

Integrating the Family in the Treatment of Psychotic Disorders

The multifamily group approach often provides opportunities for patients to break through problems that are limiting their options in living. Described here are the theoretical background for this treatment model, evidence of its effectiveness and its major components.

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ABSTRACT:

The major caretaking and psychological burdens and stresses on families who have a member with schizophrenia lead to interactions and persisting patterns of interaction that can have equally devastating effects on the patient with the disorder and its course over time. Family psychoeducation has been shown to be remarkably effective in counteracting these processes by reducing ambient social and psychological stresses. The approach provides relevant education, training and support to family members and others, who in turn provide support, protection and guidance to the patient. The cumulative record of efficacy for family psychoeducation is remarkable, demonstrating decreased psychiatric symptoms, relapse and rehospitalization rates, substantially increased employment rates, improved social functioning, decreased family distress and reduced costs of care. Described here are the theoretical background for this treatment model, evidence of its effectiveness and its major components and technical features.

Keywords: schizophrenia, psychotic disorders, family intervention, family psychoeducation, evidence-based practice, family therapy, treatment outcomes

Introduction

The early stages of onset of a psychotic disorder include the cardinal symptoms of all psychoses – major alterations of cognition, affect, sensation and behavior. These are most serious in schizophrenia. However, especially in that disorder, it has become clear that the accompanying deficit syndrome is the source of the most severe disability, lasting for a lifetime in the majority of cases. Both aspects – psychotic symptoms and functional disability – make these devastating disorders for families, who often assume major caretaking and psychological burdens secondary to the functional deficits that this and other psychotic disorders impose. These deficit processes usually begin prior to the psychotic symptoms, often persist in spite of treatment, and usually get worse with

time and with each subsequent episode. These deficits are often the most confusing and burdensome for family members, because they usually do not identify them as part of the disorder, but nevertheless find themselves supporting the affected member to compensate for those deficits. The resulting stresses on families lead to interactions and persisting patterns of interaction that can have equally devastating effects on the patient with the disorder and its course over time. Family psychoeducation has been developed and shown to be remarkably effective in counteracting these processes and in improving family functioning and coping skills, leading to greatly improved clinical and functional outcomes. Described here are the theoretical background for this treatment model, evidence of its effectiveness, and its major components and technical features.

While the scientific evidence is increasingly strong that the major psychotic disorders are based on genetic or developmental defects involving brain function, there is also abundant evidence that the final development and relapse of psychotic symptoms are the result of psychosocial stress. The stress-diathesis or stress-vulnerability model provides a widely-accepted, empirically-supported and useful framework for describing the relationships among provoking agents (stressors), vulnerability and symptom formation (diathesis) and outcome (Zubin, Steinhauer, & Condray, 1992). Thus, a genetically or developmentally vulnerable person, whose inborn tolerance for stress is incompatible with exposure to either excessive internally or externally generated stimulation, may experience an episode of psychotic illness. This principle underlies the Biosocial Hypothesis: Major psychotic disorders are the result of the continual interaction of specific biologic disorders of the brain with specific psychosocial and other environmental factors.

These psychosocial factors are the proximal causes of relapse in established cases and of the initial psychotic episode. The treatment described here is based on a simple and now plausible theory: The first episode occurs in an already evolving disorder, in which the proximal causes of the first episode are the same as those in later relapses. Therefore, treatments that prevent relapse by counteracting those proximal causes could as well ameliorate the first episode, prevent subsequent relapse and reduce the vulnerability to developing deficit symptoms. Specifically, episodes are induced in biologically vulnerable individuals by major stresses imposed by role transitions and other life events, social isolation, family expressed emotion, conflict and exasperation, separation from family of origin and stigma. This causal biosocial theory yields an interactive, feedback-based model for the final stages of onset, as compared to a simpler linear-causal model. In this conceptual framework, subtle symptoms induce anxiety, anger, social rejection, confusion and other reactions in family members, which in turn exacerbate those very symptoms by inducing psychological and ultimately physiological stress reactions in the vulnerable person. The end result is a spiraling deterioration of both the patient and the family.

Expressed Emotion (EE)

High levels of criticism and emotional over-involvement are strongly predictive of exacerbation or relapse of symptoms (Brown, Birley, & Wing, 1972). In an extensive meta-analysis, Bebbington and Kuipers (1994) cite the overwhelming evidence from 25 studies representing 1346 patients in 12 different countries for a predictive relationship between high levels of expressed emotion and relapse of schizophrenia and bipolar disorder. Inclusive reciprocal models have been proposed to increase the accuracy of the construct. For example, Strachan (Strachan, Feingold, Goldstein, Miklowitz, & Nuechterlein, 1989) and Goldstein (M. J. Goldstein, Rosenfarb, Woo, & Nuechterlein, 1994) found that expressed emotion among key relatives is a reflection of transactional processes between the patient and family, supporting the conclusion that family functioning is affected by aspects of the illness, as well as the converse.

Recent studies have provided support for an ongoing interaction between symptoms and family responses, reflected in data on EE at different stages of onset. In this regard, several studies suggest that EE is less pronounced in the earliest phases of psychosis, and increases over time. Hooley and Richters (1995) found that criticism and hostility rates rose rapidly in the first few years of the course of illness: in 14% of families with less than one year of illness, 35% within 1–3 years of onset and peaking at 50% of the sample after five years. A study by the author compared components of expressed emotion (EE) (rejection, warmth, protectiveness and fusion) across three samples, two in which the subjects had an established schizophrenic or mood disorder and a third in which the subjects were at high risk for an initial psychosis. Parental scores for rejecting attitudes and emotional over-involvement were all but identical in the two established-disorder samples but were markedly higher than scores in the prodromal sample (McFarlane, 2006). These studies strongly suggest that expressed emotion is largely reactive to deterioration manifested by the young person developing a psychotic disorder.

Attribution – the relatives’ beliefs about the causes of illness-related behavior – has also been associated with expressed emotion. Relatives described as critical or hostile misperceive the patient as somehow responsible for unpleasant, symptomatic behavior, whereas more accepting relatives saw identical behaviors as characteristic of the illness itself (Brewin, MacCarthy, Duda, & Vaughn, 1991). This is an especially acute risk in the prodromal phase and in the first episode, during which symptoms and deficits often develop slowly, appearing to reflect personality or behavioral faults. An individual who is cognitively impaired, denying illness, paranoid, angry, hostile, affectively labile, socially withdrawn or anhedonic will be much less available to receive the support needed to function at an optimal level (McFarlane & Lukens, 1998). If family members confronted by such symptoms in a loved one have little formal knowledge of the illness, they are likely to respond with increased involvement, emotional intensity or criticism.

Stigma

Stigma is often associated with a withdrawal of social support, demoralization, and loss of self-esteem, and can have far-reaching effects on daily functioning, particularly in

the workplace. With the availability of new medications and concomitant emphases on improved functioning and rehabilitation, this arena becomes an ever more important focal point for intervention. As Link and colleagues (Link, Mirotznik, & Cullen, 1991) observed, stigma had a strong continuing negative impact on well-being, even though proper diagnoses and treatment improved symptoms and levels of functioning over time. Stigma affects the family as well. Effects include withdrawal and isolation on the part of family members, which in turn are associated with a decrease in social network size and emotional support, increased burden, diminished quality of life and exacerbations of medical disorders. Self-imposed stigma tends to reduce the likelihood that early signs will be addressed and treatment sought and accepted, especially during the first episode (Phelan, Bromet, & Link, 1998).

Communication Deviance

Communication deviance, a measure of distracted or vague conversational style, has been consistently associated with schizophrenia. It was the other factor in the prospective long-term outcome study that predicted the onset of schizophrenic psychosis in families of disturbed, but non-psychotic, adolescents (M. Goldstein, 1985). More recent studies have demonstrated that it is correlated with cognitive dysfunction in the relatives which is of the same type, but of lower severity, as is seen in patients with schizophrenia (Wagener, Hogarty, Goldstein, Asarnow, & Browne, 1986). This suggests that some family members have difficulty holding a focus of attention, with important implications for treatment design. The result is that a child with subtle cognitive deficiencies may learn to converse in a communication milieu that is less able to compensate and correct.

Social Isolation

The available evidence across several severe and chronic illnesses indicates that ongoing access to social contact and support prevents the deterioration of such conditions and improves their course (Penninx, Kriegsman, van Eijk, Boeke, & Deeg, 1996). Family members of the most severely ill patients seemed to be isolated, preoccupied with, and burdened by, the patient. Brown et al. (1972) showed that 90% of the families with high expressed emotion were small in size and socially isolated. In addition, social support buffers the impact of adverse life events (Lin & Ensel, 1984) and is one of the key factors predicting medication compliance (Fenton, Blyler, & Heinsen, 1997), behavior toward treatment in general, schizophrenic relapse, quality of life (Becker et al., 1998) and subjective burden experienced by relatives (Solomon & Draine, 1995). Social network size decreases with number of episodes, is lower than normal prior to onset and decreases during the first episode (Anderson, Hogarty, Bayer, & Needleman, 1984).

Effects of Psychosis on the Family

Because there is so much evidence that some family members of patients with established psychotic disorders share subclinical forms of similar deficits and

abnormalities, treatment for early stages of psychosis must be designed to compensate for some of those difficulties. Those deficits lead to diminished coping ability, which is required in abundance in order to provide a therapeutic influence on the affected family member. Further, the psychotic disorders exact an enormous toll on family members, in anxiety, anger, confusion, stigma, rejection and exacerbation of medical disorders (Johnson, 1990). The organization of most families undergoes a variety of changes, including alienation of siblings, exacerbation or even initiation of marital conflict, severe disagreement regarding support versus behavior control, even divorce. Almost every family undergoes a degree of demoralization and self-blame, which may be inadvertently reinforced by some clinicians. During the prodromal phase, family members are mystified by the often dramatic emotional, cognitive and behavioral changes that they are seeing, and react in a wide variety of ways, from anger to denial to profound anxiety and worry.

Prospective Studies of Family Interaction Prior to Onset

Tienari and his colleagues, like Goldstein and his colleagues earlier, have shown in a prospective study that family-expressed emotion and communication deviance, especially negativity directed toward the at-risk young person, predict onset of psychosis, interacting with genetic (having a biological mother with schizophrenia) or psychiatric (already having non-psychotic symptoms and behavioral difficulties) risk. (M. Goldstein, 1985; Tienari et al., 2004). In support of the stress (or environmental risk) part of the stress-diathesis model, Goldstein demonstrated that onset of psychosis in disturbed adolescents seeking psychological treatment could be predicted by in-vivo assessment of negative family Affective Style (AS, a directly observed form of EE) and difficulties in clarity and structure of communication (CD). The Finnish Adoption Study rigorously combined and tested both psychosocial and genetic risk factors, and their interaction, in a developmentally sensitive design. This study provided the first compelling evidence for a gene-environment interaction for schizophrenia spectrum disorders. The results indicated that risk for development of schizophrenia spectrum disorders was much higher among genetically at-risk adoptees reared in families in which there were higher levels of negativity, family constrictedness (flat affect, lack of humor), and family boundary problems (e.g., generational enmeshment, chaotic family structure, unusual communication). There was no increase whatsoever in the incidence of schizophrenia spectrum disorders among genetically at-risk adoptees reared in less distressed families. Thus, not only were certain types of common family dynamics implicated in triggering the onset of schizophrenia in vulnerable children, healthier family dynamics also played a protective role (i.e., preventing an illness in genetically-predisposed individuals).

A Model of Reciprocal Causation

These critical factors lead to psychosis via [a] a general sensitivity to external stimulation and [b] a discrepancy between current stimulus complexity and cognitive or information processing capacity. Subclinical cognitive deficits, effects of the

psychosis on the family and characteristic coping styles combine to contribute to external illness-generated stresses that induce a spiraling and deteriorating process that ends in a major psychosis. These factors are potential targets for family psychoeducation and multifamily groups.

Family Psychoeducation: Outcomes in Schizophrenia and other Psychiatric Disorders

Family intervention alters critical environmental influences by reducing ambient social and psychological stresses, by building barriers to excess stimulation and by buffering the effects of negative life events. The family psychoeducational model defines schizophrenia and other psychotic and mood disorders as brain disorders which are sensitive to the social environment. Thus, this form of treatment is seen as bimodal, influencing both the disease, through medication, and the social environment, through techniques which deliberately reduce to tolerable levels stimulation, negativity in interpersonal interaction, rate of change and complexity. The approach achieves that goal by providing relevant education, training and support to family members and others, who in turn provide support, protection and guidance to the patient.

The cumulative record of efficacy for family intervention, variously termed family psychoeducation, family behavioral management or family work (but not family therapy) is remarkable. Over 20 controlled clinical trials have demonstrated markedly decreased relapse and rehospitalization rates among patients whose families received psychoeducation compared to those who received standard individual services, 20–50% over two years. At least eight literature reviews have been published in the past decade, all finding a large and significant effect for this model of intervention (Dixon, Adams, & Lucksted, 2000). Since 1978, there has been a steady stream of rigorous validations of the positive effects of this approach on relapse in schizophrenic disorders. Overall, the relapse rate for patients provided family psychoeducation has hovered around 15% per year, compared to a consistent 30–40% for individual therapy and medication or medication alone (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998). This effect size equals the reduction in relapse in medicated vs. unmedicated patients in most drug maintenance studies.

McFarlane and colleagues have consistently shown that when a very similar version of family psychoeducation is incorporated, multifamily groups lead to lower relapse rates and higher employment than single-family sessions (McFarlane, Link, Dushay, Marchal, & Crilly, 1995; McFarlane, Lukens et al., 1995). The simplest explanation is that enhanced social support, inherent only in the multifamily format, reduces vulnerability to relapse, probably by reducing anxiety and general distress (Dyck, Hendryx, Short, Voss, & McFarlane, 2002). In a study of differential effects in schizophrenia of single- (SFT) and multifamily group (MFG) forms of the same psychoeducational treatment method, better outcomes were observed for multifamily groups among those having their first hospitalization (McFarlane, Dushay, Stastny, Deakins, & Link, 1996; McFarlane et al., 1995), including very low relapse rates over four

years (12.5% per year). Both of these empirical results strongly suggest a multidimensional effect as the explanation for improved clinical outcomes. That argument is strengthened further by recent studies showing dramatic improvements in employment among people with schizophrenia, especially when combined with other interventions, such as supported employment, that are designed to achieve functional goals (McFarlane et al., 1996; McFarlane et al., 2000).

Recent reports have only added to the strong validation of the effects on relapse, particularly because these later studies have been conducted in a variety of international and cultural contexts. Reductions in relapse for family intervention, compared to the control conditions, have been demonstrated in China (Zhao et al., 2000), Spain (Muela Martinez & Godoy Garcia, 2001), Scandinavia (Rund et al., 1994) and England (Barrowclough et al., 2001). The universality of this approach seems to have been demonstrated in contexts different enough that further generalization in other cultures and countries appears likely to succeed, especially if the necessary adaptations are made. For instance, a new model has been developed specifically for Asian-Americans, designed to fit this population's different value orientations and cultural characteristics (Bae & Kung, 2000).

These and other studies have demonstrated significant effects on other areas of functioning, going beyond relapse as the main dimension of outcome. Many patients and their family members are more concerned about the functional aspects of the illness, especially housing, employment, social relationships, dating and marriage and general morale than about remission, which tends to be somewhat abstract as a goal. Several of the previously mentioned models, particularly the American versions – those of Falloon, Anderson and McFarlane – have used remission (the absence of relapse) as both a primary target of intervention and a necessary first step toward rehabilitative goals and recovery. In addition, these models all include major components designed to achieve functional recovery, and the studies have documented progress in those same domains. Several investigators, including our research team, have shifted focus to targeting these more human aspects of illness and life. Other effects have been shown for:

- improved family-member well-being (Cuijpers, 1999; Falloon & Pederson, 1985)
- increased patient participation in vocational rehabilitation (Falloon et al., 1985)
- substantially increased employment rates (McFarlane et al., 2000)
- decreased psychiatric symptoms, including deficit syndrome (Dyck et al., 2000; Zhao et al., 2000)
- improved social functioning (Montero et al., 2001)
- decreased family distress (Dyck et al., 2002)
- reduced costs of care (McFarlane, Lukens et al., 1995; Rund et al., 1994)

As a result of the compelling evidence, the Schizophrenia Patient Outcomes Research Team (PORT) project included family psychoeducation in its set of treatment recommendations. The PORT recommended that all families in contact with their

relative who has mental illness be offered a family psychosocial intervention spanning at least nine months and including education about mental illness, family support, crisis intervention, and problem solving skills training (Lehman et al., 1998). Other best practice standards (American Psychiatric Association, 1997; Frances, Docherty, & Kahn, 1996) have also recommended that families receive education and support programs. In addition, an expert panel that included clinicians from various disciplines, families, patients and researchers, emphasized the importance of engaging families in the treatment and rehabilitation process (Coursey, Curtis, & Marsh, 2000).

It is important to note that most studies evaluated family psychoeducation for schizophrenia or schizoaffective disorder only. However, several controlled studies do support the effects of family interventions for other psychiatric disorders, including dual diagnosis of schizophrenia and substance abuse (Barrowclough et al., 2001; McFarlane, Lukens et al., 1995), bipolar disorder (Miklowitz et al., 2000; Tompson, Rea, Goldstein, Miklowitz, & Weisman, 2000), major depression (Emanuel-Zuurveen, 1997; Leff et al., 2000), depression in mothers with disruptive children (Sanders & McFarland, 2000), mood disorders in children (Fristad, Gavazzi, & Soldano, 1998), obsessive-compulsive disorder (Van Noppen, 1999), anorexia (Geist, Heinmaa, Stephens, Davis, & Katzman, 2000) and alcohol abuse (Loveland-Cherry, Ross, & Kaufman), Alzheimer's disease (Marriott, Donaldson, Tarrier, & Burns, 2000), suicidal children (Harrington et al., 1998), intellectual impairment (Russell, John, & Lakshmanan, 1999), child molesters (Walker, 2000) and borderline personality disorder (Gunderson, Berkowitz, & Ruizsancho, 1997), including single- and multifamily approaches. Gonzalez and Steinglass have extended this work to deal with the secondary effects of chronic medical illness (Steinglass, 1998).

Psychoeducational Multifamily Group Treatment of Prodromal and Early First-episode Psychosis

The psychoeducation multifamily group treatment model described here is designed to assist families directly in coping with the major burdens and stresses during the prodromal and psychotic phases of these disorders. Thus, this approach: a. allays anxiety and exasperation; b. replaces confusion with knowledge, direct guidance, problem-solving and coping skill training; c. reverses social withdrawal and rejection by participation in a multifamily group that counteracts stigma and demoralization, and d. reduces anger by providing a more scientific and socially acceptable explanation for symptoms and functional disability. In short, it relieves the burdens of coping while more fully engaging the family in the treatment and rehabilitation process, and compensating – non-pejoratively – for the expected subclinical symptoms that many relatives can be expected to manifest. The goal of intervention is to provide optimal treatment as early as possible for those who are experiencing a first episode of psychosis. The multifamily group intervention, which incorporates elements of family psychoeducation and family behavioral management, is described briefly here and in detail elsewhere (McFarlane, 2002). The intervention model consists of four treatment stages which roughly correspond to the phases of an episode of schizophrenia, from the

acute phase through the recuperative and rehabilitation phases. These stages are (1) Engagement; (2) Education; (3) Re-entry; and (4) Social/Vocational Rehabilitation (Anderson, Hogarty, & Reiss, 1986).

Engagement

Contacts with the families and with the newly admitted individuals are initiated within 48 hours after a hospital admission or onset of psychosis. Initial contacts with the patient are deliberately brief and non-stressful. The young person is included in at least one of the joining sessions, and is excluded from at least one. If the patient is actively psychotic, they are not included in these sessions, but only engaged in a patient-clinician format. The aim is to establish rapport and to gain consent to include the family in the ongoing treatment process. The clinician emphasizes that the goal is to collaborate with the family in helping their relative recover and avoid further deterioration or relapse. The family is asked to join with the clinician in establishing a working alliance or partnership, the purpose of which is to provide the best post-hospital environment for the patient to recover. This phase includes typically three to seven single-family sessions for the multiple family group format, but more may be required until a sufficient number of families is engaged.

Education

Once the family is engaged and while the patient is still being stabilized, the family is invited to a workshop conducted by the clinicians who will lead the group. These six hour sessions are conducted in a formal, classroom-like atmosphere, involving five or six cases. Biological, psychological, and social information about psychotic disorders and their 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 clinicians, patient and family will continue to work together is presented. The families are also introduced to guidelines for management of the disorder and the underlying vulnerability to stress and information overload (please see Table 1). Patients attend these workshops if clinically stable, willing, interested and seemingly able to tolerate the social and informational stress.

TABLE 1. GUIDELINES FOR FAMILIES: WAYS TO HASTEN RECOVERY AND TO PREVENT A RECURRENCE

Believe in your power to affect the outcome: you can.

Make forward steps cautiously, one at a time.

Go slow. Allow time for recovery. Recovery takes time. Rest is important. Things will get better in their own time. Build yourself up for the next life steps. Anticipate life stresses.

Consider using medication to protect your future.

A little goes a long way. The medication is working and is necessary even if you feel fine. Work with your doctor to find the right medication and the right dose. Have patience, it takes

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time. Take medications as they are prescribed. Take only medications that are prescribed.

Try to reduce your responsibilities and stresses, at least for the next six months or so.

Take it easy. Use a personal yardstick. Compare this month to last month rather than last year or next year.

Use the symptoms as indicators.

If they reappear, slow down, simplify and look for support and help, quickly. Learn and use your early warning signs and changes in symptoms. Consult with your family clinician or psychiatrist.

Create a protective environment

Keep it cool.

Enthusiasm is normal. Tone it down. Disagreement is normal. Tone it down too.

Give each other space.

Time out is important for everyone. It's okay to reach out. It's okay to say «no».

Set limits.

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

Ignore what you can't change.

Let some things slide. Don't ignore violence or concerns about suicide.

Keep it simple.

Say what you have to say clearly, calmly, and positively.

Carry on business as usual.

Reestablish family routines as quickly as possible. Stay in touch with family and friends.

Solve problems step by step.

In the early intervention version, the clinicians build education and information-sharing on each patient and family's unique and evolving experience, as assessed during the engagement process. Psychosis is defined as a reversible, treatable condition, like diabetes. The core problem is presented as an unusual sensitivity to sensory stimulation, prolonged stress and strenuous demands, rapid change, complexity, social disruption, illicit drugs and alcohol, and negative emotional

experience. As for blame and assigning fault, the clinicians take an important position: neither the patient nor the family caused that sensitivity. Whatever the underlying biological cause might be, it is part of the person's physical personhood, with both advantages and disadvantages. Families are explicitly urged not to blame themselves for this vulnerability.

The Re-entry Phase

Following the workshop the clinicians begin meeting twice monthly with the families and patients in the multiple family group format. The goal of this stage of the treatment is to plan and implement strategies to cope with the vicissitudes of a person recovering from an acute episode of psychosis or to facilitate recovery from the prodromal state. Major content areas include treatment compliance, stress reduction, buffering and avoiding life events, avoiding street drugs and/or alcohol, lowering of expectations during the period of negative symptoms and a temporary increase in tolerance for these symptoms. Two special techniques are introduced to participating members as supports to the efforts to follow family guidelines: formal problem solving and communications skills training (Falloon, Boyd, & McGill, 1984).

Social and Vocational Rehabilitation

Approximately one year following initiation of treatment or an acute episode, most patients begin to evidence signs of a return to spontaneity and active engagement with those around them. This is usually a sign that the negative symptoms are diminishing and the patient can now be challenged more intensively. The focus of this phase deals more specifically with his/her rehabilitative needs, addressing the three areas of functioning in which there are the most common deficits: social skills, academic challenges and the ability to get and maintain employment.

Multifamily Groups

These groups address elements of expressed emotion, social isolation, stigmatization and burden directly by education, training and modeling. Some of this effort focuses on modulating emotional expression and clarifying and simplifying communication. However, much of the effectiveness of the approach results from increasing the size and density of the social network, by reducing the experience of being stigmatized, by providing a forum for mutual aid, and by providing an opportunity to hear similar experiences and to find workable solutions.

A stable membership of from five to seven families meets with two clinicians on a bi-weekly basis usually for one to three years following the onset of an initial episode of psychosis; all family members would have participated in an educational workshop. Unless psychotic, the patients also attend the group, although the decision to do so is based upon the patient's mental status and susceptibility to the amount of stimulation such a group occasionally engenders. Each session lasts for 1 ½ hours.

A Case Example

The multifamily group approach often provides opportunities for patients to break through seemingly intractable problems that are limiting their options in living. Although the initial stage of work in the psychoeducational framework is focused on preventing relapse and overcoming symptoms, the second phase is explicitly focused on achieving the life goals of the patient, with the family's and the group's assistance. The case presented here illustrates how the PMFG promotes functional recovery, almost always by proceeding in small steps, carefully thought through in the problem-solving process with input from many – and often all – members of the group.

R. 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. The group process addressing this conflict was as follows:

Step 1: What is the problem?

How can R. 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 for R.:
- 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.

R. 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.

R. 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.

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

- 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 a while; 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!

R tried these suggestions and found that they were actually important for improving her performance at work and making her feel more comfortable and less isolated at work.

Conclusion

Family psychoeducation and multifamily groups have shown remarkable outcomes in more than a score of studies, and multifamily groups appear to have a specific efficacy in earlier phases. Our experience suggests strongly that family-oriented, supportive, psychoeducational treatment is acceptable to families and in clinical trials appears to meet many of their needs. There is theoretical support for the efficacy of these methods, with their strategy of stress-avoidance, -protection and -buffering, while the multifamily group format adds an inherent element of social support and network expansion.

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