Psychoeducational and family therapy in relapse prevention


Recent shifts to briefer hospitalization and an emphasis on community care have emphasized the significance of patient-family interactions in this phase of treatment. Psychoeducational family programs designed to increase medication compliance and effectiveness in coping with stressors have been successful in reducing the risk of relapse in the first year following hospital discharge. Various models for family intervention are discussed and their strengths and weaknesses evaluated.

During the past 5 years, there has been a remarkable acceleration in the development and evaluation of psychosocial treatments for schizophrenia. This interest has been stimulated by a number of factors, such as problems in ensuring compliance with maintenance medication, the limited impact of pharmacologic agents in the recovery of social functioning of patients, the reduction of periods of inpatient stay so that patients are treated in the community in states of partial remission and the fact that family members have in many instances found it necessary to function as caregivers for their schizophrenic offspring or spouses.

The confluence of these factors has resulted in a strong interest in family-based intervention programs designed to use the resources of the family unit to increase medication compliance and reduce the impact of stressors which could serve as triggers of relapse. These family intervention programs have been termed psychoeducational by Anderson et al. (1) because they involved a combination of didactic materials about schizophrenia for patients and relatives and therapeutic strategies designed to improve stress management by all family members through enhanced communication and problem solving skills.

Undoubtedly, these psychoeducational family programs received a major impetus from research originating in Great Britain and subsequently replicated in other countries on the concept of expressed emotion (2). This concept refers to affective attitudes of criticism and/or emotional overinvolvement directed at the patient-relative, expressed by relatives during a semistructured interview typically conducted during hospitalization of the patient for an episode of schizophrenia. The fact that these assessments have been found to correlate moderately with the behavioral expression of these attitudes after the patient is discharged and is in regular contact with relatives (3-5) supported them as targets for intervention. Following the epidemiological model, the psychoeducational models developed were designed to reduce the properties of patient-relative interaction predictive of relapse.

The strategic goals of a psychoeducational family program

All psychoeducational family programs appear to possess similar strategic goals. These are summarized in Table 1. As indicated in Table 1, these issues involve first assisting the patient and his or her relatives to make some sense of the psychotic episode by providing some explanatory model of the disorder. Second, to assist all people in confronting the painful issue that a vulnerability to future episodes exists. Third, to assist the patient and family in dealing with the continued dependence on medication for symptom control. Fourth, to appreciate and utilize the fact that stressful life events, and how they are dealt with, relate to the course of

Table 1. Critical issues in the psychoeducational treatment of psychotic patients and their relatives

- integration of the psychotic experience
- acceptance of vulnerability to future episodes
- dependence on psychotropic medication for symptom control
- the significance of stressful life events as triggers for the recurrence of the disorder
- distinguishing personality from disorder

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Table 2. Common ingredients in effective family intervention programs

- engagement of the family early in the treatment process in a "no fault" atmosphere
- education about schizophrenia concerning:
  - the vulnerability-stress model
  - etiologic theories
  - variations in prognosis
  - rationale for various treatments
  - recommendations for coping with the disorder
- communication training directed at:
  - improving communication clarity in general
  - improving ways of providing positive and negative feedback within the family
- problem-solving training directed at improving:
  - management of day-to-day problems and hassles
  - management of discrete stressful life events
  - generalized problem-solving skills
- crisis intervention:
  - in times of extreme stress involving one or more members of the family when incipient signs of recurrence are evident

the patient’s disorder. And fifth, the patient and relatives need to learn to separate the characteristics of the patient that reflect enduring personality traits from variations in the expression of his or her disorder.

Tactics in psychoeducational family therapy

If the patient is in regular contact with family members, it is advisable to engage these relatives in the patient’s care. Most studies have indicated that a program that covers a 9- to 12-month period following hospital discharge is acceptable to both patients and their relatives. Table 2 presents the essential elements found useful in such a program. Generally, all of the specific components in such a program are organized by an orientation to a vulnerability-stress model (6), which links theories of etiology, course and rationale for pharmacological and psychosocial treatment. There have been 5 published reports to date evaluating the additive role of psychoeducational family treatment to regular maintenance antipsychotic medication. Fig. 1 presents the results from the studies (7–11), which demonstrate that there is a consistent reduction in the risk of relapse when family treatment is provided.

Variations in the format of psychoeducational programs

While all of the above programs share the common features outlined in Table 2, there are notable variations in approach, varying from those that engage the patient in individual family sessions (7, 9–11), to those that primarily focus on relatives seen in groups (8). This has raised the question of what are the essential ingredients in a useful psychoeducational program. Because the provision of didactic materials is a relatively simple and inexpensive procedure, some have questioned whether this is the most important ingredient in such a program. However, in a controlled trial, Cozolino et al. (12)
found that a brief educational package had significant, but limited, effects on relatives' attitudes and behaviors. The factors that were affected by this educational module and those not affected are summarized in Table 3.

Perhaps the biggest question at present has to do with whether the patient or just his or her relatives are required participants in a psychoeducational program. The trial by Leff et al. (13) contrasting relatives-only groups with individual family sessions with the patient present was inconclusive, largely because so many participants dropped out of the relatives-only group.

The recently completed multisite trial (Treatment Strategies Studies: TSS) organized by the US National Institute of Mental Health, directed by Schooler and Keith (14), has shed some light on this issue. While only preliminary results from this study have been presented at scientific meetings, the data support the importance of an intensive educational experience and continuing support for relatives. This study tested whether in-home family sessions according to the Falloon et al. (9) model added anything to the other conditions which involved an intensive educational session and monthly relatives' group. Note that all participants in this study had education and access to the groups. The results reported to date failed to find further relapse protection from the additional in-home family sessions.

The results of the TSS study support the position of MacFarlane (15), who has advocated an intermediate position between individual family therapy and relatives-only groups: multiple family groups. These groups, composed of relatively small numbers of patients and close relatives, operate best when organized according to the psychoeducational model. In one pilot study, reported in (15) above, MacFarlane reported that, over a 5-year follow-up period, psychoeducational multiple family groups (PE-MFG) were associated with the lowest relapse risk compared with more traditional multiple family groups or single family psychoeducational therapy. The differences were greatest when contrasted with the non psychoeducationally oriented family group.

MacFarlane argues that PE-MFG offers numerous opportunities for interfamilial support, reduction of stigma and an interesting process termed cross-parenting, in which parents in one family can assist patients in another, because of their reduced emotional involvement with one another. The results of a multisite trial testing PE-MFG against the analogous single-family approach will be significant in evaluating the relative efficacy of these 2 models.

### Interactions with medication strategies

In the earlier study by Goldstein et al. (7), the presence or absence of family therapy was tested against 2 medication conditions: a standard or a very low dose. The best results were found for the addition of family therapy and the standard dose of antipsychotic medication. The NIMH multisite study cited above investigated a similar question using randomization of patients to 3 drug strategies: standard, low-dose and intermittent medication. No interaction was found, and the best results, as far as relapse prevention, were found for the standard dose. It was not possible to test the additive value of either family program to any of the drug conditions, as this study did not contain a medication management-only condition in which family involvement was minimized. Thus, the issue of whether the potential exists for psychoeducational family programs to facilitate variations in maintenance medication strategies is still an open one.

While psychoeducational family therapies have proved effective in reducing relapse, it does not appear that their sole mechanism of action involves enhancing medication compliance. All but the Falloon et al. (9) study used depot medication, in which the delivery of the antipsychotic medication was assured. The Falloon study began with oral medication (tablets) for everyone, and only shifted patients to the depot preparation if they were non-compliant. In general, Falloon et al. found higher compliance with either regimen in patients assigned to the family condition and a lower dose level required to maintain patients. Even if the effect of psychoeducational family therapy is not mediated by increased medication compliance, most investigators have noted this as an important side effect of this approach even when depot preparations are used: e.g., patients are more willing to show up for injections and continue on their medication regimen. Implicit in the strategic goals outlined in Table 1 is that when some of the issues outlined there are resolved, the probability of compliance

### Table 3. Factors affected and not affected by a brief family education program

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<thead>
<tr>
<th>Factors affected</th>
<th>Factors not affected</th>
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<td>- felt support from treatment team</td>
<td>- information retention</td>
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<tr>
<td>- family's sense of responsibility for the illness</td>
<td>- perception of symptoms</td>
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<tr>
<td>- illness understandable*</td>
<td>- interactions with patient</td>
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<tr>
<td>- patient behavior not intentional</td>
<td>- burden from illness</td>
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<tr>
<td>- less rejection of patient*</td>
<td>- hope for future</td>
</tr>
<tr>
<td>- hours per week spent with patient</td>
<td>- secondary (not interactive with initial expressed emotion level of family. Source: adapted from Cozolino et al. (12).</td>
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with maintenance medication is greatly improved. As suggested in a previous article on compliance by Goldstein (7), the attainment of these strategies involves going beyond the simple provision of information and involves reliance on psychotherapeutic skills to resolve the resistance that occurs naturally and inevitably when one has to incorporate notions of patienthood and medication dependence into one’s self-concept.

References