Chapter 2

# Models of Family Intervention

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## Why families Need Special Information

Families of people with severe mental illness live with considerable stress, or as it is commonly called, burden. They are puzzled by strange behaviours in a person they know well, they are frightened by threats or outright hostile attacks, they have never encountered anything like this before, and none of their prior experience has prepared them to handle this new situation. Family members may develop feelings of depression or anxiety, and are certainly well-acquainted with feelings of disempowerment, low self-esteem and loss of confidence.

Family members need help, often from other family members who have similar experiences, but also from mental health professionals. Basically, they need to be educated in the whys and wherefores of severe mental illness, but they also need help in knowing how to solve the many problems that arise when living with a person who is psychotic.

This chapter deals with what we know about educating and helping families. The intention is to lay out what mental health professionals can do that will make a difference.

## Family Education

In this type of intervention information about serious mental illness is presented to family members, usually in a group format, by a mental health professional or by a trained family member. Typical topics are the nature of mental illness: schizophrenia, bipolar disorder, major depression; causes of mental illness; treatment of mental illness—medication, psychosocial treatments; the subjective experience of mental illness; coping skills, problem solving.

- Family education is distinct from family psychoeducation in that the intervention is relatively brief, less than 6 months, and the patient does not participate with the family.
- Evidence of effectiveness has been examined in 24 studies that had an appropriate control group. Nineteen had results that favoured the group receiving family education.
- The total number of hours of the sessions ranges from 3 to 26.
- The choice of outcome measurement varied greatly, but most studies found increases in knowledge about mental illness, greater feeling of competence, and less depression.

- Seven of the studies examined patient relapse, and one had a significant effect on relapse.

## Family Self-Help Organization Courses

Local, national and regional family self-help and support organizations have developed family education programs on their own. These programs present similar contents to family education programs provided by mental health professionals, but in most cases the presentation is by a specially trained lay member of the organization.

| Nation | Name of Course | No. of Sessions | Frequensy | Teachers |
|---|---|---|---|---|
| Australia | Well Ways | 8 (3 hours) | Weekly; 3-month follow-up for 1 year | Trained Family Members (2 together) |
| Canada | Strenghtening Families Together | 10 (2 hours) | Weekly | Trained Family Members (2 together) |
| Europe | Prospect | 10 (2 hours) | Weekly | Trained Family Members |
| United Kingdom | Carers' Education & Training Programme | 11 (3hrs) | Weekly | Carer professionals |
| United States | Family to Family | 12 (2 hours) | Weekly | Trained Family Members |
| WFSAD | Reason to Hope | 8 (2.5 hours) | Variable – 3-day workshop or weekly | Two Trained Family Members of One Trained Family member & a Trained Professional |

Positive characteristics of these courses:

- Volunteer run and therefore inexpensive
- Training costs often covered by local mental health systems
- Acceptance of the programs is high and drop-out rates are low. It possible this has occurred because the time commitment is not great, but also because the sharing of lived experiences is paramount. Being with others who have been through the experience and are continuing to should a heavy caretaking role is probably a potent factor in the success of these programs.
- Family-to-Family, U.S. has been successfully evaluated with random assignment to program and control groups. Results showed increased knowledge about the mental illnesses covered; some reduction in burden and decreased worry and depression for families (Dixon et al., 2004).
- Well Ways has been externally evaluated by La Trobe University, Melbourne, Australia, and continues to use a number of measures to track outcomes for participants.
- It is presumed that outcomes for the other courses above would be similar to the outcomes for evaluated family education programs

- Relatives of people with psychiatric disorders like to participate in these programs

### Limitations

- Family education has not been shown to reduce relapse rates.
- The existence of these programs may hinder the introduction of comprehensive family work into clinical services. Programs outside mental health services run the risk of helping to perpetuate the divisions between family carers and professional staff.
- Meetings are held at times when some families would be unable to attend. Literature provided by family organizations can help mitigate this.
- Literacy is assumed, but is usually not necessary for participation. Adaptations can be made if there are homework assignments.

### What the Mental Health Professional Should Do

- Refer families to family education programs especially to education programs run by family organizations, particularly where family psychoeducation is not available or where families do not live close to the relative who is under treatment
- Provide evidence-based family psychoeducation to families

## Family Psychoeducation

Evidence-based interventions that last more than 6 months and include the patient with the family have been called family psychoeducation (FPE), Behavioural Family Therapy (BFT) and other similar names. The interventions are carried out by trained mental health staff from most mental health professions. Quite often nurses are the primary therapists, but all mental health professionals may be involved.

A set of programmes defined by the Schizophrenia Patient Outcomes Research Team (PORT) in the United States (Lehman et al. (2004) as well as the NICE Guidelines in the UK (National Institute for Clinical Excellence, 2002) include FPE in their recommendations.

### Positive Features of Family Psychoeduction:

- Improves patient social adjustment
- Reduces expressed emotion (i.e., high level of critical or hostile comments or over-involvement. High expressed emotion is associated with higher relapse
- Decreases the family stress or burden that is associated with living with someone developing psychotic symptoms leading to hospitalization often accompanied by a police action and other distressing circumstances.
- Increases consumer/patient satisfaction with services

- Can be carried out in the family home or in a clinic
- Interventions take place within individual families or in groups
- The patient does not need to live with the family to participate in family sessions with the family
- Is often used in integrated treatment programs as one key element
- Encourages acquisition of skills especially in communication and problem solving

## Research is International

The research on FPE is truly international and outcomes have been much the same in all countries. The following nations have been involved: Australia, China, Denmark, Germany, India, Ireland, Italy, Japan, Netherlands, Norway, Spain, Sweden, United Kingdom, and the United States. The commonality of the results in such a variety of cultures suggests that the core ideas of FPE can be carried from one culture to another without loss of vigour. Of course, adaptations must be made for language and differing cultural contexts.

*Positive Findings of Studies*

Seventeen studies with patients who had schizophrenia were found that compared behavioural family therapy with treatment as usual. Two additional studies compared two types of FPE. Two studies examined FPE and bipolar disorder. Of these 17 studies, 16 found significant group differences showing that FPE reduced relapse rates. The two studies that compared types of FPE had comparable low relapse rates. Both studies of bipolar disorder had significant effects on relapse.

The positive results may largely be a function of the longer treatment time and the fact that patients are present as co-participants. Families and patients have repeated opportunities to practice communication skills and to solve a greater variety of problems. The emphasis on understanding early warning signs and instigating earlier treatment is effective in relapse prevention.

*Relapse Prevention as an Outcome*

Relapse prevention is an important outcome measure because it is an index of an increase in symptoms in patients and also because it is associated with rehospitalization and an associated increase in costs.

## Common Characteristics of Models of FPE

The goals and objectives of successful family work as conceptualized by the World Fellowship for Schizophrenia and allied Disorders were described in Chapter 1 (p.3). Below we list the common characteristics of the different models of family psychoeducation as described by Pilling et al. (2002):

- Family members and patient take part in the sessions
- Optimum medication management information
- Education of patients and family carers in stress management strategies

- Education to enhance understanding of psychotic disorders
- Symptom management strategies
- Development and maintenance of effective social support
- Crisis resolution strategies
- Social living skills training for achieving personal goals
- Strategies for coping
- Education for problem solving
- A duration of longer than six months

### Limitations

FPE calls for a long time commitment and a number of people decline invitations, usually because of work pressures. As the patient must participate for at least some of the sessions it will only work if the family and patient live together or not far apart. This can exclude families whose ill relative is in a hospital or lives at some distance from the family. However, most families are viable candidates for FPE, and will make arrangements to meet for sessions. Therefore, it is contingent upon mental health professionals to understand FPE and to know how to engage families in order to encourage them to participate in FPE programs.

## Types of Family Psychoeducation

Several types of FPE have been developed. Each has unique features, but they have much in common. For example, all include family education, communication skills and emphasize problem-solving and goal achievement. In addition, all have manuals. A close reading of these manuals can prepare staff to carry out the intervention, but they are most useful when used in conjunction with a rigorous training program. We recommend additional training.

### Behavioral Family Therapy (BFT)

Behavioral Family Therapy is the name Falloon and co-workers gave their intervention. This form of family psychoeducation is perhaps the one that is most commonly used internationally. It is based on the stress-vulnerability model of family coping. It is assumed that patient relapse is related to increased stress and that people with serious mental illnesses are especially vulnerable to stress. Coping skills can be used to manage stress.

The intervention is carried out in the family home, to promote generalization across situations, with individual families. Sessions are about 90 minutes long. They are continued for an indefinite period (Mueser & Glynn, 1999). Some families continued for five years (Falloon, personal communication).

Training includes:

- Engagement with and assessment of the family
- Education of the family on the basics of severe mental illness

- Information sharing and education
- Communication skills training
- Problem-solving training
- Dealing with special problems

There are two manuals: Falloon, Boyd and McGill (1984) and Muesser and Glynn (1999).

An updated version of the Falloon et al. (1984) manual is available and used routinely in the Meriden Programme (Falloon, Fadden et al. (2004).

### Anderson, Reiss and Hogarty Program

While the patient is still in crisis, usually in a hospital, the staff develops a relationship with the family. During this period one member of the staff becomes the family. representative. This is a clinic-based intervention.

The family program is explained and a treatment contract for at least one year is agreed upon.

- The next phase is a full-day Survival Skills workshop. A group of families is formed and they are told about the basics of serious mental illness.
- Next, on leaving the hospital, staff meet with the family and patient together at two week intervals. Families are also invited to make telephone contact with the staff as needed. The focus is on solving problems as they arise. In the second phase of this year tasks are assigned and reviewed. These typically involve common household chores. Emphasis is placed on medication compliance.
- The next major phase focuses on social and vocational rehabilitation which involves supported moving into the community. This might mean regular attendance at a health club, going out to a coffee house, or taking university classes.
- In the final phase there is decreasing contact with the family, but they are informed that their representative will continue to take phone calls. If wanted, additional family sessions are held.

There is a manual: Anderson, Reiss and Hogarty (1986).

### Leff: Working with Families

The approach begins with the assumption that schizophrenia is a brain disease that makes the person especially sensitive to the social environment, and that the environment can be modified to reduce stress. The intervention is carried out in the home and has several parts:

- Education, two sessions.
- Improving communication, several months at two-week intervals.
- Problem-solving.

- Reducing expressed emotion.
- Adjustment of lowering expectations.
- Skills training, anger management.

The manual is Kuipers, Leff and Lam, 1992.

### Tarrier and Barrowclough Behavioral Family Intervention

This intervention takes place in four components over a nine-month period following discharge from the hospital. Each session lasts one hour.

- Education. Two sessions.
- Stress management. Three sessions.
- Goal setting and coping strategies Seven sessions.
- Stress prevention.
- The patient takes part in al of these sessions except stress management.

A manual is available: Barrowclough, & Tarrier (1992).

### McFarlane and Multifamily Psychotherapy Groups

Based on Falloon's work with behavioural family therapy, McFarlane has developed a multifamily group model (MFG) of family and patient psychoeducation that has met with considerable success in the U.S. (New York, New Hampshire, Maine and Michigan); and in Scandinavia; Japan; Spain; Australia and China. His recent book explains all aspects of the model (McFarlane, 2002).

In these treatment groups, several families are brought together to form a mini-organization, led by professional clinicians, that meets regularly over an extended course of treatment and rehabilitation, with the participation of the patient. The approach builds upon the effects of antipsychotic medication and assumes that other treatment and rehabilitation resources are used when indicated. The multifamily group is the primary vehicle for case management for most of those participating and will be for many the only treatment other than medication. In some instances it is combined with supportive vocational rehabilitation. It provides patients and families with the following:

- An alliance with knowledgeable and empathic professionals
- Information about schizophrenia
- Guidelines for managing the illness itself
- Practice in solving problems created by the illness

The multifamily group improves outcomes by reducing stigma and increasing social network size and support, allowing families to benefit from each others' experiences in solving specific problems and helping them to exploit shared opportunities that promote

rehabilitation and recovery. The principal theoretical foundation is that almost all types of severe illnesses have a better course if the afflicted person has a large and knowledgeable social support system. This is a restatement of the conclusions of literally hundreds of studies of social networks conducted over the past three decades. Multifamily groups are rooted in clinical and/or rehabilitation systems that have formal links to the health system.

There have been many debates on the comparative efficacy of group psychoeducation versus single family psychoeducation. Both reduce hospitalizations and relapses and have also resulted in less family stress and improved patient self esteem (Dyck et al., 2000, Hazel et al., 2004). In brief, multi-family groups can stimulate patient networks, reduce stress on the patient as the focus of treatment, and provide an empathic, supportive environment. Examples of services using the McFarlane model appear in Chapter 6.

The manual is McFarlane (2002).

## Some Generalizations about Family Interventions

The various family methods are not the same and do not have the same outcomes, costs are not the same, and the amount of family time required is not the same (Fadden, 1998). It is possible to make a few generalizations about what each does.

1. If information about serious mental illness is provided to relatives then there tend to be positive educational outcomes for relatives.
2. More sessions are better than few sessions.
3. Include the patient in sessions if the goal is to reduce relapse.
4. For serious mental illness medication must be maintained at an optimal level.
5. Programs that are tailored to meet the needs of individuals are better than those that are not
6. An environment that is clear, simple and free of excess emotions, as tends to appear in family psychoeducational programs, is less likely to cause relapse
7. Family psychoeducation is not always better than appropriate individual therapy.

## What Types of Help Should be Offered?

Mental health professionals need to be aware that different outcomes will result depending on what type of help they offer to families. What can be offered often depends on what resources are available in services.

- If the goal is symptom alleviation and relapse reduction in the patient, in addition to support for relatives, and if necessary resources can be found, then family psychoeducation should be the choice.

- If they only want to help relatives of people with serious mental illness, to relieve their burden and help them cope better, but have only limited resources, then family education is the reasonable choice**.**
- Ideally, a range of options should be offered to families, as they will have different needs at different stages, and there are individual differences. Some families will not opt to take part in a group, while others value knowing that others are in the same situation that they find themselves in.

## The Optimal Treatment Program

Although the program evaluation results for FPE are strong, some mental health experts, led by Ian R.H. Falloon, examined the evidence for effective treatments for schizophrenia and put together a more comprehensive and ~~an~~ integrated program than those described above, which they called the Optimal Treatment Program (OTP). It is made up of evidence-based treatments, which have been tested many times and found to be effective in many parts of the world. The OTP was the first attempt to bring these together in an integrated package.

They began by reviewing the effectiveness of various treatments for severe mental illness. In doing this they held to the requirements of evidence-based interventions:

- A clear and complete description of the program.
- A clear and complete description of the participants.
- Sample sizes large enough for generalization of results.
- Assessment instruments that are appropriate, reliable and valid.
- Use of treatment manuals.
- Therapists trained and monitored for program fidelity.
- Appropriate data analysis.
- Random assignment to groups.
- Replication by at least one independent research team

They put together an integrated program of effective treatments and called it the Optimal Treatment Program (OTP) (Falloon, 1999). The OTP includes:

- minimal effective medication use
- medication use training
- behavioral family therapy
- assertive community treatment, skills training
- cognitive behavior therapy
- supportive vocational training

Patients participate in the treatment modes that the treatment team, which includes the patient and the family, believe are necessary. Note that behavioural family therapy, a family psychoeducational intervention, but not family education, is part of this program.

The program, based on the stress-vulnerability model, now has been tested for effectiveness. In a large study with many nations involved, some 600 patients are being followed for five years. At this time results are available for the two-year data point.

The 13 nations involved in the large study are the following: Andorra, Australia, Canada, Germany, Greece, Hungary, Italy, Japan, New Zealand, Norway, Sweden, Turkey, and United States. This international trial provides an excellent test of the cultural appropriateness of the treatments, and it appears that they are equally effective in each country.

The results of the OTP are perhaps the strongest that have been presented in the literature on services for people with schizophrenia. The OTP reports that after two years of treatment

*"One half of recent cases had achieved full recovery from clinical and social morbidity."(p.107) (*Falloon et al., 2004*)* These are truly remarkable results.

Treatments included in the OTP Program are listed above. How the whole comes together is described by Falloon (1999) in this way:

> "The project's approach encourages the treatment team to focus at all times on helping patients achieve their personal goals, even during periods of crisis. Several patients have been able to continue to work or study and maintain their roles in their households despite experiencing symptom exacerbations. Patients, family members, and friends who have received education about the disorder and its treatment and have been trained in strategies for efficient problem solving can often provide substantial assistance at times of crises. This informal crisis management, combined with comprehensive daily—and nightly when necessary—treatment from the multidisciplinary professional team, including careful pharmacotherapy, has helped many patients cope with major illness episodes without suffering serious setbacks in their personalized rehabilitation programs." (p. 616)

## Conclusion

Families who have struggled with schizophrenia or other serious mental illnesses for many years, and who recall the terrible first years of the illness, routinely say they wish any of the family programs described here had been available to them. They would have reached out for information, training, advice, consultation, and education. A one-day session would have been welcome, and many family members would have benefited, but a two or three-year program would have been better. The state of science for family interventions is such that there is considerable evidence that they are effective. Now it is time to see that every family has the opportunity to take part in these programs. Not all families will be able to take part, some will not want to, and for them alternatives should be available, but all should have the opportunity to participate.

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