
Partnering With Families: Multiple Family Group Psychoeducation for Schizophrenia



Thomas C. Jewell

*Coordinated Care Services, Inc. & University of Rochester
Medical Center*



Donna Downing

Maine Medical Center



William R. McFarlane

Maine Medical Center & University of Vermont

Family psychoeducation (FPE) is one of six evidence-based practices endorsed by the Center for Mental Health Services for individuals suffering from chronic mental illnesses. Multiple family group psychoeducation (MFG) has been shown to be an effective component of FPE in reducing symptom relapses and rehospitalizations for individuals with schizophrenia. It is especially effective when family members participate on a consistent basis, which allows them to increase their understanding of the biology of the disorder, learn ways to be supportive, reduce stress in the environment and in their own lives, and develop a broader social network. When used in conjunction with medication, MFG can help an individual with schizophrenia progress towards the rehabilitation phase of recovery. A case illustration describes the engagement of a chronically ill, mid-thirties male in MFG and how his family's participation for 2 years benefits all members, in spite of the longevity of his illness. © 2009 Wiley Periodicals, Inc. *J Clin Psychol: In Session* 65: 868–878, 2009.

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Families constitute major sources of support and care for persons with severe mental disorders, such as schizophrenia and bipolar disorder (e.g., Lefley, 1989). This

Correspondence concerning this article should be addressed to: Thomas C. Jewell, Coordinated Care Services, Inc. (CCSI), Director, Evaluation and Services Research, 1099 Jay Street, Building J-3rd Floor, Rochester, NY 14611; e-mail: tjewell@ccsi.org

support does not come without consequence, as family members experience many challenges and needs as they attempt to provide long-term support and caregiving for their relatives (e.g., Lefley, 1989).

Psychoeducational treatments, that have been developed and supported by over 25 years of research, that address the needs of family members have consistently shown that clients' outcomes improve when the needs of family members are met. In spite of its clinical relevance and established effectiveness, family psychoeducation (FPE) is underutilized in clinical practice.

In this article, we overview the typical family experiences and needs, outline the principles of FPE, describe the practice elements of multiple family group psychoeducation (MFG), and summarize research about the clinical impact of addressing consumer and family needs via MFG. We also describe an MFG intervention for a family with whom the second author worked for several years.

Family Experiences and Needs

In studies conducted as early as the 1950s and 1960s, it was found that family members experience stress in dealing with a loved one with mental illness (e.g., Clausen & Yarrow, 1955). Researchers found that mental illness can affect family members across a range of domains, such as work, leisure, family health, children, and social relationships. Unfortunately, the situation largely remains the same as it was 20 years ago, when Chafetz and Barnes (1989) observed that the fundamental support services and resources that were provided in institutions "have not followed the chronically mentally ill to communities." As a consequence, family members are frequently called upon to provide these services informally for their ill relative, and they are estimated to provide as much as two thirds of the supportive care given to people with severe and persistent mental illness (Dorfman, 1991). As many as 65% of discharged psychiatric patients return to live with a family member (Goldman, 1982). Further, many families remain involved with their relative with psychiatric illness whether or not the relative lives with them (Carpentier et al., 1992).

Most research has been focused on parents, largely because parents are the family members who tend to have the most involvement with their children with mental illness (Lefley, 1987). Empirical studies suggest that curtailed activities, financial shortages, altered social relationships, high stress, marital strain, and burnout are among the problems faced by parents caring for a mentally ill child (e.g., Chafetz & Barnes, 1989). Concerns expressed by parents often include worry about their child's finances, feelings of helplessness, alarm over their child's dependency, confusion over how much assistance to offer, and wishing for their child to return to his or her "old self." There is increasing concern about what happens to the quality of life of people with psychiatric disability as their parents become unavailable to provide support and caregiving due to a lack of personal resources, disability, or death. A generation of parental caregivers for people with severe psychiatric disability will themselves become too old or disabled to be caretakers in the near future (Lefley, 1987). Without parental caregivers, the mentally ill who tended to rely on their parents may find themselves homeless, turning to additional family members for assistance, or needing more community services. Adult well siblings may be called upon to become caregivers for ill siblings when parents die or become disabled (Horwitz, Tessler, Fisher, & Gamache, 1992; Lefley, 1987).

Descriptive reports about siblings' difficulties of finding a balance between self-care and caring for one's family of origin emerged over two decades ago. Carlisle

(1984) wrote a book about the unique experiences of siblings of people with serious mental illness. One of the sibling participants in her book stated, "I'm stuck between feeling the responsibility of a parent and the not being responsible feelings of being a sibling who is just starting his life and should be living for himself" (p. 122). Since that time, numerous studies have documented adult siblings' concerns about the struggle of maintaining their own personal lives while simultaneously remaining involved with their ill family member (e.g., Marsh & Dickens, 1997).

Family Intervention for Severe Mental Illness

The Final Report of the President's New Freedom Commission on Mental Health (2003) stated that "too often, treatments and services based on rigorous clinical research languish for years rather than being used effectively at the earliest opportunity." The Freedom Commission report emphasized the importance of family involvement in the treatment of mental illness and recognizes specific family-based interventions as evidence-based practices. The main goal in working with families is to help them develop the knowledge and skills instrumental in promoting the recovery of their family member while eschewing family dysfunctional etiological theories of the past.

A strong consensus about the critical elements of family intervention emerged in the late 1990s under the encouragement of the leaders of the World Schizophrenia Fellowship (1998). The resulting consensus on the elements of effective family intervention was as follows.

- Coordinate all elements of treatment and rehabilitation to ensure that everyone is working towards the same goals in a collaborative, supportive relationship.
- Pay attention to the social as well as the clinical needs of the client.
- Provide optimum medication management.
- Listen to families and treat them as equal partners in treatment planning and delivery.
- Explore family members' expectations of the treatment program and for the client.
- Assess the family's strengths and limitations in their ability to support the client.
- Help resolve family conflict through sensitive response to emotional distress.
- Address feelings of loss.
- Provide relevant information for client and family at appropriate times.
- Provide an explicit crisis plan and professional response.
- Help improve communication among family members.
- Provide training for the family in structured problem-solving techniques.
- Encourage the family to expand their social support networks, e.g., participation in multifamily groups or family support organizations such as the National Alliance on Mental Illness.
- Be flexible in meeting the needs of the family.
- Provide the family with easy access to a professional in case of need if the work with the family ceases.

FPE for Schizophrenia

FPE for schizophrenia incorporates the principles outlined above and has been identified as an evidence-based practice by such organizations as the Substance Abuse and Mental Health Services Administration (SAMHSA), National Alliance

on Mental Illness (NAMI), and various state offices of mental health. An FPE toolkit developed by several leaders in the field (Family Psychoeducation Implementation Resource Kit, 2003) can be downloaded free of charge from the SAMHSA Web site (<http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/family/>).

Originally developed by Anderson, Hogarty, and Reiss (1980), FPE for schizophrenia involves intensive engagement efforts with family and client followed by extended education about the disease and guidelines for recovery based on research and best clinical practice. It pursues a careful, gradual process to promote a strong stable symptomatic recovery and relapse prevention, and it incorporates problem solving based on the needs and wants of both family and client. FPE emphasizes partnering and joining with family members (Anderson, 1983) and incorporating family members' and clients' goals as the core of the treatment plan.

FPE for schizophrenia was heavily influenced by findings that psychotic relapse is a major impediment to longer term clinical and functional improvement (e.g., Hogarty & Ulrich, 1977). But after roughly a year of remission, most people with schizophrenia make significant functional gains, are more resistant to stress, and can tolerate increasing mental and physical demands. This translates into working closely with the family, making coordinated efforts toward improved community participation, and using clinical condition as the guide to what a client can handle. Finally, FPE uses clinical skill and expertise in training families to assist in creating an optimal psychosocial environment for recovery from schizophrenia. Optimal environments are those that are somewhat quieter, less intense, and less complex than the world in general. Family members are assumed to be functional until proven otherwise (for example, by resisting or failing to use the treatment). Family members are instructed about and encouraged to implement specific strategies to create a low stimulation social environment to adapt to, and compensate for, the specific sensory and cognitive characteristics of a given disorder.

Multiple Family Psychoeducation Groups

The term *multiple family group psychoeducation* (MFG) refers to a specific FPE treatment that combines education about mental illness, family support, crisis intervention, effective communication strategies, and problem-solving training (McFarlane, 2002). MFG attempts to reflect contemporary understanding of schizophrenia and other severe mental illnesses from biological, psychological, and social perspectives.

MFG comprises three components that roughly correspond to the phases of the group. In the first phase, the therapist emphasizes joining with each family in a single-family format, conducting a multifamily educational workshop, focusing on preventing relapse and fostering social and vocational rehabilitation. Family members and consumers meet with two clinicians for 90 minutes on a regular basis (typically bi-weekly) and utilize a structured problem-solving format to guide the group process. The second phase involves moving beyond stability to gradual increases in consumers' community functioning. This usually occurs during the second year of the MFG. The third phase comprises deliberate efforts to mold the family into a social network that can persist for an extended period and satisfy family and consumer needs for social contact, support and ongoing clinical monitoring. This format is also an efficient context in which to continue psychopharmacologic treatment and routine case management. Expansion of the families' social networks occurs through problem solving, direct emotional support and out-of-group socializing, all involving members of different families in the group.

MFG is based on research showing that families attempting to cope with mental illness experience stressors that frustrate and discourage them. These responses often take the form of high-expressed emotion, in which relatives are highly critical or over-involved, a factor empirically shown to be associated with relapse (Hooley, Rosen, & Richters, 1995). Multifamily groups address social isolation, stigmatization, and increased financial and psychological burden directly. They achieve these by increasing the size and richness of the social support network, connecting the family to other families like themselves, providing a forum for mutual aid, providing an opportunity to hear the experiences of others who have had similar experiences and have found workable solutions, and building hope through mutual example and experience. A key component of MFG involves teaching families to implement the MFG Family Guidelines, which were developed for families based on the biology of the illness, to help them reduce stress in the environment and generally cope with the challenges of schizophrenia in the most calm and effective manner possible.

Many controlled studies have found MFGs to reduce relapse for people with schizophrenia, increase problem-solving skills, improve quality of life, and reduce burden among family members (e.g., McFarlane et al., 1995; Weiden et al., 1999). Programs fail to reduce relapse rates if they present information without also providing family members with skills training, ongoing guidance regarding illness management, and emotional support (e.g., Greenberg, Greenley, & Kim, 1995). Additionally, a meta-analysis of 16 studies found that family interventions of fewer than 10 sessions had no important effects on relatives' burden (Cuijpers, 1999). The behaviors and disruptions of schizophrenia, in particular, may require more than education to ameliorate family burden and enhance client outcomes.

A number of studies have shown markedly higher reductions in relapse and rehospitalization rates among adults with schizophrenia whose families received psychoeducation than among those who received standard individual services, with differences ranging from 20% to 50% over 2 years (e.g., Falloon, Held, Coverdale, Roncone, & Laidlaw, 1999). For programs of more than 3 months' duration, the reductions in relapse rates were at the higher end of this range. Overall, the relapse rate for clients provided FPE has hovered around 15% per year, compared with a consistent 30% to 40% for individual therapy and medication or medication alone (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998). In 11 of the most rigorously designed and conducted studies, with an average study duration of 19.7 months, the overall average for family intervention was about 27%, and for the control groups it was 64%, a reduction of about 58% of the standard or routine treatment rate (Baucom et al., 1998).

Many studies reported in the past few years have demonstrated significant effects on areas of functioning other than relapse rates (e.g., Cuijpers, 1999). These studies address a frequent criticism of the randomized clinical trials: that relapse is only one dimension of outcome. Many consumers and their family members are more concerned about the functional aspects of the illness, especially housing, employment, social relationships, and dating and marriage than about remission, a more abstract goal. More recently, several investigators have shifted focus to targeting these more human aspects of illness and life.

Case Illustration

Client Description

Sam had his first psychotic break at the age of 17, during his senior year in high school. He lived in a rural part of the state with a loving mother and two older

sisters; his father had abandoned the family when he was young. There were grandparents and other extended family members in his town who provided a supportive network throughout his youth. Sam was an average student with an active social life through sports, church, and school. He was well liked by classmates and was mentored by several teachers and coaches. His mother, sisters, and other family members attributed his periodic substance use and declining school performance during high school to being a teenage male.

When Sam became overtly psychotic and required a lengthy hospitalization, his immediate family received minimal information about his probable diagnosis of schizophrenia and how they could support one another and him during his recovery. His mother tried to hide his illness from friends and extended family members—she was overwhelmed and ashamed. She felt blamed for Sam's illness. When people asked her about Sam, she told them only that he had been hospitalized due to "exhaustion" and was taking time off.

At the time of discharge to his mother's home, Sam's positive symptoms of paranoia, delusional thinking, and auditory hallucinations had decreased, but had not completely subsided. Additionally, he experienced significant negative symptoms, which led to isolation and disinterest in activities. Because his mother advocated for school support, they eventually received funding for a tutor so that Sam could complete the requirements of his senior year and earn his diploma.

Once Sam received his diploma, his mother decided they needed to move so that the family could live closer to quality mental health services offered by an urban community. After selling their home, they moved 6 hours away to a small city. Her new professional job gave them improved insurance coverage, but by making this move, she and Sam left a supportive network of family and friends. His sisters had already moved away from home to attend college.

Sam's mother made friends at her new job; Sam spent his days watching TV and smoking cigarettes on the back porch of their condominium. His early efforts to work were brief and unsuccessful—he was able to get entry-level jobs, but he could not retain them. His family was not aware of existing vocational support services in their area. After a while, Sam stopped thinking about work, as did his family.

Fifteen years later, at the age of 33, Sam was receiving disability and still living with his mother in the condominium. During those 15 years, he had had multiple relapses and re-hospitalizations, mainly as a result of not taking his medications due to forgetfulness or discomfort with side effects. He spoke infrequently and used few words when he did communicate. His eye contact tended to be poor and his affect was generally blunted. His appearance was usually unkempt as evidenced by poor hygiene and soiled clothes. He continued to spend most of his time watching TV or smoking cigarettes on the back porch, but on occasion, he walked for long distances without a destination. His mother worried about his safety in the house, because he was forgetful when using the stove, and for his safety in the community when he wandered. She was concerned that he would be victimized, even though he had developed into a large man. Unfortunately, there was no one to check on Sam during the day because his mother worked and he had declined case management and other outpatient services other than quarterly medication management with a psychiatrist.

As she approached 60, Sam's mother began to feel a sense of urgency to find alternative treatments for him because of her concerns about being less able to care for him over time. She also did not want to burden Sam's sisters, knowing that distance and personal obligations made it difficult for them to be present in his life. Mother asked him if she could accompany him to his next session with his

psychiatrist, at which time she asked the doctor for recommendations for their situation.

Case Formulation

Through the years, Sam's illness had impacted his cognitive and functional abilities, as well as his insight into the nature of his mental health problems. Each psychotic episode left him less functional and less emotionally connected to others. He was disabled in every sense of the term. Unfortunately, because he had demonstrated little or no change for years, his prognosis was poor.

Although Sam's mother and sisters remained supportive and cared deeply about his well-being, they often felt unsupported by the mental health system and alone with their concerns about Sam's isolation, symptoms, and declining functioning. His mother tended to shoulder the blame for his illness because she lived with Sam. She also never talked about Sam or their situation to her friends. Family members rarely asked about him. His sisters remained involved with his life, but they each had successful careers in other states and were understandably focused on their professional and personal lives. Since his first psychotic episode, the family had not received much education about schizophrenia nor had they received guidance about handling specific illness-related situations, such as medication non-compliance and safety. They had come to accept Sam's disability and lack of assistance.

Sam's psychiatrist had worked with him for 6 years, during which time she had seen minimal change. His negative symptoms remained strong, with occasional relapses of positive symptoms. Most antipsychotic medications had produced uncomfortable side-effects, which had led to relapses in symptoms and three hospitalizations. Following each relapse, there had been a lengthy recovery, along with increased functional decline.

Course of Treatment

Sam's psychiatrist, who worked in an outpatient psychiatric clinic connected with a large teaching hospital, was familiar with FPE. She was more familiar with the MFG format of FPE than the single-family therapy (SFT) format because there were several groups running in the outpatient clinic. Through the years, several of her patients and their families had positive experiences with this treatment.

Sam's psychiatrist could tell that his mother was loving and supportive, but also tired from years of caring for Sam on a daily basis. She knew that Sam's family had essentially been dealing with his illness on their own for 15 years. She talked candidly with them about their situation, validating the mother's concerns. Although Sam had shown reluctance to engage in treatments that had been offered in the past, his doctor also knew that Sam's mother and sisters needed more current information about the biology of his illness as well as additional support from families who had lived with the illness. She suggested they try MFG, knowing they could quickly enter one of the clinic MFG's.

Sam's mother expressed interest in joining a MFG even though Sam was resistant. This was one instance when she did not concede to Sam, finally insisting that they try the group. Sam agreed to accompany her, saying he would do it as a favor to her. Mother felt more hopeful as well as relieved when the doctor told her that she was not to blame for Sam's condition. Then the doctor wrote a prescription for MFG.

Prior to attending a MFG, Sam reluctantly agreed to accompany his mother to meet one of the co-facilitators. Knowing Sam's history, the clinician viewed this first

appointment as an opportunity to meet Sam and invite him to participate in the session in a relaxed, non-threatening manner—requiring Sam to talk would only make him uncomfortable and would not encourage engagement. Therefore, after greeting Sam, the therapist mentioned that he was welcome to get up at any point to walk outside. Hearing that he was not expected to sit through a talking session seemed to reduce Sam's anxiety. He stayed for a few minutes and then left to smoke outside. The clinician continued the first "joining" session with Sam's mother alone.

Sam's departure allowed his mother to talk freely about her experience with Sam's illness, her grief and sadness about his quality of life, the impact of his illness on the family, her sense of shame and blame, and her embarrassment about Sam's behaviors. Throughout the conversation, the therapist gently validated the mother's feelings and actions. He reinforced that she had always done the best she could with available information and resources. Plus, she had continuously acted in a way that demonstrated her deep commitment to her son and daughters—often to the detriment of her own health and life plans.

Toward the end of the session, the clinician explained the format of MFG in greater detail, giving examples of how it could help their family feel less alone and less responsible for Sam's illness. He explained that the mother and sisters should plan to attend the Family Education Workshop the following month, where they would receive in-depth information about the biology of schizophrenia, medications, stress reduction, and the importance of following MFG Family Guidelines. Sam was invited to attend the workshop for as long as he could tolerate; he would be free to take breaks as needed.

The clinician stressed the importance of including Sam's sisters in the MFG process and asked to meet with them both prior to the workshop. He also scheduled another session with the mother to continue the joining process. At the same time, he asked Sam if he could spend a short time with him alone when his mother came for the next session. Sam agreed. Together, the clinician and mother outlined goals for her participation in the group, such as learning more about the illness, identifying warning signs of symptom exacerbation, taking time for her, and developing a network of support people who understood what she and her daughters had experienced for more than 15 years. The clinician emphasized that the family might experience immediate benefits from MFG participation and that changes might occur more slowly for Sam.

During the Family Education Workshop, Sam's mother and sisters gained a better understanding of schizophrenia by learning about the biology of the illness, different medications, and how to identify Sam's early warning signs of increasing symptoms. They also had opportunities to meet 5 other families as well as a few consumers. Sam chose not to attend the workshop, but his mother assured him that she would share what she learned when she got home. The classroom format of the workshop reduced the family's nervousness about being with other people while focusing on the topic of mental illness.

During the subsequent MFG meetings, which were held every other week on the same night and at the same time, Sam's family learned ways to keep stress low and the importance of doing things for themselves, such as taking a vacation with family and reconnecting with friends. Sam and his mother rarely missed a multifamily group during 2 years, and when Sam's sisters could join them, they did.

Initially, Sam's mother was easily embarrassed by his appearance and poor social skills. With gentle encouragement from the MFG co-facilitators she was able to ignore Sam's behaviors that embarrassed her. Sometimes, sitting away from Sam

during the group allowed her to relax more while simultaneously allowing Sam to have more autonomy. The clinicians modeled acceptance and a non-critical approach when interacting with all participants.

The gains that Sam made during the first year of attending multifamily group were subtle yet noticeable. During the first 6 months, he wore his coat regardless of the weather and did not make eye contact. He brought his own soda and declined snacks that were offered. He only offered his name during the check-in portion of the session. It was unclear whether he was listening to group conversations due to a lack of responsiveness. He took frequent smoking breaks but always returned to the group.

Over time, Sam began to show signs that he was listening to conversations. He occasionally took snacks. Parents of other consumers began to take an interest in him and often offered him suggestions in a non-threatening way. They understood his situation and illness. Sam began to make brief eye contact during the exchanges with group members. Eventually, he took his coat off when he entered the room. Toward the end of the first year, Sam was engaging in some humor with one of the co-facilitators, who asked him in a light manner each session if he would consider joining a different outpatient group that was just for men—the clinician suggested he would have fun and that the group would enjoy his company. Eventually, Sam smiled when the clinician brought up the subject of the men's group.

Outcome and Prognosis

A year later, Sam's mother looked healthier and claimed she was feeling less overwhelmed. During the previous year she had developed close relationships with the other families in the group, sometimes meeting them socially outside of group. Although Sam did not demonstrate major clinical improvements during the first year in multifamily group, he did show gains in his interpersonal skills with his family and other group members. During the second year, Sam made additional gains that involved more interest and success in his environment. For example, he left the house more often and walked to a nearby store to buy his cigarettes rather than rely on his mother to get them. The family reported that he was talking more and isolating less. Additionally, they felt they could include him in decisions that affected the whole family. For instance, during one MFG he worked with his family to develop a plan to keep stress low on the day one of his sisters was getting married. Another time, he agreed that the MFG participants could help him explore ways to be safer at home, especially when using the stove. Sam seemed less withdrawn and his family felt less alone with his illness.

Throughout his 2 years in the group, Sam did not experience a relapse or re-hospitalization, which was a significant improvement for him. Toward the end of the second year, Sam agreed to a referral for case management services and attended the outpatient men's group a few times. His mother was hopeful that he would consider an eventual move to an agency-run apartment living situation within a year—conversations had started around this topic both inside and outside of the multifamily group.

Clinical Issues and Summary

When working with individuals with schizophrenia, MFG can help all family members better understand the illness process while learning ways to cope with symptoms and prevent relapse. FPE offers families a new social network that shares

a common bond: schizophrenia. FPE is an evidence-based practice for schizophrenia, and a growing body of literature suggests that MFG is helpful with other diagnoses (e.g., Clarkin et al., 1998). When family members are given the information they need to understand the biology of their loved one's illness as well as guidelines for dealing with symptoms, they have a better chance of preserving their relationships and helping with the recovery process.

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