (b) a smaller number of nodal alterations whose secondary effects ramify throughout the family system and biological levels. The second option is strongly supported by the findings that all the efficacious family psychoeducational models reduce family expressed emotion and that doing so is directly associated with the reduction in relapse found in clinical trials. This linearity of effects is reassuring, because the intent of the early models, those developed by Leff, Kuipers, and Berkowitz (1983) particularly, was to reduce expressed emotion.

However, the better-known variants—family psychoeducation, family behavioral management, and PMFGs—have deliberately added important new dimensions of intervention, tending to support the first theoretical possibility, that these models have several different domains of effect. These include good general clinical management strategies and empathic engagement of patient and family members in Anderson’s (1983) model, problem solving, communication skills training, and in-home sessions in Falloon et al.’s (1984) model, and multifamily participation in problem solving and expanded social networks and support in the PMFG format. Each of these components is designed to impact specific and somewhat separate aspects of the illness and the family system, other than expressed emotion. Falloon et al. (1985) demonstrated that successful mastery of problem solving by family members was more directly associated with relapse prevention than reductions in expressed emotion. McFarlane and colleagues (McFarlane, Link, et al., 1995; McFarlane, Lutkens, et al., 1995) have consistently shown that when a very similar version of family psychoeducation is incorporated, multifamily groups lead to lower relapse rates and higher employment than single-family sessions. The simplest explanation is that enhanced social support, inherent only in the multifamily format, reduces vulnerability to relapse, probably by reducing anxiety and general distress (Dyck et al., 2002). Both of these empirical results strongly suggest a multidimensional effect as the explanation for improved clinical outcomes. That argument is strengthened further by recent studies showing dramatic improvements in employment among people with schizophrenia, especially when combined with other interventions, such as supported employment, that are designed to achieve functional goals (McFarlane et al., 1996, 2000).

Therefore, both theoretical possibilities are supported by present evidence. Many of the effects of these models are mediated by reductions in expressed emotion, but that effect is enhanced by elements that focus on general empathic support for families and patients, coping and communication skills training, and enhanced social networks and support.

Delivery of the *appropriate components* of family psychoeducation to patients and families appears important in determining outcomes of families and patients. Several studies (Greenberg, Greenley, & Kim, 1995) have demonstrated that programs fail to reduce relapse rates if they present information without also providing family members with skills training, ongoing guidance regarding illness management, and emotional support. Information-only interventions also tend to be quite brief; a meta-analysis of 16 studies found that family interventions of fewer than 10 sessions had no important effects on relatives’ burden (Cuipers, 1999). However, the number of sessions could not explain completely the differential outcomes: length of total time, allowing for refinement of coping skills and strategies by the family and patient, rather than number of sessions may be a factor, as may be the therapists’ styles of dealing with the emotional reactions of patients and relatives to the educational material. One study, using a multiple regression analysis of the variables measured, found that coping skill improvement was the best predictor of outcome for the patient, surpassing expressed emotion and other variables to explain patient clinical outcomes (Falloon et al., 1985). The behaviors and disruptions of schizophrenia, in particular, may require more than education to ameliorate family burden and enhance patient outcomes.

It is important to note that most studies evaluated family psychoeducation for schizophrenia or
schizoaffective disorder only. However, several controlled studies do support the effects of family interventions for other psychiatric disorders, including dual diagnosis of schizophrenia and substance abuse (Barrowclough et al., 2001; McFarlane, Lukens, et al., 1995), bipolar disorder (Clarkin, Carpenter, Hull, Wilner, & Glick, 1998; Miklowitz & Goldstein, 1997; Miklowitz et al., 2000; Moltz, 1993; Parikh et al., 1997; Simoneau, Miklowitz, Richards, Saleem, & George, 1999; Tompson, Rea, Goldstein, Miklowitz, & Weisman, 2000), major depression (Emanuels-Zuurveen, 1997; Emanuels-Zuurveen & Emmelkamp, 1996; Leff et al., 2000), depression in mothers with disruptive children (Sanders & McFarland, 2000), mood disorders in children (Fristad, Gavazzi, & Soldano, 1998), obsessive-compulsive disorder (Van Noppen, 1999), anorexia (Geist, Heinmnaa, Stephens, Davis, & Katzman, 2000) and alcohol abuse (Loveland-Cherry, Ross, & Kaufman, 1999) in adolescents, posttraumatic stress disorder (PTSD) in veterans (Saldanha, 2002), Alzheimer’s disease (Marriott, Donaldson, Tarrier, & Burns, 2000), disruptive behavior disorders (Bustamante, 2000; Nicholson & Sanders, 1999), suicidal children (Harrington et al., 1998), congenital abnormalities (Pelchat, Bisson, Ricard, Perrault, & Bouchard, 1999), intellectual impairment (Russell, John, & Lakshmanan, 1999), child molesters (Walker, 2000), and borderline personality disorder (Gunderson, Berkowitz, & Ruizsancho, 1997), including single- and multifamily approaches. Gonzalez and Steinglass (Gonzalez, Steinglass, & Reiss, 1989; Steinglass, 1998) have extended this work to deal with the secondary effects of chronic medical illness.

The best-studied and developed versions of family psychoeducation beyond those for schizophrenia have focused on bipolar disorder. The single-family approach developed by Miklowitz and his colleagues (Miklowitz & Goldstein, 1997; Miklowitz et al., 2000) has been validated in clinical trials and described in a recent volume. The psychoeducational multifamily group model has been described by Moltz and Newmark (2002). The approach must be significantly modified for bipolar disorder. The symptoms, course, and family responses have been shown to be different than in schizophrenia, and recent biological research has highlighted major differences in brain function between the disorders. A key finding is that family expressed emotion affects relapse, but there is a greater biological contribution to relapse than in schizophrenia. For instance, Miklowitz and his colleagues found that family psychoeducation, in the form of single-family behavioral management, reduced relapses markedly, but from nearly 90% to about 50%, as opposed to the 40% to 15% reduction observed for schizophrenia. Thus, biological and psychosocial factors seem to be more evenly weighted in determining course of illness; nevertheless, family psychoeducation remains a powerful treatment in preventing relapse and improving longer-term outcomes in bipolar disorder.

For instance, the multifamily group model, developed by Moltz and Newmark (2002), was first implemented at a public mental health center in the South Bronx of New York City and later at a community mental health center in coastal Maine. It has been effective in both settings. The key elements of this model are the same as in the approach for schizophrenia. Each is modified in important ways to match the clinical and psychosocial problems encountered in bipolar disorder. During joining, sessions are held separately for the individual and the family, although individual and family sessions have similar structure, since the individual with bipolar illness is usually able to participate fully. Meetings with the consumer and the other family members are often carried out separately during the acute phase of illness, but usually together if joining occurs after the manic phase is over and family meetings with the consumer are less likely to be emotionally intense. The content of the joining sessions is modified to reflect the specific impact of bipolar illness on the family. Among several foci, it includes extensive discussion of the history of symptoms and course of illness and discussion of inter-episode functioning. The structure and format of the bipolar workshop are similar to the schizophrenia workshop except that the consumer is included. Content is determined by the specific characteristics of the illness and includes symptoms of manic and depressive episodes, differences from normal highs and lows, the issue of willpower and the question of the “real” personality, among several key topics. The structure of the multifamily group meetings is essentially the same as the schizophrenia model. The patients have reported that, after varying lengths of treatment, they were less angry over time, had less debilitating episodes when they did occur, were better able to manage symptoms and episodes, experienced fewer hospitalizations, and were more able to appreciate their family’s experience. Family members reported
increased confidence in their ability to cope with the illness, increased confidence in their ill relative’s ability to manage the illness, and benefits from the program even if the consumer did not attend.

**FUTURE DIRECTIONS FOR RESEARCH**

Family psychoeducation has a solid research base and a consensus among leaders in the field regarding its marked efficacy, essential components and techniques; it should continue to be recommended for application in routine practice. However, there continues to be a number of important gaps in the knowledge needed to make comprehensive evidence-based practice recommendations and to implement them with a wide variety of families:

- More needs to be described, both quantitatively and qualitatively, about the patient/consumer’s outcomes and experiences. Most patients have been increasingly enthusiastic about family psychoeducation, but would often not view it as useful or even tolerable at the outset. Also, the benefits that do occur for the primary participants in the treatment need to be linked to the benefits sought by them. This most often occurs around employment, less around relapse. The author’s research team, for instance, has focused on employment and other outcomes desired by patients in its last three outcome studies, seeing relapse prevention as a means to more consumer-based outcomes. In the American approaches—family psychoeducation, family behavioral management, and multifamily groups—the patient’s perspectives, feelings, hopes, and pains are central to the effort, although this aspect is not emphasized in the respective research reports. It is important to include the descriptions in the treatment manuals as the basis for developing further research on patient/consumer experiences and outcomes. For instance, it is not uncommon in PMFGs that the patients recover to the point that they are doing most of the talking, joking and relating to one another, often remarkable outcomes given where they usually start. These observations need to be quantified and described, though that is not easily done.

- Although the World Schizophrenia Fellowship and others have delineated the core components of a successful family intervention, the minimal ingredients are still uncertain. This was highlighted by the Treatment Strategies in Schizophrenia study (Schooler et al., 1997). The investigators found no significant difference in relapse rates between families receiving the more intensive program that consisted of a simplified version of cognitive behavioral family intervention plus a multiple family group and those receiving a less intensive psychoeducational (supportive) multifamily group program. However, both conditions provided support and education to families far beyond that found in usual services, including most of the key elements of the psychoeducational multifamily groups approach described previously (Schooler et al., 1997). More studies that are designed to identify the least intensive and smallest “close” of family psychoeducation are necessary to increase the cost-effectiveness of the model and to decrease the burden on families.

- Increasing the sophistication, variety, and scope of measurement and outcomes used to evaluate “benefit” is essential. Commonly used benchmarks are subject to complicated intervening variables and need to be correlated with other results. For example, increased hospitalizations for an ill relative could be a good sign in the year after family psychoeducation if it indicates that the patient is getting previously neglected care and that the family is more able to identify prodromal symptoms indicating an impending relapse (McFarlane, Lukens, et al., 1995). In addition, family well-being and health should be routinely measured.

- Since the development of family psychoeducation, other psychosocial programs have also developed a substantial evidentiary base including supported employment and assertive community treatment (ACT; Bond et al., 2001). For instance, ACT in combination with family psychoeducation (FACT) led to better noncompetitive employment outcomes than ACT alone (McFarlane et al., 1996) and the combination of ACT, family psychoeducation, and supported employment led to better competitive employment outcomes than conventional vocational
rehabilitation (McFarlane et al., 2000). A more recent study, yet to be published, demonstrated unusually high employment rates for persons with schizophrenia, about 67% at 2 years, using the family-aided ACT approach. In this study, the FACT package incorporated supported employment and cognitive assessments to provide employment opportunities, adaptation of the job to the patient and vice versa, with family involvement in the entire process. The opportunities for family psychoeducation to be combined and/or compared with these new psychosocial models have not been fully explored.

• Research is needed to refine the interventions so they better address different types of families, in different situations, and at different points in course of illness. For example, there is some evidence that individualized consultation may have more benefit (than group psychoeducation) for families who already have ample natural supports or are part of a support group (Solomon, 1996; Solomon, Draine, & Mannion, 1996; Solomon et al., 1997). Multifamily groups are specifically more effective than single-family format for patients who respond only partially to medication, families with high expressed emotion, and first episode cases (McFarlane, 2002).

• Although family psychoeducation has been tested in a wide range of national and global settings, there remains a need to assess modifications in content and outcome among particular American subcultures as well as internationally. As noted previously, in the United States, the one study involving Latino family members reached mixed conclusions, whereas several studies in Spain have found the expected robust results (Canive et al., 1995; Telles et al., 1995). However, studies completed in China and under way with Vietnamese refugees in Australia have found comparable effects to those conducted with Anglo populations (Xiang, Ran, & Li, 1994; Xiong et al., 1994; Zhang et al., 1994). Single-family format may be more effective in low-expressed emotion African-American families than multifamily groups (McFarlane, 2002).

• What happens after a family has completed a family psychoeducation program? Families of patients with long-term problems and disability may need ongoing support and problem-solving skills to deal with the vicissitudes of illnesses. Lefley (2001) has described ad hoc psychoeducation in informal settings such as an ongoing medical center family support group. McFarlane's (2002) multifamily group structure is usually open-ended for families in need. The Family-to-Family program of the National Alliance for the Mentally Ill (NAMI) in the U.S. is limited to 12 sessions of formal education but offers continuity in the NAMI support and educational group structure (Burland, 1998).

BARRIERS TO IMPLEMENTATION OF FAMILY PSYCHOEDUCATION

Despite the research gaps, the extensive documentation of family psychoeducation's basic benefits prompts questions of why it is rarely offered. In general, low levels of any contact between programs/staff and family members in public and community-based settings may preclude the more substantial educational or support interventions. In addition, the availability of any intervention is limited by the availability of people to provide it and the training necessary to equip them. Such staffing requires willing clinicians, resources, time, and financial reimbursement that have not been forthcoming for family psychoeducation. These imply the existence of larger attitudinal, knowledge, practical, and systemic implementation obstacles.

Patients/Family Members

Implementation of family psychoeducation may be hindered by realities in the lives of potential participants. Practical issues like transportation, time commitment, and competing demands for time and energy are common (Solomon, 1996). If family members perceive that "training" through family psychoeducation includes expectations they will take on yet more care-giving responsibilities, they may stay away (World Schizophrenia Fellowship, 1998). Sessions must be scheduled when facilitators are
available, but doing so may not mesh with potential participants’ needs. Family members report significant burdens that may pose barriers to attendance though attendance may lighten these burdens (Gallagher & Mechanic, 1996; Mueser, Webb, Pfeiffer, Gladis, & Levinson, 1996). Stigma, too, is common—family members may not want to be identified with psychiatric facilities. They may feel uncomfortable revealing to others the psychiatric illness in their families and airing their family problems in a public setting. Family members may also have had negative experiences in the past and be hesitant to open themselves to that possibility again. Most have not had access to information documenting the value of family programs and so may not appreciate their potential (World Schizophrenia Fellowship, 1998). Indeed, hopelessness can be a barrier in that family members may believe that nothing will help. Patients may experience some of the same hesitations as their family members about participating in family psychoeducation. In addition, they may worry about losing the confidential relationship with their treatment teams and about losing autonomy.

Clinicians/Program Administrators

The lack of family psychoeducation availability may reflect mental health providers’ under-appreciation and lack of knowledge about its utility and importance (Dixon & Lehman, 1995; Greenberg et al., 1995; Solomon, 1996). Clinicians and administrators may not appreciate the impact of mental illness on families, or may not know about the effectiveness of family psychoeducation (World Schizophrenia Fellowship, 1998). They may focus on medication over psychosocial interventions, and the individualistic orientation of medicine may make family involvement seem superfluous. Additionally, some may still follow theories that blame family dynamics for causing schizophrenia. Bergmark (1994) noted the persistence of psychodynamic theories as a potential barrier since many families perceive them as blaming. The findings regarding expressed emotion that were the original basis for family psychoeducation are often perceived similarly, despite attempts by expressed emotion researchers to avoid any implication of blame.

Important though they are, individuals’ knowledge and underlying assumptions are only part of the picture. Wright, Takei, Rifkin, and Murray (1995) found that job and organizational factors were much more predictive of the frequency of mental health professionals’ involvement with families than were professionals’ attitudes. Clinician work schedule and professional discipline were the strongest predictors, but other organizational factors have posed barriers as well. Dissemination of McFarlane and Deakin’s (2002) multiple-family psychoeducation group model has been hindered by a paucity of programmatic leadership supporting implementation, conflicts between the model’s philosophy and typical agency practices, insufficient resources supporting practice change, and inadequate attention to human dynamics on a systems level (Dixon, McFarlane, Hornby, & McNary, 1999; McFarlane et al., 1993). For example, reasonable concerns about confidentiality issues may be seen as roadblocks to family involvement rather than as opportunities to create useful innovations that respect everyone’s right to privacy (Boise, Heagery, & Eskenazi, 1996). Almost identical barriers to implementation of family treatments were found in Italian health services (Falloon, Casacchia, et al., 1999).

Mental health professionals have also expressed concern about the cost and length of structured family psychoeducation programs (Dixon, Lyles, et al., 1999), although medication and case management services for clients usually have to be continued for much longer periods. The lack of reimbursement for sessions with families in the absence of the patient, a component of many family psychoeducation programs, is a significant disincentive to provide such services. Caseloads are universally very high, and staff time is stretched thin. Therefore, devoting substantial staff resources to training, organizing, leading, and sustaining family psychoeducation is seen as a luxury (World Schizophrenia Fellowship, 1998). In such an atmosphere, horizons tend to be short. The long-term investment and payoff in reduced crises, hospitalizations, and total treatment costs of family psychoeducation are overshadowed by immediate organizational crises or short-term goals.

Mental Health Authorities

At the level of health care systems, pressures to focus on outcomes, cost effectiveness, and
“customer” satisfaction would seem in principle to favor widespread adoption of family information/support interventions. However, other tenets of the current health care environment—such as emphasis on short-term cost savings, technical (as contrasted with human-process-oriented) remedies, and individual pathology—encourage little attention to such services, which may be viewed as ancillary. At this level, also, it seems the evidence and mindset in favor of family psychoeducation has not been accepted. Many of the impediments mentioned above as patient- and program-level issues have their parallels in larger administrative systems; lack of awareness of evidence, ingrained assumptions about how care “should” be structured, and inadequate resources.

STRATEGIES FOR OVERCOMING BARRIERS TO IMPLEMENTING FAMILY PSYCHOEDUCATION

Research on technology transfer has identified four fundamental conditions that must be met in order for individual or system change to occur: dissemination of knowledge; evaluation of programmatic impact; availability of resources; efforts to address the human dynamics of resisting change (Backer, 1991). Implementation strategies must include clear, widespread communication of the models and of their benefits to all stakeholders. This must be done through channels accessible and acceptable to the various stakeholders—including families, patients, providers, administrators, and policy-makers. It must be accompanied by advocacy, training, and supervision/consultation initiatives to raise awareness and support at all organizational levels (McFarlane, 1994).

Patient/Family Members

On the individual family member and patient level, effective family psychoeducation models include strategies for overcoming barriers to participation such as the family’s sense of hopelessness and stigma. For example, offering sessions at home, helping family members understand that the intervention is designed to improve the lives of everyone in the family (not just the patient), being flexible about scheduling family meetings, and providing education during the engagement process destigmatize mental illness and engender hope (Mueser & Glynn, 1999; Tarrier, 1991).

Recent efforts to disseminate family psychoeducation in New York State, Los Angeles, Maine, and Illinois have illustrated clearly the importance of including representatives of the recipients—patients and their families, practitioners—of these services in their planning, adaptation, and eventual implementation. In the New York example, the dissemination was initiated and sponsored by the state’s AMI (now NAMI New York) chapter (McFarlane et al., 1993). In comparing dramatic differences in the outcome of dissemination in Maine and Illinois, one key difference is the strong, formal support from NAMI Maine for the effort there, versus occasional resistance by local chapters and the absence of involvement of the state NAMI in Illinois (McFarlane, McNary, Dixon, Hornby, & Cimett, 2001). Experience and now some empirical data illustrate the need to include patients and families in efforts to disseminate. The often-encountered tension between some patient advocacy groups and family advocacy organizations can be bridged by emphasizing the complementarity of the outcomes in family work. As patients’ symptoms are reduced and functioning improves, relatives become more engaged in and satisfied with community life, and family burden and medical illness decrease (Dyck et al., 2000; Falloon, Falloon, & Lussciti, 1997; McFarlane et al., 1996).

Clinicians/Program Administrators

Among professionals working in community mental health services, awareness and evidence, although necessary, are often not sufficient for adoption of new programs. Although interventions must maintain high fidelity to their model to obtain client and family outcomes, they also have to be responsive to local organizational and community cultures. Engagement and implementation strategies, as well as the interventions themselves, must be tailored for local and cultural characteristics, workload, and other stresses facing clinicians and agencies, particular diagnoses, relationships, duration of disorder and disability, and whether the ill person is in medical treatment (Guarnaccia & Parra, 1996;
Jordan, Lewellen, & Vandiver. 1995). Perhaps even more critical to adoption is matching administrative support and expectations for evidence-based practice with a rationale and explication of advantages that are meaningful to clinicians. Advantages can include avoidance of crises, more efficient case management, gratitude from families and patients, and more interesting, invigorating work-lives for the clinicians. Recent studies demonstrate that on whole, knowledge about empirical advantages of family psychoeducation, such as reduced relapse and rehospitalization rates, carry almost no weight in convincing most working clinicians to change attitudes toward families and adopt a new clinical practice (McFarlane et al., 2001).

Consensus building among agency staff and directors, including a wide range of concerned parties in a bottom-up planning process, is critical but must be tailored to address local operational barriers and contrary beliefs. Successful implementations have also required ongoing supervision, operational consultation, and general support to achieve high levels of adoption. In a sense, these provide ongoing consensus building. For instance, the PORT dissemination found that it was possible to change practice with a high level of technical assistance and a supportive environment reflected in staff agreement with the principles and philosophy of the new program (Dixon, Lyles, et al., 1999). A recent dissemination of a family psychoeducation program in Los Angeles County succeeded due to the persistent advocacy of the local NAMI group, the support of top management, the 9-month duration of training, the high quality and commitment of trainees, and the skill of the trainer (Amenson & Liberman, 2001).

Mental Health Authorities/Government

Although it is tempting to assume that state mental health authorities could mandate adoption of family psychoeducation centrally, experience suggests that a more complex approach is required. New York partially succeeded in dissemination by partnering with the NAMI affiliate and an academic center; unfortunately, the mental health authority there also abruptly terminated their large dissemination program prior to achieving a widespread impact. Maine’s recent success was initiated by the trade association of mental health centers/services, with support but little involvement by the state authority, which has recently begun exploring a formal partnership to continue and deepen this largely successful effort. A simultaneous effort in Illinois, initiated by the state authority but distinctly lacking consensus by center directors or the state NAMI chapter, has had much less success. One exception is New Jersey that succeeded in dissemination by setting expectations and requirements for family psychoeducation at the central level.

New Jersey aside, the most likely strategy based on experience to date is one in which provider organizations take the initiative while being supported in implementation by patient and family organizations, the state mental health authority, and the key insurance payers as a consensus-driven partnership. Appropriate reimbursement for the service will follow from this collaboration. Experience also suggests that this process requires several years of consistent effort and ongoing monitoring to succeed. Happily, it is not necessarily a fiscally expensive process: Maine achieved 90+% agency implementation for about $25 per capita over 4 years, including evaluation costs. The principal costs are in human effort, especially the effort required to overcome resistance to change.

There also must be accountability and tracking of delivery of services to families. Although many states encourage the delivery of services to families, few monitor or make funding contingent on such services being delivered (Dixon, Goldman, Hirad, Adams, & Lucksted, 1999). One system level option is for mental health centers to create the role of adult family intervention coordinator, who serves as the point-person for such intervention, running interference, supervising clinicians, and monitoring fidelity (Mueser & Fox, 2000).

Family-To-Family Programs

In the absence of professionally-led family psychoeducation programs, voluntary peer-led family education programs have developed, epitomized by Burland's Family-to-Family Education Program (FFEP) provided through NAMI (Burland, 1998; Solomon, 2000; Solomon, Draine, & Mannion, 1996; Solomon, Draine, Mannion, & Meisel, 1996). FFEP is currently available in 41 states, often with wait
lists. FFEP and other mutual-assistance family programs are organized and led by trained volunteer family members. They are offered in the community regardless of the ill relative’s treatment status, tend to be brief (e.g., 12 weeks for FFEP), and mix families of persons with various diagnoses but focus on schizophrenia and bipolar disorder. Based on a trauma and recovery model of the family experience of coping with mental illness, FFEP merges education with specific supports to help families through stages of apprehending and coping with a relative’s mental illness (Burland, 1998). The FFEP focuses first on family member outcomes and well-being, although benefits to the patient are also considered important.

Uncontrolled research on FFEP and its NAMI predecessor program, Journey of Hope, suggest that program participation increased the participants’ knowledge of the causes and treatment of mental illness, their understanding of the mental health service system, and their well-being (Pickett-Schenk et al., 2000). A prospective naturalistic study showed that FFEP participants reported significantly less displeasure and worry about their ill family member and significantly more family, community, and service-system empowerment at program completion (Dixon, Stewart, et al., 2001). This finding has now been replicated in a study with a waiting list control design. Benefits observed at the end of the program were sustained at 6-months postintervention (Dixon, Stewart, et al., 2001). Although FFEP currently lacks rigorous scientific evidence of its efficacy in improving clinical or functional outcomes for the patient with mental illness, it shows considerable promise for improving family well-being, at least over short periods. The most recent research and practice has attempted to optimize the clinical opportunities provided by family psychoeducation and peer-based programs such as FFEP by developing partnerships between the two strategies. For example, family psychoeducation programs have utilized FFEP teachers as leaders, and participation in FFEP has facilitated eventual participation in family psychoeducation.

CONCLUSIONS

Family psychoeducation has established its efficacy and effectiveness as an evidenced-based practice. To date, its use into routine clinical practice is alarmingly limited. This is particularly unfortunate, because nearly all practitioners, of many disciplines, who use the approach report marked increases in their sense of professional satisfaction, gratification, and enjoyment of their work, and gratitude and appreciation from families and patients, often rarities in work with severe mental illness. Recent research has begun to develop dissemination interventions targeted at programmatic and organizational levels with some success. Ongoing research must continue to develop practical and low-cost strategies to introduce and sustain family psychoeducation in typical practice settings. More research is also needed on identifying the barriers to implementing family psychoeducation in various clinical settings (i.e., the impact of clinicians’ attitudes, geographic factors, funding, disconnection of patients from family members, stigma), as well as the extent to which modifications in these factors mediate the outcomes of educational interventions. Dissemination could also be facilitated by further exploration of integration of family psychoeducation with psychosocial interventions such as assertive community treatment, supported work and social skills training, and other evidence-based cognitive behavioral strategies to improve patient treatment outcomes.

However, the first step toward dissemination is awareness among practitioners that new approaches are not only available, they are much more effective than previous models, particularly those that are oriented toward the individual patient alone and those that target family dysfunction. This new approach builds on the fundamental strength of family loyalty and altruism to achieve results that to date have been more cost-effective than any model previously developed for this serious type of disorder.

Perhaps the most immediate implication for family therapists is that these approaches are not difficult to learn or practice, if training and supervision are available, if it is reasonably competent, and if it is applied in practice. Further, using the key elements of the models as described earlier in this chapter, an office practice with a patient with schizophrenia is likely to achieve nearly the same results as a more formalized implementation in an organized practice setting. Family therapists primarily need to see the family as a resource for, not the source of, the disorder, as being equally the victim of a
neurological disorder in a loved one as is the patient. The technical aspects could be less important to outcome than simply having the right attitude and an empathic approach to both patient and family. Families themselves are usually appreciative of, and have profound need for, the support of professionals. Focus group feedback has shown repeatedly that it is the basics of family psychoeducation—support, guidance, sharing the burden, information—that families most value. The more technical aspects seem to be effective in achieving outcomes, but are not noticed as much by the recipients. In short, it is far more effective to apply the key elements in whatever way seems to be feasible in one’s practice than to not include the family in treatment at all. It is important for clinicians to remember that the first study of the modality, Goldstein et al.’s (1978) crisis family therapy, did not include some of the components developed later, but was nevertheless dramatically effective and started the process of empirically-based family treatment for schizophrenia.

Hopefully, readers of the Journal of Marital and Family Therapy will agree that this is a new frontier for work by family therapists, since they are inherently more familiar with working with families and comfortable with this more complex form of treatment than those with individual therapy as their only background. The question remaining is whether family therapists will be able to adopt the necessary empathic, educational, and supportive approaches that have been proven effective. The authors urge the reader to make the effort, because the rewards are not only great, they tend to be mutual for all concerned.

REFERENCES

References marked with a double asterisk are recommended for clinicians.


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Randomised controlled trial of antidepressants v. couple therapy in the treatment and maintenance of people with depression living with a partner: Clinical outcome and costs. *British Journal of Psychiatry*, 177(2), 95–100.


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