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Introduction

This section provides an introduction to approaches to including families in the treatment and recovery of persons with severe mental illness.

What is family psychoeducation?

Family psychoeducation is a method for working with families, other caregivers and friends who are supportive of persons with mental illness. Based on a family-consumer-professional partnership, it combines clear, accurate information about mental illness with training in problem solving, communication skills, coping skills and developing social supports. The goals are to markedly improve consumer outcomes and quality of life, as well as to reduce family stress and strain. It builds on and combines the complementary expertise and experience of family members, consumers and professionals to develop coping skills that lay the foundation for mastery and recovery.

The term *family* includes those who undertake the care and support of the person with a severe mental illness, regardless of whether they are related or live in the same household. The term is used in this Workbook to mean "family and supporters", as used throughout the other Implementation Resource Kits in this series of Evidence Based Practices.

Who is this Workbook for?

For *mental health practitioners and case managers* learning and applying this approach to treatment and recovery.

For *clinical supervisors and mental health program leaders* as a reference for program development and ongoing administration.

☞Practitioners of all mental health disciplines—psychiatrists, psychologists, social workers, nurses and nurse practitioners, counselors, occupational therapists and licensed counselors—have proven to be remarkably capable of conducting this model of treatment. In some carefully supervised situations, para-professionals working closely with a professional clinician have effectively conducted family psychoeducation.

The knowledge and skills presented here have become part of the competency expectations for all professionals, in all disciplines, who work with consumers with severe mental illness. These approaches are especially relevant in *outpatient and mental health centers*, as hospital stays have become very short. While all practitioners who do such work may not be able to implement Family Psychoeducation (FPE) fully, the knowledge and skills, and particularly the perspective on the family that are described here, are useful, if not indispensable, in any work with such consumers. For instance, knowing how to engage family members to collaborate in treatment and recovery is key to those working on inpatient services or short-term outpatient services, because that engagement, if done well, will facilitate families continuing in longer-term work and greatly improve outcome for both consumer and family. This workbook could be useful for *family members* who become co-teachers and/or co-leaders in multifamily groups and for *consumers* who establish and run educational services and programs for their peers.

For which consumers and which disorders is this Workbook designed?

Family psychoeducation has been demonstrated remarkable effectiveness when provided to families and consumers, especially when there is a family member available. This approach is particularly beneficial in the early years of the course of a mental illness, when improvements can have a dramatic and long-term effect and while family members are still involved and open to participation. As well, consumers who experience frequent hospitalizations or prolonged unemployment and families who are especially exasperated and confused about the illness benefit substantially and often dramatically.

Clearly, it should be offered whenever consumers or family members request assistance in learning more about a particular illness and how to overcome it. It is particularly useful for families who have previously benefited from family-to-family education programs and want to learn how to assist in treatment and recovery.   It is highly

effective when the consumer wants family members to support him or her in better ways and/or when the family wants to know how to provide better support.

At present, FPE has been shown to be most effective for individuals diagnosed with schizophrenia. There have been at least 20 controlled trials, involving nearly 5000 consumers and their families and two are underway in Scandinavia that will involve nearly 1000 consumers and their families. Outcome has been remarkably consistent across all but two of these clinical trials. Services have become routine in a few states, involving a few thousand consumers, most with schizophrenia. For that reason, schizophrenia is the principal diagnostic focus of this Workbook. Although not fully described within this Workbook, modifications have been developed and tested for bipolar disorder, depression, borderline personality disorder and OCD. Multifamily group versions for these disorders have recently been described in William R. McFarlane's *Multifamily Groups in the Treatment of Severe Psychiatric Disorders.* The authors of this Implementation Resource Kit have attempted to provide guidance to practitioners that is as broad, diagnostically speaking, as can be justified by present empirical evidence or by a consensus among experienced practitioners of the psychoeducational approaches. Once practitioners have learned this approach by working with people with schizophrenia, they find it relatively easy to carry out the modifications specific to other disorders or, when necessary by circumstances, to lead multifamily groups (MFGs) with people who have different diagnoses. We recommend that one's first experience as a practitioner be with a single disorder.

What skills do family psychoeducation practitioners need?

As families learn how to apply new information about mental illness to their lives, it is important for a family psychoeducation practitioner to assume the role of teacher. When practitioners become teachers, they interact with families and consumers in a different manner than in traditional therapy. Like classroom teachers, they have a specific curriculum that promotes distinct learning outcomes. In this new role, they are immediately free to partner with family members and consumers, they can cheer them on as new skills are learned and new challenges are tackled. This may be an unfamiliar experience for many practitioners since their training as therapists supports certain interpersonal boundaries and specific methods to assist individuals with developing new skills. According to Christopher Anderson, Ph.D., the three most effective qualities a practitioner can have for meeting families' educational needs are: 1.)

collaborating with families and demonstrating a commitment to recovery; 2.) providing information and advice; 3.) sharing about oneself within the boundaries of the teacher role.

Does this Workbook contain all that one needs to learn to practice successfully?

This Workbook presents an overview, which may be supplemented by the following books described below and other materials referenced in the bibliography section of this Workbook.

1. For conducting multifamily groups (MFGs), the book *Multifamily Groups in Severe Psychiatric Disorders* (William R. McFarlane, New York: Guilford Press, 2002; see Bibliography, below) is important reading and serves as the treatment manual for this more effective and more efficient format. It fully describes the approach for schizophrenia, and reviews key differences for several other disorders particularly bipolar disorder and depression, as well as OCD, borderline personality disorder, integration with assertive community treatment, and applications when there is no family member available.

2. When offering family psychoeducation in the single-family format, the approaches that have been shown to be effective include Anderson's *Schizophrenia and the Family* and Falloon's *Family Care of Schizophrenia (see Bibliography, below).*

3. For bipolar disorder, Miklowitz and Goldstein have described their model in *Bipolar Disorder: A Family-focused Treatment Approach (see Bibliography, below.*

In addition, it is best to be trained in this approach, usually over two to three days of skills training, including explanations, demonstrations and practice exercises, followed by about one year of consultation and supervision by an experienced trainer. This workbook is part of an Implementation Resource Kit (IRK) which also provides fidelity and outcome measures to let you know how closely your experience matches that of a large body of national and international practice and study.

Is the FPE approach for the family's benefit, or the consumer's?

Both. The goal is to support recovery from a major mental illness. The FPE approach asks family members to assist in that

effort. Improvement in their well being is a helpful step in the recovery process. Though it is designed to achieve clinical and functional outcomes for the consumer, it also provides what study after study, including those carried out by family advocates, has suggested: the skills that families need to successfully contribute to recovery. Thus, the whole family improves: the consumer's symptoms and functioning improve; family members find improvements with their own health, their understanding of mental illness, and their ability to provide support to the consumer. One study from the state of Washington found both a dramatic reduction in rehospitalizations and negative symptoms among the consumer participants and a reduction in medical illness among the family participants.

Overview of Family Psychoeducation

An introduction for practitioners beginning to provide services and support for family members

The nature of professional-family relationships has varied over time according to the assumed etiology or causation of mental illness. When deinstitutionalized consumers went home to their unprepared families and supporters (and inadequate community resources), many consumers suffered relapses. In keeping with the prevailing assumptions about families at that time, these relapses were taken as evidence that the home environment was counter-therapeutic. Families and supporters found themselves in painful situations in that that they not only had to experience their loved one's suffering from mental illness, they were also blamed for its occurrence.

For most families, the guilt and confusion of being blamed by professionals, and sometimes relatives or neighbors, induced conflict within the family and usually demoralized the members. That result was particularly destructive, because it often led to breaches in family relationships and to the consumer severing ties with the family, or vice versa. Some of the homelessness that has had so many destructive effects on consumers can be traced to the rejection of the family by professionals, many of whom still expected families to provide social and economic support, housing, guidance and control. Families in many ways were the victims of a double bind, rather than the source of the problem.

As the 1990's became the decade of the brain, professional attention turned away from the family pathology models of mental illness toward the neurodevelopmental models of mental illness. With this advent of advanced research into the brain, the onus for causing mental illness began to be removed from families. From what we now

know about the brain and mental illness, we can stop blaming family interactions for precipitating mental illnesses.

Concurrently, the largest national mental illness advocacy organization, the National Alliance for the Mentally Ill (NAMI) promulgated the message that families who had long been viewed as "part of the problem" should now be considered as "part of the solution" as partners in supporting recovery. Collaborative treatment planning with family and other supportive caregivers has since been incorporated under many professionals' standards of practice, i.e., Standards of Psychiatric Mental Health Clinical Nursing, Standard VI, Collaboration (ANA, 1994).

The family psychoeducational (FPE) model emphasizes basic communication skills and problem solving skills to accommodate the needs of the individuals who have a core information-processing deficit that is often associated with serious mental illness. It is not a model of blame or family pathology. This is *a treatment for a disorder*, much as is medication, not a method of treating the family or even the consumer. The family and the consumer are recruited and asked to participate and be included as partners in that treatment process. In other words, they help to carry out the treatment, rather than participate as the object of treatment. This may appear to be a matter of semantics to some, but the differences are at the core of this approach. It intends that practitioners work *with,* not *on,* the family and the consumer. The model recognizes the vast knowledge and resources that families and supporters play in the recovery of their loved ones. This collaborative approach to sharing knowledge and "joining" together to manage the symptoms of an illness are core foundations of this model. This partnership is essential for success and recovery.

FAMILY RESPONSES

Mental illness brings about such significant changes in people's lives that many families think in terms of life before and after the onset of the illness. There is much written in the psychology literature on this topic. The literature often addresses two basic concepts: family stress and family strengths. Family stress ("burden", as it is referenced in the literature) is the overall level of distress experienced by the family in response to an illness. Further distinction can be made between objective stress, which refers to practical problems such as paying medical bills, obtaining services, and enduring daily management of the illness; and subjective stress, which refers to the family's emotional responses to the illness. Participants in FPE often find relief to discuss openly or problem solve with others "who have been there" about things others might find incredible for example, difficulties accessing treatment, bizarre behaviors, legal compliance issues, medical coverage, etc.

Family strengths have often been overlooked and unrecognized by the professional community. Families and supportive others often have had the potential to respond to the catastrophe of mental illness with great resolve and resilience. Our experience has been that families will rebound from great disappointments within the system and over the course of an illness. They can provide tremendous support and resources to their loved one and knowledge to the clinical team. In this model, families are seen as consultants to help manage an illness. The clinical team and supportive loved ones "join" in sharing their vast array of resources and expertise to assist in dealing with the illness.

As shown in Table 1, a NAMI survey of over 3,000 families confirmed that the educational interventions of lectures, books, classes, workshops and multifamily support groups were rated as of the most value to families.

Table 1: Family Evaluation of Sources of Help

Resources for families	Percent Using It	Rated of some Great Value
Lectures and books	75%	96%
Classes/workshops	21%	96%
Support Group	76%	95%
Friends	71%	90%
Relatives	72%	84%
Individual therapy	61%	77%
Group therapy	35%	68%
Family therapy	33%	61%
Clergy	42%	58%

Surveys of NAMI and non-NAMI families and of mental health professionals who have a family member with a mental illness produce similar results. Mental health professionals who have a relative with a mental illness rated education about the illness and specific suggestions for coping with the person's behavior as the two most helpful family interventions. Even though almost all of these therapists provided dynamic and family systems therapy in their own practices, they rated individual or family therapy as not very helpful for coping with mental illness.

Through NAMI, families have eloquently stated their needs. Their direct statements of need correspond to the skills that research has demonstrated to improve outcome for schizophrenia. The expressed needs of families are also consistent with the findings on adaptive coping by families with a relative who has schizophrenia. Families demonstrate more adaptive coping when they:

- have large social support systems;

- have self-efficacy (i.e., the belief that they can be effective) in dealing with their loved ones' illness;

- belong to a chapter of NAMI; and

- feel affirmed, respected, and valued for the information and skills that they possess.

Professionals should provide the information and skills that families (and research) say that they need. Families can also instruct professionals in the educational methods that they need. Families state that they prefer education that:

- provides clear, concrete information;

- is directly related to the problems that their relatives have;

- provides specific instructions and skills for coping; and

- increases their ability to access services for their relatives.

GOALS FOR WORKING WITH FAMILIES

The field of family psychoeducation has advanced to the point that there is a common set of principles that guide this work. They were developed as a consensus by the world's leading researchers, treatment developers, and practitioners. The World Schizophrenia Fellowship published these principles as part of that organization's efforts to have these approaches made available in mental health services throughout the world. They are included here to make clear the general values of this new form of clinical work, as well as describing what families need from practitioners who are working with their loved one.

The goals of family psychoeducation for people with severe mental illness and their families are:

- To achieve full participation in the community by the consumer and to facilitate full and lasting recovery from mental illness;

- The objectives of family psychoeducation are, for the consumer:

    - to reduce symptoms of mental illness,

    - to prevent relapses and rehospitalizations,

    - to provide rehabilitation for consumers so that they can achieve the maximum possible level of functioning and the best possible outcome, and

    - to provide the foundation for recovery, through collaborative treatment and rehabilitation.

    - To maximize the ability of the members of the family to foster their loved one's recovery and to alleviate their suffering and stress.

The objectives of family psychoeducation for family members are:

- to engage their assistance in supporting treatment and rehabilitation,

- to assure that they can provide knowledgeable support, and

- to alleviate suffering among the members of the family by validating their pain and grief and then supporting them in their efforts to foster their loved one's recovery.

PRINCIPLES FOR WORKING WITH FAMILIES

Practitioners who work with consumers with severe mental illness achieve best outcomes and the greatest satisfaction if they routinely involve family members in the ongoing treatment and recovery effort. Practitioners, who accept that best practices include work with families, strive to meet the needs of families as they have been described in the literature and as has been validated in many research studies.

That means that practitioners will work to:

- Coordinate all elements of treatment and rehabilitation to ensure that everyone is working towards the same goals in a collaborative, supportive relationship, and to include the family as part of the treatment team when appropriate.

- Pay attention to the social as well as the clinical needs of the consumer.

- Provide optimum medication management.

- Listen to families and consumers and treat them as equal partners.

- Explore family members' expectations of the treatment program and their hopes for the consumer.

- Assess the family's strengths and difficulties.

- Help resolve family conflict through sensitive response to emotional distress.

- Address feelings of loss.

- Provide relevant information for consumer and family at appropriate times.

- Provide an explicit crisis plan and professional response.

- Encourage clear communication among family members.

- Provide training for the family in structured problem-solving techniques.

- Encourage the family to expand their social support networks.

- 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.

All evidence-based family psychoeducational models share similar core components. They include:

- *Joining*.

  The practitioner establishes a respectful, trusting, and helpful relationship with family members and consumer and works to build hope for a better future. He or she understands the possible variation in the meaning of socializing across cultural groups and tailor the socializing aspect of the joining sessions to the specific cultural contexts of the participants.

- *Education*.

  The practitioner helps family members better understand their loved one's illness and what they can do about it.

- *Problem-solving*.

  The practitioner works with the family and consumer to identify strategies for handling difficult situations by making use of effective

behavioral, cognitive and communication techniques to address issues caused by the illness.

- ***Structural change in the treatment***.

  The practitioner works with the family and consumer to establish a strengths-based environment where all members are respectful of one another, creating an optimal environment for recovery from mental illness.

- ***Multifamily contact***.

  The practitioner creates multi-family groups in the multifamily model. In both multifamily and single family models, the practitioner recommends participation in local family support groups (National Alliance for the Mentally Ill) to reduce social isolation and sense of stigma.

Family members and significant others involved in the lives 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 imposes considerable stress. Family members often find that access to needed resources and information is lacking. Research developed over the last two decades supports the development of evidence-based practice guidelines for addressing family-members' needs for information, clinical guidance, and support. This research has demonstrated conclusively that meeting the needs of family members also improves consumer outcomes and relationships within the family. Research references can be found in the research review included in this Implementation Resource Kit and in *Multifamily Groups in the Treatment of Severe Psychiatric Disorders*

Family psychoeducational approaches have been remarkably effective in reducing rates of illness relapse when rigorously evaluated in experimental outcome studies. The results of these studies are unusually consistent and point to a valid, reliable and quite robust effect: relapse and rehospitalization rates have been reduced by 40-70% over two years, compared to those who received standard individual services. Programs longer than three months and especially those greater than nine months had better outcomes. In addition, family-member well being improved and medical illnesses decreased, negative symptoms decreased, consumer participation in

vocational rehabilitation and employment rates increased and costs of care were reduced.

As a result of recently conclusive evidence and several meta-analyses showing overall effects on outcome, 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 consumer/relative be offered a family psychosocial intervention spanning at least nine months and including education about mental illness, family support, crisis intervention, and problem solving skills training. Practice guidelines established by the American Psychiatric Association and the Expert Consensus Panel reached the same conclusion: families should receive education and support programs. In addition, an expert panel that included practitioners from various disciplines, families, consumers and researchers emphasized the importance of engaging families in the treatment and rehabilitation process. For a fuller discussion of outcomes and research, please see Dixon, et al., 2001; that article is included in Section 2 of this Implementation Resource Kit.

WHAT ARE THE VARIOUS APPROACHES THAT HAVE BEEN SHOWN TO BE EFFECTIVE?

A variety of family psychoeducation models have been developed over the past two decades. They are all professionally created and led, offered as part of an overall clinical treatment plan for the consumer, last nine months to over five years, are usually diagnosis-specific, and focus first on consumer outcomes, although family understanding and well-being are essential as an intermediary outcome. Models differ in their format (multiple-family vs. single-family sessions vs. mixed), duration of treatment, type of participation by the consumer, location (hospital- and/or clinic-based, home, family practice or other community settings), and variable emphasis on didactic, emotional, cognitive-behavioral and systemic techniques. Several models have evolved to address the needs of family-members: individual consultation, professionally-led family psychoeducation, various forms of more traditional family therapies and a range of professionally led models of short-term family education (sometimes referred to as therapeutic education). There are also family-led information and support classes or groups such as those of the National Alliance for the Mentally Ill (NAMI).

Of these models, family psychoeducation in the form of multifamily groups and single family therapy has a deep enough research and dissemination base to be considered an evidenced based practice. The descriptor "psychoeducation" can be misleading; family psychoeducation includes many therapeutic elements, often

utilizes a consultative framework, and shares characteristics with other types of family interventions.

FPE can be effective in a single-family therapy (SFT) format or in a multifamily group (MFG) format, depending on the desires and needs of the family. We describe here the major types of intervention, divided into single- and multifamily formats. The approaches described in this Workbook are derived from methods developed by Michael Goldstein, Carol Anderson and Ian Falloon and their colleagues. The practitioner applying the single-family approach may want to refer to *Schizophrenia and the Family*, by Anderson, Hogarty and Reiss, and *Family Care of Schizophrenia,* by Falloon, Boyd and McGill. The multifamily group approach has been developed by McFarlane and colleagues, and is described in detail in *Multifamily Groups in the Treatment of Severe Psychiatric Disorders*.

Another approach, the relatives' group model, developed by Julian Leff and others in the U.K., involves helping families with high *expressed emotion* (a term referring to unsupportive, critical interactions) to reduce their exasperation by learning from other families who have more fully understood and mastered the illness and how to cope with it. That approach has also been shown to be effective. That general approach has been incorporated within the multifamily group approach described here, but cannot be implemented in a single-family format. For that reason, it is not described separately here.

The family consultation approach has also been shown to be effective for some types of conditions and families, developed by Lyman Wynne and colleagues. In this approach, families sometimes with the participation of the consumer member, meet in single-family format periodically with a professional consultant, often the psychiatrist or the consumer's primary practitioner. There is no set agenda, but rather the goal is to provide information and guidance on an individual basis to address the specific concerns and problems identified by the family. Often, these sessions take the form of those in Anderson's family psychoeducation model, but are not scheduled on a regular bi-weekly or monthly basis. Again, this model is not described in detail here, because the material here can be readily adapted to the episodic consultation model. This approach appears to be especially useful when scheduling meetings involves great inconvenience, or in cases in which there are few ongoing problems and acute crises and the family is coping well with the situation. It may also be useful because it offers flexibility and so may be better in locations where the mental health system is not highly professionalized. It is often the de facto approach for long-term follow-up after the family has successfully completed the more intensive approaches described here.

Working with families requires that the practitioner adapt the approach to the cultural characteristics of the consumer and his or her family. In a sense, each family is a micro-culture that needs to be understood and addressed respectfully and with empathy. Failing to understand and assess the cultural perspective of a family may create a significant barrier to effective treatment. On one hand, there are many ways to offend family members when one does not know the proper and acceptable ways of interacting are within a given culture. On the other hand, clinical experience, now on a global basis, has shown unequivocally that mental illness usually overrides cultural factors in determining families' perceived need for help, guidance and support. Mental illness, in an important sense, creates its own culture, which family psychoeducation is designed to address for consumer and family alike. The result is a general rule that families will almost always accept the offer of help and the opportunity to participate actively in the treatment and recovery of their ill member, if the practitioner can adapt his or her approach to the culture of the family. One can do so by either being a member of that culture or actively seeking assistance and guidance in learning the key ways of respecting that culture's social norms and mores.

Family psychoeducation has been applied in the United States, and in many countries successfully, following this very general guideline. For instance, in Falloon's study in Los Angeles, CA, and the majority of the families were African-American living in Watts. In McFarlane's large multi-site study in New York, about 40% of the sample was African-American, most living in Harlem. Later implementation throughout New York State showed that sensitive application of the multifamily group version of FPE was not only acceptable but also valued by a wide range of consumers and families with varied cultural and ethnic backgrounds. The key was to assure that either the practitioners themselves or supervisors and/or consultants were familiar with the expectations of members of that given cultural group for professionals and advisors. In particular, practitioners need to understand the possible variation in the meaning of socializing across groups. Practitioners need to tailor the socializing aspect of the joining sessions to the specific cultural contexts of the participants.

Further, practitioners need to take the opportunity (starting with the socializing) to use their observation skills to begin to identify roles, values and norms within the family that could later be used to enhance communication and maximize the impact of the intervention. Linked to the need to understand the cultural context of the participants is the need to acknowledge variation in communication

styles. For example, effective communication is implicit in the tasks to be accomplished within each of the three joining sessions. Most non-European cultures do not understand the reserved, "blank-slate" style of interaction that has become the expected norm for professional psychotherapists. Additionally, most families from non-European backgrounds expect their advisors, counselors and healers to be friendly, out-going and fairly direct. This directness may appear to some practitioners as unnecessary and to others as a given in good clinical practice. Nevertheless, communication is so much influenced by cultural and social circumstances that clinicians need to assess the latter in order to engage caregivers and obtain valid information. For example, in the FPE approach described here, the intent of socializing among practitioners, family members and even consumers is to build trust and emphasize the strengths and value of the family. It is expected that practitioners will model normal social conversation. However, there are variations in power hierarchies and turn-taking behaviors during conversation that may not appear to be `normal' to the practitioner, but are `normal' for the specific cultural context of the family. Acknowledging these variations and tailoring interventions to these realities is one of the tasks requiring creativity and flexibility of practitioners. Obviously the issue of language preferences will have to be addressed.

Lopez, Kopelowicz, and Canive have recently adapted the multifamily group approach described here to a sizeable population of Mexican-Americans in Los Angeles and have found that it required little change, simply because it includes a variety of methods for including the family's and consumer's input into the process throughout the course of treatment. They found that many of its design features matched the needs of people of Hispanic origin living in southern California. This is not as surprising as might be thought: the method itself was developed in the South Bronx of New York City, where the population was entirely composed of Hispanic-, Caribbean- and African-Americans. Likewise, there have been large-scale and very successful applications of these methods in China, Norway and Denmark, Spain, Hungary and Romania, Italy, Netherlands, Germany, Japan, England, Australia and New Zealand and among immigrant groups (for instance, Vietnamese refugees in Melbourne, Australia). There seems to be no cultural group for which an adaptation done with creativity and flexibility and in the spirit of collaboration, understanding and respect has not been successful.

Single Family Psychoeducation

> Details of the single-family clinical models are to be found in Anderson's and Falloon's books and are summarized here and in the sections to follow. These useful references for family practitioners are detailed and filled with excellent clinical techniques for, and information about, schizophrenia. Both the single- and multifamily approaches described here are based on these works and the outcome research conducted by their groups. Another reference source is *Bipolar Disorder: A Family-focused Treatment Approach*, by David Miklowitz and Michael Goldstein, which describes the family behavioral management approach for that disorder. These resource books are all referenced in a bibliography at the end of this Workbook**.**

CLINICAL METHODS

The basic psychoeducational model consists of four stages that roughly correspond to the phases of an episode of schizophrenia, from the acute phase through the recuperative, rehabilitation and recovery phases.

JOINING

Joining refers to a way of working with families and consumers that is characterized by collaboration in attempting to understand and relate to the family. During this phase, a partnership is developed between the consumer, family, and practitioner. The joining phase typically extends from three to five sessions and is the same in both single- and multifamily formats. The goals of this phase are to:

- establish a working alliance with both the family members and the consumer,

- acquaint oneself with any family issues and problems which might contribute to stress either for the consumer or for the family,

- learn about the family's and consumer's strengths and resources in dealing with the illness,

- instill hope and an orientation toward recovery, and

- create a contract with mutual and attainable goals.

Joining, in its most general sense, continues throughout the treatment, since it is always the responsibility of the practitioner to remain an available resource for the family as well as their advocate in dealing with any other clinical or rehabilitation service necessitated by the illness of their relative. To foster this relationship, the practitioner

- demonstrates genuine concern for the consumer,

- acknowledges the sense of loss of hopes and dreams for their family member and grants them sufficient time to mourn,

- is available to the family and consumer outside of the formal sessions,
- avoids treating the family or consumer as patients or blaming them in any way,
- helps to focus on the present crisis, and
- serves as a source of information about the illness.

The family is invited to attend workshop sessions conducted in a formal, classroom-like atmosphere. Typically eight hours in length, several families attend the workshop at a time. The opportunity to interact with other families in similar situations greatly enhances the power of this portion of the intervention, although in some situations, the education is done in single-family format and can be done in the family's home. Biological, psychological, and social information about schizophrenia (or other disorders, as the case may be) and its management are presented through a variety of formats, such as videotapes, slide presentations, lectures, discussion and question and answer periods. Information about the way in which the practitioner and the family will continue to work together is also presented. The families are also introduced to the "guidelines" for management of the illness. These consist of a set of behavioral instructions for family members that integrate the biological, psychological and social aspects of the disorder with recommended responses, those that help maintain a home environment that minimizes relapse inducing stress.

Regularly biweekly scheduled meetings focus on planning and implementing strategies to cope with the changes of a person recovering from an acute episode. Major content areas include the effects and side effects of medication, common issues about taking medication as prescribed, helping the consumer avoid the use of street drugs and/or alcohol, the general lowering of expectations during the period of negative symptoms and an increase in tolerance for these symptoms. Two special techniques are introduced to participating members as supports to the efforts to follow family guidelines: (1) formal problem solving and (2) communications skills training. The application of either one of these techniques characterizes each session. Further, each session follows a prescribed, task-oriented format or paradigm, designed to enhance family coping effectiveness and to strengthen the alliance among family member, consumer and the practitioner. The re-entry and rehabilitation phases are addressed using formal problem-solving methods and communication skills training. The problem solving method is described more fully in the section on multifamily groups.

The principal difference is that in single-family sessions, the participants and the recipients of ideas are the same, so that family members most commonly develop new approaches to their problems by brainstorming among themselves.

Communication skills training is developed to address the cognitive difficulties often experienced by consumers with severe mental illness, especially those with psychotic symptoms. The core goal is to teach family members and the consumer new methods of interacting that acknowledge and hopefully counteract the effects of mental illness on the consumer's information-processing abilities and their marked sensitivity to negative emotion and stimulation.

The key skills include:

- Communication of positive feelings for specific positive behavior,

- Communication of negative feelings for specific negative behavior, and

- Attentive listening behavior when discussing problems or other important family issues.

The approach involves:

- rehearsing communication skills in the session,

- modeling by the practitioner,

- repeated rehearsal, often at home, and then

- homework to assist generalizing the skills learned to other contexts, with social reinforcement used throughout the process of training.

These skills are especially useful for families who are markedly exasperated, manifesting criticism or hostility toward the consumer and/or severe anxiety, preoccupation and intrusiveness as a consequence of disability and symptoms caused by the illness. Often, such reactions by family members are a result of poor treatment response, substance abuse, or treatment complications as a result of the severity of the illness.. Please see Chapters 9 and 11 of Fallon's *Family Care of Schizophrenia* for further information regarding how to implement these important skills.

Approximately nine to eighteen months following an acute episode, most consumers begin to demonstrate signs of a return to spontaneity and active engagement with those around them. This is usually the sign that the negative symptoms are lifting and the consumer can now be offered more challenges toward achieving his or her own goals. The focus of social and vocational rehabilitation deals specifically with the rehabilitative goals and needs of the consumer, addressing the two areas of functioning in which there are the most common deficits: social skills, and the ability to get and maintain employment. The family sessions are used to role-play situations that are likely to cause stress for the consumer if entered into unprepared. Family members are actively used to assist in various aspects of this training endeavor. Additionally, the family is assisted in rebuilding its own network of family and friends, which has usually been weakened as a consequence of the illness. Regular sessions are conducted on a once- or twice-monthly basis, although more contact may be necessary at particularly stressful times.

Multifamily Group Psychoeducation

The psychoeducational multiple family group (PMFG) is a treatment approach which brings together aspects of family psychoeducation, family behavioral 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 of Anderson, Hogarty and Reiss and the family behavioral management approach of Falloon and his colleagues, the model has attempted to reflect contemporary understanding of schizophrenia and other severe mental illnesses from biological, psychological and social perspectives. The assumption is that an effective treatment should address as many known aspects of the illness as possible, at all relevant system levels.

Unlike the recent origins of psychoeducation, however, multiple family group work arose nearly three decades ago in attempts by Laqueur, Detre 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 noted improved ward social functioning in inpatients that insisted on attending a group organized for visiting relatives. Detre and his colleagues started a multiple family group in order 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 consumers and family members alike, as well as improvements in social functioning among consumers and in family communication and morale. From these beginnings, the modality has grown steadily; most of the focus of the practice has continued to be the major psychiatric disorders.

Families attempting to cope with a relative who has schizophrenia, bipolar disorder or another severe mental illness, are likely to experience a variety of stressors, which can impact their ability to offer help to their ill family member. These stressors include social isolation, stigmatization, and increased financial and psychological stress. Multiple family groups address these issues directly by increasing the size and richness of the social support network, by connecting the family to other families like themselves, by providing a forum for mutual aid, and by providing an opportunity to hear the experiences of others who have had similar experiences and have found workable solutions.

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. A critical goal of all family psychoeducational and behavioral models is to reduce family expressed emotion (which is defined as perceived criticism, lack of support, and unrealistic expectations) and thereby reduce the risk of psychotic relapse. The psychoeducational multifamily group approach goes beyond this focus on expressed emotion to address social isolation, stress and stigma as experienced by families and consumers alike. That appears to be key to better overall outcomes, because families attempting to cope with mental illness inevitably experience a variety of stresses which secondarily put them at risk of manifesting exasperation and discouragement as natural reactions.

With respect to the issue of stigma, research has shown (1) that family members do not automatically feel stigmatized but often withdraw as if they have been stigmatized and (2) that friends and more distant relatives do tend to avoid them because of stigma. Thus, like many consumers, many families may be isolated and stigmatized, and may feel so as well. These problems produce strains that are likely to lead to exasperation, a sense of abandonment and eventually demoralization. These effects on the family are likely to interfere with their capacity to support their family member and to assist in their recovery process.

Multiple family groups address these issues directly by:

- increasing the size and complexity of the social network,

- bringing a given family into regular contact with 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 found workable solutions, and

- building hope through mutual example and experience.

In addition, psychoeducational multifamily groups or single-family sessions reiterate and reinforce the information learned in educational and skills training workshops. Coupled with formal problem solving, the group experience serves to enhance the family's available coping skills for the many problems encountered in the course of the consumer's recovery.

CLINICAL METHODS

The general character of the approach can be summarized as consisting of three components, roughly corresponding to the phases of the group. In the first phase, the model emphasizes joining with each family and consumer, conducting an educational workshop and focusing on preventing relapse for a year or so. 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 support gradual increases in consumers' community functioning, a process that uses psychoeducational multifamily group-based problem-solving as the primary means for accomplishing social and vocational rehabilitation. This occurs, roughly, during the second year of the multifamily 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 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..

ENGAGEMENT AND FAMILY EDUCATION

The intervention begins with a minimum of three single-family engagement sessions, in which the consumer's primary practitioner meets with the individual family, often without the consumer present. Separate meetings accompany these sessions with the consumer.

The choice of including the consumer is determined based on consumer and family choices. For both philosophical and practical reasons, we establish treatment plans based on the consumer's and family's stated goals and desires. When 5-8 families have completed the engagement process, the practitioners, usually including the consumers' psychiatrist, conduct an extensive educational workshop, again usually without consumers. The biomedical aspects of the disorder are discussed, after which the practitioners present and discuss guidelines for the family management of both clinical and everyday problems in managing the illness in the family context.

THE ONGOING PSYCHOEDUCATIONAL MULTIPLE-FAMILY GROUP

The first meeting of the ongoing psychoeducational multi-family group follows the workshop by one or two weeks; its format includes a bi-weekly meeting schedule, 1 1/2 hour session length, leadership by two practitioners and participation by 5-8 consumers and their families. In most instances, the decision to have a given consumer attend is based upon his or her mental status and susceptibility to the stimulation such a group may engender. If the consumer wants to attend, that weights the decision in favor of inclusion. The practitioner, following a standard paradigm closely controls the format of these sessions. From this point forward, consumers are strongly encouraged to attend and actively participate. The task of the practitioners, particularly at the beginning, is to adopt a business-like tone and approach that promotes a calm group climate, oriented towards learning new coping skills and engendering hope.

The multi-family group's primary working method is to help each family and consumer to 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 consumers. The actual procedure uses a multiple-family, group-based, problem-solving method adapted from the single-family version by Falloon and Liberman. 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 which is acceptable to families, remarkably effective and nicely tuned to the low-intensity and deliberate style that is essential to working with the specific sensitivities of people with schizophrenia. The same principle applies to other mental illnesses that are sensitive to interpersonal and environmental stress, like major depression and bipolar disorder.

The multi-family group maintains stability by systematically applying the group problem-solving method, case-by-case, to difficulties in implementing the family guidelines and supporting recovery. The subsequent rehabilitation phase should be initiated when appropriate for the consumer. The multiple-family group

functions in a role unique among psychosocial rehabilitation models: it operates as an auxiliary to the services being provided by the mental health treatment team. The central emphasis during this phase is the involvement of both group and family member in helping each consumer to begin a gradual, step-by-step resumption of responsibility and socializing. Practitioners continue to use problem solving and brainstorming in the MFG to identify and find support jobs and social contacts with the consumers, as they find new ways to enrich their social lives. This process helps the consumer as they work on their recovery process, which is addressed in the third phase.

Some Frequently Asked Questions About Family Psychoeducation

When directly compared, single family formats have been found to be more effective for consumers who have an unusually positive response to medication, whose families are unusually emotionally resilient and have already developed good coping skills and are from minority groups, especially if they are African-American. Psychoeducational multifamily groups (PMFGs) have been shown to be much more effective in highly-stressed and highly exasperated families in which medication and other treatments have not been fully effective and when the family is already hampered by divorce, medical illness, separation or refusal of siblings to support the relatives. PMFGs have also been found to be more effective in the first episode. Thus, a fully functioning service for a wide variety of consumers would best offer both formats. On the other hand, PMFGs are at least twice as cost-effective, so in some financially stressed services, PMFGs may be the best option. Very rural clinics, with large distances, may choose to offer single-family format. Some rural clinics have found ways to offer PMFGs by rotating locations, lengthening both the time between and the time devoted to group sessions. Nearly every practitioner who has had the opportunity to work within both formats has come to prefer the PMFG approach because it is, perhaps paradoxically, easier to do, more interesting and enjoyable and, in the end, more gratifying.

WHAT IS THE SCOPE AND EFFICIENCY OF FPE?

The simplest answer is that FPE involves the family in the acute and ongoing treatment and recovery of a person with a severe mental illness, with the goal of alleviating illness, re-integrating the consumer in community life as he or she chooses and helping to set the stage for recovery. As noted above, formats vary but the basic approaches are similar. Family members should be involved as soon as possible during psychiatric crises, inpatient or partial hospital admissions and during longer-term outpatient or Assertive Community Treatment. The other area in which family involvement has proved highly beneficial is

in supported employment., Some family meetings can replace meetings that may have involved only the consumer with other services. Most outpatient services that have applied FPE on a wide scale have experienced a net decrease in staff time, expense, stress and effort when the family is involved on a routine basis. Family psychoeducation in multifamily groups is the most cost-effective of the new evidence-based practices and can greatly improve the overall efficiency of mental health services.

HOW LONG DOES IT GO AND HOW LONG DOES IT TAKE TO WORK?

The outcome research has shown that outcome is almost proportional to the time over which services are offered, with 3 months being the minimum time required to see any effect, 9 months for the clinical effects reported in the literature, 12 months as the recommended minimum and 24 to 36 months for optimal employment and recovery outcomes. On the other hand, the usual approach is simply to ask families to participate for as long as they and the consumer find it useful. With that as the basic contract for participation, it is also the usual situation that once families participate for as little as two or three sessions after the educational session, they choose to participate for up to four or five years, especially in multifamily groups. Though it sometimes takes extra effort to engage a given family or consumer, those same people are likely to request to continue participating several years later.

WHEN SHOULD WORK WITH FAMILIES START?

The two most common points of engagement are:

1. when the consumer is experiencing an acute psychiatric crisis, and

2. during community-based treatment.

In the latter situation, both consumer and family will often be encouraged by the prospect of collaborating in the effort to seek a competitive job. Undertaking family psychoeducation and supported employment at the same time has proven remarkably effective and has achieved employment rates of 35-56% for people with schizophrenia. *Family psychoeducation should be offered as early in the course of illness as possible, because it can help prevent relapse and disability, while also preserving and enhancing family relationships and social supports for the consumer's recovery.* There is perhaps no more cost-effective psychosocial modality that has such a profound effect on the early, and probably the entire, course of illness.

Experience, both clinical and research, has not delineated any group among people with schizophrenia for whom this approach is not effective. The necessary requirement is that at least one person, other than the consumer, is close enough and concerned enough to participate as what we have come to call "sponsors" or "supporters". Most commonly those are family members, but friends, relatives, landlords, and community residence staff and significant others have all proven their value and have benefited the consumer and themselves. As noted above, greater value comes from starting this work as early in the course of illness as possible, since most consumers and families report the most extreme distress in the first year or two of attempting to cope. As well, it is often in this early period that major rifts develop between consumer and family and/or between family members, rifts that greatly exacerbate symptoms and disability. It is those very rifts that FPE has proven to prevent and often heal, as participants stop blaming themselves or each other and cooperate to assist in the overall treatment and rehabilitation process.

Family psychoeducational approaches have been developed for people with major depression, bipolar disorder, borderline personality disorder, and obsessive-compulsive disorder and for those who have no family members available, but who live in community residences. While there is as yet less empirical support for their effectiveness, these other approaches receive the same high praise from participants as has the original approach described here for schizophrenia. These are described briefly below and in detail in the books referenced in the Workbook Bibliography.

Both consumers and family members should participate in FPE. These models have all involved the entire family, consumer included, because they focus on treating a disorder, not a person. Thus, the consumer needs to be involved not only to receive benefits from the process but also to have a full voice in determining the direction of that process. Also, in psychoeducational multifamily groups, consumers have nearly universally proven to be important resources to family members in other families as well as for other consumers. Families surveyed after participating in groups with or without the consumer present both preferred including consumers, but only after direct experience of one or the other format. On the other hand, there are times, especially during engagement, when separate sessions have an important role. For instance, exploring personal matters, such as romantic entanglements, drug abuse or sexual side effects of medications, are best handled initially in consumer-practitioner meetings. Conversely, time spent in the beginning hearing about the family's frustration and anger about the effects of the consumer's symptoms are important, but usually not best done with the consumer

present, particularly during an acute crisis. Clearly, without some involvement by a family member or supporter, the approach is more difficult to implement. On the other hand, if at least one supporter *is* willing to participate, the consumer does not have to participate until he or she gives consent..

The consumer should be consulted as to whom they would like to have support their treatment and recovery, and in many instances those people can serve as the family in this approach.   Frequently, there are no family members available, but a friend, significant other, neighbor, or even concerned residential program staff will be willing to support the consumer's involvement in family psychoeducation. In fact, in multifamily groups, up to about a third of the consumers can participate without any support person and still gain a great deal from the process; support comes from other families and consumers. This variation may also be relevant when the consumer is adamant about not involving a family member because of a past history of trauma or abuse.

Family psychoeducation is *not* family therapy. It is nearly the opposite. In this approach, the object of treatment is the disorder, the illness, and not the family. Thus, the family is considered part of the team, as is the consumer if they are ready to accept such a role. In family therapy, the family itself is the object of treatment. Families do benefit from well-done family psychoeducation and family therapy, but for different reasons and in different kinds of problems and diagnoses.

Family psychoeducation is *not* just education. Both in original conception and in the evidence from outcome studies, family psychoeducation is a treatment model to achieve recovery, in which the intervening objective is enhancing the coping skills of consumer and family members. That has not proven to be possible with just information or suggestions. These models all provide direct, ongoing guidance, inter-family support (in multifamily groups), and problem solving and modeling to assist in developing individualized coping strategies and skills.

For families, benefits include enhanced coping skills, greater knowledge and insight into the disorders, reduced stress, conflict, isolation and loneliness, satisfaction with support and reduced medical illness in themselves. Consumers benefit by large reductions in hospital admissions, fewer psychotic symptoms and more energy and motivation, better family relationships and support, more time spent working or successfully completing schooling and reduced dependence on drugs and alcohol.

First, remember that the right of privacy always rests with the consumer. The consumer has the choice as to whether he or she is willing to have their practitioner or case manager include the family in treatment. If the consumer refuses to do so after a discussion of the benefits of FPE, that is their choice. However, the engagement process presents to consumers and family members alike a consent process that presents not just problems, but also likely benefits of family members participating in the treatment process. Thus, it is truly *informed* consent. For instance, many consumers are persuaded to allow and even welcome family involvement when it is made clear that the goal is to organize family support for *the consumer's* goals and for them as a person.

**WHAT IF THE
FAMILY IS ALREADY
INVOLVED WITH A
NAMI EDUCATIONAL
PROGRAM, SUCH AS
FAMILY-TO-FAMILY?**

These educational programs contain much of the same material as is provided in family psychoeducation, so there is no contradiction and much synergy between them. In fact, one could offer the National Alliance for the Mentally Ill (NAMI) course, "Family-to-Family", as the educational intervention in family psychoeducation, if some of the teaching was done by the practitioners in concert with the family members leading the course. Family members will also benefit greatly from having access to family psychoeducation after they have had a NAMI course. These educational programs do not provide the clinical intervention and skills training and have not been found to benefit the consumer directly, at least in studies to date. On the other hand, there is evidence that families gain a great deal of information and relief from these courses. The scope of family psychoeducation is far greater, with broad treatment and recovery goals that go beyond what can be offered by an advocacy organization. If they have not participated in NAMI or its educational offerings, families should be referred to the local NAMI chapter as an additional resource during the engagement process of family psychoeducation and encouraged to become members.

Joining With Individuals and Families

Engagement sessions usually involve caregivers and consumers, who may meet separately or together, depending on consumer preferences, clinical condition and other considerations, to be determined by the provider. These sessions focus on:

- exploring precipitants of episodes of illness,

- review of prodromal signs and symptoms,

- experiences of the family or in providing support to the family member with the illness,

- strengths and coping strategies that have been successful,

- social supports in the communities,

- grief and mourning in relation to the illness, and

- a contract for treatment and the development of a treatment plan.

There may be three or more engagement sessions, as early in the course of an episode and/or illness as possible. It is often better to engage families during an acute crisis, because family members and other caregivers are rightly concerned about the consumer's safety, well being and future recovery. On the other hand, many people have been dramatically helped by this approach when they and their families have begun to participate during ongoing treatment or rehabilitation at a mental health center or clinic. Usually, this approach replaces individual supportive therapy, but can integrate well with supported employment, assertive community treatment (ACT) and other evidence-based practices. It has been applied successfully in inpatient and outpatient settings, partial hospital and day treatment programs

In the case of hospitalizations, contacts with the families and with hospitalized consumers are initiated within 48 hours after a

hospital admission. For consumers who are already in community-based treatment, joining can occur as part of their ongoing services.. Initial contacts with the consumer are deliberately brief and non-stressful. The aim is to establish rapport and to gain consent to include the family in the on-going treatment process. Families are contacted either during a visit to the hospital or by telephone. They are made aware that the practitioner is willing to collaborate with them in helping their relative recover and avoid further relapse, with most of the work occurring after discharge from the hospital or partial hospital program. The family is asked to join with the practitioner in establishing a working alliance or partnership, the purpose of which is to provide the best post-hospital environment for the consumer to continue his or her recovery process. The joining phase is typically three to seven sessions, depending upon whether single-family format (three sessions) or multiple family group format is used (typically, three to seven sessions, but more may be required until a sufficient number of families are engaged).

JOINING: A PROCESS AND TECHNIQUE

In Webster's dictionary, joining means to connect, bring together, or unite. In this clinical model, the uniting is between the professionals, the consumer, and the family and other supporters. Joining is a partnering to build rapport, to convey empathy, hope, and to establish a collegial alliance with consumers and families.

Joining is the first stage in the implementation of the treatment program. Joining is the initial phase in which the family is engaged in the psychoeducational process. Ideally joining will occur soon after a crisis or a probable diagnosis is made, but joining can occur at any time that a consumer or family could benefit from, or is interested in, this approach.

☞**Tip:** Joining can occur as an outpatient with equal success. It is helpful to engage families and consumers after a crisis, yet this is not absolutely necessary. In our practice, many consumers had been stable in the acute phases of the illness, yet stalled in their recovery. The model was helpful to engage the consumers and caregiver's support to take the next step in treatment, particularly vocational rehabilitation and community and social connections, etc.

The practitioner who will eventually be the consumer's practitioner or case coordinator in the outpatient setting carries out joining. This practitioner quickly becomes identified as an advocate or a resource to the family and supporters in navigating the mental health system. The practitioner relates in a humanistic, caring, and

hopeful manner. In this, we mean, the practitioner is not afraid to step in and take on roles not traditionally practiced. This is an active process of demonstrating commitment to the consumer and family. A practitioner may act as an advocate to the inpatient team to recommend community-based services at discharge or make a referral for peer support services. The practitioner may offer practical guidance or tips on obtaining entitlements or benefits, assisting the consumer to access community services, or lend an ear for acknowledgement of the family's loss, anger, and/or guilt.

☞**Tip:** It is important to clearly establish yourself as a resource and a support.

Joining is truly the foundation of this treatment model. Establishing a relationship is obviously important in any therapeutic modality, yet establishing a real connection and a resource will also later contribute to the success in the treatment process. Again, this may mean venturing outside of your traditional role into possibly unfamiliar coordinating and case management activities. Often if practitioners are experiencing consumer or family absences, premature endings, or problems, an ineffective joining can be identified.

▪ **SUMMARY OF OVERVIEW FOR JOINING.**

- Recognize that the model is one of mutual appreciation. Families and supporters are often untapped resources.
- Joining is a process as well as a technique.
- Goals are to establish rapport, be a liaison, and to build alliance. Remember that there is a joining of expertise and strengths.
- Understand disease as a brain illness, not character or family pathology.

SETTING UP THE MEETINGS

Generally, there are three joining sessions with the family members and the consumer prior to the educational workshop. Joining sessions with the family and the consumer may begin as soon as possible after a crisis, or a hospitalization, or agreement to participate in family psychoeducation. This prompt attention is reassuring to both the family and the consumer. The goal is for the practitioner to establish that they are available as a resource and an advocate for both the consumer and the family.

The joining sessions may be held with the family and the consumer together, although the practitioner may occasionally hold separate meetings when it best suits the needs of the family and the

consumer. The meetings with the consumer may be shorter and less structured depending on the individual's circumstances. The practitioner needs to be respectful of what the consumer is comfortable with. Flexibility, on the part of the practitioner, is important. The consumer may need to take breaks. This should be stated at the beginning so there is no discomfort about this accommodation. The main goal is to allow the consumer to become acquainted with the practitioner and to see him or her as an interested and empathetic person who will act as the consumer's advocate. Sessions with consumers should include several minutes of getting to know the consumer beyond their illness.

> ☞**Tip:** Joining sessions have occurred with consumer and family members meeting together when consumers have been stable or well established as an outpatient. It may also be more comfortable for the practitioner to hold these sessions jointly. At times, the logistics simply dictate joinings occur together. Family members or other supporters may need to meet after getting out of work in the evening and they may have to assist in transportation of their loved one. It may create less stress to arrange a joint session. However, it is important for the family and the consumer to still have at least one joining that is separate so each can have the opportunity to share without feeling intimidated or feeling the need to censor.

If family psychoeducation is to occur in the multifamily group format, the co-facilitators who will run the group divide the responsibility for joinings. For example, out of eight consumers and their supporters, each practitioner would join with four out of the eight partnerships. The meetings with the family and supporters typically last for one hour and meetings with consumers are typically briefer. During the joining sessions and throughout the treatment, there is an emphasis on the families' and consumers' strengths and resources.

The timing of the joinings should not occur too far out from the planned date of the educational workshop. This obviously requires some planning and organizing. It is helpful to have a tentative list of referrals so that when a minimum quota of participants is identified, the joinings can begin. It is important to not lose the momentum for the treatment and to keep an active role as a liaison for the consumer and his or her supporters. It is recommended to schedule extra sessions if more than three weeks will pass before the workshop.

S T R U C T U R E

Gathering information is part of the joining process and there is a structure to each of the sessions. Each joining session begins with

and ends with socializing, which helps to decrease the family's anxiety, cements the relationship, provides a source of information and interests outside the illness. The sessions begin with 15 minutes of socializing about a variety of topics such as weather, traffic, etc. and ends with five minutes of socializing about any possible plans for evening, weekend, or other events.

In this model, the practitioner is open and forthcoming about whom he or she is as a person. The practitioner takes a genuine interest in each family member or supporter apart from his or her involvement with the illness. One way this principle is realized in joining is through the socializing built into each session; that is continued in the multiple family groups or single-family sessions.

During joining sessions and throughout all the stages of treatment, the practitioner needs to be comfortable in what he or she knows about the illness and also respectful of what the family knows and has experienced first hand. If the practitioner does not know the answer to a question, he or she acknowledges ignorance and assures the consumer and his supporters that the information will be sought out. Most caregivers and supporters have felt blamed and criticized by the traditional assessment questions that search for failure and pathology. In this model, the practitioner emphases successful coping and use of resources.

Whenever relevant during the joining stage, the practitioner shares information about the disorder with the consumer and his supports. As soon as possible, the practitioner expresses the belief that severe mental illness is an illness of the brain and one that is not caused by the family or the consumer. It is often necessary to repeat this many times in the course of treatment, as many families and supporters blame themselves. It is also helpful to emphasize that families and supporters will be able to help reduce relapses and crises using the information they will learn in the treatment program. Most families and supporters appreciate this positive point of view about their contributions.

Families and other supporters also need the opportunity to express their feelings of loss, frustration, anger, despair, hopelessness and guilt. The practitioner validates the expression of these feelings without probing for them. When they are left unexpressed they can form a barrier to a family finding the energy to learn new ways to manage. Whenever a crisis occurs during this period for either consumer or family, the practitioner deals with it as soon as possible. The practitioner can use a crisis as an opportunity to demonstrate willingness to help, especially in concrete ways. For example, hospital discharge planning is often a crisis for families and consumers.

From the first meeting the practitioner is active in guiding the conversation. There are tasks to be completed in each of the joining sessions so the practitioner needs to be directive and to structure the sessions. The structure of the joinings and later single or multifamily sessions is reassuring. It lets people know what to expect and helps the consumers and families to feel less anxious. Within the structure, the practitioner also answers questions and gives advice. Sometimes family members may quarrel or monopolize discussions or make repetitive complaints. This kind of communication can be interrupted by acknowledging the person's frustration and worry about the illness.

Consistent with the model, this first session starts with the fifteen minutes of socializing**.** The intent is to create a relaxed informal atmosphere, model normal social conversation, and assist families and other supporters. It will also help consumers see themselves as separate and more than the illness. This is a long process that you are entering with consumers and families and it is important to build the relationship beyond the "illness". The practitioner keeps his or her manner positive, informal and collegial.

☞**Tip:** It is important to not shortchange this step in the approach. It is common for practitioners when they are starting to want to skip or shorten this aspect of the session in an attempt to get to the work of the treatment, yet this usually backfires.

During the first joining sessions, the present crisis is reviewed with particular attention to the early warning signs, how the family or supporters have coped, who or what have been helpful for interventions in the past. Here, it is important to understand the family's unique experience and their reactions to this severe illness that has arisen in their midst. Crises, which result in hospitalization of a loved one, are always difficult experiences, and the practitioner needs to express his or her appreciation of this fact at this time. If there is any particular assistance to be provided at the time and seems appropriate, the practitioner should feel free to offer it.

This first session is also used to begin the process of delineating each consumer's prodromal symptoms or personal early warning signs. The practitioner guides the family and supporters through a review of the prior weeks with emphasis on any changes in the consumer's symptoms, thoughts, or feelings during that time. These changes, which may be either quite apparent or barely noticeable, constitute the prodromal symptoms for that individual consumer. In most cases, there are idiosyncratic behaviors that

precede the more common prodromal symptoms, i.e., poor sleep, anorexia, pacing, restless behaviors and irritability. These become even more important in the future to assist in preventing relapse.

- Review the present crisis.

- Identify any precipitating events.

- Explore the idiosyncratic early warning signs.

- Review how family and supporters have coped.

- Validate their experience as normal human responses to an abnormal condition

- Identify who or what interventions have or have not been helpful.

JOINING SESSION

NUMBER TWO

Once the fifteen minutes of socializing is complete, the second joining session is focused on the impact of the illness to the family and supporters and the consumers. In some cases, this session may be best done in separate sessions, especially if the consumer does not accept that he or she has an illness or a problem. Families and supporters may verbalize their feelings of loss, despair, grief, and frustration about coping with the demands of the illness. Practitioners can offer support, validation, and recognition of these normal human reactions. It is also during this session that the practitioner wants to learn about the family and supporter's social network, extended supports, and other resources. A genogram, including key friends and neighbors, might also be done during this session. The practitioner will also want to learn what the supporters' and family's experiences have been during past acute episodes and what has been their experience of the mental health system. The session ends with five minutes of socializing.

- Explore feelings and reactions to illness.

- Identify social networks and extended supports.

- Construct a genogram.

- Review past experiences with mental health system.

JOINING SESSION

NUMBER THREE

During the third joining session, the practitioner pays close attention to other areas of personal strengths for the consumer and the family, such as work, hobbies, school and other connections that may offer support. It is in this last joining session that a discussion

about the goals of treatment should occur. Short-term goals are generally identified as goals to help stabilize the consumer's symptoms and long term goals focus on increasing vocational, academic, and social skill development, all with the eventual goal of recovery.

The practitioner prepares the family and supporters for the educational workshop where they will meet the other group members for the first time. It is wise to review the structure and goals for the regular meetings in single-family or multi-family format that will follow. The practitioner briefly describes how the group proceeds and what other participants have gained from these groups in regards to new and workable solutions to difficult problems of illness management.

The practitioner inquires about the participants' experience with groups and what concerns they might have, including confidentiality, shyness and feeling pressured to speak in groups or the workshop. Each participant is assured that they need contribute only as much as they wish. The practitioner should feel free to schedule additional sessions as needed to ensure a good connection and that sharing of information has occurred.

If meetings have occurred separately, the practitioner tells the consumer that his family and supporters will also be attending the workshop. The practitioner also prepares the consumer for the multiple family groups. As with the family, it is important to agree on short-term and long-term goals. Again, the practitioner is free to schedule as many additional sessions as needed.

SUMMARY OF TASKS JOINING SESSION THREE	• Identify personal strengths, hobbies, interests, work, school, etc.
	• Identify short and long term goals.
	• Discuss any concerns about participation in workshop or groups.
	• Maintain climate of partnership.

CULTURAL ADAPTATIONS: JOINING IN A FAMILY OF HISPANIC ORIGIN

As an example of adapting the methods used in FPE to another culture, the following vignette is offered. It illustrates some of the ways in which the broader meaning of cultural competence can be made real. In this sense, the goal is that the practitioner, regardless of his or her own cultural background, attempts to bridge the inevitable cultural differences between him or her, the consumer and the family.

Parents are in their late fifties. Father works at an office. Mother is a housewife. The couple has two other adult children, both of them married with children living in the same city. The consumer is their youngest daughter, age 25. The consumer was not present during the first session. Although the parents' primary language was Spanish, both of them spoke English well. They have been in the U.S. for the previous fifteen years.

During the initial joining session, the father was distant. Although polite, he remained silent, sitting in a corner during the socializing portion. The mother was visibly nervous, but made efforts to maintain some communication going with the practitioner. As the session progressed and the practitioner moved on to review the present crisis and early warning signs, the father addressed the mother in Spanish: "No veo de que sirve todo este interrogatorio." ("I don't know what is the use of all of this interrogatory.") The provider decided to slow down in the gathering of information and moved back into using a more non-directed style of questioning. Despite this change in style, the father kept on looking at his watch, and by the end of the session he addressed his wife again in Spanish: "Por que no se apurara? Necesitamos llegar a la casa para cenar" (Why doesn't she hurry? We need to get going to the house and eat.")

During the closing socializing portion, the practitioner thanked both parents for their willingness to participate making a point to recognize their coming to the hospital after a long day of work either at the office or at home. The practitioner went on then to do some self-disclosure: "I know that for me, when it gets to be this late, I have difficulty concentrating as I start thinking about what should I be making for dinner. Somehow I forgot to start the coffee this evening, but next time I'll have it ready with some cookies so my stomach doesn't growl so much."

There are several aspects of culture that should be considered in this very brief example. The first is that the practitioner should be sure to assess the level of English fluency. The fact that someone speaks English does not imply that it is the preferred language for communicating. Further, be aware that primary language may be

preferred to express emotions and English to discuss public matters. It is not uncommon for families to switch to their native language when expressing emotionally-laden material. If families frequently switch to their primary language in the course of the interaction, the utilization of practitioners who are fluent in this other language should be strongly considered. Practitioners should give consideration to the timing of language switching, as it can provide insights into relevant issues for the family interactions.

The second recommendation is to follow cultural etiquette to protect the dignity of the family. In this case, the practitioner was bilingual and able to understand the father's statement. The practitioner decided not to initially disclose this fact, based on the hypothesis that acknowledging her understanding could make the family feel uneasy because that would point to the father being "not polite." At the same time, the practitioner did not want to appear deceiving. To solve the dilemma, the practitioner decided to introduce some brief statements in Spanish during the next session.

Alternatively, the practitioner could have introduced statements in Spanish during the session operating under the hypothesis that in doing so, the parents would feel more comfortable because they would be able to utilize either of the two languages. There is no set appropriate response. It is up to the practitioner to use clinical skills to choose the hypothesis that appears to fit best. In this case, the practitioner hypothesized that the family valued appropriate 'polite behavior' and that the father wanted to maintain some matters private, thus switching to Spanish.

The third point is that one should not rush the engagement process. It may take longer for certain family members to 'trust' the practitioner and the intervention offered. The practitioner needs to be aware of both verbal and non-verbal indicators that could suggest a need to get back into a different style of questioning. In this example, the provider used not only non-verbal behavior but also language switching and the father's description of the interaction as an interrogatory as indicators of the need to switch to a conversational 'platica' style before moving into specific questions about the illness. The practitioner begins to entertain the notion that it may take more than three sessions to engage the family.

Fourth, self-disclosure (*personalismo*) is an important foundation of the relationship. Timing and content are important considerations to maximize the effectiveness of the intervention. In this case, in the closing socializing portion, the practitioner presents herself as a 'real person' who shares with them the experience of feeling tired and hungry after a long day. The practitioner also has mundane obligations, such as cooking dinner. In doing so, she makes herself more approachable, as the family may be able to identify with

aspects of her daily routine. She models disclosure of her own 'flaws' and ends in a positive and playful note, setting the stage for the next session.

It is important for practitioners who are working with families or MFGs for the first time to receive supportive supervision beginning with the preparation for contacting supporters, families and consumers. For many practitioners, the techniques described above are new. It can be stressful to learn new ways of forming alliances and conducting sessions. Although professional behavior and boundaries are still important in this model, the socializing aspect of the model and the process of sharing may feel unfamiliar and uncomfortable. It can also be stressful to hear about the difficult experiences and emotional pain the participants have endured. Supervision can be very helpful in dealing with these stresses when it is conducted with the same positive, supportive, collegial tone the practitioner uses with group members.

SUMMARY OF TIPS ON JOINING

- Research demonstrates improved effectiveness and outcomes in management of illness when consumers and their loved ones are informed and involved in their care.

- Psychoeducation stays focused on the ultimate goals of illness management, prevention of relapse and recovery.

- There is a partnership and joining of expertise with consumers and their loved ones.

- Psychoeducation allows expansion of team and base of knowledge.

- Allows provider to offer hope. This approach does not pathologize and it does not offer false reassurances.

- Psychoeducation helps with role definition and focus. There are definite techniques and tasks to accomplish in each stage and throughout the process.

Educating Families Using a Workshop Format

Family psychoeducation begins with the joining process, but intensifies when a formal educational workshop is offered to multiple families. Carol Anderson developed this pragmatic, classroom format as a way to offer families current information about the psychobiology of illness, while receiving the latest information about medication, normal reactions to illness, and possible coping mechanisms. In the single-family psychoeducational model, this format is optional. For instance, Ian Falloon found that the same workshop format could be used on an individual basis in a family's home and be effective. However, the single-family method eliminates the possibility of families exchanging valuable information.

Education is one of the four essential components of family psychoeducation, along with joining, problem-solving and social network expansion. Education consists of sharing information with family, other caretakers, and consumers themselves about the underlying biological and social processes. The goal is to relieve families of their guilt and anxiety so they can contribute to the treatment and rehabilitation of their family member.

When families do not have information about the illness, they tend to adopt the beliefs of their own families, culture or community. While they may have the best interest of the person with illness in mind, their actions may actually interfere with recovery, since the most effective interpersonal and rehabilitative approaches are often counter-intuitive. Therefore, it is the responsibility of professionals to give concerned families the information and guidance that they need to promote recovery and rehabilitation.

Information creates a shared language that allows families and practitioners to work together. The message for families is: schizophrenia is a very difficult illness for families to live with, but it will become easier if we learn skills to cope with it. It is <u>especially</u> important that families understand that they did not cause the illness.

The family advocacy movement of the National Alliance for the Mentally Ill supports involving families in treatment decisions and in their loved ones' diagnoses, treatment and longer-term prospects. The psychoeducational workshop takes it one step further by sharing information and ideas among several families at once. Thus, the educational aspects of this approach empower families and, over time, those with the illness.

> ☞ **TIP:** While the educational process begins in the joining meeting, it continues throughout the workshop and in every subsequent meeting. There will always be new information discovered and new questions to answer.

In order for families to successfully solve problems of illness management, they must understand the physiology and psychology of schizophrenia or other disorders at a basic level. Eventually, they can develop their own strategies based on their particular circumstances.

One critical aspect of family education is that it gives families hope that they will be able to alter the course of illness. As the educational process continues with families, they see increasing evidence of their own effectiveness. As the consumers improve, they join in the process as partners. They become interested in the information and in achieving their own rehabilitative goals. Of the nearly six hundred families that have attended these workshops, in no instance has the information had a significant negative effect. On the contrary, there have been hundreds of examples of relieved and grateful families.

CONDUCTING A PSYCHOEDUCATIONAL WORKSHOP

The Psychoeducational Workshop helps families understand:

- the seriousness of the disorder
- the role of stress in precipitating episodes
- early signs of relapse
- symptoms, especially the negative variety
- the basics of brain function and dysfunction in mental illnesses
- how psychiatric medications affect brain function and cause side effects
- how severe mental illness in one of their members affects families
- effective coping strategies and illness management techniques
- the causes and general prognosis of the illness
- the psychoeducational treatment process itself

Psychoeducation is an opportunity for families to begin learning to cope with, and improve the outcome of schizophrenia and other major mental illnesses. However, those solutions must fit the family's individual history and style. The challenge for practitioners is to adapt the educational process for each participant. Anderson and her colleagues have emphasized that the workshop is most effective if the information is tailored as much as possible to the actual participants. Further, education for a minority group and/or another cultural group will require careful consideration of the differences in content, language, style of delivery and expectations of professional in each culture represented within a workshop audience. For instance, a Spanish-language version of the educational videotape for families is available on request from the toolkit authors.

GUIDELINES FOR PRACTITIONERS

In some cases, teaching and giving direct advice may be new skills for practitioners. The presentations should be empathic as well as informative. Practitioners should use group leadership skills to elicit comments and experiences from the audience, in a manner that invites, but does not obligate, participants to respond. Even if multifamily group co-facilitator is a new role for the practitioner, family members usually prefer to work with the same person who has been working with their ill relative.

Practitioners will also have to keep current with any breakthroughs in research. This increases their credibility with families. It is less helpful if families hear about new developments before the practitioners hear it. They need to broaden their own knowledge and always recognize and share the limits of what they know.

> ☞**TIP:** Group leaders are not expected to be expert in all areas of psychology and biology. It is helpful if they can call on colleagues with particular areas of expertise, such as a nurse, psychologist or doctor specialist. Materials from any previous workshops should also be used, if available—it is not necessary to reinvent the wheel.

PRACTICALITIES AND PROCEDURES

The all-day Family Psychoeducational Workshop is usually held on a weekend day after families have had at least three joining sessions. Sensitivity to the needs and schedules of the family members in scheduling this is important. This workshop is modeled after the workshop described by Anderson and her colleagues [96].

The workshop provides information about the key disorder and effective ways of managing the illness. The leaders present in an open, collegial manner, encouraging families to comfortably ask questions. Families will discover that their experiences and problems

are similar. Because the workshop is conducted by the two multifamily group co-facilitators, it is the first time families meet the other members of the group and the other practitioner. The psychiatrist who is working with the consumers should present the material on the psychobiology of the illness. Other staff may be invited to contribute their expertise.

☞**TIP:** Group leaders should review the materials before the workshop. Practicing presentations with colleagues helps increase confidence and provides an opportunity for feedback on clarity, rate of speech, etc. It may be helpful to videotape or audiotape the practice presentations and to rehearse responses to common questions.

☞**TIP:** The workshop should be organized in a classroom format, with the speaker in front and a board to write on. The classroom arrangement invites a more neutral atmosphere.

☞**TIP:** Refreshments are supplied throughout the all-day workshop, including morning coffee, lunch and afternoon tea. Only decaffeinated beverages are served and there is no smoking in the meeting room. Refreshment breaks provide an informal setting for spontaneous socializing. The group leaders act as hosts and hostesses during these times; it is strongly recommended that they spend time during the breaks with families and other attendees and not solely with their colleagues.

STARTING THE WORKSHOP

The practitioners introduce themselves and explain the day's agenda. For example, a co-facilitator might say,

"Welcome, and thank you for coming on this beautiful Saturday morning! My name is Bob Smith and this is Peg Rutherford. Some of you already know us because we've been meeting individually for quite some time now. Today, we want you to know as much as possible about this illness --what's known, and what's not known, as of now. Schizophrenia is a very complex and confusing illness. We have found that the more information people have, the better equipped they are to deal with problems as they occur. We will also be discussing some guidelines for coping that have been shown to be helpful.

"This workshop is only one step of our work together. After the workshop, we will be meeting together as a group of families, including consumers, on a regular basis and we will continue to

provide relevant information and assistance to you. We have found that working together with consumers, families and the treatment team in this program has resulted in fewer and less severe relapses. We will answer as many questions as possible in this workshop today. If we cannot answer something, we will find someone who knows the information and get back to you."

Outline of the Educational Workshop

9:00 - 9:15   Coffee and Informal Interaction

9:15 - 9:30   Formal Introductions/Explanation of the Format for the Day

9:30 - 10:30   Information about the Phenomenology, Etiology, Course, and Outcome of the Illness

Biochemical theories

Genetic theories

Socio-cultural theories

Family Theories

The private experience of schizophrenia

The public experience of schizophrenia

10:30—10:45   Coffee Break and Informal Discussion

10:45 – 11:15   Treatment of Schizophrenia with Medications

How it works

Why it is needed

Impact on outcome

Side effects

11:15—12:00   Other treatments

Family psychoeducation and multifamily groups

Social skills training

Day treatment

Vocational rehabilitation and supported employment

Psychotherapies

Megavitamin and other dietary treatments

Management of the illness

Health

Diet

Stress

12:00 - 1:00   Lunch and Informal Discussion

1:00 - 3:00	The Family and Schizophrenia
	The needs of the consumer
	The needs of the family
	Family reactions to the illness
	Emotional reactions
	Common interactions
	Common Problems that Consumers and Families Face
	"What the Family can do to Help"
	Family Guidelines
	The problem-solving method
3:30 - 4:00	Questions regarding specific problems
	Description of the multifamily group process
	Having patience with the slow pace of improvement
	Keeping hope alive
	Wrap up and scheduling
	Informal interaction

(Agenda adapted from Anderson, et al, 1986, p. 76)

Since there is a lot of information to cover, is important to stick to the agenda and to keep track of time. Often, questions asked by families will be answered by content covered later in the day. Therefore, practitioners may ask families to write and save their questions until after the appropriate section is presented. If necessary, discussions can also be continued either after the workshop or during a subsequent meeting of the multifamily group.

FAMILY GUIDELINES

The Family Guidelines are based on the specific effects of schizophrenia on the consumers and families. People present at the workshop should have a copy of the "Family Guidelines" that they can refer to as the practitioners review them, one by one. This will not be the first time families have heard about the "Family Guidelines", but it is first time they will be fully discussed. Practitioners take turns reading a guideline, connecting it to the biological information discussed in the morning, and asking family members for their reactions, questions, and experiences. It is helpful to illustrate the guidelines with examples based on the kinds of problems described by families during joining sessions.

The Family Guidelines

Here's a list of things everyone can do to help make things run more smoothly:

1. GO SLOW. Recovery takes time. Rest is important. Things will get better in their own time.

2. KEEP IT COOL. Enthusiasm is normal. Tone it down. Disagreement is normal. Tone it down, too.

3. GIVE EACH OTHER SPACE. Time out is important for everyone. It's okay to reach out. It's okay to say "no".

4. SET LIMITS. Everyone needs to know what the rules are. A few good rules keep things clear.

5. IGNORE WHAT YOU CAN'T CHANGE. Let some things slide. Don't ignore violence.

6. KEEP IT SIMPLE. Say what you have to say clearly, calmly, and positively.

7. FOLLOW DOCTOR'S ORDERS. Take medications as they are prescribed. Take only medications that are prescribed.

8. CARRY ON BUSINESS AS USUAL. Re-establish family routines as quickly as possible. Stay in touch with family and friends.

9. NO STREET DRUGS OR ALCOHOL. They make symptoms worse, can cause relapses and prevent recovery.

10. PICK UP ON EARLY SIGNS. Note changes. Consult with your family.

11. SOLVE PROBLEMS STEP BY STEP. Make changes gradually. Work on one thing at a time.

12. LOWER EXPECTATIONS, TEMPORARILY. Use a personal yardstick. Compare this month to last month rather than last year or next year.

☞**TIP:** Practitioners should explain that while the Family Guidelines may seem counter-intuitive, they are based on a great deal of experience. Also, some Family Guidelines apply at different times and in different situations. The work of the group is figuring out how to apply these guidelines.

☞**TIP:** Printed handouts are important. Family members should each receive a folder containing the information the leaders will be presenting, along with the Family Guidelines, diagrams and other aids they can follow throughout the day. Leaders should suggest that people post the Family Guidelines at home where they will be handy as a reference.

CONCLUDING THE
WORKSHOP

The workshop ends on a positive note. The practitioners should make sure that families feel their optimism about this approach. It is helpful to give examples of how life improves for the consumer and family with this process. Then, the practitioners should outline the format for multifamily groups, emphasizing the problem-solving method and its usefulness for families and consumers. The agenda for the first two meetings is presented and any questions about the multifamily group are addressed. Group members should know how to contact the practitioners in case they have questions or crises between sessions. The group co-facilitators should remind families that improvement will occur very slowly and to be patient: "Slow and steady wins the race" should be a theme.

Finally, family members should be invited to talk about their reactions to the workshop. Some common reactions are relief at finally knowing some facts, anger at being kept in the dark, sadness, despair, hopefulness about this approach and eagerness to get on with the work. Since consumers will be invited to all subsequent multifamily group meetings, this is a good time to briefly discuss any misgivings family members may have about those with an illness being present. The practitioners should conclude by again thanking all participants for coming to the workshop on a day off.

☞**TIP:** When providing education and Information to people with illness, group co-facilitators should take into account their illness and preferable methods for self-management. Since clinically unstable consumers do not attend the psychoeducational workshop, they need to learn about the guidelines in a different setting. This may happen in a shorter "consumers only" workshop or in the whole group, as a repeat or an update, after the consumers have achieved clinical stability.

☞**TIP:** It is important that practitioners keep in mind that group members are not obligated to speak during the workshop. However, since there are few places during this session where facilitators have opportunities to ask probing questions, they do need to be creative in explaining what sorts of responses they expect. It is part of the practitioners' skill to elicit reactions without demanding them.

The first and second PMFG sessions

During the first two multi-family group sessions, the goal is to quickly establish a partnership between all participants. The initial sessions are intended to build group identity and a sense of mutually shared interest before going on to discuss clinical and rehabilitation issues. This approach promotes inter-family and interpersonal social support.

Traditional multi-family therapy models emphasize expressing feelings, while risking negative emotional interactions among group members. These spontaneous initial techniques often spark conflict between family members, disagreement between families about the purpose of the group, and anger or confrontation with the leaders. People with schizophrenia and other serious mental illnesses often become overwhelmed and subsequently give up on the group. Similar reactions have been seen in minority groups with less experience in therapy and who simply do not understand the function or value of non-directed conversation among a group of strangers.

Since successful outcomes depend on at least one member of each family participating in the group for at least one year, it is important to avoid dropouts. Solving problems in the group depends on ideas being shared and accepted across family boundaries, so it is best to proceed slowly and take the time to develop trust and empathy. In situations where the family prefers to meet individually with a practitioner rather than join a multi-family group, or a multi-family group is not imminent, the practitioner should maintain the goal of developing a partnership with the family and consumer. This process is started in the joinings and continues through the single family sessions as the family and practitioner learn about one another, then learn to solve problems that interfere with the consumer's progress in daily life.

People need an opportunity to get to know one another apart from the effects of mental illness on their lives. The first and second group sessions are designed to help the participants and co-facilitators learn about each other and bond as a group.

Unlike traditional group process sessions, people in multi-family groups are encouraged to also talk about topics unrelated to the illness, such as their personal likes, dislikes, and daily activities. The first two sessions are especially important in this regard.

The co-facilitators act as good "hosts". They make introductions, point out common interests and guide conversations to more personal subjects, such as personal histories, leisure activities, work, and hobbies. Practitioners act as role models. They demonstrate by their own example that people are expected to talk about topics other than the illness. This means practitioners should be prepared to share a personal story of their own.

Practitioners should pay close attention to each individual who speaks and thank him or her when they finish. It may be necessary for co-facilitators to prompt reluctant group members with questions or offer encouragement to talk more. It is also important for practitioners to understand that many people in the group may benefit from a slow conversational pace to better absorb information that they hear.

☞**Tip:** Multifamily Group Behavior

Practitioners who are trained in traditional group process models should not expect groups to interact in exactly the same way as in a group process setting.

The first session is not intended to be an opportunity to share deep emotions and feelings about the illness or about the group itself. This is a time for families to get to know each other and discover common interests, issues, and concerns.

In the joining session, consumers and families learn that they are expected to meet with five to eight other families for 1 1/2 hour meetings every other week for at least six months, and then monthly for as long as families find it helpful.

The goal of the first group is for practitioners and family members to get to know each other in the best possible light.

Refreshments, including de-caffeinated beverages, should be available to allow relaxed interactions before and during the group. Co-facilitators should say at the start of the session that it is all right to move around, get a drink or go to the bathroom whenever necessary. Consumers, especially, should be made to feel they can leave the room whenever necessary.

Practitioners should think of this group in terms of any group of people who are meeting each other for the first time. The facilitators act like good hosts by guiding the conversation to topics of general interest, such as: where people live, where they were born and grew up, what kind of work people do both inside and outside the home, hobbies, how people like to spend their leisure time, recent movies they've seen, what plans people have for holidays or vacations, etc.

The co-facilitators begin by introducing themselves. Next, they welcome the entire group and remind them of the format of future groups. They might say: *"This is our first meeting. We will meet every other Thursday at this time. We will work together for the next year or two. Our goal is to problem-solve ways of achieving more satisfaction with our family lives, work and social lives."*

The practitioner continues by setting the agenda for this particular group. He or she might say*: "Tonight we will try to get to know each other since we will be working together for a long time. We will go around the room and each of us will say something about ourselves. It is understandable that people may want to talk about the effects of a mental illness. We will get to that at our next meeting.*

Tonight, we want you to talk about the rest of your life and the things about you and your family you are proud of. I would like to start by telling you about myself."

When co-facilitators participate and talk about themselves, it allows them to act as members of the group and creates a feeling of partnership with the families. The practitioner's goal is to provide a model for the group. For instance, a practitioner might say:

"Hi, my name is Margaret Hanson. Some of you have already met me, and some of you are meeting me for the first time tonight. I am a nurse and have worked in the community mental health center here for 15 years. I grew up in this area and my parents still live in the house I grew up in. I'm the mother of three teenage girls who keep my husband and me very busy and challenged! Even though the girls are growing up and going in different directions, we still like to do things together as a family. One of the things we like to do is go camping. Over the years, we've acquired a lot of equipment so the children could each invite a friend along on our trips. This summer, we're planning a trip to the White Mountains, and we're bringing along 2 large canoes since the girls are inviting friends. I especially enjoy these trips since I don't do much of the cooking…my husband does! It's so peaceful to camp and to spend time in a less harried environment. We have an old yellow lab that stays home when we go camping, but when we're home, she likes to take me for a walk every morning, usually as the sun comes up! In my spare time, I enjoy gardening, scouting flea markets for "finds", spending time with friends, sewing, and reading. Occasionally, my husband and I catch a movie, go out to eat with friends, or walk the beach when the tourists aren't around. Well, that's enough about me for now. I'm looking forward to getting to know all of you better as time goes by."

Then the practitioner turns to the next person and continues around the circle, thanking each one after his or her contribution. The second practitioner sits halfway around the circle, and takes his or her turn in sequence.

The guiding principles for this session are validation and positive reinforcement. It may be useful for practitioners to tell members that they should only share information they think others will view in a positive light. Unpleasant family background, like criminal activity, addictions, etc., is of little help in problem solving and, if presently under control, is not especially relevant.

Co-facilitators should strive to point out similarities or common interests in the group. For example, he or she might say: *"I notice that several of us like to go to the movies. Maybe sometime we can talk about our most recent favorite films."* This helps develop relationships and group cohesion.

It is also helpful to point out group members' different approaches to solving problems. This diversity of ideas is one of the keys to success in problem solving in multifamily group sessions.

It is key that during this session, the leaders have thought through how this format may contradict cultural norms for one or several families and be prepared to adapt and explain the approach to them, allowing them to introduce themselves in whatever way would be culturally congruent. It greatly helps in this regard if at least one of the leaders represents that cultural population and can interpret both at

the linguistic and social level, and make them feel comfortable and respected.

☞**Tip:** Sharing personal information

Practitioners may find it uncomfortable to share personal information, since this is a departure from the usual way of conducting groups. However, it is essential to create a friendly, comfortable atmosphere between practitioners and families.

It may be helpful for co-facilitators to rehearse with each other ahead of time. Think of a few superficial, but personal, stories about family or favorite activities or foods and be prepared to talk about these topics for about five minutes.

THE DESIGN OF THE SECOND GROUP

This group will focus more on how the mental illness has changed the lives of the people in the group. The co-facilitators should state clearly that the focus of the evening is "how mental illness has changed our lives." In this session, the goal is to continue building trust among group members. This meeting is intended to help participants quickly develop a sense of a common experience of having a major mental illness or having a relative with a disorder. The mood of this session is usually less lighthearted than the previous session, but it is the basis for the emergence of a strong group identity and sense of relief.

Both practitioners welcome members to the group as they arrive, and direct them to the refreshments. To start the group, one practitioner outlines the agenda for the meeting. He or she begins by saying, *"Thanks for being here tonight. Last time we spent time getting to know each other. Tonight, let's begin by visiting with each other for 15 minutes. Then we will discuss how mental illness has affected us."*

The practitioner begins the socializing with a comment or question unrelated to the illness, and perhaps somewhat superficial, such as, *"Did any of you see the rainbow on the way over here? It actually looked like a double rainbow, which I have only seen one other time."*

☞**Tip:** The importance of humor

Early on, it is helpful to introduce humor into the group dynamic. The practitioner should let group members know that it is okay to have fun and laugh, and should model this behavior as well.

It is important to begin groups by socializing. The practitioners should encourage participation by modeling, pointing out connections between people and topics, and asking questions. Also, they should feel free to join in the discussion, especially if the topic is relatively neutral and does not reveal sensitive personal information. Side conversations, interrupting, monopolizing, criticizing, complaining and speaking for others are discouraged with positive redirecting remarks, such as: *"It's hard for me to hear when more than one person is talking," or "That's interesting; I wonder if Mr. Smith has something to say about this," or "Your wife says she thinks you're over the flu. How long were you sick?"*

After socializing, the practitioners proceed to the topic for this meeting. One of them might say, *"Now it's time for us to focus on our topic for the evening. Mental illness has touched all of our lives in some way and is the reason we are getting together on a regular basis. Tonight, we will each have a chance to share our personal story of how mental illness has impacted our life. You can share as much or as little as you would like, but also feel free to ask one another questions and to provide support to one another. I would like to start off by sharing my story."*

☞**Tip:** Difficulties of the second session

It may be difficult for group members to confide their problems. Co-facilitators need to work hard to encourage people to talk and to promote connections between people, such as similar problems, worries or stories. It may be necessary to ask questions to keep people talking.

Since group members will follow the practitioners' examples, practitioners should share as much as possible about their own professional and personal experiences. Practitioners may want to share a story about a friend or family member with mental illness or talk about how they became interested in their work and how they have been affected by treating people with serious mental illnesses.

It is important to encourage group members to express any feelings that surface while discussing these difficult experiences, especially the feelings that families commonly have but are reluctant to talk about. These include anxiety, confusion, fear, guilt, anger, sadness, and grief.

When the practitioner finishes his or her story, he/she turns to the person in the next chair. *"How has it been for you? How has mental illness affected your life?"*

Some individuals may find it difficult to talk about their experiences. People can say as much or as little as they wish. After each person has briefly shared his or her story, the co-facilitator should thank him or her. This is a good time to point out any similarities to another group member's experience. This group meeting may be the first time some families realize they are not alone.

Compared to the first meeting, the mood of this meeting is often sad, and there may be anger and frustration expressed as well.

The leaders also remind group members that during future meetings everyone will be working on solving problems like the ones expressed in this meeting and that similar issues have been successfully dealt with in previous groups. **It is important to be optimistic and send people home with the sense that the group can and will help them.**

At the end of the group meeting, the facilitator should remind members of the time and date of the next meeting. There should be 10 minutes or so to socialize before concluding the group. Practitioners should promote socializing at the end of the group and tie conversations into concrete topics, like weekend plans, recent movies seen, holiday plans, etc. The purpose of the socializing is to re-acquaint people with the art of small talk and to gain confidence in making interpersonal contacts.

☞**TIP:** Dealing with complaints

Sometimes group members will express their unhappiness with the consumer's psychiatrist, the mental health system, or a particular institution. The practitioner should validate these feelings and experiences and ask for specific details. However, this discussion should not dominate the session. If group members start to talk about specific problems that they want to solve immediately, the practitioner helps them return to the agenda of the meeting by saying something like, *"We will have an opportunity to solve problems at a later session."* Or, the practitioner might suggest meeting outside the group to discuss the problem.

☞**TIP:** Keeping the family up-to-date

Co-facilitators should share with the group any new research or information they come across. This includes articles, helpful strategies and medications.

☞**TIP:** Timeline for group meetings

These sessions are usually biweekly and become monthly after stability has been achieved. They continue for at least six months. Research has shown that two years is indicated for schizophrenic disorders.

☞**TIP:** Case management

Some groups have found it helpful to provide case management during the multifamily group sessions. It can be an effective way to deal with several families' problems at one time.

An Introduction to Problem-Solving

The problem-solving portion of the PMFG is the essence of the process. Many individuals and families have expressed dissatisfaction with groups in general due to high degrees of emotion and low degrees of productivity. The problem-solving aspect of the PMFG responds to those concerns. It is in this portion of the group that consumers, families and practitioners begin to make clear gains in dealing with symptoms of illness, in a planned and structured manner. It is our intention to present a method of defining and solving illness related issues to the group members. Our method for doing so is the PMFG. The goal of the PMFG process is not just to have the group's help to solve these problems. Rather, it is to provide individuals and families with an on-going means to manage the symptoms of the illness beyond the PMFG.

Each session of the PMFG begins and ends with a period of purely social chat, facilitated by the practitioners. The purpose is to give the consumers and even some families the opportunity to re-capture and practice any social skills they may have lost due to their long isolation and exposure to high levels of stress. Following the socializing, the practitioners specifically inquire as to 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. The affected family then reviews all suggestions for their relative advantages and disadvantages, with some input from other families and practitioners. Typically, the most attractive of the proposed solutions is reformulated as an appropriate task for trying at home. An action plan is created and tasks are assigned to the consumer and family members. This step is then followed by another period of socializing. This format continues for most of the duration of the group, but is sometimes interspersed with visiting speakers, problem-solving focused on generic issues facing

several families and/or consumers and celebrations of steps toward recovery, holidays and birthdays.

☞**TIP:** Solving long-standing problems

    Many issues presented by the group members are perceived as not solvable. These are often longstanding problems that have resisted all attempts to make them better. Group members seldom have much hope that things will get dramatically better. With this in mind, facilitators should approach problem-solving based on the Family Guidelines: go slow; keep things cool; set limits; keep it simple and solve problems step-by-step. When things do indeed change, facilitators must help group members recognize the benefits of the MFPEG process in resolving these issues.

TECHNIQUES FOR FORMAL PROBLEM SOLVING

    This six-step approach helps breaks down problems into a manageable form, so that a solution can be implemented in easy-to-follow steps, usually with more success. Experiencing success in small steps gives families and consumers hope that change is possible. Often a small success will motivate families to apply the method to other aspects of their lives.

    In formal problem-solving, one practitioner leads the group through the six steps. The other practitioner ensures group participation, monitors the overall process and suggests additional solutions. The practitioners choose someone to write down the six steps of the problem-solving process. This recorder can be a practitioner, a family member, or a consumer. The proceedings can be recorded on a chalkboard or a note pad or both. A pre-formatted worksheet can be used to make copies as needed. Whichever method of recording is selected, the practitioners and the family should have a copy to keep.

After a recorder is chosen, the practitioners follow each step of formal problem-solving, as shown here:

Structure of Psychoeducational Multi-family Group Sessions

Socializing with families and consumers   15 minutes

A go-around reviewing;   20 minutes

    The week's events

    Relevant biosocial information

    Applicable guidelines

Selection of a single problem   5 minutes

Formal problem-solving   45 minutes

    Problem definition

    Generation of possible solutions

    Weighing pros and cons of each

    Selection of preferred solution

    Delineation of tasks and implementation

Socializing with families and consumers   5 minutes

Total: 90 minutes

The Steps of the Problem-Solving Process Are:

Step 1. Define the problem or goal:

       Family, consumer & practitioners

Step 2. List all possible solutions:

       All group members

Step 3. Discuss first advantages and then disadvantages of each in turn:

       Family, consumer, and practitioners, group members

Step 4. Choose the solution that best fits the situation:

       Consumer and family

Step 5. Plan how to carry out this solution by forming a detailed, written action plan:

       Consumer, family & practitioners

Step 6. Review implementation.

       Practitioners in concert with consumer and family.

Defining the problem, while sometimes viewed as a rather simple process, is often the most difficult step in the MFPEG process. If the problem is not properly defined, consumers, families and practitioners become frustrated and convinced that the problem cannot be solved. It is helpful if this information is shared with group members. Acknowledging that the process is not necessarily simple may alleviate some frustration later.

Some common difficulties that groups experience in this aspect of the process are:

- Choosing a problem that is too large or too general, [e.g. "I want to get a job"]

- The definitions of the problem by the facilitator and by the individual are different

- The problem is stated as "the person is the problem."

☞**TIP:** Phrasing the problem

Remember, "The problem is the problem!" The person is never the problem.

☞**TIP:** Clarifying the problem
It is important for a practitioner to clarify what is written with the presenting individual. This step helps to avoid inaccurate perceptions/definitions.

The problem-solving process begins in the "go-around". It is often helpful to write the query, "How have you been affected by the Illness since we last met?" on the top of the board or easel, giving the members a focus for their check-in and facilitating the problem definition process.   As each person checks in, one of the facilitators should make a list of presented concerns for all to see. It is helpful to write problems on a flip chart or blackboard at this point.

The practitioners should address each issue presented individually, avoiding the temptation to combine similar concerns of group members. Each person will have his or her own perception of the problem and its resolution. Practitioners need to respect these individual perceptions. This approach also helps to keep the problem definitions simpler and more accurate.

After each person has had an opportunity to "check-in" about their perceptions of difficulties with the illness, the practitioners review

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the issues presented to determine which will be the focus of the groups' efforts. Once a problem has been defined in a way that is acceptable to each member of the family, one of the practitioners asks the recorder to write it down and read it back to the group.

> ☞**TIP**: The practitioners decide the issue for the group to focus on. Group members benefit from hearing the practitioners discuss the issues presented. Listening to them "thinking out loud" and determining a problem to focus on for that particular group helps the group members learn how to simplify, clarify and prioritize concerns.

The practitioners need to consider carefully any report of actual or potential exacerbation of symptoms. Areas of particular significance are:

1. Safety. Safety is always of primary importance. As issues are reviewed, any that involve potential threats to personal safety should be addressed. An issue where safety is a factor should be clarified first. If, after clarifying, safety is not an issue, other concerns may be addressed. Safety issues may be addressed in front of the group *provided* the issues are not so emotionally charged as to disrupt the group. In many cases, these issues become a learning experience for the group.

> ☞**TIP:** There may be occasions when the best way to address a safety issue is apart from the group. This may be the case when emotionality or another persons' confidentiality is a factor. It is helpful to inform the group that the issue will be addressed outside of the group because of "personal reasons" and that the group will be informed of the resolution as it occurs. It is important for the practitioners to discuss these plans, and the reasons, in as much detail as possible so that the group members have the best possible learning experience.

2. *Family guidelines.* When identifying and solving problems, practitioners should try to incorporate the Family Guidelines, as these will support the structure of the group. As issues are presented, it is helpful to refer to the guidelines whenever it is appropriate.

3. *Medication issues and substance abuse.* Issues concerning medications and substance use are of great importance. These are potentially emotional issues, so care should be taken to present or reframe the problem in "non-blaming" terms. Modeling this non-judgmental, non-blaming approach can often be a good learning opportunity for group members.

4. *Life events.* Sometimes, a major event occurs (e.g., divorce, death, marriage, graduation, birth of a child, etc.) in a family, which can be unsettling for the whole family and especially for someone with a severe mental illness. It is natural for the stress level to rise within the family at such times and it is important for the practitioners to listen carefully for signs of increased family stress, which may be connected, to the exacerbation of symptoms while providing education around managing stress. This may even occur with "good" stress.

5. *Outside agency events.* On occasion, changes occur within provider agencies, such as a move to another building or practitioners leave for various reasons. These changes maybe as distressing to a consumer and his/her family as other major life events and should be considered as such.

6. *Disagreement among family members.* It is natural for family members to disagree at times, but when the disagreement becomes intense, outside help may be necessary. The importance of keeping criticism and emotionality to a minimum cannot be stressed strongly enough. Sometimes, an issue surrounded by intense disagreement is better resolved in individual counseling and not in the group setting. This may be a time for the practitioners to suggest an outside meeting to help with the problem. However, if the disagreement is not extreme and especially if it is a consequence of the illness, it can be helpful for all family members to hear from other families and consumers. The problem-solving format of the group makes suggestions and feedback more pragmatic and less stressful. The approach used here is one of problem-solving the means for avoiding untoward consequences of the disagreement for the consumer. The problem definition takes the general form of "How can the Smith family manage their disagreements so that John will not be overwhelmed and relapse?"

In order to decide which problem to work on, the practitioners ask detailed questions to clarify the problem, such as....

- What is the current "undesired situation?"

- When was the problem first noticed?

- When does it occur? How often? In what situations?

- Has the problem, or its effect, changed in any way recently?

- Who is affected by the problem and how?

- With what activities does the problem interfere?

- What attempts have been tried to alleviate the problem? With what results?

- Who seems to have the most impact on the problem?

The scale of problems, at least in the first few months of the group, is also a factor in selecting the problem. For instance, long-standing or previously intractable problems should only be addressed if they can be broken down into more solvable sub-problems.

> ☞**TIP:** In the discussion of which issue to address, it is important to stress to the group that the goal is to teach a problem-definition/problem-solving skill and that, with practice, group members will refine that skill. It is also important to say something like, "Although the problem chosen may not currently be the problem of every individual or family, it is likely that this problem has been of concern to other members or will be experienced over the course of the group." It is also important to say that, "Over the course of the group everyone's issues will be addressed."

Practitioners may choose to select simpler problems early in the group, so that the members learn the method, gain trust in each other and achieve a few   successes. Often, the primary guideline for choosing an issue is "Upon which issue can we have the greatest chance of making a positive impact?"

It is important for practitioners to check in with the individual who raised this issue to be sure that the group truly understands their perception of the issue, including, "What will things look like when they are better?"

GENERATING SOLUTIONS

Each group member is asked to offer whatever solution they think may be helpful. Practitioners should stress that it is important to resist evaluating or discussing solutions, since doing so dramatically reduces the number of solutions presented.

> ☞**TIP:** It is often helpful to say to the group, "It has been our experience that it is difficult to resist discussing suggestions as they are generated. However, we have found that by discussing them as we go, some solutions are left unspoken. Therefore, we would like to help the group delay evaluating solutions until after all suggestions have been made." This reminds the group that other groups and individuals have had similar experiences. It also sets the stage for the practitioners to intervene when members find it difficult to resist responding immediately to suggestions.
> ☞**TIP**: Take time to evaluate solutions. Some groups find that time is a factor and decide to streamline or eliminate the evaluation process.

They simply move to presenting the solutions to the individual for their review and selection. There is some loss involved here since valid information as to the efficacy, or lack thereof, of certain solutions may not be presented.

EVALUATION

After all solutions have been presented, facilitators invite group members to share their thoughts on the efficacy of each solution. Each solution is addressed individually, marking the "pros" [+] and "con's [-] after each solution. This allows the group to become active in thinking about possible solutions, even when there are multiple solutions available.

When faced with a difficult situation, many people find it helpful to make a list of possible solutions. Since this list is often quite large and can seem overwhelming, the individual quickly and arbitrarily reduces the solutions to the two that hold the most appeal. They then choose between these two. However, if the chosen solution does not provide satisfactory results, the individual often feels that the situation is hopeless. "I chose the best solution, [A was better than B], and it did not work, so nothing will." They often forget that the choice was not just between "A" and "B," there were numerous other solutions that were arbitrarily eliminated, one of which may be more helpful. This is the rationale for the problem-solving process. Reminding the group of this phenomenon may be helpful.

CHOOSE THE BEST SOLUTION

When all solutions have been evaluated, the practitioners review the list, stressing those with the most positive and fewest negative responses. The whole solution list is then discussed with the individual who provided the issue originally. They are asked which of the solutions they would like to test out for themselves and for the group over the next two weeks.

☞ **TIP:** It is important to stress that testing solutions is for the benefit of both the individual and the group, as everyone is looking for things that work.

☞**TIP:** During the identification or solution stages, the individual and/or family who have identified the problem may begin to struggle with the process. If this happens, the practitioners should make sure the problem has been accurately defined and that the group is addressing the true problem.

Once a solution has been selected, a very detailed plan is developed. Each step is discussed and a person is assigned responsibility for completion of each step. ***The greater the detail, the better.***

☞**TIP:** Some groups offer the solutions to all group members to try, asking that the group be informed of their efforts, successes or lack of success, thus increasing the repertoire of knowledge of the group.

The individual is reminded that the practitioners may call during the coming week to check on their progress and to offer assistance. The individual is also asked to report at the next PMFG how successful they were and any obstacles they encountered.

Problem Solutions from Actual Practice

Case Study Solutions

Formal problem-solving techniques should be used whenever the family encounters difficulties that cannot be solved by advice or action on the part of the practitioners or other families. We have compiled some case studies from actual multifamily groups. These examples may be helpful to practitioners who use this model, since they indicate the types of problems and solutions that have emerged in real groups in the past. The examples used here can also be used in single family sessions, where formal problem-solving can be helpful.

Common categories of problems that occur:

1. finding and keeping employment
2. medication
3. alcohol and substance abuse
4. daily living skills

Since every group and family is unique, there is no one approach that will solve all families' difficulties. Successful solutions must always be relevant to the individual family and acceptable to its members. In the case studies that follow, we have described the process in detail only in the first example. For all other examples, the problems will vary, but the problem-solving process will be the same.

Background for problem #1: Pedro is a man in his mid-30's who has struggled with severe, persistent mental illness since his late teens. He has been able to maintain an apartment and stay on medication for years with minimal support, but has not worked since his teen years. Since he has not had much experience working with people or practicing social skills, he finds he is uncomfortable with co-workers. He is working closely with an occupational therapist and employment specialist to make his part-time job a success, but shares his concerns with the multifamily group.

Step 1: What is the problem?

"How can Pedro become more comfortable with his co-workers?"

In Step 1, the goal is to narrow the definition of the problem so that the group can achieve practical, concrete solutions. The practitioners return to the problem raised in the go-round. They gather information in order to reach a definition of the problem. The practitioners question family members, gathering relevant recent historical, social-contextual and clinical details. The practitioners ask additional questions about the situation from the perspective of how it relates to either relapse prevention or to the next step in the recovery process. Every family member present must agree with the definition of the problem. The more concrete and behavioral the definition, the more useful and focussed the solution-generating implementation-planning steps, and the more successful the overall outcome.

It is very helpful to ask each person's view of the problem and what they desire as an outcome, in concrete terms.

The following questions are often helpful. Some may have been asked in the go-round.

- When did you first notice the problem?

- Is it related to biochemical factors, such as changes in medication or substance abuse?

- How often does it occur?

- Is it getting worse? At what rate?

- Does it occur with certain people or under certain conditions?

- Is it occurring more or less frequently than when it was first noted?

- Who is affected by the problem, and how?

- What has been tried to alleviate the problem in the past? What was helpful?

- With what activities does the problem interfere?

When a problem has been defined in a way that is acceptable to each member of the family, the practitioner asks the recorder to write it down and read it back to the group.

Here is the problem that was defined for the first example: *"How can P. become more comfortable with his co-workers?"*

Step 2: List all possible solutions.

When the problem has been defined, the practitioner asks the group members for suggestions. The purpose is to generate a lot of ideas about how to solve the problem or achieve the goal. The more possible the solutions, the more likely there will be one that adequately addresses the problem or goal. This step is open to all members of the group, and it is desirable for each family to contribute a possible solution.

The practitioners might begin by saying, "Now that we have defined the problem or goal, let's hear from everyone in the group about possible solutions. This is a time for brainstorming. All ideas are taken seriously and recorded, even if a suggestion seems wild or a little silly; be as imaginative as possible. Then we will discuss the advantages and disadvantages of each one." At this time, the recorder is asked to write down each suggestion, while one of the practitioners is writing down suggestions on a large pad or blackboard in front of the group.

The following is a list of possible solutions that might be generated for the problem defined in Step 1 above, "How can Pedro become more comfortable with his co-workers?"

- tell yourself there's no pressure to be friends, especially with everyone

- ask for support

- connect with people who do the same job

- do the best job you can

- plan pleasure/fun activities outside of work

- make small talk

- give compliments

- give yourself credit

- use humor

- join activities/lunch etc.

- bring in food to share

- ask questions to get to know others – one question at a time

Step 3: Discuss each possible solution, listing the advantages and disadvantages of each one.

After the possible solutions have been listed, the practitioners move on to first discuss the advantages and then the disadvantages of each solution. The practitioner asks the recorder to read each solution aloud, then asks the consumer, the involved family and the group, "What are the main advantages of this solution?" After the advantages are recorded, the practitioner then asks, "What are the disadvantages of this solution?" Advantages are always listed first, and there should be at least one advantage and at least one disadvantage for each solution.

Step 4: Choose the best solution or combination of solutions.

The practitioner asks the recorder to read each solution aloud, including the principle advantage and disadvantage. If the disadvantages strongly outweigh the advantages, the practitioner consults the family and, if they agree, asks the recorder to cross off that solution. If any family member, especially the consumer, is very opposed to that particular item, they are allowed to exercise a categorical veto. After more discussion of the solutions, the practitioner asks the family whose problem or goal is being worked on which solution or combination of solutions suits them best. Although the group does this part of the problem-solving process, it is the family with the specific problem or goal who is most involved and who carries out the solution.

P. chose the following solutions:

- Don't feel you have to be good friends with everyone.
- Bring in food to share.

Step 5: Plan how to carry out the best solution.

The practitioners help the group break down the solution(s) into manageable, concrete, specific steps. The family and the consumer with the problem makes the final decisions, since ultimately, the family members and consumer are responsible for putting the solutions into action. However, group members often can be helpful in making reminder phone calls, giving rides, accompanying someone to an appointment, providing names of helpful agencies or people, etc. The practitioners help the group to be as specific as possible in each step of implementation, by asking such questions as:

- "What needs to happen first?"
- "Who will be doing that step?"
- "When will that step happen?"
- "Where will people meet for that step?"

The practitioners also help to anticipate things that might go wrong and formulate a back-up plan. When the steps of implementation have been clarified as much as possible, the practitioners ask the recorder to read back the steps. The family and the practitioners both keep copies of the problem-solving worksheet. The practitioners should thank everyone in the group for their hard work and help.

Pedro's action plan:

1) Shop for apricot bread ingredients during the week:

- make a shopping list
- set aside grocery money

2) Bake on Saturday afternoon.

3) Bring bread to work on Sunday.

4) Lower expectations of making friends quickly…*go slow*.

Step 6: Review implementation

In the go-round of the next group meeting, the practitioners ask how the implementation went. What steps did the family and the consumer complete? What went well? What did not go so well? The practitioners praise ALL efforts of the family, consumer, and any others involved, and point out any progress made. The practitioners might suggest how to continue with the implementation, how to use a back-up plan, or how to use an alternate solution. Sometimes, the practitioners might suggest "taking a break" from working on the particular problem, especially if implementation was not successful. If a decision is made to take a break, the practitioners might suggest that the consumer and family continue the problem-solving effort with them outside of group. If it seems appropriate, it is important to ask the other families if the solution or any of the suggestions would be, or have been, useful and effective for them. Group members may find it encouraging seeing completed solutions as potentially applicable in similar situations in each family. This generalizing will also help alleviate any sense that a particular family is uniquely deficient because they are having a particular type of difficulty.

Background for problem #2: Sharon is a 38-year-old woman who has schizoaffective disorder. Although she has had a diagnosed illness since her teens, she has worked hard to manage her illness. Her parents are in their mid-60s and attend the MFG regularly with her. She lives alone with her cat and works part-time (every morning for 4 hours) in the mailroom of a large insurance company. The bus stop to work is within easy walking distance of her apartment. She likes the routine of working every day, and has become quite efficient at her job, which does not vary too much from day-to-day. One challenge is that the company sometimes has bulk mailings that need to go out quickly, which means there is increased tension at the work site. Sharon finds it difficult to switch her pace and tasks at these times.

Step 1: What is the problem?

What can Sharon do to feel less overwhelmed at work when there are bulk mailings that need to go out quickly?

Step 2: List all possible solutions.

The group generated the following solutions*:*

- Quit.
- Talk to the supervisor.
- Set limits for you.
- Take more frequent breaks.
- Go to the gym to relieve tension.
- Get a massage - reward yourself for good efforts.
- Reduce your hours at those times.
- Scream into a pillow.
- Practice stress reduction techniques before and after work.
- Balance your life with a variety of activities.
- Clean your apartment.
- Seek out peer/mentor support.

Step 3: Discuss each possible solution.

The advantages of each suggestion were discussed first, then the disadvantages. Sharon decided she did not like #8 (scream into a pillow), so it was eliminated.

Step 4: Choose the best solution or combination of solutions.

Sharon chose the following solutions, and her parents agreed they were good ones to try:

- Talk to your supervisor.
- Practice stress reduction techniques before and after work.
- Balance life.

Step 5: Plan how to carry out the best solution.

With the practitioners' help, Sharon and her family formed a plan during the MFG:

- Talk with supervisor tomorrow.
    - Identify a good time to talk (break time?).
    - Approach the supervisor first thing in the morning to request a meeting time.
- Try to "go slow".
- Use stress reduction techniques.
    - Identify 2 techniques to try.
    - Identify what techniques you will try and how often (it may be helpful to record this on a calendar)

Step 6: Review implementation

At the next MFG, Sharon was asked how she had done with the action plan. She reported that she had been hesitant to talk with her supervisor, so had not approached him during the previous two weeks. She had been successful in identifying and trying one stress reduction technique, which she liked (listening to classical music with her headset). She also had tried some "self-talk" in order to *go slow.* When the practitioners questioned her about whether she would like more outside support in approaching her supervisor; she said *yes.* Her parents volunteered they did not want to appear as though they were taking control of this situation when they found out that she had felt uncomfortable approaching her supervisor. A discussion ensued about when family should offer more help and how to do that without appearing controlling. The practitioners volunteered that they wished they had called her during the 2-week period when there was no MFG, which demonstrated to Sharon and her parents that the practitioners were in partnership with them. The practitioners offered to continue the problem-solving process with Sharon and her family outside of the MFG.

Background to Problem #3: Rebecca is a woman in her mid-20s with a serious mental illness that is presently stable. She tries to take good care of herself and to stay on her medication regimen. Although she lives alone, her mother attends the MFG with her regularly. She has recently started working 20-hours a week as a caretaker for severely mentally retarded adults in a group home. So far, she likes the training and the work, but feels she cannot remember all of the information that she is receiving. This experience is starting to make her feel stressed and inadequate. Although she is working closely with an employment specialist, she does not want on-site supervision or to disclose her illness to her employer. She is wondering what she can do to feel less stressed and more in control of the situation while learning a new skill.

Step 1: What is the problem?

How can Rebecca receive support with her training and best approach her job in order to be successful?

Step 2: List all possible solutions.

The group generated the following suggestions

- Review the written literature that the group home offers about specific tasks during the training period.

- Ask for a written job description.

- Speak to co-workers about what to expect on the job while training and shadowing.

- Don't be afraid to ask questions.

- Ask for extra training if you feel you need it, and tell the employer that helps you learn the best.

- Know who to call for support.

- Make notes of questions to ask your supervisor and write down the answers.

- Make notes of tasks while being trained.

- Don't be afraid to go to supervisor.

Step 3: Discuss each possible solution.

Rebecca decided she liked all of the suggestions and did not eliminate any during this section of the problem-solving process.

Step 4: Choose the best solution or combination of solutions.

Rebecca thought the following suggestions would be worth trying, and her mother agreed:

- Make notes of questions to ask your supervisor and write down the answers.

- Make notes of tasks while being trained.

- Speak to co-workers about what to expect on the job while training and shadowing.

- Bring a notebook and pen to work the first day and from then on keep it with you.

- Try to approach a co-worker who seems friendly and has worked there for awhile; ask that person about what you can do to make the learning process less stressful. They might share their own learning experiences and offer helpful tips!

Background for the problem: Darcy is a 29-year-old woman who has a severe mental illness with paranoid features. She is the mother of two young children. It is important to her to function well enough to care for her family, as well as to take one college-level course each semester as she works towards her undergraduate degree. Her family is very supportive of her efforts to stay stable.

Step 1: What is the problem?

What can Darcy do if she starts experiencing early warning signs of illness? (Warning signs include: sleeplessness, loss of appetite, stopping medication, restlessness, noticeable mood changes, and auditory hallucinations.)

Step 2: List all possible solutions.

- Call the doctor.
- Take more medication.
- Write down feelings or tell someone.
- Find out more information about the medication.
- Alert friends so they can give you feedback.
- Keep a diary about food intake to see if there is a change.
- Say a prayer.
- Talk to family and friends.
- Call the Hotline.
- Talk a walk.

Step 3: Discuss each possible solution.

What are the advantages of each solution for Darcy? Disadvantages? Neither she nor her husband asked to eliminate any of the suggestions.

Step 4: Choose the best solution or combination of solutions.

Darcy chose the following solutions:

- Take medication again, but call the doctor first.
- Say a prayer.

Step 5: Plan how to carry out the best solution.

Darcy and the group developed the following action plan:

After talking with doctor, resume your daily strategy for remembering medications (e.g., set up pill caddy and put reminder sign on bathroom mirror).

Tell family and friends that you are restarting medication, and ask for feedback as a way to monitor changes.

Step 6: Review implementation.

One of the practitioners who works closely with Darcy telephoned her the week prior to the MFG to see how she was doing and if she needed any help with the action plan. At that time, Darcy felt she was following through well with the suggested solutions, and that her family was quite supportive of her efforts. The following session, the practitioners "checked in" with Darcy to find out whether she had been able to continue to follow through with the action plan. She had been concerned that her doctor and treatment team would be angry with her, and had been relieved to find out that they were supportive of her restarting the medications without being angry. That had helped her to regain confidence in managing her treatment herself. Her family had also been able to provide feedback about the positive changes they were seeing in her behavior and mood.

SOLUTIONS RELATING TO DAILY LIVING SKILLS

Background to problem #1: Sometimes several consumers are struggling with the same issue at the same time, and while it is usually preferable to focus on one person's difficulty during a session, the group can benefit from solving a generic problem. A group of consumers in one particular multifamily group were having interpersonal problems with other residents during the same time period, so the practitioners opted to offer a "generic" question, which the group thought was helpful. Some of the interpersonal problems stemmed from other residents disobeying house rules.

Step 1: What is the problem?

What are some ways you can cope with (relate to) difficult people in your living situation?

Step 2: List all possible solutions.

The group generated the following list of suggestions:
- Don't take it personally.
- Become angry.

- Use humor.
- Say "no" repeatedly if the other person isn't listening.
- Explain your point of view (reasonably and calmly).
- Set clear limits about what you can deal with and what you can't.
- Let them know you don't like it.
- Walk away.
- Talk about consequences.
- Get out of the situation…get help!
- Use "I" sentences, not "you" sentences.
- Don't accuse.
- Move!

Step 3: Discuss each possible solution.

The entire group reviewed each suggestion, starting with advantages of each and then exploring disadvantages. They did not eliminate any suggestions.

Step 4: Choose the best solution or combination of solutions.

The group as a whole narrowed down the list of suggestions to the following 4 that they wanted to start practicing:

- Say "*no*" repeatedly if the other person isn't listening.
- Set clear limits.
- Talk about consequences.
- Get help.

Step 5: Plan how to carry out the best solution.

- Set limits by nicely reminding the other person about the house rules, such as "no cigarette smoking in the house".
- Repeat the reminder without accusing the other person.

- Be more firm each time.

- Write down an agreement and have each person sign it.

Step 6: Review implementation.

Each person in the group received a copy of the solutions and action plan. During the following group's check-in, the practitioners reviewed each person's experience with implementing the action plan. Some people needed further help outside of the group, while other people found they had been successful trying the action plan as well as some of the other suggested solutions.

> ☞**TIP:** Serious problems, such as substance abuse, should never be ignored and should be dealt with during the problem-solving session if the consumer will allow it.

Background to problem #2: Katrina is a 42 year-old woman with a history of schizophrenia and only a fair response to medication. She has been able to live alone in an apartment with her cats for the past 12 years, but receives significant support from community providers. She and her older siblings attend multifamily group on a regular basis. In the past 6 months, Katrina has developed a relationship with an older man who is transient, which frightens her family and friends. Katrina has difficulty staying away from this man, even though he forces her to do things she would prefer not to do, such as give him money. She would like to stay away from him, and her family would also like her not to see him any longer, but she has trouble saying "no" to his phone calls and ignoring the doorbell when he shows up in her apartment house. Recently, she has experienced more anxiety with this situation to the point that she sometimes feels unsafe in her own home. The police have intervened on her behalf several times, and her family finds they are becoming frustrated and angry. The primary difficulty seems to be Katrina's increased feeling of discomfort in her own apartment.

Step 1: What is the problem?

What can Katrina do to feel safe in her own home?

Step 2: List all possible solutions.

Katrina was nervous about having the MFG focus on her group, but felt it might help her. She listened while other group members offered suggestions and asked her for more information during the brainstorming:

- Keep a cane or baseball bat near the bed for protection.

- Play soothing music.

- Get friendly with your neighbors…they could come if you called for help!

- Call the police if you feel you're in danger.

- Check all windows to be sure they are down and locked.

- Call the landlord to put a lock on a window that doesn't have one on it.

- Buy a whistle.

- Put bottles by the door and windows - soda cans with pennies in them to make noise.

- Ask someone to visit you each evening (for encouragement).

- Ask a friend to stay with you a while.

- Ask to stay with friends.

Step 3: Discuss each possible solution.

Katrina and her family participated in the review of the suggestions and did not eliminate any solutions.

Step 4: Choose the best solution or combination of solutions.

Katrina identified solutions that she felt she would try:

- Get friendly with neighbors.

- Call the landlord to put a lock on a window that doesn't have one on it.

- Ask a friend to stay with you a while.

Step 5: Plan how to carry out the best solution.

Katrina felt she knew several neighbors on her floor, but needed to get to know the next door neighbors, which she felt confident in doing. Her main focus was to invite a good friend to spend evenings with her for awhile. One woman in the group, who has known Katrina casually for several years, offered to come over each evening for a week to help K. feel more confident in dissuading the male friend.

Step 6: Review implementation.

At the next meeting, Katrina shared that she had had a phone call from one of the practitioners a few days after the meeting. The woman who had offered to spend evenings with her had been able to do so regularly, and at the same time, a friend in Katrina's building had offered to spend time with her some evenings. The practitioner and Katrina had also contacted Katrina's case manager for further brainstorming and assistance with this difficult issue.

A Catalogue of Problem Solutions

Introduction. The psychoeducational model for the family management of schizophrenia stresses the application of formal problem-solving techniques whenever the family is beset by difficulties, which do not lend themselves to resolution by advice from the practitioner or other families. We have attempted to catalogue here a variety of responses to problems which were generated by families and practitioners dealing with three of the most commonly presented issues: finding or keeping a job, drug and alcohol abuse and using medications. We fully recognize the uniqueness of every family system and do not pretend to offer a "cookbook" of approaches that will solve all families' difficulties. Rather, it is presented as a log of the experiences of other FPE practitioners and families as they sought better solutions to their problems. It is clear that each successful solution must be relevant to the individual consumer and the family and acceptable to all of its members. The solutions outlined here may be applicable across many different contexts, or they may in some instances be uniquely adapted to only one family at one point in time. Regardless, they are useful to practitioners as they set out to use this model, because they portray the kinds of discussions and ideas that have emerged around these particular issues in the past.

The three areas were selected because these are the issues most commonly raised by families and consumers. They are also especially challenging, because declining the use of medication and abusing substances can precipitate relapse, and finding a job is inherently difficult to people with severe mental illness. As well, the presentation of these issues as problems often reflects a disagreement somewhere within the family-consumer-clinical staff social system. As the reader is likely to be aware, tension and conflict almost always accompany substance abuse. Decisions regarding the use of medication are close behind in its potential for conflict. These disagreements can be destabilizing or at least prevent rehabilitation, if left to their own devices. Rather than directly attempt to resolve disagreements, the problem-solving approach is to alleviate the effects of the conflict and to find a third (or fourth) path, while not

pretending to resolve the disagreement or criticize any one person's position or opinion. It is much more successful at achieving at least a tentative agreement than more direct conflict resolution methods, in this population and context.

Solutions for Finding and Keeping Employment.
The problem of finding meaningful work is remarkably difficult for people with schizophrenia, and other serious mental disorders. Great progress has been made recently in the application of supported employment strategies. Please consult the Evidence-Based Practices Supported Employment Implementation Resource Kit for additional information and valuable guidance. One of the paradoxes of family intervention is that work often becomes a problem precisely because so many consumers achieve a previous unheard-of level of stability and a simultaneous desire to be more independent. Frequently, their motivation for work is remarkably strong after achieving clinical stability and remission. As has been documented in research studies, employment was the most prominent outcome when a FACT (Family-aided Assertive Community Treatment) team provided intensive treatment and supported employment.

Vocational rehabilitation has been the focus of our treatment development and research efforts since 1990. As a result, a large body of solutions has emerged from hundreds of multifamily group sessions devoted to finding and keeping a job. Some of those are reviewed here. Again, these solutions have been useful to other families and consumers in the past and can serve as a template for the kinds of approaches that may be developed for the practitioner reader's families and consumers. They are not presented as methods that will be assured of success for all participants. Some of them are the product of multifamily groups that have had employment or vocational specialists co-leading the groups. Thus, these groups have begun after professionals helped to set realistic and meaningful goals for employment and assessing strengths and specific deficits. These specialists have proven to be essential to achieving high rates of employment success in this population. Thus, in some solutions it is assumed that there is adequate support by professionals to carry them out.

(1) Laying out and planning the initial steps to preparing and finding work.

This has included very basic ideas, such as looking through want ads and marking jobs that are interesting, to simply walking or driving around the community to see what might be available, to networking in the multifamily group or in the person's natural

network, to shadowing jobs of interest, to using the yellow pages, to formally engaging a vocational counselor. One group urged an individual to look for work with a friend, especially with regards to filling out applications. For many, methods like setting up a daily routine and moving the hour of rising back to early morning have been suggested and proved useful. For some, simple attention to hygiene and appearance is a first step. Very often, group members urge the individual to "just do it", reflecting recent strategies in supported employment. While it sounds naive, the notion that one of the barriers is simply lack of confidence becomes remarkably persuasive, when it is accompanied by ample encouragement from a large number of one's peers. Some groups urge the person to "psyche yourself up"; it seems to work when it comes as the group's message and the individual seems to feel some obligation to the group as a support system. One person found work after a group developed the idea of setting daily goals, which were shared and posted at home.

(2) **Keeping up one's hope and motivation**. Solutions have included keeping a daily routine, regardless of job-finding success, not taking unsuccessful job applications personally, following up on all job leads, exercising and working on a hobby. The more successful approaches have tended to involve intersecting these methods with supports provided by employment specialists. One group simply adopted a solution that all job leads be followed up, rather than dismissed or forgotten. One solution involved writing a check for tuition for a critical class and hanging it on the refrigerator at home to remind the student/worker-to-be to take it himself to the technical college for the first class.

(3) **Dealing with the first few days on the job is difficult and needs special effort and strategies.** Various groups have suggested simple approaches, such as taking one day at a time, not taking initial errors too seriously, making sure one asks about uncertain aspects of the job and going in a bit early to avoid being late and to get acclimatized. One group had reminded the potential employee that everyone has a first week and that it is difficult for most people. In a sense, success in entering the job depends on *lowering expectations* for other aspects of one's life. This principle extends to family and professionals, as well. One solution involved going to the job site, a library, before the first day, to reduce the novelty of being in that setting. They also suggested volunteering prior to starting on salary, so any mistakes would not be counted against the employee's record.

(4.)Learning a new job may be difficult and may require techniques to overcome one's cognitive deficits. One group suggested that the person make notes of all the questions that she might ask a supervisor and to take notes to the company's instruction on her tasks. Also, one suggestion was to feel free to go to a supervisor to check on uncertainties that are not anticipated. One group urged that a person get literature on CPR and read it in advance of training at work and that she obtain a written job description. One solution was simply to make sure to take a notebook and pen to write down any ideas or reminders that seemed to be needed. Another idea was to deliberately make the acquaintance of co-workers, so that they might be able to help with questions. While these may seem rudimentary or even self-evident to well people seeking work, in the presence of a schizophrenic disorder these can be crucial to surviving the initial week or two of a job.

(5.)Managing the job requires thought and effort, even after one has had it for several months. One man was concerned about reconciling his various responsibilities on the job, a common dilemma for many employees in the over-stressed workplaces of recent years. The group and he decided that making a list of present duties and checking them over with his supervisor would be helpful. Other suggestions included comparing tasks he might like to do with those he did not enjoy and asking the supervisor what he expected of him. Very often, the suggestions are more detailed than might be usual, but it is just that level of detail that is critical to overcoming the planning and sequencing difficulties that are inherent to schizophrenia. Making lists and corroborating them with supervisors is not the rule in many entry-level jobs, but they counterbalance the most frequent deficiencies that lead to job loss. Also, making sure there is adequate on-the-job training can ensure success. These are, in all senses of the concept, reasonable accommodations.

(6.)Dealing with stress, symptoms and emotional reactions on the job will help to keep a job. sometimes, solutions for this common dilemma revolve around the susceptibility of the consumer to be overwhelmed by the intensity of stimuli that are encountered on the job. Suggestions have included taking mini-vacations instead of longer but less frequent vacations, exercising, taking on fewer hours than usual, learning stress reduction techniques and engaging a vocational counselor or agency to provide ongoing support. Though more general and therefore more difficult to implement, there has been considerable emphasis

on balancing one's life and using Eastern meditation techniques to reduce arousal after work, or even during breaks. One group suggested going slow; that is, building up one's resistance to stress gradually. One suggestion was to use a temporary employment agency staff as a mentor and emotional support during times of stress and vulnerability. Clearly, engaging the psychiatrist was one method, especially when symptoms re-appeared on the job. Other suggestions included taking one extra dose of medication when the psychiatrist is unavailable, and directly alerting other staff, family members or even a supervisor, as opposed to simply waiting to see if more severe symptoms developed. One group devised a plan for the person to call a friend and set a time to go for a walk.

(7.) **For many of those with schizophrenia, feeling comfortable with co-workers is difficult**. This is a common complaint among those who succeed in finding and keeping a job. The social skills required to get along at work are an area of concern for everyone involved. A variety of ideas have been tried in this domain. At the suggestion of a group member, one woman brought a special bread that she baked to work as a way to communicate what she could not easily say in words. One person was advised that making good friends with everyone at work was not necessarily the standard or, in some situations, not particularly desirable. Other suggestions have included using humor, asking advice about the job tasks, and giving a compliment, connecting with those who do the same job, joining in activities at lunch and joining a car pool. While these have been successful, it is also clear that this is still a kind of frontier for vocational rehabilitation. The workplace remains a difficult place for those with schizophrenia, in no small part because of the stigma that still accompanies those who have the disorder, wherever they find themselves.

Other suggestions developed from problem-solving sessions include:

- Having a buddy as you both enter a new job together;
- Educating treating and caretaking agencies that they should anticipate the change and the attendant stresses;
- Rehearse transportation and other practical aspects, (remembering medication, setting an alarm clock, finding lunch, making telephone calls, etc.)
- Make sure that practitioners and employment specialists increase their contact with the person assuming the new roles;

- If agreed to by the consumer, the employment specialist may have contact with the employer to carry over plans developed in multifamily groups to the work site;

- Develop a plan to deal with the impact of the extra money on the consumer and her or his family. For instance, many families and consumers are concerned about the potential loss of medical or income benefits. Benefits counseling is valuable to assist consumers and families in making informed decisions about this process;

- Advocate for a medication review to see if medication changes may be helpful if there is stress and strain when starting a new job. Re-evaluate this once the job is learned.

- Address the impact of work on medical or income benefit programs in advance;

- Cut back on social life at the start of the job and whenever there is a change in hours or shift;

- Many people understand what they like about jobs through different work experiences. If a consumer starts with a job that is unsatisfying to them, then changing to one that better matches his or her strengths and abilities may be a positive rather than a negative experience.

   The assistance of an employment specialist can be crucial to assisting consumers in finding and keeping jobs of their own choice. The combination of the ideas and social support from the multifamily group and the specific assistance of an employment specialist is a powerful combination. Many participants cite it as the reason they were able to finally return to work successfully.

Solutions for Alcohol and Substance Abuse.

Another large problem area identified by families and practitioners has been the abuse of alcohol and the use of illicit street drugs. The following methods have been remarkably effective when applied consistently over longer periods of time. These approaches overlap with those found in the Evidence-Based Practices Integrated Dual Diagnosis Treatment Implementation Resource Kit, which should be consulted for further guidance and information. As in the methods suggested in that Resource Kit, consistency and persistence are the key characteristics, as opposed to any specific intervention.

   Because the consequences for substance abuse by the consumer are often rather serious for family members, the approaches described here may not be entirely consistent with those

in the IDDT Resource Kit, in that families often choose to exercise influence over the consumer in an attempt to prevent those consequences. Thus, some of these approaches are also not entirely consistent with complete autonomy on the part of the consumer, because at the time they are used, he or she may be engaging in markedly self-destructive behavior. Many recovering consumers, however, are grateful for the interventions of those who care and who, by intervening, set the stage for their own choice to decrease or discontinue abuse of alcohol or drugs.

Some of these interventions, such as referral to self-help options, require full participation and agreement by the consumer. This can be often explored in multifamily groups when more experienced and recovering dual diagnosed group members can offer persuasion to the consumer to address his or her substance use. Peer support is often a key to helping consumers begin the recovery process with substance use disorders. These kinds of interventions are highly preferable, because they support the independence and self-determination of the consumer. Because other interventions usually involve a degree of coercion by relatives and friends, they are not often applied and are usually only undertaken when the consequences of the continuation of the abuse are more serious than the violation of the person's right of self-determination. Concerned family members and/or friends usually institute them, with assistance from the practitioners.

The initial goal for many people with a dual diagnosis of schizophrenia and substance use disorder is not necessarily abstinence, but rather clinically insignificant use. For many, this will be tantamount to abstinence, because they cannot limit use once it starts. Some individuals, however, showed that they could achieve substantial improvements in general functioning by achieving strict limits on use, *without* achieving abstinence. In this regard, psychoeducational approaches to dual diagnosis differ from 12-step approaches, which view abstinence as the only successful option. The differences, in our view, have to do with the differences in populations. All those with schizophrenia are not constitutionally vulnerable to tolerance and addiction. Rather, they suffer consequences because of the interaction of even moderate use of drugs and/or alcohol with their illness, their medications and their functional capacity. In that context, strict limits may be sufficient to alleviating these interaction effects, without complete abstinence. Obviously, these issues can only be resolved by assessing each individual's unique situation. It needs to be reported, however, that no practitioner in any of our research experience has felt that they had been completely successful in eliminating "crack" cocaine from some consumers' repertoire of street drugs, although several of the

interventions listed below did have at least a modest impact on some of these consumers.

Consistent with the model, educational approaches were tried first. These included:

(1) Review of relevant biological information linking substance abuse to schizophrenic symptomatology, using the consumer's psychiatrist to make salient points. We have often emphasized the stimulant action of many drugs, including the secondary effects of alcohol. Although it may seem self-evident to practitioners, it is usually helpful to assist consumers in making the connection between the use of hallucinogens and psychostimulants and relapse of the illness. This also sometimes includes the less obvious effects of nicotine and caffeine. **(2) Encouraging consumer and family to accept that the consumer has two diseases: chemical dependency and schizophrenia**. When it applies, using the disease concept with both conditions serves to alleviate some families' anxiety about the behaviors associated with each and to remove some of the pressure to "behave, immediately" from the consumer.

(3) Reviewing the history of substance abuse as linked to symptom appearance and/or return. The practitioner needs to know about the consumer's history in order to make this intervention effective. The family can contribute to the practitioner's knowledge base; this should be achieved through the joining process.

 (4) Persistent review of use of proscribed substances. The practitioner needs to find a tactful way to regularly inquire about the status of the consumer with respect to drug and/or alcohol use. This usually means inquiring directly about the amount of use in every session, during the go-around, regardless of other issues that are brought up or a report that all is well. The most successful outcomes occur when practitioners make this focussed inquiry part of the routine of each contact with the consumer, while avoiding an accusatory tone.

(5) Predicting probable consequences of return to drug use. This technique is used when consumers share with practitioners or family their desires to return to drug or alcohol use. Typically, this would be in the context of wanting to be more like their peers, or participating in social gatherings. Because the consequences of even minimal use of these substances cannot be reliably

predicted, practitioners promoted the most conservative strategy: total abstinence.

(6) Encouraging other recovering consumers in the multifamily group to tell of their experiences and their decision to abstain. Here the use of peer pressure is found to be of value in dissuading consumers from returning to drug and/or alcohol use. Homogeneity among consumers appears to maximize the likelihood of success.

The measures described above are more likely to succeed if the consumer is currently taking medication as prescribed and not physically dependent. When the consumer has resumed abusing chemicals, more intensive and directive methods may be used. They include:

(7) Referral to Alcoholics Anonymous, Narcotics Anonymous, or Dual Recovery Anonymous. Before referring a consumer to a self-help group it may useful for the practitioner and the consumer to attend the group to see if the dynamics of that particular group will be helpful for the consumer. For instance, some self-help groups discourage the use of medications as a general rule. For consumers who have decided to use medication as a self-management tool, being prepared to help them resolve that dilemma is important.

(8) Close supervision by family.

Other suggestions developed from problem-solving sessions include:

- Referral to a dual diagnosis rehabilitation unit for detoxification.

- Restricting access to money.

- Using legal restraints, such as parole board, etc.

- Removing substances from home.

- Re-hospitalization.

- Instituting a buddy system, as per 12-step programs.

- Blocking inadvertent enabling by family members.

- Referral to an outpatient drug abuse group.

- Relocating consumer out of customary environment.

- Encouraging family to set limits (i.e., as a condition of going home, or staying in the family home, or getting money from family).

- Allowing the person to "bottom out" and seek help when the consequences become unacceptable.

Solution to Problems Associated with the Use of Medications. Practitioners have usually considered this to be one the most common problem areas within the families of people who have major mental illnesses. A variety of techniques have evolved to deal with it. Two distinct aspects of this issue have been identified: the problem posed when the consumer does not want to use medication and the problem of reliable delivery of medication when the consumer has accepted medication but cannot remember to take it as prescribed. Many practitioners are of the opinion that injectable time-delayed medication, when available, is preferable to oral doses, particularly during the first year following an acute episode of the illness. Many feel that having a family member supervise and monitor medication use is appropriate, although this is obviously not a problem-free solution. Many members of the consumer movement decry interventions that reduce autonomy and self-determination with regard to the right of consumers to accept medication or not.

Using newer atypical antipsychotic medications, which sometimes have fewer side effects, reduces one of the principal sources of medication refusal: the intensely unpleasant and often intolerable cognitive, sexual, motor and energy-sapping side effects of conventional medications., especially when they are used at higher, and often excessive, doses. Nevertheless, even the newer drugs have side effects that are intolerable for some people, especially weight gain and sedation with olanzapine and clozapine. Recent research has shown that even conventional antipsychotic medications can be used without burdening the consumer if doses are kept lower than usually prescribed.[i] This is true as well for atypical drugs. For further information please refer to the Evidence-Based Practices Medication Management Approaches in Psychiatry Implementation Resource Kit.

As is consistent with the model, the first efforts are educational in nature and involve directly talking with the consumer and family about the issue of medication usage. This educational approach includes reference to the relevant biological information, which could serve to reinforce the value of using medications. It must also include information that will allow the consumer to make an educated decision in choosing or declining medication. This is a continuous process that begins in the engagement phase, is concentrated in the educational workshop and repeated often during the go-around portions of the ongoing multifamily groups. For more information, please refer to the

medication section of the Evidence-Based Practices Illness Management and Recovery Implementation Resource Kit. Some consumers may be willing to discuss the value of taking medications for themselves personally in the group. Some consumers respond to this encouragement, especially if the accomplishments of some of those on medications are in the same domains as their own goals. However, these generic approaches have been less successful than some developed during problem-solving in multifamily groups.

Interventions developed during FPE problem- solving sessions included the following, in roughly the order, beginning with the simplest and least intrusive, in which they might be applied:

Reviewing the consumer's immediate past history, drawing the contrast between life and function while on medication and while not on it. This intervention is an expansion of informed consent, in that it makes explicit the advantages to taking medication as a balance to the consumer's concern about side effects or other disadvantages. It is most successfully offered to consumers who are considering cessation of medications primarily because they currently feel well. Here the practitioner's job has been to help the consumer (and the family) come to understand the potential value of maintenance doses of medication in order to avoid relapse and to allow the healing process to take place. It may also be necessary to review the consumer's dosage of medication to determine if a reduction in dosage is possible, something that is usually indicated as the person moves toward recovery. Reviewing the dosage of medication prescribed for consumers is too often not done, which in tern may lead to the consumer refusing to use any medication.

Bolstering and supporting the families' beliefs that the medications have substantial advantages. This sometimes entails re-educating the family about medication and its effects on psychotic symptoms and differentiating the negative symptoms of the illness such as lethargy, inertia, withdrawal and anhedonia from the side effects of the medications. This intervention is also most likely to succeed when the consumer is still on medication but is considering cessation, although it is a necessary first step towards more direct interventions with the family if the consumer does eventually decide to discontinue medication.

Careful understanding and inquiry as to why the consumer wishes to stop medication and then an equally careful attempt to address the issues. These are usually unstated and sometimes not

in the awareness of the consumer and the family. The most common issues include stigmatization as a mental patient, undesirable and very unpleasant side effects, and difficult times of administration and feelings of loss of personal control. These specific issues then become problems in themselves and are subjected to problem-solving techniques. It is absolutely necessary to respond to these issues as quickly as they are raised, rather than downplaying the consumer's complaints. Coupled with this approach is the importance of helping the consumer to accept that some of their side effects may be unavoidable, but that they may be preferred to the return of symptoms and a relapse. It has often been helpful to enter into a discussion of the various medications prescribed and a description of their specific side effects and advantages as a means of de-mystifying them. It is crucial to engage the consumer in the choice about medication taking as a key ingredient in supporting autonomy and informed choices about the possible paths to recover. The practitioners will need to be conversant with some of the advantages of the newer atypical antipsychotic drugs as a possible solution to these kinds of complaints. The treating physician, if available, might be called into the session to do this as a means of reinforcing the message.

(1) **Bargaining for a moderate decrease in medication.** This technique was found to be moderately successful, if the practitioner could convince the consumer to return to medications if prodromal (early signs of relapse) symptoms should appear. It is best combined with the daily diary method, as well as increased practitioner-to-consumer contact.

Reviewing prodromal signs of relapse with both family and consumer in order to heighten sensitivity to the issue. This intervention is most appropriately tried when the consumer seems about to cease medication, despite the prior efforts of practitioners and family to convince him or her otherwise. It is essentially a matter of providing information to the family and the consumer about what has not yet occurred, but nevertheless communicating the practitioners' cautions that it is highly likely to occur, in spite of everyone's wishes and efforts to the contrary.

Exploring how the consumer's life will be more limited if prodromal symptoms return. This should be done in enough detail to help the consumer make a fully informed choice about stopping medication. It is helpful for the practitioner to be well informed about the consumer's past, as well as hopes and aspirations. *The thoroughness of the early joining process, especially regarding the*

review of goals and the initial contracting, is crucial to making this intervention successful. Many consumers believe that their lives will be more limited with medication than without it, and there are some examples of that occurring. However, more of the people who are attempting to recover from a major psychotic or depressive episode will reach their goals on medication than without it. That is what should be communicated to the consumer and family.

Encouraging other consumers to share their experiences about their experiences of stopping medication. There is an aspect of this intervention that includes peer pressure, and may have an aspect of subtle coercion. However, it has been found to be very powerful if the consumer connects with other consumers in the group and identifies with them. It is consistent with the ways that consumers have influenced each other within the recovery movement, but without the influence of practitioners and family members. Here, all three groups are working together to help the person make an informed decision.

Encouraging the consumer to make a connection between accepting medication and avoiding the return of prodromal or primary symptoms by the use of a diary kept daily by consumer. This would most logically follow the consumer's decision to stop medications or to cut the dose down to below therapeutic levels. To be effective, this intervention is sometimes combined with increased contact between the mental health treatment team, the consumer and the family. Practitioners generally felt that these efforts had more chance of success if the consumer was already taking the medication as prescribed.

In situations in which the consequences of the consumer declining medication are known to be serious and perhaps irreversible, more directive solutions have also been used. It is important to recognize that these approaches decrease the consumer's right of self-determination and sense of autonomy and should be seen as a means to help establish enough insight so that he or she will be able to later make an informed choice that leads to recovery.

Encouraging the consumer to agree to continue on medications for a certain specified period of time. Here, the practitioner's strategy is essentially that of buying time, recognizing the need to lower stimulation and other causes of relapse if the consumer does decline medication altogether. Often this strategy produces a temporary solution, but not a permanent resolution. The practitioner needs to be careful not to get into a pact with the consumer whereby

medication is stopped regardless of the consumer's condition simply because time has run out. Toward the end of the test period, it is crucial to use the methods cited above to promote an informed decision on the consumer's part. On the other hand, this process often needs to be repeated, because of changes in the consumer's experience of taking the medication.

Using a family agreement to establish requirement of medication adherence as a condition for returning home after a hospital stay, or for continuing to live at home. This approach has proven successful with families who have had previous experience with very serious consequences of the consumer choosing to decline medication and who were able to exercise some control over discharge. The number of families who are actually willing to refuse to let a family member live at home because of the effects of not using medication is negligible, although many practitioners had initially espoused this as a possible solution. It is usually an approach to use when all else has failed and only when the consequences are serious enough to justify reducing the consumer's choice and autonomy.

Family distributing and tracking the consumer's use of medication according to the prescribed dosage schedule. The family's willingness to do this appears predicated on a number of factors. First, they themselves must be convinced of the necessity for the medication. Second, they must be willing to suspend their expectations of autonomy on the part of the consumer. Third, they must feel they have some leverage to enforce the procedure. Fourth, they must feel that it can be implemented in such a way as to avoid embarrassing or humiliating the consumer (one mother counted out the day's dosage and simply left them on the kitchen table in the morning). This is best seen as a temporary step toward the consumer taking more direct control of their medication usage as recovery proceeds.

Other Clinical Models For Psychoeducational Multifamily Groups

As the effectiveness of the family psychoeducational approaches to the treatment of schizophrenia has become established, interest has developed in extending these models to other conditions. That has led to the development of several newer approaches designed for consumers with specific diagnoses or for specific situations, such as when a given consumer has no family available or family involvement is complicated by a history of trauma within the family. The design of these newer models has proceeded with the same method as was done in working with people who experience schizophrenia: specific aspects have been designed to ameliorate phenomena that have been shown to influence outcome in previous research.   That is, they are rooted in empirical findings, rather than theory, and those findings range over the entire body of psychiatric and psychological research, including both biological and psychosocial studies. Though they do not have the depth of outcome study results that has been shown for the models for people who experience schizophrenia, evidence is accumulating that they are just as effective. The practitioner who sets out to apply these models should review the available literature, since at the time of this writing many of these models were being tested, but results were not yet published.

Included here are brief summaries of descriptions of psychoeducational multifamily group treatment approaches for people with several common diagnoses as well as a model for ameliorating the effects of chronic medical illness on the family. The practitioner interested in applying these newer methods should consult the volumes in which they are described fully and seek training from qualified trainers.

Multifamily Groups for Bipolar Illness

David A. Moltz, M.D.

Margaret Newmark, M.S.W.

The psychoeducational multifamily group model must be significantly modified for people who experience a 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" (defined earlier in text as behaviors perceived by the consumer as being critical and/or lacking warmth/support) affects relapse, but there is an even 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 consumers with schizophrenia. Thus, biological and psychosocial factors seem to be more evenly weighted in determining course of illness in bipolar disorder; nevertheless, family psychoeducation remains a powerful treatment in preventing relapse and improving longer-term outcomes.

This model, developed by Moltz, Newmark, McFarlane and associates, 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. Only one other group has published a report of psychoeducational multifamily group approach. Anderson and associates compared a family process multifamily group to a psychoeducational multifamily group for short-term treatment of hospitalized consumers with affective disorders. One of the few significant differences between the groups was that those attending the psychoeducational group reported greater satisfaction than those attending the process group. Therefore, whether or not the psychoeducational format had measurable clinical advantages, it was more valued by family members. For further information please refer to the citations in the Bibliography.

A MODEL FOR BIPOLAR DISORDER

The key elements of this model are the same as in the approach for consumers with schizophrenia. Each is modified in important ways to match the clinical and psychosocial problems encountered in bipolar disorder.

The materials cited in the bibliography contain information regarding the use of single family groups for individuals with bi-polar disorder.

Joining

- Initial joining sessions are held separately for the consumer and the family.
- 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.

Content

The content of the joining sessions is modified to reflect the specific impact of bipolar illness on the family. It includes:

- Extensive discussion of the history of symptoms and course of illness
- Identifying precipitants and prodromal signs
- Emphasis on differing attitudes and attributions
- Discussion of inter-episode functioning, that is to say, "how is life between episodes?"

Conjoint sessions

After several sessions with the family and the consumer meeting separately, they are seen together for one or more conjoint sessions facilitated by the two practitioners who will be co-facilitating the group. These conjoint sessions allow the family to come together as a unit prior to the multifamily group, while the separate sessions allow each party to express their concerns without constraints and thereby diminishes conflict during the joinings.

Educational workshop

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 depressed episodes, differences from normal highs and lows
- The issue of will-power
- The question of the "real" personality
- The impact of acute episodes on the family
- The long term impact of the illness on the family
- Theories of etiology of the illness
- Short and long-term treatment strategies

Ongoing group meetings

The structure of the multifamily group meetings is essentially the same as the schizophrenia model.

Challenges to group formation and maintenance

Several issues related to specific characteristics of bipolar illness have presented challenges to group formation and process:

- Diagnostic ambiguity
- Maintaining the group structure
- Coexisting conditions, especially substance abuse in consumer and other family members.

Outcomes

In general, consumers reported that:

- they were less angry over time;
- they had less debilitating episodes when they did occur;

- they were better able to manage symptoms and episodes;

- they experienced fewer hospitalizations; and

- they 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 the consumer's ability to manage the illness; and

- benefits from the program even if the consumer did not attend.

Practitioners reported:

- it took about two years to master the techniques;

- they learned to see their role more as consultant than therapist;

- they better appreciated family's and consumer's experience of illness and efforts to cope with it; and

- each person's struggle with illness is different.

Multifamily Group Treatment For Major Depressive Disorder

Gabor Keitner, M.D.   Ivan W. Miller, Ph.D.

Laura M. Drury, M.S.W.   William H. Norman, Ph.D.

Christine E. Ryan, Ph.D.   David A. Solomon, M.D.

To date, the only previous multifamily group treatment for consumers who experience depression has been the model developed by Anderson (1986). This multifamily approach has been used at the University of Pittsburgh for many years, however the only empirical data collected on this model is a comparison of participants' satisfaction with the group. This study indicated that consumers and families were very satisfied with the treatment and believed that they

obtained significant benefits. However, despite the fact that this intervention has been incorporated into several long-term studies of depression, there has been no study of the potential effects of this multifamily treatment on outcome or course of illness in major depression.   Such studies are underway now and preliminary results are promising.

Conducting multifamily group treatment for people with depression

Consumers with mood disorders participated in multifamily psychoeducational groups in a 5-year NIMH-sponsored research study. Consumers with unipolar and bipolar illness were combined in order to ensure a critical mass of consumers and families, and also because we felt that there was a significant overlap in the themes of remission and relapse between unipolar and bipolar forms of mood disorders. In addition, both unipolar and bipolar consumers had a common experience in the depressive phase of the illness and it was assumed that a certain percentage of unipolar consumers may eventually experience an episode of mania.

Much of the following material was drawn from previous descriptions of psychoeducational groups.

Overview of goals and structure

- Helping consumers and family members become knowledgeable about the signs and symptoms of depression and mania.

- Promoting relationships and increasing understanding of the effects of the illness by sharing information, support and members' perspectives on family interactions.

- Consumers and family members gain insights and learn new coping strategies in dealing with different phases of the consumer's illness.

- Consumers and families have a better understanding of how they can work with each other and with mental health professionals to deal with the illness.

Family and group composition

A core feature of this program is that both the consumer and family members attend the sessions. All family members of the household over the age of 12 are expected to attend. A minimum of four families seems to be necessary to insure adequate activity and group discussion. Groups of five to six families, or twelve to fourteen people, are optimal. Groups typically include consumers with both bipolar disorder and others with major depression.

Practitioners

Two co-leaders are needed. The leaders deal with any consumers or family members who become upset during a session. Leaders should be experienced in working with consumers, their families, and also in group process and therapy. They should know about current issues and treatments of major depression and bipolar illness, including the biopsychosocial model of mood disorders.

Clinical Procedures

The group leaders (practitioners) should meet before each session to discuss the content of the session and the division of tasks between them. They should also meet immediately after the session to review and assess group members and plan future agendas and strategies. This debriefing is especially important if a crisis occurred during the group session with either a consumer or a family member.

Screening session

This is an individual meeting between the consumer, family member(s) and one of the two co-leaders. It serves to:

- Introduce the consumer and family to the therapist;
- Provide an opportunity to assess the family's and consumer's knowledge about mood disorders, coping skills and methods of dealing with the illness;
- Build an alliance between the therapist consumer, and family; and

- Let the therapist assess the appropriateness of the family and the consumer for the psychoeducational group

Structure of psychoeducation groups

Please refer to the citations in the bibliography specific information about the structure of these groups.

Conclusion

The optimal treatment of depression has yet to be defined. Pharmacotherapy, psychotherapy, family therapy and group therapy all play a role for some consumers at some point in the illness. The multifamily group format is a welcome addition to the currently available treatments for depression. The role of the family is significant in determining the course of the depression and its response to treatments.

Multifamily Psychoeducational Treatment of Borderline Personality Disorder

Cynthia Berkowitz, M.D.

John Gunderson, M.D.

The development of psychoeducational multifamily treatment of borderline personality disorder (BPD) is prompted by four factors:

- the need for novel psychosocial interventions in this disorder,
- the success of multifamily psychoeducational treatment of schizophrenia,
- the need for more effective family interventions in this disorder, and
- the emergence of a deficit model of BPD.

Dialectical Behavioral Therapy (DBT) has been developed by Marsha Linehan and colleagues as a disorder specific treatment of BPD, focusing on the diminution of the self-destructive behavior that is the major cause of morbidity in BPD. It is the only psychosocial treatment of this disorder that has been subjected to a controlled

outcome study. Linehan has established the effectiveness of this cognitive-behavioral treatment of BPD.

Practitioners who treat individuals with BPD know that the recurrent crises that mark the course of the illness often occur in response to interactions between the individual with BPD and relatives. This pattern strongly suggests that a treatment targeted at altering the family environment could positively influence the course of the disorder. The findings of Young and Gunderson, (1995) suggest that adolescents with BPD saw themselves as being significantly more alienated than did adolescents with other disorders. Their research found that alienation in the family environment is a useful target for intervention and indicates that psychoeducation may be able to diminish feelings of alienation.

Based on studies of the role of expressed emotion (EE) in BPD by Jill Hooley as well as by John Vuchetich, (the latter study in association with development of the current treatment), we hypothesize that EE in the family may be a risk factor for worsening psychosocial functioning in the individual with BPD.

Rationale for psychoeducational multifamily treatment of BPD

The following principles borrow heavily from the previous work of Anderson, Hogarty, Falloon, Leff and McFarlane in the development of psychoeducational treatment but also incorporate emerging concepts of BPD, particularly the functional deficit model.

- BPD is characterized by functional deficits of (i) affect and impulse dyscontrol, (ii) intolerance of aloneness and (iii) dichotomous thinking. If individuals with BPD have functional deficits in their ability to cope, it follows that they would benefit from an environment that could help them cope with those deficits.

- The functional deficits above may render individuals with BPD handicapped but not disabled. This means that they can be held accountable for their actions but that change for them occurs very slowly and with great difficulty.

- BPD is an enduring disorder characterized by recurrent crises. The specific goal of the treatment is to diminish crises rather than to cure the disorder. We hypothesize that stress in the family environment may significantly influence the course of the disorder.

- Families can influence the course of illness in that they can either diminish the stresses that cause relapses or

inadvertently create them. Families are asked specifically to make the home environment calmer and to reduce the stress the consumer who experiences BPD is subjected to.

- Living with an ill relative has stressful consequences for the family. A major goal of the current treatment is to diminish stress within the family.

- Family members will want to use education to change their behavior if they believe they can help an ill family member by doing so.

- Stress within the family may have at its root alienation between the individual with BPD and the family. Psychoeducational treatment moves parents away from issues of their possible causal role in the occurrence of the illness and away from blaming and criticizing the individual with BPD.

The role of the multifamily group in treatment of BPD.

The mechanisms of the multifamily group directly address the particular problems facing the families of individuals with BPD:

- the need for improved clarity of communication and directness;

- diminished hostility; and

- diminished over-involvement.

Structure of psychoeducational multifamily treatment.

The same three-stage structure used in the treatment of people with schizophrenia can be applied to people with borderline personality disorder. In this model, family psycoeducational treatment begins with a joining phase followed by an educational workshop. Families then join a multifamily group for an extended period of biweekly treatment. Again, the details of conducting the joining sessions, educational workshop and multifamily group sessions are described in the citations in the bibliography.

Treatment Outcome

The psychoeducational multifamily treatment of BPD is currently under study in a project involving two multifamily groups.

Each of the families consisted of a mother or two parents with a daughter having BPD. Data is currently available for only eight of the participating families:

- 66.7 percent felt that the multifamily group helped them to modulate angry feelings

- 66.7 percent felt less burdened

- All participating families felt that the group improved their communication with their daughters (75 percent felt that the improvement was "very great.")

- All participating families felt that the treatment improved their knowledge of the disorder

- 91.6% of parents felt that the treatment had helped them to set limits

- All of the participating families felt supported by the group

Conclusion

While the evidence supporting its effectiveness for people who experience borderline personality disorder is preliminary, the data available suggests that consumers are experiencing improved communication and diminished hostility within their families.

Multifamily Behavioral Treatment of Obsessive Compulsive Disorder

Barbara Van Noppen, M.S.W.

Gail Steketee, Ph.D.

Education about consumers with obsessive compulsive disorder (OCD) and the reduction of critical responses to behavioral symptoms are important family factors in the course of illness and possibly in treatment outcome for OCD. Clinical investigation of family members' responses to OCD symptoms and of their impact on the symptoms can lead to the development of family behavioral interventions that may help both the consumer and the family. Multifamily behavioral treatment (MFBT) includes consumers and their significant others in a 20-session intervention (12 weekly and 6 monthly sessions) over a period of 9 months. Preliminary findings revealed efficacy of MFBT comparable to standard individual behavioral therapy. Furthermore, reductions in the symptoms experienced by consumers with obsessive compulsive disorder who completed MFBT have been maintained at one-year follow-up.

Multiple family group treatment

Multifamily behavioral therapy (MFBT) compared to single family behavioral therapy, offers the opportunity for reduction in perceived isolation, enriched opportunities for problem solving and emotional distancing, enabling family members to respond in a less personalized way to the symptoms. A sense of community and social support often develops through the course of the MFBT, as families share stories with one another. There is a lessening in feelings of shame and stigma, which encourages family members to take a larger role in treatment and join with the consumer to combat the symptoms of obsessive compulsive disorder. The presence of other families with similar problems provides an opportunity for consumers and families to learn effective negotiation of agreements and to adopt symptom management strategies modeled by other members of the group. Additional potential benefits of multifamily intervention are reduced therapist burnout and greater cost-effectiveness of treatment.

A recent uncontrolled trial by Van Noppen and colleagues examined the effects of MFBT for 19 consumers and family members

treated in 4 groups. Consumers experienced significant reductions in obsessive compulsive symptom severity and similar reduction in scores on a measure of family functioning (FAD). Among MFBT consumers, 47% made clinically significant improvements (reliably changed and scoring in the non-clinical range on OCD symptoms) at post-test and 58% achieved this status at 1-year follow-up. Results from multifamily behavioral treatment were comparable to those achieved by individual behavior therapy. Overall, the multifamily intervention was quite effective, although some consumers did not show strong gains and there is clearly room for improvement.

Features and procedures of multifamily behavioral treatment (MFBT)

The multifamily intervention is similar to methods described by McFarlane and Falloon, but uses interventions specifically aimed at reducing obsessive compulsive symptoms and changing dysfunctional patterns of communication. This family group treatment incorporates psychoeducation, communication and problem-solving skills training, clarifying boundaries, social learning and in vivo rehearsal of new behaviors. There is also in-group observation of exposure and response prevention with therapist and participant modeling.

- 4-6 families (no more than 16 total participants is recommended), including consumer and others who have daily contact with the consumer. Co-leaders are optimal; at least one leader should have an advanced degree in social work, psychology or certified counseling and experience in clinical work with individuals, families and groups.

- Sessions are 2 hours long and typically meet in the late afternoon or early evening.

The key clinical procedures include:

- each consumer and family has a pre-treatment screening by phone with the therapist(s) to determine appropriateness for the group and readiness for treatment, following this two intake sessions are scheduled;

- at the intake sessions, 11/2 hours each, pretreatment forms are completed, symptom severity and family response styles determined, goals of the group and behavioral therapy principles are discussed, pre-treatment concerns and questions are addressed;

- treatment: 12 weekly sessions, 6 monthly group follow-up sessions, providing:

    1. education about OCD and reading of self-help material;

    2. education about families and OCD;

    3. in vivo exposure and response prevention plus homework and self-monitoring;

    4. homework discussion with family group feedback and problem-solving; and

    5. behavioral contracting among family members and communication skills training.

Conclusion

MFBT appears to be a good alternative to labor-intensive individual behavioral treatment. Recent research findings suggest that MFBT may especially help consumers who experience obsessive compulsive disorder and have not benefited from standard individual treatment and who are living with family members. MFBT incorporates family members into behavioral treatment by teaching family members and consumers to negotiate contracts. The goal of this treatment is to encourage anxiety reduction for the consumer, to educate and model reasonable interactive responses within families, and to remove family members from the consumer's compulsions in a supportive manner.

A full description of this approach is to be found in the references cited in the bibliography.

Supervision for Practitioners Beginning to Use Family Psychoeducation

Training and supervision are key elements in achieving the expected results described in this resource kit. We have found that training and supervision of family psychoeducation is most effective when it follows the fundamental principles of work with families. That is, the psychoeducational principles developed by Anderson and Falloon (see references cited in the Bibliography of this Workbook) encourage the use of formal problem-solving techniques to minimize stress and distraction, temporarily lower expectations and encourage optimism about finding solutions. Trainees and administrative and advocacy participants are encouraged to apply this collaborative, gradualist method to the administrative difficulties they encounter, thus gaining experience in using a step-by-step method not only with families, but also with other service providers, such as the staff of day hospitals and community residences. For example, management guidelines such as "going slow" or "encouraging periods of social withdrawal" are occasionally at odds with local practice standards in the treatment of severe mental illness. In our approach, clinicians are taught to avoid conflict and confrontation by negotiating changes in treatment plans on a case-by-case basis. They rely on the improved functioning of these consumers to argue for the advantages of embracing the entire model. Thus far, by simplifying and making more manageable the process of innovation, we have dealt successfully with the many barriers that can prevent successful implementation of this approach.

The value of training is that senior practitioners can demonstrate the key methods and techniques in a way that is difficult to communicate in writing. The training that has been most successful involves some didactic presentation to clarify concepts from the toolkit and books. The key, however, is role play demonstrations and other exercises to give the practitioner a more vivid and emotionally meaningful picture that can serve as a guide to the process, tone,

style and sequences that usually lead to the best outcomes. Training is also crucial to understanding the details of the sessions' pacing and the usual methods for balancing the needs of the various members of the family and interactions among multifamily group members.

Supervision, though usually relatively minimal in scope, has also proven to be a key ingredient in reliably carrying out this approach. The reasons are similar to the need for supervision in any therapy. It is common to encounter situations and complexities that are not addressed fully in written materials or training exercises but which have been encountered by experienced practitioners. Supervision is often simply sharing what others have encountered previously and the solutions that worked in those situations. Also, it is very easy to misinterpret recommendations and get off track, again in ways that many others have done and which have relatively clear solutions. In essence, an effective supervisor can assure that the new practitioners will succeed, when they might not, at least initially, on their own. In actual practice, many of the issues for supervision are the practicalities of setting up this service in an existing treatment or case management program for the first time. Most clinicians in fact find that they spend an equal time setting up procedures and organizing participation by their colleagues, as compared to struggling with clinical dilemmas. Again, supervision can greatly reduce the confusion and false starts that may occur in many mental health service settings.

We have found that supervision for both single and multifamily versions of family psychoeducation can be accomplished through group supervision occurring semi-weekly or monthly, and often using videotapes of early sessions. This can be done via teleconferencing or, videoconferencing, if there are no supervisors available locally. This usually continues on a scheduled basis for the first year of practice, then on an ad hoc basis thereafter. In nearly two decades of experience training and supervising practitioners working with people with severe mental illness, we have seen that very few clinicians have failed to help consumers and families achieve results similar to or better than those reported in research studies. It should be noted this has occurred only after the practitioners and supervisors have been trained and thoroughly reviewed the appropriate materials.

Readings and other Resources

ESSENTIAL READINGS FOR PRACTITIONERS

The following four books are recommended references for those wanting to master this approach. The first includes key elements of the Anderson and Falloon approach and should be read first. The Miklowitz, et al., book is an important reference for those working with consumers with bipolar disorder.

McFarlane, W.R., **Multifamily Groups in the Treatment of Severe Psychiatric Disorders**, New York, NY, Guilford, 2002.

Anderson, C., Hogarty, G., Reiss, D., **Schizophrenia and the Family**, New York, NY, Guilford Press, 1986

Falloon, I., Boyd, J., McGill, C., **Family Care of Schizophrenia**, New York, NY, Guilford Press, 1984.

Miklowitz, D.J., Goldstein, M., Bipolar Disorder**: A Family-focused Treatment Approach**, New York, NY, Guilford Press, 1997

ADDITIONAL RESOURCES FOR PRACTITIONERS

Amenson, C., **Schizophrenia: A Family Education Curriculum**, Pacific Clinics, 1998.

Provides 150 slides with lecture notes for a class for families with a member with schizophrenia. Includes information about the illness, medication and psychosocial treatments and the role of the family in promoting recovery.

Amenson, C., **Schizophrenia: Family Education Methods**, Pacific Clinics, 1998.

Companion handbook to Schizophrenia: A Family Education Curriculum provides methods for forming a class, optimizing the learning of families, and dealing with typical problems that arise in conducting family classes.

Mueser K, Glynn S: **Behavioral Family Therapy for Psychiatric Disorders**.
Oakland, New Harbinger Publications, 1999

A comprehensive model of single-family Psychoeducation that includes a multifamily discussion/support group. The book contains individual educational handouts for various psychiatric diagnoses and handout for various related topic areas.

PSYCHOPHARMACOLOGY

The Essential Guide to Psychiatric Drugs by J. Gorman, St. Martin's Press, 1995.

Written for a sophisticated consumer, it is the most accessible source of information about psychotropic medications. It distills the Physician's Desk Reference into understandable language. It describes the individual "trees" (such as Prozac) in the forest of medicines. "The benzodiazepines: Are they really dangerous?" is a typical section heading.

Medicine and Mental Illness by M. Lickey and B. Gordon, Freeman, 1991.

A scholarly yet readable work written for professionals, it is best at teaching the principles of diagnosis, neurophysiology and psychopharmacological treatment of mental illness. It describes the "forest" of psychopharmacology, why it is there and how it works. "The blockade of dopamine receptors and antipsychotic potency" is a typical section heading. It does not discuss the profiles of individual medications.

CULTURAL COMPETENCE

The Cross-Cultural Practice of Clinical Case Management in Mental Health edited by Peter Manoleas, Haworth Press, 1996.

A collection of useful articles about the role of gender, ethnicity, and acculturation in treatment seeking and response. Provides guidelines for engaging and intervening with specific ethnic and diagnostic groups in varying treatment contexts.

VIDEOTAPES

Schizophrenia Explained by William R. McFarlane, M.D.

Produced by, and order from, the author at Maine Medical Center, 22 Bramhall Street, Portland, ME 04102. (Phone 207-871-2091). mcfarw@mmc.org

This provides a full review in lay language of the psychobiology of schizophrenia, emphasizing the key concepts in family psychoeducation: stress reduction, optimal environments and interactions for recovery, and support for the family's ability to contribute to recovery in many ways. It is often used in lieu of a psychiatrist during Family Education Workshops and for staffs of case management programs, community residences and employment programs to help them understand how to assist consumers with this disorder.

Exploring Schizophrenia by Christopher S. Amenson, Ph.D.

Produced by the California Alliance for the Mentally Ill (Phone 916-567-0163).

This videotape uses everyday language to describe schizophrenia and give guidelines for coping with illness for persons and their families.

Surviving and Thriving with a Mentally Ill Relative by Christopher Amenson, Ph.D., Third edition 1998.

Eighteen hours of good "home video quality" videotapes cover schizophrenia, bipolar disorder, major depressive disorder, medication, psychosocial rehabilitation, relapse prevention, motivation, and family skills. Order from Paul Burk, 1352 Hidden Springs Lane, Glendora, CA 91740. (Phone 626-335-1307).

Critical Connections: A Schizophrenia Awareness Video produced by the American Psychiatric Association, 1997. This 30 minute video was designed by the APA to help consumers and families cope with the disabling effects of schizophrenia. It provides a hopeful, reassuring message about new medications and psychosocial treatments that assist with recovery.

Exploring Bipolar Disorder by Jerome V. Vaccaro, M.D., 1996

One hour professional quality videotape describes the illness, recovery, and the role of the family. Persons with the illness contribute valuable insights. Produced by and ordered from the California Alliance for the Mentally Ill, 1111 Howe Avenue, Suite 475, Sacramento, CA 95825. Phone 916-567-0163.

PERIODICALS

Schizophrenia Bulletin: Highly technical and difficult to read but it is the ultimate source for research findings. The fall 1995 issue summarizes "Treatment Outcomes Research".

Psychiatric Services: Practical articles in all aspects of mental illness. Brief clinically relevant articles on medication and other treatments. The most useful periodical for clinical staff.

Psychosocial Rehabilitation: Practical psychosocial rehabilitation articles. Easy to read and understand. Provides "how to" details. Contains good consumer written articles.

OTHER RESOURCES

There are a number of excellent books written for persons with a mental illness and their families to help them understand and deal with these illnesses. Many of these are helpful for professionals directly and all are important resources to which to refer patients and families. (See Reading List for Families.) Many of the professional and family books are offered at a discount by the National Alliance for the Mentally Ill, 200 N. Glebe Road, Suite 1015, Arlington, VA 22203-3754. Phone 703-524-7600.

BOOKS ON MOOD DISORDERS (BIPOLAR AND UNIPOLAR DEPRESSIONS)

A Brilliant Madness: Living with Manic Depressive Illness by Patty Duke and Gloria Hochman. (Bantam, 1992)

Combines personal experience with clinical information to describe manic depression in understandable terms and provide guidelines for coping with it.

Control Your Depression by Peter Lewinsohn, Ricardo Munoz, Mary Ann Youngren, and Antonette Zeiss.(Prentice Hall, Englewood Cliffs, New Jersey, 1979)

Self-help book which assesses contributors to depression and includes activities, relaxation techniques, thinking, social skills, self-control, and specific ideas and exercises for each problem area.

The Depression Workbook by Mary Ellen Copeland. (Harbinger, 1992)

Assists individuals in taking responsibility for wellness by using charts and techniques to track and control moods. The most complete and useful self help book for bipolar and unipolar depressions.

The Feeling Good Handbook by David Burns, (Penguin, New York, NY, 1989)

Self-help book presents rationale for cognitive therapy for depression. Gives specific ideas and exercises to help change thought patterns associated with depression and other problems.

Lithium and Manic Depression: A Guide by John Bohn and James Jefferson.

A very helpful guide for people with manic depression and their families regarding lithium treatment. Order from Lithium Information Center, Department of Psychiatry, University of Wisconsin, 600 Highland Ave., Madison, WI 53792.

Our Special Mom and Our Special Dad by Tootsie Sobkiewicz (Pittsburgh: Children of Mentally Ill Parents, 1994 and 1996)

Two interactive storybooks that allow primary school age children to understand and identify with the problems associated with having a mentally ill parent. Can be well utilized by a relative or therapist in individual or group work.

Overcoming Depression, Third Edition by D. & J. Papolos (Harper & Row, 1997). A comprehensive book written for persons suffering from manic depression and major depression, as well as their families. It is the best source of information about these disorders. Does not offer coping strategies. This book and *The Depression Workbook* are the best two to read.

An Unquiet Mind by Kay Redfield Jamison

A compelling and emotional account of the author's awareness, denial, and acceptance of her bipolar disorder. It offers hope and insight regarding recovery for anyone who reads it.

BOOKS ON DUAL DIAGNOSIS (MENTAL ILLNESS AND SUBSTANCE ABUSE)

Alcohol, Street Drugs, and Emotional Problems: What you need to know by B. Pepper and H. Ryglewicz.

These informative pamphlets come in versions for the client, for the family and for professionals. They can be ordered from TIE Lines, 20 Squadron Blvd. Suite 400, New York, NY 10956.

Lives at Risk: Understanding and Treating Young People with Dual Disorders by B. Pepper and H. Rygelwicz

Poignant description of the combination of schizophrenia, mood disorders, and/or personality disorders with substance abuse. Strong on empathy and understanding of the multiple problems. Provides little specific guidance.

Hazelden Publications (RW9 P.O. Box 176, Center City, MN 55012-0176 Phone 1-800-328-9000 or Website www.htbookplace.org

Publishes a large number of pamphlets and self-help books on substance abuse and dual diagnoses. Examples of titles include:

> **Preventing Relapse Workbook**
>
> **Taking Care of Yourself: When a family member has a dual diagnosis**
>
> **Twelve Steps and Dual Disorders**
>
> **Understanding Schizophrenia and Addiction**

BOOKS ABOUT CHILDREN WHO HAVE A MENTAL ILLNESS

Children and Adolescents with Mental Illness: A Parents Guide by E. McElroy (Woodbine House, 1988)

Useful guide written by a psychologist who heads the NAMI Children's and Adolescent network.

Educational Rights of Children with Disorders: A Primer for Advocates by Center for Law and Education. (Cambridge 1991.)

Neurobiological Disorders in Children and Adolescents by E. Peschel, R. Peschel and C. Howe. (Oxford Press, 1992)

Biological mental illnesses among children are less common and less understood "family problems". This book helps to define childhood neurobiological disorders and gives guidance for finding appropriate treatment.

BOOKS ON SPECIAL TOPICS

Planning for the Future and the **Life Planning Workbook** by L. Mark Russell and Arnold Grant (American Publishing Company, 1995)

This book and accompanying workbook are guides for parents seeking to provide for the future security and happiness of an adult child with a disability following the parents' deaths.

A Parent's Guide to Wills and Trusts by Don Silver. (Adams-Hall, 1992)

Information on how to protect a disabled child's financial future, written by an attorney and NAMI member.

Schizophrenia and Genetic Risks by Irving Gottesman.

This pamphlet contains detailed information about this single topic. It may be ordered from NAMI.

A Street is Not a Home: Solving American's Homeless Dilemma by Robert Coates. (Prometheus, 1990)

Analysis and guide to dealing with homelessness among persons suffering from mental illness.

Suicide Survivors: A Guide for Those Left Behind by Adina Wrobleski. (Afterwards, 1991.)

With an understanding attitude, the author explores and offers coping suggestions for the many issues that confront families who have had a member kill himself.

READING LIST FOR FAMILIES WITH A MEMBER WHO HAS A MENTAL ILLNESS

Annotations by Christopher S. Amenson, Ph.D.

BOOKS WHICH OFFER GUIDANCE TO FAMILIES

Coping with Schizophrenia: A Guide for Families by Kim Mueser and Susan Gingerich. (New Harbinger, 1994)

Comprehensive guide to living with schizophrenia and the best source for practical advice on topics including medication, preventing relapse, communication, family rules, drug use, and planning for the future. Includes forms and worksheets for solving typical problems.

Schizophrenia: Straight Talk for Families and Friends by Maryellen Walsh. (Morrow & Co., 1985).

A parent who, as a professional writer, thoroughly researched the field writes this book. This book is emotional in ways that will touch you and deals with all the issues important to families of persons of schizophrenia. If you can read only one book, select this one if you want to feel understood; select *Understanding Schizophrenia* to access current research on causes and treatments; select *Coping with Schizophrenia* if you want concrete advice about coping with the illness.

Surviving Schizophrenia: A Family Manual, Third Edition by E. Fuller Torrey. (Harper & Row, 1995).

Beloved by the Alliance for the Mentally Ill because it was the first book in 1983 to support and educate families. Contains one of the best descriptions of "The Inner World of Madness". Discusses the major topics in easy to read and very pro-family language.

Troubled Journey: Coming to Terms with the Mental Illness of a Sibling or Parent by Diane Marsh and Rex Dickens (Tarcher/Putnam, 1997)

The best book for siblings and adult children. Helps to recognize and resolve the impact of mental illness on childhood. Seeks to renew self-esteem and improve current family and other relationships.

Understanding Schizophrenia: A Guide to the New Research on Causes and Treatment by Richard Keefe and Philip Harvey. (The Free Press, 1994)

The best description of research on schizophrenia as of 1994. It provides more depth and detail than Surviving Schizophrenia and is a little more difficult to read. A must for families that want to understand the science of schizophrenia.

How to Live with a Mentally Ill Person: A Handbook of Day-to-Day Strategies by Christine Adamec. (John Wiley and Sons, 1996) This comprehensive, easy-to-read book is written by a parent. It reviews methods for accepting the illness, dealing with life issues, developing coping strategies, negotiating the mental health system, and more.

BOOKS DESCRIBING THE EXPERIENCE OF SCHIZOPHRENIA

Anguished Voices: Siblings and Adult Children of Persons with Psychiatric Disabilities by Rex Dickens and Diane Marsh (Center for Psychiatric Rehabilitation, 1994.)

Collection of 8 well-written articles which describe the impact of mental illness on siblings and children. A poignant statement of the issues across the life span that need to be addressed when a person grows up with mental illness in the family.

Crazy Quilt by Jocelyn Riley (William Morrow, 1984)

Fictional account of a 13-year-old girl whose mother has schizophrenia. Written for children and adolescents. Provides understanding for these forgotten victims.

Is There No Place on Earth for Me? by Susan Sheehan. (Houghton-Mifflin, 1982.)

A very realistic depiction of the experience of schizophrenic woman is interwoven with information about legal, funding, and treatment issues. Gives a good description of historical and political influences on the treatment of persons suffering from schizophrenia. Won the Pulitzer Prize.

Tell Me I'm Here: One Family's Experience with Schizophrenia by Ann Devesch. (Penquin, 1992)

Written by a United Nations Media Peace Prize winner and founder of Schizophrenia Australia, this book describes their family's experience.

The Quiet Room by Lori Schiller. (1994)

The life story of a person who had an almost full recovery from schizophrenia with clozapine. Great for its inspirational value.

The Skipping Stone: Ripple Effects of Mental Illness on the Family by Mona Wasow (Science and Behavior Books, 1995)

Describes the impact of mental illness on each member of the family in a "Tower of Babel". Information is from in-depth interviews with family members and professionals.

The Girl with the Crazy Brother by Betty Hyland (Franklin Watts, 1986)

Written for adolescents by an Alliance for the Mentally Ill member. Describes in short novel form the experience of a teenage girl trying to understand the sudden deterioration of her older brother.

Website resources

Schizophrenia:

Medscape Resource Center - Schizophrenia: Wellness Center:

http://www.schizophrenia.com/

Bipolar Disorder:

http://www.mhsource.com/bipolar
http://www.bpkids.org

NAMI:

http://me.nami.org/

http://www.nami.org/

http://www.nami.org/helpline/peoplew.htm – well-known people w/ mental illnesses

Professional Organizations/Publications:

Most valuable for schizophrenia information of high quality from peer-reviewed journals would be the APA's site:

www.psych.org

Multi-specialty site cooperating with APA:

www.medem.com

Government Sites:

http://www.nimh.nih.gov/

http://www.nimh.nih.gov/publicat/childmenu.cfm

http://www.nimh.nih.gov/events/earlyrecognition.cfm

http://www.samhsa.gov

http://www.mentalhealth.org/cmhs/

Schools:

http://csmha.umaryland.edu/ - center for school mental health assistance

General:

http://www.mentalhealth.org/

http://www.mentalhealth.org/stigma

www.medscape.com

Early Intervention w/ Psychosis:

http://www.iepa.org.au International Early Psychosis Association

http://www.rcpsych.ac.uk – Psychological approaches to psychosis

Depression:

www.copewithlife.com, which is more of a self help Website for depression

Spanish language version:

http://www.nimh.nih.gov/publicat/spdepwomenknows.cfm.

Antistigma:

www.NoStigma.org
www.mentalhealth.org/search/DoSearch.asp

Stress and Drug Abuse:

www.nida.nih.gov/DrugPages/Stress.html