Recent studies suggest that the multiple-family group is a preferable vehicle for assisting families and treating and rehabilitating persons with schizophrenia within a psychoeducational clinical framework. This approach is probably the most cost-effective treatment for schizophrenia developed since antipsychotic medication.

Multiple-Family Groups and Psychoeducation in the Treatment of Schizophrenia

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With the growing interest in family-based psychoeducational and behavioral management approaches has come a revisiting of multiple-family groups (Goldstein and others, 1978; Leff and others, 1982; Falloon and others, 1985; Hogarty and others, 1991). Unlike psychoeducation, which has recent origins, the use of multiple-family groups began nearly three decades ago in attempts by Laqueur (1964; personal communication, December 1974) and Detre, Sayer, Norton, and Lewis (1961) to develop psychosocial treatments for hospitalized patients with schizophrenia. Unlike family therapy during its early period, work in multiple-family groups 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 noted improved ward social functioning in patients who insisted on attending a group organized for visiting relatives. Detre and his colleagues (1961) started a multiple-family group to encourage cooperation between resident psychiatrists and social workers on an acute inpatient service. However, 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.

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From these beginnings, the approach has grown steadily; most of the focus has continued to be on the major psychiatric disorders (Strelnick, 1977; Benningfield, 1980; O'Shea, 1985). Many clinicians 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 (Lansky, Bley, McVey, and Bottram, 1978; McFarlane, 1983).

This chapter describes a new technique that attempts to capitalize on the unique nature of the multiple-family group and goes on to present recent empirical data that validate that efficacy. This treatment approach brings together aspects of psychoeducational, family behavioral, and multiple-family approaches to create a new model—the psychoeducational multiple-family group (PEMFG) (McFarlane, 1990). As such, it is a second-generation treatment model that incorporates the advantages of each of its sources, reduces their negative features, and leads to a number of synergistic effects that appear to enhance efficacy. Building on the psychoeducational family approach of Anderson, Hogarty, and Reiss (1986), the model presented here has attempted to reflect contemporary understanding of schizophrenia from biological, psychological, and social perspectives. A basic premise is that an effective treatment should address as many known aspects of the illness as possible, at all relevant system levels.

Social Dimensions of Schizophrenia

Psychoeducation and family behavioral management were developed to reduce family expressed emotion (EE) and thereby to reduce the risk of psychotic relapse (Leff and Vaughn, 1985). The multiple-family group approach goes beyond the focus on EE, because families attempting to cope with schizophrenia experience a variety of stresses that put them at risk of frustration and discouragement, as natural reactions (Johnson, 1990). The focus here is on social isolation and family stigma. Multiple-family groups address these issues directly by increasing the size and complexity of the social network, by exposing a given family to other families like themselves, by offering a forum for mutual aid, and by giving family members an opportunity to hear the experiences of other adults who have had similar experiences and found workable solutions. In addition, psychoeducational multiple-family groups reinforce the information learned at coping skills workshops. Coupled with formal problem-solving instruction (Falloon, Boyd, and McGill, 1984), the group experience enhances the family's available coping skills for the many problems that occur in the course of the patient's recovery and rehabilitation.

**Family Isolation.** The common observation that many families with a member with schizophrenia seem more socially isolated has been partially confirmed by studies of social networks. Brown, Birley, and Wing (1972) noted that 20 percent of the families in their study were both extremely isolated and high on ratings of EE. Another 50 percent were moderately isolated
and showed consistently higher EE than did the 30 percent who seemed to have low levels of isolation. Hammer (1963) had noted earlier that patients whose friends and family members knew each other tended to keep those relationships intact after hospitalizations, compared with those without such “dense” (that is, interconnected) networks. Tolsdorf (1976) found that patients with schizophrenia at first admission had smaller, more family-based, and more “asymmetrical” (giving less than what is received) networks than medical patients. This tendency has been noted in several studies by Pattison, Llama, and Hurd (1979), who found that social network size and density were strongly associated with acute and chronic schizophrenia—that is, a network about half the normal size, composed predominately of immediate family members. Garrison (1978), studying Puerto Rican women in New York City, found an association between degree of psychopathology and the size and type of network of the patient and his or her family. A related finding is that the constriction of networks noted at or just prior to the first episode is magnified by that episode itself and by the burdens imposed by the subsequent development of the illness (Lipton, Cohen, Fischer, and Katz, 1981). For family members, this probably results from protective preoccupation with the patient and withdrawal from and by friends and other relatives (Potasznik and Nelson, 1984).

Isolation of the family assumes significance when one considers the functions of a social network. Hammer (1981) has emphasized social and instrumental support, access to other people and resources, mediation of information, the placing of demands, and the imposition of constraints, all of which are essential to developing skills for coping with a chronic mental disability. Lack of social support markedly increases vulnerability to ordinary stressors in both medical and psychiatric illness, while moderate network size and density interact to predict low relapse rates (Dean and Lin, 1977; Dozier, Harris, and Bergman, 1987; Steinberg and Durell, 1968). Although the lifetime risk of schizophrenia is about the same the world over, its course is more benign in developing nonindustrialized cultures with a more permeable village social structure (World Health Organization, 1979). Thus, the social support available to the family may be one of the critical factors determining outcome; the lack of it appears to make everyone, especially the person with schizophrenia, more vulnerable to stress. Where social support is not available, the treatment context may have to provide it.

**Family Stigma.** Rabkin (1974) reviewed the literature on the stigma of mental illness and concluded that only slight progress had been made in reducing the degree of public rejection of the mentally ill. Surprisingly, most families do not report feeling stigmatized by the emergence of schizophrenia in one of their members (Freeman and Simmons, 1961). On the other hand, many family members attempt to conceal the presence of the illness from friends and more distant relatives and, in many cases, drop friends following the initial episode (Yarrow, Clausen, and Robbins, 1955). Lamb and Oliphant (1978) reported that many parents found it difficult to talk to other parents.
about their children's achievements—simply because the contrast was too painful—and gradually saw less of them. While the available studies are somewhat inconsistent, the conclusion can reasonably be drawn that a patient's family members do not automatically feel stigmatized but often behave as if they do, and that friends and relatives do tend to avoid them as if they are stigmatized. The widespread, though invalid, assumption that families play a role in causing schizophrenia is probably a significant contributor to the stigma that family members receive and feel.

Thus, a picture emerges that many families may be isolated and stigmatized, and may feel so as well, in combinations that may be complex and variable. These problems produce strains that are likely to lead to exasperation, a sense of abandonment, and eventually demoralization. These effects on the family often interfere with their capacity to support the ill member and to assist in rehabilitation.

Clinical Methods

The psychoeducational multiple-family group has been designed to counter family isolation and stigma while incorporating the clinical methods that have been shown to reduce EE and foster extended remission. The approach consists of three components, roughly corresponding to the phases of the group. In the first phase, the content of the model follows that of Anderson, Hogarty, and Reiss (1986), with its emphasis on joining in a collaborative alliance with family members, conducting an educational workshop, and focusing on preventing relapse for a year or so after discharge from an acute hospitalization. Unlike the single-family psychoeducational approach, the format for treatment after the workshop is a multiple-family group.

The second phase involves moving beyond stability to gradual increases in patients' community functioning, a process that uses problem solving based on the multiple-family group as the primary means for accomplishing social and vocational rehabilitation. This occurs, roughly, during the second year of the multiple-family group.

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 patient needs for social contact, support, and ongoing clinical monitoring. This format is also an efficient context in which to continue psychopharmacological 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. The multiple-family-group treatment approach is briefly described below, and in detail in a treatment manual available from the author.

Initial Interventions. The intervention begins with a minimum of three engagement sessions, in which the patient's primary clinician meets with the individual family unit, usually without the patient present. These are
accompanied by separate meetings with the patient. For both philosophical and practical reasons, we establish treatment plans based on the patient's and family's stated goals and desires. When five to eight families have completed the engagement process, the clinicians—usually including the patients' psychiatrists—conduct an extensive educational workshop, again usually without the patients. The biomedical aspects of schizophrenia are discussed, after which the clinicians present and discuss guidelines for the family management of both clinical and everyday problems in managing the illness in the family context. These initial interventions are modeled after those described in detail by Anderson, Hogarty, and Reiss (1986).

**Ongoing Psychoeducational Multiple-Family Group.** The first meeting of the ongoing psychoeducational multiple-family group follows the workshop by one or two weeks. Its format includes a biweekly meeting schedule, with each session lasting an hour and a half; leadership by two clinicians; and participation by five to eight patients and their families. From this point forward, patients are strongly encouraged to attend and actively participate. The multiple-family group's primary working method is to help each family and patient apply the family guidelines to their specific problems and circumstances. This work proceeds in phases whose timing is linked to the clinical condition of the patients. The actual procedure uses a multiple-family problem-solving method adapted from a single-family version by Falloon and Liberman (1983). Families are taught to use this method in the multiple-family group, as a group function. It is the core of the multiple-family-group approach, one that is acceptable to families, highly effective, and nicely attuned to the low-intensity and deliberate style essential to working with the sensitivities of people with schizophrenia.

The first phase concentrates on problems that patients experience as they begin to reenter the world outside the protection of the hospital or clinic. A central goal during this phase is prevention of relapse, achieved primarily by limiting functional expectations and demands and artificially reducing the level of stimulation and stress in the social environment. That is, the family is encouraged to create a relatively simple, low-demand, and low-intensity milieu at home, to the degree possible without totally disrupting family life. Beyond that general approach, the multiple-family group maintains remission by systematically applying the group problem-solving method, case by case, to difficulties in implementing the family guidelines and fostering recovery. The rehabilitation phase should be initiated only by patients who have achieved clinical stability by successfully completing this community reentry phase.

As stability increases, the multiple-family group functions in a role unique among psychosocial rehabilitation models: it operates as an auxiliary to the in vivo social and vocational rehabilitation effort being conducted by the clinical team. The central emphasis during this phase is the involvement of both the family and the group in helping each patient gradually take on responsibility and begin to socialize again. The clinicians continue to use problem solving and brainstorming in the multiple-family group to identify and develop
jobs and social contacts for the ill group members, to help individual patients obtain job placement, and to find new ways to enrich their social lives.

A Technical Paradigm for Multiple-Family-Group Sessions. In the current model, a stable membership of from four to eight families meets with two clinicians on a biweekly basis for two years or more following the onset of an episode of schizophrenia. In most instances, the decision to have patients attend is based on their mental status and receptivity to the stimulation such groups may bring about. The format of the sessions is closely controlled by the clinician, following a standard paradigm. This structure reduces the likelihood that the sessions will turn into emotional “potboilers” or nonproductive gripe sessions that, given the nature of the illness, would not be rehabilitative for the patient or helpful to families. The task of the clinicians, particularly at the beginning, is to adopt a businesslike tone and approach that promotes a calm group climate, oriented toward learning new coping skills and engendering hope.

Each session of the multiple-family group begins and ends with a period of social chatting, directed by the clinicians, the purpose of which is to give the patients and even some families the opportunity to recapture and practice any social skills they may have lost due to their long isolation and exposure to high levels of stress. After the socializing, the clinicians specifically ask about the status of each family, offering advice based on the family guidelines or direct assistance, when it can be done readily. A single problem that has been identified by any one family is then selected, and the group as a whole participates in problem solving. This problem is the focus of an entire session, during which all members of the group contribute suggestions and ideas. Their relative advantages and disadvantages are then reviewed by the affected family, with some input from other families and clinicians. Typically, the most attractive of the proposed solutions is reformulated as an appropriate task for trying at home and assigned to the family. This step is then followed by another final period of socializing.

Treatment Effects

Outcome studies of multiple-family-group treatment were quasi-experimental or impressionistic during the period from 1960 to the advent of the psycho-educational treatment models. In spite of their less rigorous design, these reports’ consistency lends them a certain credence, especially since the effects on relapse match those measured in more recent experimental studies (Berman, 1966; Levin, 1966; Lurie and Ron, 1972; Lansky, Bley, McVey, and Botram, 1978; Falloon, Liberman, Lillie, and Vaughn, 1981).

Bergen County, New Jersey, Outcome Study. In an attempt to more accurately assess outcome and to sort out various elements of the multiple-family group, I have undertaken two studies using experimental designs and standardized measurements. In the first, forty-one patients, with a diagnosis of schizophrenia or schizoaffective disorder, were randomly assigned during
MULTIPLE-FAMILY GROUPS IN THE TREATMENT OF SCHIZOPHRENIA

an acute inpatient hospitalization to one of three alternatives: psychoeducational multiple-family group, dynamically oriented multiple-family therapy, or psychoeducational single-family treatment, without interfamily contact. The design tested two treatment elements, with the hope of distinguishing separate and possibly additive effects. Medication was used in all cases; dosage was determined by the staff psychiatrist for the patients and set at lowest effective dose levels.

At four years after discharge, psychoeducational multiple-family group had a significantly longer time to first relapse than psychoeducational single-family treatment (Cox's coefficient/standard error = 2.09; \( p = .01 \)). Final four-year relapse rates were 50 percent for psychoeducational multiple-family group, 57.1 percent for dynamically oriented multiple-family therapy, and 76.5 percent for psychoeducational single-family treatment. The earliest psychoeducational multiple-family group cohort of ten patients had six who have remained in remission for five years or more. The data suggest that a specific and independent multiple-family-group effect exists that seems to prevent or forestall relapse from roughly one year after an index episode to an as-yet-undetermined end point. As for functional outcome, 32.5 percent of all study patients at intake were occupied in full- or part-time work, in a full- or part-time sheltered workshop, or as a student or homemaker. At two years, 51.6 percent were functionally occupied across all treatment types. The psychoeducational multiple-family group registered the highest increases, but the differences were not significant.

New York State Family Psychoeducation in Schizophrenia Study. These results were promising but needed replication in a larger sample. Started in 1985, this study utilized a two-cell design to experimentally compare psychoeducational multiple-family and psychoeducational single-family treatment, over a two-year period. The design included random assignment, full specification of the test therapies, extensive training and ongoing supervision of experienced therapists by the project's supervisory staff, a standard-dose medication strategy, and wide-ranging measurement of patient and family outcomes. To our knowledge, this study is the largest clinical trial of psychoeducational family intervention reported to date and the first major experimental trial of multiple-family groups.

The total sample consisted of 172 DSM-III-R patients with schizophrenic, schizoaffective, or schizophreniform disorders. They were recruited and treated at six New York State public psychiatric facilities and represented a wide range of the public service patient population in terms of chronicity, race, ethnicity, social class, and geography. Clinicians at each participating site assessed and treated twenty-four to thirty-six patients. No significant differences at baseline existed between the treatment conditions on any of the measured variables.

Relapse Outcome. One-year relapse outcome was determined using symptom criteria based on the Brief Psychiatric Rating Scale (BPRS): 19.0 percent of multiple-family-group cases relapsed during the first year, as compared to 28.6 percent of single-family treatment cases. The relapse rates at two years were 28
and 42 percent, respectively. For cases completing the treatment protocol (80 percent of the sample) or when controlled for medication compliance, this was a statistically significant difference ($p < .05$). Rates of clinically significant relapse (cases that met criteria for seven days) were 16.3 versus 25.6 percent, respectively. The multiple-family result—an annual clinically significant relapse rate of under 10 percent—compares favorably to expected relapse rates of about 40 percent using medication alone or with supportive individual therapy (Hogarty, Schooler, and Ulrich, 1979). Among Caucasian families with patients who only partially remitted during the index admission, a marked difference in relapse existed, again favoring the multiple-family-group format: 17 percent versus 59 percent, at two years, using the more rigorous criteria. That is, in the highest-risk subsample, the multiple-family-group relapse rates were actually lower than in more well-stabilized patients, while the opposite effect was observed in single-family treatment. Interestingly, little difference in relapse rates existed between the modalities in minority patients.

**Rehospitalization Outcome.** We compared the mean number of hospitalizations for the entire sample for two years prior to the study with hospitalizations during the study period. These rates dropped to about one-third of the sample’s prior rate by the end of the two-year observation and treatment interval.

**Employment Outcome.** The sample as a whole increased significantly in employment (full- or part-time competitive or sheltered job), from 17.3 percent two months prior to the test treatments to 29.3 percent during the eighteen- to twenty-four-month period in treatment (chi square = 7.63; $p = .001$). Although multiple-family group yielded a higher employment gain than single-family treatment (16 percent versus 8 percent), the difference was not statistically significant.

**Cost-Ef fectiveness and Medication Compliance.** A final measure of effectiveness has to do with the relative expenditure of staff time in implementing a treatment. Because the multiple-family-group approach not only yields a better outcome but also requires exactly one-half the staff time expenditure of single-family treatment, the cost-benefit ratio (1:2.5) strongly favors the multiple-family-group format. Furthermore, the psychosocial treatment appeared to affect pharmacological treatment. Medication compliance, as assessed by the treating psychiatrists, averaged close to 90 percent for the entire sample across the two years, increasing slightly over that period. The study was conducted in a large state hospital system, under less-than-ideal circumstances, yet the outcome was fairly dramatic, suggesting wide applicability to a variety of less financially stressed settings.

**Conclusion**

The paradigm presented here for the treatment of schizophrenia—an educational and clinical management model that aligns with, and supports, the family—is a cause for new optimism about the treatment of the mentally ill, with treatment effects comparable in magnitude to those of psychotropic medication.
Particularly in its multiple-family format, psychoeducation is a powerful tool for preventing relapse and for achieving significant improvement in the quality of life for both chronically ill patients and their families.

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