

Family Services for Severe Mental Illness

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Family psychoeducation is now recognized as a valuable, evidence-based practice for improving the outcome of severe mental illness (Dixon et al., 2001). While families were once viewed by the mental health profession as possible culprits in causing severe mental illness (Appleton, 1974; Fromm-Reichman, 1948), the field has now become enlightened to the fact that families do not cause mental illness; in fact, families can play a vital role in helping consumers make progress towards their recovery goals (Lefley & Johnson, 1990). In this brief introduction to family services, we provide a rationale for the importance of engaging and working collaboratively with the families of persons with severe mental illness. This is followed by a brief description of the core components of family psychoeducational programs shown to be effective in controlled research. We conclude with a brief summary of the findings of research on family psychoeducational programs for severe mental illness. The next section provides a description of family services for persons with severe mental illness.

There are several reasons for providing services to the families of persons with a severe mental illness. First, many people with severe mental illness either live with family members (such as parents, spouses, siblings, or children) or maintain regular contact with their relatives (Clark, 1996; Goldman, 1984). High levels of contact with family members mean that the involvement of these individuals in the planning and implementation of treatment can increase support for follow-through on treatment recommendations and improve the monitoring and responsiveness to changes in the illness. Enhanced ability of family members to detect early warning signs of relapse, and to notify treatment team members if such signs are detected, can be crucial in preventing relapses of these episodic disorders.

Second, having a close relationship with someone with a severe mental illness, and providing care to that person, can take a heavy toll on relatives (Baronet, 1999; Webb et al., 1998). While there are many positive aspects to a close relationship with a loved one who has mental illness (Bulger, Wandersman, & Goldman, 1993; Greenberg, Greenley, & Benedict, 1994), the caregiving role can be challenging and stressful for relatives, and may contribute to negative feelings, including anxiety, depression, and a sense of loss (Baronet, 1999; Miller, Dworkin, Ward, & Barone, 1990). Decreasing caregiving burden is an important goal of family

psychoeducation that can enable family members to remain involved with their loved ones while staying psychologically and physically healthy.

Third, high levels of stress in the family, often related to the burden of caregiving, can have a negative effect on the mental illness, increasing vulnerability to relapses and rehospitalizations (Butzlaff & Hooley, 1998). Reducing stress in the family can improve the quality of life for everyone, and decrease stress-related relapses and rehospitalizations. In addition, improving the ability of the family to manage stress effectively may also help persons with severe mental illness deal with stress from outside the family more effectively, thereby helping them to pursue their goals (Mueser & Glynn, 1999).

Core Ingredients of Effective Family Psychoeducational Programs

Over the past 25 years several models of family psychoeducation for severe mental illness has been developed and empirically tested. While each of these models is unique in its own right, there are several common elements shared across the programs (Dixon et al., 2001). Because ample research has shown that different models of family psychoeducation are effective, it may be inferred that their effectiveness is largely determined by these common elements. These common elements include structural aspects, philosophical perspectives, and the content and aims of the programs. Each of these core components is discussed below.

Several *structural features* are common across effective family intervention programs. To date, family programs that have been demonstrated to be effective have been conducted by mental health professionals. An advantage of having professionals provide family services is that it requires them to establish working relationships with families, thereby helping families gain access to their relatives' treatment teams. In the absence of professional-based family services, relatives often have difficulty accessing the treatment team (e.g., treatment team

members may refuse to take calls from relatives or may dismiss what they have to say), leading to lost opportunities to intervene rapidly at the early stages of a relapse.

Effective family programs are also usually long-term, with most programs providing services for nine months to two years. The practical need for long-term family services may be due to the fact that developing a good relationship between family members and professionals takes time, and significant time is required for family members to learn the information and skills needed to play an active role in helping with the management of a relative's mental illness. Another common structural feature of effective family programs is the inclusion of the person with the illness in the family work. By including both the person with the mental illness and his or her relatives in family work, direct and effective communication may be fostered while the family learns to work as a whole in managing the illness and striving to achieve goals.

With respect to *philosophical commonalities* across family programs, all of them focus on the here-and-now and improving the future, while avoiding delving into the past and assigning blame. Mental illnesses are viewed as caused by psychobiological vulnerability, with their course and outcome influenced by biological (e.g., medication) and psychosocial (e.g., stress, coping skills, social support) factors (Lieberman et al., 1986; Nuechterlein & Dawson, 1984). The overriding philosophy across family programs is that the treatment team seeks to establish a collaborative relationship with the family in order to share the task of managing the mental illness and working towards recovery goals. Such a relationship is most effectively established when there is mutual respect, each side perceives that it has something to learn from the other, and differences in opinions and perspectives can be aired openly and resolved through discussion and consensus-building.

In terms of the *goals and content* of family psychoeducational programs, all focus on providing basic information about the specific nature of the mental illness (e.g., symptoms, course), the principles of its management, and ways that family members can help. Such information is critical for family members to play a role in the management of the illness. In addition, family psychoeducational programs seek to reduce stress by improving the communication skills of family members. Finally, effective family programs focus on improving the ability of the family to solve problems on its own and to make progress toward personal and shared goals. Family programs differ in the precise methods used to educate families, reduce stress, and promote effective problem-solving, but the net result is the same: the family is more knowledgeable about mental illness, more able to work together and with the treatment team, and more capable of solving problems and supporting one-another in pursuing goals.

Research on Family Psychoeducation

Research on family intervention programs for persons with severe mental illness enjoys a relatively long history, dating back to the mid- to later-1980s, when a series of studies were published showing that several different approaches to family intervention were effective at reducing relapses in schizophrenia and improving family functioning (Falloon et al., 1985; Falloon, McGill, Boyd, & Pederson, 1987; Falloon & Pederson, 1985; Hogarty et al., 1986; Hogarty et al., 1991; Leff, Kuipers, Berkowitz, & Sturgeon, 1985; Tarrier et al., 1989). Since those pioneering studies, multiple additional studies have been published replicating the findings of earlier models for schizophrenia, and demonstrating the effectiveness of newer models (Barrowclough et al., 1999; Brooker et al., 1994; Dyck et al., 2000; Leff et al., 1990; McFarlane, Link, Dushay, Marchal, & Crilly, 1995; McFarlane, Lukens et al., 1995; Montero et al., 2001; Mueser et al., 2001; Schooler et al., 1997; Xiong et al., 1994; Zhang, Wang, Li, & Phillips, 1994;

Zhang et al., 1993). As described in the previous section, effective interventions tended to share a common set of features, including their long-term nature, a psychoeducational and stress-reduction orientation, delivered by professionals, focus on the future rather than the past, and involvement of all interested family members, including the consumer. Both single-family and multiple-family formats have been found to be effective, with no consistent differences between the two.

While abundant evidence supports the effectiveness of family intervention for schizophrenia, controlled research has only recently begun to accrue demonstrating the beneficial effects of family intervention for persons with bipolar disorder (Clarkin, Carpenter, Hull, Wilner, & Glick, 1998; Miklowitz et al., 2000; Rea et al., in press). Although fewer in number, family work in bipolar disorder produces similar benefits to those found in schizophrenia. Shorter-term family intervention programs (e.g., 3-4 months), that incorporate education and the involvement of family members in treatment, have also been found to improve the outcome of depression, anxiety disorders, and substance use disorders (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Mueser & Glynn, 1999; Stanton & Shadish, 1997).

Thus, research provides a solid basis for the effectiveness of family intervention programs for severe mental illness.

Overview of Family Services

Two types of professional-based family services are recommended for individuals with severe mental illness and their relatives: single-family intervention and multiple-family group intervention. Single-family intervention involves working with individual families, usually on a time-limited basis, in order to provide them with the necessary information and skills to manage their relative's psychiatric illness in collaboration with the professional treatment providers.

Single-family intervention has the advantage that it can be provided in the home of family members (if desired), it is more suited to families facing multiple hardships due to the ability to focus more directly on the specific needs of the family, and it is easier to engage families in treatment early on in the course of the mental illness when family members most strongly perceive the stigma of mental illness and may be initially reluctant to participate in multiple-family groups.

Multiple-family groups are aimed at providing continued education and support for individuals with severe mental illness and their relatives, and are usually provided on a time-unlimited basis. These groups have the advantage of being economical, providing more opportunities for social support among participants, and providing a forum for continued psychoeducation about the nature and management of mental illness. Families may benefit from participating in either or both single-family or multiple-family group programs. Families may also benefit from participating in the National Alliance for Mentally Ill Family-to-Family Educational Program, although controlled research on the effectiveness of this program is not available.

We describe here two models for conducting family intervention services, including single- and multiple-family groups. For the single-family intervention we describe an extensively researched model, *behavioral family therapy for psychiatric disorders* (BFT). BFT is a social-learning based approach to helping family members learn how to manage the psychiatric illness of a relative in collaboration with mental health professionals. BFT is based on teaching structured, educational curriculum and skills that serve as the foundation for effective family management of the illness. The model can be broken down into six component phases,

including: engagement, assessment, psychoeducation, communication skills training, problem-solving training, and termination. Each phase is tailored to the unique needs of the family.

We also describe a multiple-family group model, which involves biweekly or monthly meetings with families of persons with psychiatric disorders, and including both consumers and relatives. Meetings involve a combination of didactic presentations on different educational topics with group discussion and optional problem-solving. The generation of social support is a key goal of multiple-family groups, as well as continued monitoring of the psychiatric illness. Detailed manuals for BFT include Mueser and Glynn (1999), Falloon, Boyd, and McGill (1984), and Miklowitz and Goldstein (1997). Detailed manuals for conducting multiple-family groups can be found in McFarlane (2002) and Mueser, Noordsy, Drake, and Fox (in press).

Target Population

BFT and multiple-family group approaches were developed for individuals with a major psychiatric disorder such as schizophrenia, schizoaffective disorder, bipolar disorder, major depression, obsessive compulsive disorder, or posttraumatic stress disorder. At this point, the preponderance of evidence supporting the effectiveness of BFT is for schizophrenia, schizoaffective disorder, and bipolar disorder (Mueser & Glynn, 1999). Similar but briefer models of BFT have also been found to be effective for the treatment of depression (Emmanuel-Zuurveen & Emmelkamp, 1997), anxiety disorders (Emmelkamp et al., 1992), and substance abuse (McCrary, Stout, Noel, Abrams, & Nelson, 1991). Most of the evidence supporting the effectiveness of multiple-family groups for severe mental illness is limited to schizophrenia-spectrum disorders (Dixon et al., 2001). Nevertheless, both the BFT and multiple-family group models can be readily adapted to address the needs of any family coping with a major psychiatric disorder.

With respect to family members' participation in BFT or multiple-family groups, any individual who has a caring, non-professional relationship with the consumer can participate. The most common relationships include parents, spouses, siblings, and children, although participation of persons with more distant relationships such as grandparents, aunts and uncles, may occur, as well as friends or significant other persons, such as a member of the clergy or residential staff member. The greatest benefit from participation in family services will be realized in families in which key members have the most contact with the consumer, such as four hours a week of contact or more. Nevertheless, participation of family members with less than four hours of weekly contact with the consumer may also be helpful, especially if it is possible that the amount of contact is likely to increase in the future, as is often the case with siblings who may over time assume greater caregiving roles with consumers as parents age (Horwitz, Tessler, Fisher, & Gamache, 1992; Marsh & Dickens, 1998).

BFT and multiple-family groups have been implemented across a wide variety of socioeconomic and ethnic/cultural groups (Falloon et al., 1985; McFarlane, Lukens et al., 1995; Montero et al., 2001; Mueser et al., 2001; Xiong et al., 1994). Similarly, family intervention programs have been successfully implemented with families from a range of different socioeconomic backgrounds (Dixon et al., 2001). To ensure the appropriateness of family intervention for each particular cultural group, clinicians must be familiar with that culture and family norms regarding culturally defined family leaders (McGoldrick, Giordano, & Pearce, 1996). At this time, there are no known contraindications for family interventions for clients with severe mental illness.

Organizational Framework for Family Services

Although family intervention programs have been shown to be effective in numerous studies, implementation of these programs has lagged far behind the research (Dixon et al., 2001). In order to make family services available to the majority of the consumers who have contact with their relatives, mental health centers need to develop an organizational framework for providing those services and ensuring their quality (Mueser & Fox, 2000). Such a framework is outlined here.

The proposed organizational framework is based on five propositions. First, learning how to become a skillful family clinician requires investment in time and energy. Rather than expecting all clinicians at a mental health center to have the skills to deliver family intervention services, it is more economical to focus on developing psychotherapeutic skills for working with families in a selected group of clinicians. These clinicians can become *family specialists*, although their time need not be exclusively devoted to family work.

Second, all consumers with involved families need to have access to family services. Third, the provision of family intervention needs to be integrated with other psychiatric services at the level of the team. The second and third propositions can be achieved by having each multidisciplinary treatment team at a mental health center designate one or more clinicians to become family specialists, and who provide the majority of family services.

Fourth, family specialists benefit from case consultation and continued training opportunities. Training and education are ongoing activities and opportunities for continued improvement need to be build into the family service structure of the organization. Fifth, the quality of family services needs to be evaluated on an ongoing basis by a supervisor (i.e., a director/coordinator of adult family services), who can perform checks on the fidelity of

interventions to the family treatment models. Since the training of new clinicians and the supervision of trained clinicians go hand-in-hand, the director/coordinator who supervises family clinicians and provides updated training opportunities also trains new clinicians in the family intervention models.

Family services at a typical mental health center can be organized by designating one or more family specialists for each treatment team. The number of specialists per team depends on the number of consumers served by the team and the degree of family contact consumers have. Most estimates suggest that between 60-80% of persons with severe mental illness have some ongoing contact with family members (Clark, 1996; Mueser et al., 2000). Because not all consumers have contact with family members, and some family intervention is time-limited, there should be at least one family specialist for every 50 consumers on a team.

To ensure that family specialists have opportunities for case consultation, supervision, and ongoing training, a 60 to 90 minute group supervisory time should be set aside each week. All family specialists should be expected to come to this meeting, which should be led by the director/coordinator of adult family services. It is critical that family specialists are expected to attend supervision meetings and that they are not penalized by doing so by inflexible productivity expectations. Supervision and training are just as important activities for clinicians to engage in as direct consumer care, and productivity quotas should be consistent with this fact.

The director/coordinator of adult family services should be an individual capable of acting in a leadership role as both a trainer and supervisor of the family clinicians. The role of director/coordinator need not be full-time, although depending upon the size of the agency and the number of family specialists, some time needs to be protected for attending to the duties of the role. These duties include training clinicians in family intervention models, leading weekly

supervision/case consultation meetings, meeting with the agency director to review family services, conducting fidelity checks to the family intervention models, running interference and addressing obstacles to implementing family services (e.g., meeting with treatment team leaders to ensure support for providing family services), and serving as a liaison to local chapters of the National Alliance for the Mentally Ill.

Behavioral Family Therapy (BFT)

A synopsis of the BFT model is provided here. For more details, including more specific explication of the treatment components, detailed case vignettes, educational handouts, and forms and instruments see Mueser and Glynn (1999).

Logistical Considerations

BFT is an individual based family intervention program that can be provided either in the home or the clinic. Home-based sessions have several advantages over clinic-based sessions, including greater ease in engaging a larger number of family members in the program, access to valuable assessment information regarding the circumstances in which family members live, and lower rates of cancellation by family members. A combination of at-home and clinic-based sessions is also possible; several initial sessions may be conducted at home, followed by a transition to clinic-based sessions.

Sessions typically last one hour, although length can be decreased or increased depending upon attention span, psychotic symptoms, and other factors. Sessions are usually conducted on a weekly basis for several months followed by biweekly sessions, followed by monthly sessions. Although BFT is generally provided as a time-limited intervention for 9-24 months, some families benefit from ongoing sessions without formal termination of the program (see Termination section below).

Engagement

Engaging the family is usually most successfully accomplished by first exploring the benefits of family work with the consumer, followed by discussions with family members. As previously reviewed, research shows that family work has a positive effect on the course and severity of mental illness. However, many consumers are not aware of these benefits. Therefore, the clinician must explain the nature and goals of BFT to the client, and clearly state that in the clinician's opinion this program is in the consumer's best interest. If the clinician believes that family work will benefit the consumer, in most cases he or she will be able to successfully convey this to the consumer.

With respect to the benefits of family work, the clinician can inform the consumer that the family program is aimed at providing education to family members about the nature of mental illness and its treatment, preventing relapses and rehospitalizations, and helping family members (including the consumer) develop skills for pursuing personal and family goals. Depending on the consumer's relationship with his or her family, other goals can be described, such as decreasing stress and tension in the family, improving the ability of family member to solve problems together, increasing the consumer's independence, and addressing other problems areas such as substance abuse, depression, or anxiety.

Some consumers are wary of family therapy because they have had negative experiences with less structured and more exploratory family therapy models (Terkelsen, 1983). It is important to address these concerns by letting the consumer know that BFT sessions are not stressful, and that the focus is on teaching information and specific communication and problem-solving skills, with an overall orientation towards the future, not the past. The clinician can also

explain that it is his or her responsibility to maintain a good, mutually respectful, and supportive working atmosphere in all family sessions.

Some consumers need only a single meeting to discuss the benefits of family psychoeducation before they agree to it and the clinician can move onto contacting other family members. Other consumers need several meetings, and may want to talk it over with family members on their own. The support of other treatment team members for the consumer's participation in BFT is also helpful to enlisting their interest in participating in the family program. Once the consumer has agreed to participate in BFT, the clinician finds out which family member would be a good person for the clinician to contact next about the program.

When contacting the family member about participating in BFT it is often helpful to first have a brief telephone conversation, followed up by an in-person meeting. During the initial conversation the clinician can explain that the consumers' treatment team recommends that the family participate in this program, which they believe will be of benefit to both the consumer and relatives. The clinician explains that the focus of the program is on teaching families about the consumer's mental illness and the principles of its treatment, and teaching strategies for communicating more effectively and solving problems. The overall goals of BFT are to reduce relapses and rehospitalizations and to promote more independent living for the consumer. Similar to engaging the consumer, other goals such as reducing stress in the family, addressing substance abuse, or helping other family members make progress toward their personal or family goals can be mentioned as well.

Similar to consumers, relatives often need to be informed that BFT is a learning-oriented approach that is both highly structured (while tailored to the needs of the individual family) and oriented towards working together for a better future. In this way, BFT needs to be distinguished

from more exploratory, and potentially more stressful, family therapy approaches. In fact, for families who appear wary of participating in family “therapy” the word “counseling” may be substituted.

A useful concept for motivating families to participate in BFT is to state that a goal of the program is to help the family, including the consumer, become members of the consumer’s treatment team. This communicates to family members that clinicians see the family as important allies in the treatment of the mental illness, that they recognize the caring relationship between the consumer and relatives, and that they view collaboration between the treatment team and the family as essential to the success of psychiatric treatment.

Once the consumer and family members have agreed to participate in the BFT program, an orientation meeting is scheduled to set positive expectations for participation and to address logistical issues. This orientation meeting should be attended by the consumer and any relatives who may participate in the program. At the beginning of the meeting, the clinician hands out an orientation sheet (see Mueser & Glynn, 1999) that addresses the logistics of the BFT program (location, session duration, scheduling and canceling appointments, etc.), the specific components of the program (e.g., individual interviews with each family member, regular family sessions to teach psychoeducation, communication skills, problem-solving skills), expectations of family members (e.g., cooperation with one another, completion of assigned homework, etc.), and expectations of the clinician (e.g., thoughtful intervention, homework materials, etc.). The clinician reviews these points on the orientation sheet with family members, eliciting questions and clarifying points as necessary, and at the end of the orientation session schedules appointments for individual interviews. The clinician may find it helpful to explain that the purpose of the individual interviews are to get each family member’s perspective on the

consumer's mental illness and on the family as a whole, including its strengths and desired areas of change.

Assessment

Individual interviews with family members generally last between 45 minutes and 1.5 hours, and are designed to gather information from each family member's perspective and to solidify the therapeutic relationship with the clinician. Interviews typically begin by gathering background information from each family member, including demographics, history of relationship with consumer, education, occupation, and living situation.

Following obtaining background information, the clinician asks questions to ascertain the family member's knowledge and understanding of the consumer's psychiatric illness. Questions are asked regarding whether family members have knowledge of the consumer's diagnosis, what that diagnosis means to them, and their familiarity with treatment strategies for the disorder. Family members are also queried as to what they have observed that improves or worsens the illness.

The clinician can engage in some psychoeducation about the illness during these interviews, although the primary purpose is to gather assessment information and not to rectify misconceptions about the disorder. The general goal of these questions is to understand each family member's awareness of the psychiatric disorder and its treatment, and to assess the degree of supportiveness the family member has for helping the consumer better manage his or her psychiatric disorder. Questions are also asked to determine the impact of the psychiatric illness on other family members. An important focus of treatment is reducing the impact of psychiatric illness on the family, which can reduce stress and tension in the family, increase mutual supportiveness, and contribute to an improved course of the psychiatric illness.

At the end of each family interview the clinician discusses the importance of each family member having personal goals to work towards over the course of the BFT program. These goals that may be related to the consumer, but they are specifically for the family member and not for the consumer. For example, a mother may feel overburdened by housework and receive little help from her son who has schizophrenia or her husband. Getting more help doing the housework could be identified as a goal, with a possible solution down the road (in problem-solving) of the husband and/or son pitching in to lighten the load on the mother. Goals can also be identified by a family member that are completely unrelated to the client (e.g., joining an exercise class, getting a part-time job). Such goals may be addressed in the problem-solving sessions of BFT, with all family members working together to help the individual make progress toward his or her goal.

The reason for each family member to identify personal goals in BFT is that the program is aimed at improving the lives of everyone in the family, and not just the consumer. Such improvements are most likely to occur if each individual identifies personal goals to work towards. The notion of establishing personal goals in a family program aimed at improving the management of a psychiatric illness may come as a surprise to family members, who may experience difficulty identifying goals in the first assessment interview. In such cases, the family member can be provided with an orientation to the concept of goal-setting, with the clinician then following up at subsequent meetings to help the family member specify goals to work on.

In addition to the individual interviews, the clinician assesses family strengths and potential areas for change when meeting with the entire family based on observations of how the members interact. Family strengths serve as an important foundation for helping members acquire additional knowledge and skills for the management of the psychiatric illness. Examples

of family strengths include demonstrated commitment to each other, spending a lot of time with one-another, shared interests, and evidence or expressions of love and other positive feelings, such as caring, empathy, and enjoyment of each other.

Observing the family interact also provides valuable information about potential targets for change over the course of BFT. High levels of criticism, hostility, or intrusiveness (e.g., putting down the other person, telling another person what he or she is thinking, telling someone else you know what is best for him or her) may be stressful to family members, and indicate that the family may benefit from improved communication skills. Similarly, the clinician assesses family members' ability to express feelings clearly, including both positive and negative feelings, to make requests of others in a diplomatic and effective way, to be behaviorally specific, and to work collaboratively toward addressing problems. These behaviors are other examples of family communication skills that may be a focus of training in later sessions.

Psychoeducation

The goals of psychoeducation are to legitimize the psychiatric illness to family members, to familiarize them with the symptoms of the disorder and its epidemiology and course, and to describe the principles of treatment, including the role of the family in monitoring symptoms, facilitating treatment adherence, and reinforcing and supporting improvements in the consumer's independence and role functioning. The underlying philosophy of psychoeducation is that in order for family members to play an active role in collaborating with the treatment team, they need to understand basic facts about the psychiatric disorder and its treatment.

Between three and six sessions are usually spent on the psychoeducational component of BFT. Psychoeducation is taught through a combination of educational handouts and interactive discussions with the family. In the psychoeducational sessions, the consumer is connoted as the

“expert” in the psychiatric illness and his or her personal experiences are used to illustrate specific educational points. Designating the consumer as the expert has the effect of showing the person that his or her experiences are valued and that he or she has much to contribute to helping the family understand the nature of the psychiatric illness. Family members’ experiences living with the consumer mean that they too have expertise in the psychiatric illness, and this expertise can also be elicited in the psychoeducational sessions.

The general approach to teaching information about the psychiatric illness is to present basic information, either paraphrased from the handout or directly read from the handout, and to then ask the consumer and family members about their understanding and experiences related to the information. Family members sometimes have different perspectives on the consumers’ diagnosis or particular symptoms. Attempts to resolve these differences are not made in the psychoeducational sessions; rather, the differences are acknowledged, respectfully aired, and allowed to stand without direct challenge. If family members begin to try to resolve discrepancies or differences of opinion, the clinician steps in to stop these efforts, emphasizing that what is most important is that the family members have agreed to work together toward achieving individual and mutual goals.

Some consumers do not accept having a specific diagnosis. In some cases, the consumers may acknowledge having “psychiatric problems,” a “mental illness,” or “problems with nerves” while disagreeing with the specific diagnosis. Some consumers believe they have no psychiatric disorder whatsoever. In these circumstances, the clinician does not try to persuade the consumer that he or she has the psychiatric disorder, and intervenes to prevent family members from attempting to persuade the consumer as well. Instead, the clinician looks for some common ground in referring to the consumer’s experiences and difficulties, and when possible may use an

euphemism to refer to such experiences such as “these kinds of difficulties.” Consumers are often willing to be the expert for a more generically termed set of problems rather than for a specific psychiatric disorder. Frank acknowledgement of the psychiatric disorder is not a prerequisite for participating in and benefiting from BFT.

Educational curriculum in the form of standardized handouts can be obtained from a variety of sources. Books by Mueser and Glynn (1999) and Mueser, Noordsy, Drake, and Fox (in press) contain educational handouts that can be duplicated on the following topics:

- Schizophrenia
- Schizoaffective Disorder
- Bipolar Disorder
- Major Depression
- Posttraumatic Stress Disorder
- Obsessive-Compulsive Disorder
- Antipsychotic Medications
- Antidepressant Medications
- Mood Stabilizing Medications
- Sedative and Hypnotic Medications
- Stress-Vulnerability Model of Psychiatric Disorders
- The Role of the Family
- Drug and Alcohol Abuse
- Infectious Diseases
- Communication Skills

Additional educational information can be obtained and adapted from other books or internet sites for professionals or families.

Communications Skills Training

The goals of communication training are to advance the ability of family members to communicate in direct, effective, and non-stressful ways. Effective communication lays the groundwork for problem-solving; if families are unable to communicate to one-another effectively, their ability to solve problems together will be limited. Good communication includes the ability to speak clearly, to make clear verbal feeling statements when appropriate, to be behaviorally specific, and to be succinct and to-the-point.

Communication patterns that suggest the family may benefit from training in communication skills are summarized in the previous section on assessment. For families who communicate relatively effectively, one session is spent reviewing the points of good communication using an educational handout (Mueser & Glynn, 1999). For families who will benefit from skills training, between three and six sessions are typically spent on improving communication skills. These sessions involve experiential learning, based on the principles of social skills training (Bellack, Mueser, Gingerich, & Agresta, 1997), that place a premium on role playing, positive and corrective feedback, and at-home exercises to practice the skill. The steps of communication skills training are described below.

1. Establish a Rationale for the skill. The rationale for each communication skill is established by asking open-ended questions of family members designed to elicit reasons for the skill. For example, some of the reasons for learning the skill “expressing positive feelings” include: it makes other people feel good, it lets them know they’re appreciated, and it increases the chances that the person in the future will engage in the same pleasing behavior

again. Examples of the rationale for the skill “expressing negative feelings” include: people need to communicate to each other when they feel upset or displeased about something, effective communication can enable the person to change his or her behavior in the future, it can help avoid the problem of carrying grudges about things that other people have done.

2. Break the skill down into component steps. Each communication skill is broken down into component steps. For example, the skill of expressing negative feelings can be broken down into the following steps: 1) look at the person; speak with a firm voice tone, 2) tell the person what you are upset about, 3) tell the person how it made you feel, 4) suggest a way of preventing the situation from occurring again in the future. These steps make it easier to teach the skill over successive role plays. Each step of the skill is reviewed with the family, eliciting the reason for each individual step. See Mueser and Glynn (1999) for the steps of other communication skills taught in BFT.
3. Demonstrate the skill in a role play. The clinician next demonstrates how the skill should be performed in a role play for the family. This modeling of the skill is done explicitly, with family members informed that the clinician is going to show them an example of how the skill could be used. Role plays are kept short and simple, and use typical, everyday situations.
4. Review which steps of the skill the members observed. The clinician goes over each step of the skill that was just modeled, asking for feedback from family members and encouraging them to provide an overall evaluation of the clinician’s performance in the role play. This review reinforces the importance of each the step of the skill.
5. Engage a family member in a role play of the skill. A member is asked to try using the skill in a role play with another family member. Members are encouraged to select a recent

situation in which they could have used the skill, or actually did use the skill. Members are encouraged to try to incorporate of the steps of the skill during the role play.

6. Provide positive feedback. Role plays by family members are always immediately followed by specific and positive feedback from other family members. The clinician can query family members by asking questions such as “What did you like about the way Mary made a positive request of John in that role play?” and “Which of the steps of the skill did you see Mary doing in that role play?” The clinician cuts off negative feedback in order to ensure that family members receive positive and encouraging feedback first after completing a role play. The clinician can also provide positive feedback himself or herself about the member’s performance in the role play. Feedback is limited to a few minutes.
7. Provide corrective feedback. After positive feedback has been given, suggestions for how to use the skill more effectively are elicited from family members. Suggestions should be conveyed in a positive, upbeat manner so as not to discourage the person learning the skill. Suggestions should be limited to one or two to avoid overwhelming the individual. The clinician can make suggestions as well as family members.
8. Engage the family member in another role play of the same skill. Another role play should be conducted using the same situation as the previous role play, and the member should be asked to make one or two specific changes in his or her use of the skill. The clinician should focus on helping the family member make changes in the most critical components of the skill. Most improvement in communication training occurs over a series of role plays as family members gradually learn how to make small but important changes in specific communication skills.

9. Provide additional positive and corrective feedback, and conduct more role plays as necessary. As with the first role play, the second and subsequent role plays are followed by positive and corrective feedback about specific components of the skill that were performed well or could be improved. Typically, family members engage in two to four role plays per skill per communications skill training session. When family members have difficulty improving their skills based on verbal feedback provided following role plays, additional teaching strategies can be used, such as supplementary modeling by the clinician, providing verbal coaching during a role play (and then fading the coaching in subsequent role plays), and using nonverbal props during the role play, such as motioning ones thumb up to indicate that the person should speak louder. When one family member has had sufficient practice with the skill, the clinician engages another member in practicing the same skill, and follows the same steps of role playing, followed by positive and corrective feedback.
10. Assign homework. At the end of the session the clinician assigns family members homework to find situations where they can practice the skill over the following week. Members are encouraged to write down their experiences using the skills (or trying to use it), and to bring these homework sheets to the following session. In the next session the clinician reviews the homework sheets and helps family members set up role plays to demonstrate how they tried to use the communication skill in specific situations that occurred over the past week. When sufficient progress has been made, the clinician that introduces a new communication skill, which is the focus of that week's session.

Problem Solving Training

The goals of problem-solving training are to teach family members a standardized approach for helping them agree on problems that need to be solved and collaboratively

exploring and agreeing upon solutions to the problem. Problem-solving training acknowledges that families inevitably face problems, either by individual members or as a family, and these problems need to be solved in as effective and stress-free manner as possible. Problem-solving can also be used to help family members identify and pursue personal and shared goals.

Problem-solving training is taught by having the clinician first explore with family members how they solve problems together, and then establishing a rationale for the problem-solving approach. The steps of problem-solving are then illustrated by the clinician, who walks the family through the steps while working on a specific problem or goal identified by the family. During this demonstration of problem-solving, the therapist assumes the role of the chairperson, leading the family through the steps and recording progress on the standardized problem-solving sheet (see Mueser & Glynn, 1999). While the clinician takes on the role of chairperson and secretary in demonstrating and recording the steps of problem-solving during the initial sessions devoted to problem-solving training, over time these functions are shifted to the family and the clinician focuses his or her efforts on helping family members use the approach to solve their own problems.

Early in the course of problem-solving training it is important to select problems that are relatively simple, and for which the clinician can envision at least one or two possible solutions. Over time, as families become more competent at the method, increasingly difficult problems and goals can be targeted. Over the course of problem-solving training, the clinician tries to avoid being so active in solving each problem that the family begins to depend on him or her for all their problem-solving.

In order for family members to learn the problem-solving method, families are requested to schedule a weekly family meeting during which problem-solving can be practiced. At the

beginning of problem-solving training the clinician gives the family very specific instructions for which steps to practice during their home sessions. As family members become more skillful at solving problems, more and more actual problem-solving takes place at home, with the clinician assuming the role of helping family members troubleshoot the solving of especially difficult problems, or honing their skills at specific steps of problem-solving. Ambitious goals or very difficult problems can often be most effectively handled in problem-solving by breaking them down into smaller more manageable chunks.

The steps of problem solving are briefly described below:

1. Agree on a definition of the problem. In order for family members to solve problems together, they first they must arrive at a definition of the problem. This is achieved through family members sharing opinions on how the problem should be defined, and reaching a consensus on the definition of the problem. Such a consensus may require compromise and negotiation among family members so that each person views the problem as something they are invested in resolving.
2. Brainstorm possible solutions. Family members generate as many possible solutions to the problem as possible. At this point in problem-solving, a premium is placed on the number of solutions identified and thinking of creative, unusual solutions. Solutions are not evaluated at this step in order to create a free and non-evaluative atmosphere in which all possible solutions to the problem are considered.
3. Evaluate the solutions. Each solution is evaluated in terms of its advantages and disadvantages for solving the problem. The evaluation need not be exhaustive, but should at least consider the main advantages and disadvantages of each potential solution.

4. Select the best solution or combination of solutions. Sometimes the optimal solution to the problem is apparent to all and relatively little discussion is needed to choose the best solution. At other times, either when no one solution is clearly best or when family members disagree about the best solution, a combination of solutions may be selected, or several solutions may be combined to develop a novel solution that all members agree upon.
5. Devise a plan to implement the solution. Solutions to problems can only be effective to the extent that they are actually implemented. This step of problem-solving involves planning on the steps necessary to implement the chosen solution. Implementation plans benefit from considering the following questions: Are there any skills or other resources needed to implement the solution? Who will implement what steps of the solution? What time-frame will be used to implement the solution? Can any obstacles to implementing the solution be anticipated? What could go wrong with the solution?
6. Review problem-solving efforts at a later time. Sometimes problem-solving is successful the first time around, and at other times more than one problem-solving meeting is needed. In order to ensure that problem-solving continues until the problem has been resolved or substantially addressed, each problem-solving meeting should end with planning a follow-up meeting where family members can review problem-solving efforts and troubleshoot any obstacles that have been encountered. When family members have regular meetings on their own, these meetings can be used to follow-up on problem-solving initiated during therapy sessions, as well as to conduct additional problem-solving.

Termination

Termination of BFT typically occurs between 9 and 24 months after initiating family sessions. The primary criteria for termination is that family members have learned the requisite

information and skills to be able to manage the psychiatric illness in collaboration with professionals, but without the need for ongoing family sessions. In order to achieve this, family members need to comprehend basic information about the psychiatric illness and the principles of its management, and to be able to engage in effective problem-solving on their own. Ideally, families should be having regular family meetings in which problems are addressed and goals are set, and which past problem-solving efforts are reviewed and modified as needed. In the absence of ongoing family meetings, family members need to be able to engage in constructive problem-solving, with or without the aid of the problem-solving worksheet, in an impromptu fashion.

While the goal of BFT is to provide time-limited intervention in order to teach information and skills for managing psychiatric disorders, some families benefit from ongoing, rather than time-limited sessions. Characteristics of families that may benefit from continued BFT include: families that experience a myriad of life problems other than the management of the psychiatric illness (e.g., extreme poverty, multiple ill family members with problems such as mental illness, substance abuse or health problems), extreme impairment in the consumer (e.g., severe cognitive impairment, persistent psychotic symptoms, severe and treatment-refractory substance abuse), and significant impairment in a key family member that limits the person's ability to manage the mental illness and solve problems without the assistance of the therapist. The frequency of BFT sessions in families who have an ongoing need for such service should be titrated to the individual family's need. Some families who experience frequent crises may need to have ongoing weekly or biweekly sessions. Other families may benefit from ongoing monthly or bimonthly sessions.

As with other cognitive-behavioral treatment approaches, families in BFT are prepared for termination from the earliest sessions onward. Families are informed that the intervention is

time-limited and that its focus is on helping them to develop basic skills for the management of psychiatric disorder, including skills for resolving family problems and achieving goals. In BFT sessions, the clinician often alludes to and plans for when regular family sessions will no longer be conducted. Family members are involved in the decision of when to terminate BFT, and in making plans to address needs that may arise after BFT ends. Many families appreciate the opportunity to have some booster BFT sessions with the clinician if the need arises.

In the final BFT session, the therapist begins by reminding the family that this is their last session, and focuses the session on reviewing prior accomplishments and planning for the future. Each family member is encouraged to give his or her perspective on the ways in which that individual, and the family, has benefited from participating in BFT. The clinician also provides positive feedback to members about their participation, and gives specific examples of gains the family has made.

After discussing the family's accomplishments, the clinician shifts the topic to planning with the family on how they will reach goals or satisfy needs that currently exist or that may develop in the future. Discussing possible resources, including access to the clinician and other members of the treatment team, is a crucial part of the discussion. The discussion should also include a review of relapse prevention plans; these plans include the steps for detecting and responding to the early warning signs of a psychiatric relapse (and for a relapse of substance abuse for those families who have addressed that problem in BFT; see Mueser, Noordsy, Drake, & Fox, in press). Procedures for recontacting (or ongoing contact) with the family clinician are also covered.

Multiple Family Groups

Considering the advantages of both single- and multiple-family formats of family intervention, mental health centers will meet the needs of the greatest number of people by developing the capacity to deliver both approaches. Some families are easily engaged in and benefit from multiple-family groups, and never need single-family intervention such as BFT. Other families benefit from BFT alone, or in combination with (or followed by) participation in multiple-family groups. For example, one approach is to involve families in BFT for a limited period of time (e.g., 9-24 months), to invite them to participate in a multiple-family group after initiating the BFT, and for the family to continue to participate in the multiple-family group after BFT has ended. Such an approach permits the more intensive BFT to focus on teaching the family basic information and skills for the management of the psychiatric illness, while allowing the less intensive multiple-family groups to provide ongoing education, support from other family members, and continued contact with the treatment team.

Logistics

Multiple-family groups are preferably conducted by two co-leaders, at least one of whom is a clinician at the mental health center. Some multiple-family groups have been co-led by professionals and family members. Multiple-family group sessions are usually held once every two to four weeks, with sessions lasting between 75 and 90 minutes. Refreshments are usually given. When sessions are conducted on a monthly basis, reminder letters are sent out to participants. Since many families have members who work, the most convenient meeting time for the groups is usually in the early evening, beginning some time between 6 and 7 PM.

Participants in multiple-family groups include consumers, involved family members, and any other individual who has a caring relationship with the consumer. Although the groups are

intended for families, some group sessions may be attended by a consumer without family members or vice-versa if an obstacle interferes with attendance of those family members.

General Goals of Multiple Family Groups

Multiple-family groups are guided by five general goals: 1) educating family members about mental illness and its treatment, 2) generating social support for consumers and relatives, 3) shared problem-solving to address common difficulties and frustrations, and 4) continued monitoring of the consumer's psychiatric disorder, and 5) consultation with and access to the treatment team. Strategies for achieving these goals are briefly described below.

Education About the Psychiatric Illness

Multiple-family groups provide many opportunities for educating family members about psychiatric illness and its treatment. Education may be conducted formally, with group sessions devoted to specific educational topics, which are planned in advance and frequently involve the distribution of educational materials to participants. Such formal psychoeducational approaches have the advantages of being easy to plan, guaranteeing that certain basic information is provided, and providing clear focus for the multiple-family groups that is easy for all members to grasp.

When ongoing education is the a focus of a multiple-family group, part of the group is devoted to presenting the educational topic (e.g., 30 to 45 minutes), with the group process segueing into a discussion of the topic and the sharing of experiences and coping strategies among the participants. Special speakers may be invited to talk on selected topics, with the leaders working to field questions and answers and stimulate the group process. When group members have become familiar with the multiple-family group format, part of each session can be spent discussing possible topics for future groups, and identifying potential speakers. The

actual strategies for teaching the educational material in these groups are the same as those described in the psychoeducational component of BFT.

Psychoeducation can also be conducted informally by identifying educational issues during group sessions and addressing them when they arise. For example, a family member may be critical of a consumer for not showing enough initiative, and the group leader could educate family members about the nature of negative symptoms. Leaders of groups always need to be on the lookout for opportunities to provide or reinforce participants' understanding of mental illness and the principles of its treatment. In addition to directly providing basic information when such opportunities arise, the leaders may encourage other group participants to share their understanding and perspectives on a particular issue.

Generating Social Support

A unique advantage of multiple-family groups is the opportunity for consumers and relatives to get support from others with similar experiences. Feelings of social support reflect a combination of feeling understood and having access to help (or being open to the possibility of receiving help) from others. Helping consumers and relatives realize that they are not alone in living with and coping with mental illness can help to bridge the social isolation many consumers and relatives feel when a member develops a mental illness. Leaders can help generate social support by frequently posing questions and encouraging direct sharing of experiences between participants.

Social support usually develops gradually in multiple-family groups over a period of several months, as families become familiar with one-another and more comfortable in sharing their experiences. When family members contribute to helping one another solve problems, and when they can lend a sympathetic ear, feelings of support grow. Several manifestations of social

support often emerge in multiple-family groups. Participants may form relationships with one-another that exist outside of the confines of the group meetings. As support develops, group participants often spontaneously express sympathy, empathy, concern, and support for one-another during group sessions without prompting from the leader. Similarly, as support develops family members more readily jump in to help each other deal with pressing problems.

Increased feelings of social support may also be reflected by an expressed desire to celebrate certain social aspects of the group. For example, group members may elect to schedule a potluck dinner for a group meeting in which each family brings a food dish to share with the group. Similarly, part of a session could be devoted to playing music if a number of participants are musicians and group members express an interest in hearing them perform. While the focus of multiple-family groups is on improved family management of the psychiatric illness and reduced stress among relatives, participants' efforts to increase feelings of support and togetherness should not be discouraged.

Problem Solving

Because of the breadth of experience among participants, multiple-family groups provide a unique opportunity for problem-solving about topics that families face. Problem-solving can be conducted both informally and formally. Informally, leaders can respond to problems that family members raise by asking other group participants about their experiences with such problems, and encouraging them to share strategies they have used to cope with them. Such problem-solving emerges naturally from ongoing conversations among group members. When a particularly thorny problem is addressed, leaders can write down different coping strategies or solutions on a blackboard or flip chart, and elicit family members' comments as to the effectiveness of the different possible solutions.

Problem-solving can also be conducted in a more formal fashion, based on the six steps of problem-solving taught in BFT. The steps of problem solving can be reviewed by group leaders so that members are familiar with them, and suitable problems identified by participants that are the focus of group problem-solving. Similar to BFT, the leaders can record on a blackboard or flipchart the specific definition of the problem, possible solutions, and the other steps of problem-solving. As each family's situation is unique, different families may elect to choose different solutions. Part of a subsequent session can be spent reviewing the effectiveness of solutions family members elected to implement, and conducting additional problem-solving as needed. Some families may elect to conduct problem-solving on their own, while others may do so only in the group. What is most critical is that each family feels that it has the support and help from others in the group in dealing with their own problems, or in making progress towards goals.

Monitoring the Psychiatric Disorder and Ensuring Access to the Treatment Team

An important function of multiple-family groups is that they provide clinicians an opportunity to informally monitor the consumer's psychiatric disorder, and they ensure that the family has access to the treatment team. This monitoring and access to the team can play a critical role in responding to the early signs of relapse, addressing treatment non-adherence, reducing stress in the family, and promoting effective communication between the family and the treatment team. To accomplish this, leaders need to be familiar with the consumers participating in the group and their treatment, and they should be available for post-group consultation should family members request it.

Leaders may observe that a consumer appears more symptomatic at a group meeting, and arrange to meet with him or her, with or without family members, after a session. Family

members may approach a leader and express concerns about a member. The leaders should be responsive to family members' desire for their expertise and consultation, especially because the family may have a closer working alliance with the leader than with any other member on the consumer's treatment team. When the leader is not a formal member of the consumer's treatment team, it is nevertheless important that he or she be familiar with the consumer's treatment, and be able to facilitate effective communication between the family and the team. Thus, the leaders of the multiple-family groups act as conduits to facilitate ongoing contact between family members and the consumer's treatment team.

Resources for Clinicians

The following books or manuals provide specific guidelines to clinicians working with families of persons with severe mental illness.

Anderson, C. M., Reiss, D. J., & Hogarty, G. E. (1986). *Schizophrenia and the Family*. New York: Guilford Press.

Atkinson, J. M., & Coia, D. A. (1995). *Families Coping with Schizophrenia*. New York: John Wiley & Sons.

Barrowclough, C., & Tarrier, N. (1992). *Families of Schizophrenic Patients: Cognitive Behavioural Intervention*. London: Chapman & Hall.

Bisbee, C. C., & Lee, L. N. (1988). *Patient Education in Psychiatric Illness: A Practical Program Guide*. Tuscaloosa: Bryce Hospital.

Falloon, I. R. H., Boyd, J. L., & McGill, C. W. (1984). *Family Care of Schizophrenia: A Problem-Solving Approach to the Treatment of Mental Illness*. New York: Guilford Publications.

Hatfield, A. B., & Lefley, H. P. (1987). *Families of the Mentally Ill: Coping and Adaptation*. New York: Guilford Publications.

Hatfield, A. B., & Lefley, H. P. (1993). *Surviving Mental Illness: Stress, Coping, and Adaptation*. New York: Guilford Publications.

Kuipers, L., Leff, J., & Lam, D. (1992). *Family Work for Schizophrenia: A Practical Guide*. London: Gaskell.

Lefley, H. P. (1996). *Family Caregiving in Mental Illness*. Thousand Oaks, CA: Sage.

Lefley, H. P., & Johnson, D. L. (1990). *Families as Allies in Treatment of the Mentally Ill: New Directions for Mental Health Professionals*. Washington, DC: American Psychiatric Press.

MacFarlane, M. M. (Ed.). (2001). *Family Therapy and Mental Health: Innovations in Theory*

and Practice. New York: Haworth Press.

Marsh, D. T. (1998). *Serious Mental Illness and the Family: The Practitioner's Guide*. New York: John Wiley & Sons.

Marsh, D. T., & Magee, R. D. (Eds.). (1997). *Ethical and Legal Issues in Professional Practice with Families*. New York: John Wiley & Sons, Inc.

McFarlane, W. R. (2002). *Multifamily Groups in the Treatment of Severe Psychiatric Disorders*. New York: Guilford Publications.

Miklowitz, D. J., & Goldstein, M. J. (1997). *Bipolar Disorder: A Family-Focused Treatment Approach*. New York: Guilford.

Mueser, K. T., & Glynn, S. M. (1999). *Behavioral Family Therapy for Psychiatric Disorders* (Second ed.). Oakland, CA: New Harbinger.

Resources for Families

The following books may be helpful to families coping with a mental illness in member.

- Backlar, P. (1994). *The Family Face of Schizophrenia*. New York: Tarcher/Putnam.
- Berger, D., & Berger, L. (1991). *We Heard the Angels of Madness: A Family Guide to Coping with Manic Depression*. New York: Morrow.
- Burns, D. D. (1980). *Feeling Good: The New Mood Therapy*. New York: Avon.
- Court, B. L., & Nelson, G. E. (1996). *Bipolar Puzzle Solution: A Mental Health Client's Perspective*. Washington, DC: Taylor & Francis.
- Duke, P., & Hochman, G. (1992). *A Brilliant Madness: Living with Manic-Depressive Illness*. New York: Bantam Books.
- Green, M. F. (2001). *Schizophrenia Revealed*. New York: W.W. Norton.
- Greenberger, D., & Padesky, C. A. (1995). *Mind over Mood: Changing How You Feel by Changing How You Think*. New York: Guilford Publications.
- Hyman, B. M., & Pedrick, C. (1999). *The OCD Workbook: Your Guide to Breaking Free from Obsessive-Compulsive Disorder*. Oakland, CA: New Harbinger Publications.
- Jamison, K. R. (1993). *Touched With Fire: Manic-Depressive Illness and the Artistic Temperament*. New York: Free Press.
- Jamison, K. R. (1996). *An Unquiet Mind: A Memoir of Moods and Madness*. New York: Vintage.
- Jeffers, S. (1992). *Feel the Fear and Do it Anyway*. New York: Fawcett Books.
- Keefe, R. S. E., & Harvey, P. D. (1994). *Understanding Schizophrenia: A Guide to the New Research on Causes and Treatment*. New York: Free Press.
- Marsh, D. T., & Dickens, R. (1998). *How to Cope with Mental Illness in Your Family: A Self-*

- Care Guide for Siblings, Offspring, and Parents*. New York: Jeremy P. Tarcher/Putnam.
- Miklowitz, D. J. (2002). *The Bipolar Disorder Survival Guide: What You and Your Family Need to Know*. New York: Guilford Press.
- Mondimore, F. M. (1999). *Bipolar Disorder: A Guide for Patients and Families*. Baltimore: Johns Hopkins University Press.
- Moorman, M. (1992). *My Sister's Keeper: Learning to Cope with a Sibling's Mental Illness*. New York: Norton.
- Mueser, K. T., & Gingerich, S. L. (1994). *Coping with Schizophrenia: A Guide for Families*. Oakland, CA: New Harbinger (currently being revised for Guilford Publications).
- Nicholson, J., Henry, A. D., Clayfield, J. C., & Phillips, S. M. (2001). *Parenting Well When You're Depressed: A Complete Resource for Maintaining a Healthy Family*. Oakland, CA: New Harbinger Publications.
- Secunda, V. (1997). *When Madness Comes Home*. New York: Hyperion.
- Swados, E. (1991). *The Four of Us: A Family Memoir*. New York: Farrar, Straus and Giroux.
- Torrey, E. F. (2001). *Surviving Schizophrenia: A Manual for Families, Consumers and Providers* (Fourth ed.). New York: HarperTrade.
- Torrey, E. F., & Knable, M. B. (2002). *Surviving Manic-Depression: A Manual on Bipolar Disorder for Patients, Families, and Providers*. New York: Basic Books.
- Vine, P. (1982). *Families in Pain: Children, Siblings, Spouses, and Parents of the Mentally Ill Speak Out*. New York: Pantheon Books.
- Whybrow, P. C. (1997). *A Mood Apart: Depression, Mania, and Other Afflictions of the Self*. New York: Basic Books.

Woolis, R. (1992). *When Someone You Love Has a Mental Illness*. New York: Jeremy P. Tarcher/Perigee Books.

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