

## RECENT DEVELOPMENTS IN FAMILY PSYCHOEDUCATION AS AN EVIDENCE-BASED PRACTICE

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*Among potential resources for people with serious mental illnesses (SMI) and their families, professionally delivered family psychoeducation (FPE) is designed to engage, inform, and educate family members, so that they can assist the person with SMI in managing their illness. In this article, we review research regarding FPE outcomes and implementation since 2001, updating the previous review in this journal (McFarlane, Dixon, Lukens, & Lucksted, Journal of Marital and Family Therapy 2003; 29, 223). Research on a range of FPE variations continues to return mostly positive effects for adults with schizophrenia and increasingly, bipolar disorder. More recent studies include functional outcomes as well as the more common relapse and hospitalization. FPE research involving adults with other diagnoses is increasing, as is FPE research outside the United States. In both cases, uneven methodologies and multiple FPE variations make drawing conclusions difficult, although the core utility of access to information, skill building, problem solving, and social support often shines through. Since the previous review, several FPE programs for parents of children or youth with mood disorders have also been developed, with limited research showing more positive than null results. Similarly, we review the developing inquiry into early intervention and FPE, short-form FPE, and cost studies involving FPE. The second half of the article updates the paradox of FPE's evidence base versus its persistently low use, via recent implementation efforts. Multiple challenges and facilitating factors across healthcare systems and financing, individual programs and providers, family members, and consumers shape this issue, and we conclude with discussion of the need for empirical evaluation of implementation strategies and models.*

As part of this article series, we were invited by the American Association of Marital and Family Therapy to review developments in research and implementation of family psy-

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choeducation regarding serious mental illness (SMI) since our earlier article (McFarlane, Dixon, Lukens, & Lucksted, 2003). We refer readers to the 2003 article for the extensive description of the origins and initial development of family psychoeducation in its multiple variations and for summaries of earlier research. Herein we will integrate and critically review the range of published work regarding professionally delivered family psychoeducation (FPE) since 2001.

In addition to FPE, many other interventions exist to assist consumers in the context of their families, and family members themselves, regarding the challenges of SMI. These include peer-led community-based self-help programs (Dixon et al., 2004; Dixon, Stewart, Burland, Delahanty, Lucksted, & Hoffman, 2001; Pickett-Schenk, Cook, & Laris, 2000), provider-family consultation models, consumer-centered family models, and family psychotherapies (Dixon, McFarlane, & Lefley, 2001; Pharaoh, Rathbone, Mari, et al., 2010). Within this range of potential resources, this review will address only the clinical intervention of family psychoeducation. As a group of related models with common characteristics (Substance Abuse and Mental Health Services Administration [SAMHSA], 2009, World Schizophrenia Fellowship, 1998), FPE.

1. Assumes that most involved family members of individuals with mental illnesses need information, assistance and support to best assist their ill family member and cope with the challenges posed to the family system.
2. Assumes that the way in which relatives behave toward and with the person(s) with mental illness can have important effects on that person's well-being and clinical outcomes.
3. Combines informational, cognitive, behavioral, problem-solving, emotional, coping, and consultation therapeutic elements.
4. Is created and led by mental health professionals.
5. Is offered as part of a clinical treatment plan for a specific consumer.
6. Focuses primarily on benefitting consumer outcomes, but family-member outcomes (e.g., reducing distress) are also important.
7. Includes content about illness, medication, and treatment management; services coordination; attention to all parties' expectations, emotional reactions, and distress; assistance with improving family communication; structured problem-solving instruction, expanding social support networks, and explicit crisis planning with professional involvement.
8. Are generally diagnosis-specific, although cross-diagnosis models are being developed.

Around these core elements, FPE programs vary considerably: FPE may take place with just one family (individual family psychoeducation, I-FPE) or in multiple-family groups (MFG-FPE). The consumer may be included in all (most common), some, or no sessions. FPE may vary in the length of sessions, number of sessions, settings (clinic, inpatient, home-based), and overall time span (generally months or years). Different programs may also vary in how much they emphasize cognitive behavioral, informational, clinical, rehabilitation, and family systems theory and techniques. FPE programs seek to enlist the assistance of loved ones and train them to help a person with SMI manage their illness. "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" (Jewell, Downing, & McFarlane, 2009, p. 870).

As our previous JMFT article and other reviews since have argued, evidence that FPE benefits certain clinical outcomes has been established, particularly regarding people with schizophrenia. As a result, FPE has been deemed an evidence-based practice and has been included in various treatment guidelines for schizophrenia and other serious mental illnesses: The U.S. federal Center for Mental Health Services (SAMHSA, 2009), national Schizophrenia Patient Outcomes Research Team (PORT) report (Dixon et al., 2009), and the Presidents New Freedom Commission (Hogan, 2003). Unfortunately, this does not mean it is commonly available or fully utilized, as we will discuss. First, we will summarize and discuss empirical research since 2001 regarding a range of FPE interventions that address a range of participant groups, diagnostic categories, and outcomes.

## NEW OUTCOME RESULTS

Positive outcomes research continues to accrue for Family Psychoeducation. Below we synthesize outcome studies since the previous JMFT review (McFarlane et al., 2003), grouping research by diagnosis and population. Most research studies to date have evaluated FPE for a specific diagnostic group (e.g., adults with schizophrenia or youth with mood disorders). Therefore, the generalizability of each area of research to other audiences and disorders is unknown to date.

### *Family Psychoeducation Involving Adults with Schizophrenia*

Since the 2003 article, five research reviews have addressed FPE regarding schizophrenia (Jewell et al., 2009; Murray-Swank & Dixon, 2004; Rummel-Kluge & Kissling, 2008; Taylor et al., 2009; Zygmunt, Olfson, Boyer, & Mechanic, 2002). Taylor's is the broadest, surveying evidence for all services used by people with "longer-term mental health problems" in the British system, and concluding that family psychoeducation should be a central component of effective treatment of schizophrenia. Zygmunt's is the narrowest, reviewing only literature evaluating medication adherence effects published 1980–2000. It concludes that "interventions and family therapy programs relying on psychoeducation" were "typically ineffective" for that outcome.

Reviews by Murray-Swank and Dixon (2004), Jewell et al. (2009) and Rummel-Kluge and Kissling (2008) all come to similar conclusions: FPE as a clinical intervention for schizophrenia is now considered a solid evidence-based effective practice for reducing relapse and hospitalizations, and for several functional outcomes, especially in conjunction with effective psychiatric medication. Rummel-Kluge further concludes that "studies on psychoeducation in schizophrenia in real-world settings show results comparable to those in experimental settings."

In keeping with these conclusions, the US Dept of Health and Human Services SAMHSA includes McFarlane's Multiple Family Groups as an evidence-based practice and has released a "tool kit" developed by US leaders in the field to promote its widespread implementation (SAMHSA, 2009). Additionally, recently updated PORT treatment recommendations regarding schizophrenia state that family interventions should last at least 6–9 months and should include illness education, crisis intervention, emotional support and training for coping skills. They add that if delivery of this long an intervention is impossible or unacceptable, adults with schizophrenia and their family members then be offered a program of at least four sessions (Dixon et al., 2009).

*U.S. randomized trials regarding adults with schizophrenia.* Since the previous JMFT review, a Washington state team of researchers have published additional sets of results from a randomized trial of 97 adults with schizophrenia and their family members. The core study compared 2 years of McFarlane model multifamily FPE (MFG-FPE) against standard care, finding effects for relapse and negative symptoms (Dyck, Hendryx, Short, Voss, & McFarlane, 2002; Dyck et al., 2000). The recent publications report that the MFG-FPE condition participants showed no reductions in family burden (McDonnell, Short, Berry, & Dyck, 2003), significant decrease in consumer hospitalizations with no net increase in outpatient services use over the 3 years after baseline (Dyck et al., 2002; McDonnell et al., 2006), and significantly reduced family-member distress but no increase in family-member active coping nor perceived social support (Hazel et al., 2004).

Additionally, Mueser et al. (2001) published additional analyses from the randomized Treatment Strategies in Schizophrenia study ( $n = 528$  consumers + family members, Schooler et al., 1997) but was omitted from our previous review. TSS compared (a) 2-year supportive family management (SFM; monthly multiple-family information or support meetings) with (b) more intensive applied family management (AFM) involving individual in-home behavioral family therapy. Both ran alongside three medication regimens. The recent analyses found: (a) there was no effect in either condition on family burden, (b) consumer social functioning improved equally in both, (c) AFM was associated with family-member perceptions of lower family friction and rejecting attitudes toward consumers, and (d) there was no medication–condition interaction.

*New international randomized trials.* Internationally, family psychoeducation research has been proliferating, most recently focusing on family-member outcomes as its effectiveness regarding consumer relapse is accepted.

Six randomized trials of FPE addressing schizophrenia have been recently published from China: Ran et al. (2003) assigned 326 family members to usual care, enhanced medication management, or FPE plus medication management, in rural China, by randomizing conditions by township where participants lived. In addition to significantly improved knowledge and caring attitude among family members and increased treatment compliance among consumers in the psychoeducation + medication management condition, at 9 months, the relapse rate among consumers in that group (16.3%) was half that of the med-management only group (37.8%), and approximately one quarter of the rate of the control group (61.5%;  $p < 0.05$ ).

Among 96 families in Hong Kong, (Chien & Chan, 2004) found that a family-led mutual support group for families returned significantly greater benefit for consumer psychosocial functioning, use of mental health services, and rehospitalization over 1 year than either family psychoeducation group or usual care. Separately, Cheng and Chan (2005) randomized 64 family-member caregivers of people with schizophrenia in Hong Kong to evaluate a 10-week FPE program. They found significant improvement in family burden, self-efficacy and support after 10 weeks for FPE, over usual care. They did not measure consumer outcomes.

Chien and Wong (2007) compared 36 weeks of MFG-FPE to usual care, enrolling 84 family members of people with schizophrenia (also Hong Kong) in another randomized trial. MFG-FPE participants showed greater improvement in both family and consumer functioning, family self-perceived burden of care, and the number and length of participant rehospitalization in the year following the intervention. In a separate trial, Chien (2008) randomized 68 primary family caregivers of adults with schizophrenia attending one of two participating outpatient psychiatric clinics. The study again found significant benefit for 9 months of FPE (vs. usual care) for consumer and family functioning, reduced burden scores, and shorter hospitalizations, compared with a control group.

Chan, Yip, Tso, Cheng, and Tam (2009) randomized 73 consumer-family pairs to either a 10-session FPE group versus usual care. Results showed no significant between-group effects on consumer outcomes (medication adherence, mental status, or illness insight), but significant treatment effects for family-members' self-efficacy, satisfaction, and perceived family burden 6 months after the intervention's end with attrition by 12 months.

Viewed collectively, these recent trials suggest that FPE confers benefits over usual care participants in China as measured by various metrics of relapse, family reports of burden, aspects of consumer and family functioning, and family self-efficacy. Results regarding treatment compliance and medication adherence are less clear.

Beyond China and the United States, there are six randomized studies published since the previous JMFT review, some the very first from their country. Reported as the first evaluation of McFarlane style MFG-FPE in Australia, Bradley et al. (2006) compared outcomes for English-speaking (34 consumer-family member pairs) and Vietnamese-speaking (25 pairs) participants (schizophrenia spectrum), in part to investigate the feasibility of using the MFG model cross-culturally and cross-linguistically. Participants were randomized to case management versus case management plus MFG-FPE delivered with minimal cultural adjustments advised by an experienced Vietnamese therapist. The intervention utilized experienced clinicians, clinical supervision, and adherence to fidelity guidelines. There was significantly less relapse in the MFG-FPE condition (3 people or 12% vs. 9 or 36%) during the year of intervention, and a larger difference 6 months after it ended (6 people or 25% vs. 15 or 63%), fewer symptoms and better vocational functioning. In survival analyses, time to relapse was 890 days for those in the MFG condition versus 642 days for control participants, although the duration of relapse episodes were not significantly different.

Two Italian studies showed similar results. Magliano, Fiorillo, Malangone, De Rosa, and Maj (2006) had 34 clinicians trained in family psychoeducation select 71 families of consumers with schizophrenia to be randomized to a 6-month Falloon-model FPE program or a wait list. They found significant improvements in consumer social functioning and self-care, as well as

family-member social contacts and perceptions of professional support in the intervention condition. Family burden improved for both groups.

Carrà, Montomoli, Clerici, and Cazzullo (2007) chose random samples from a large pool of family members referred to a family support center for each of three conditions: treatment as usual (control), 24 weekly group information sessions, or the same group information sessions followed by two additional years of group FPE. Only compliance with standard care was significantly greater in the FPE group at 1-year, but this diminished by 24 months. While “expressed emotion” (EE) was more often reduced among those in the experimental condition, this effect also had dissipated after an additional year.

In Lahore, Pakistan, a randomized study of primary family members for 108 persons with schizophrenia (Nasr & Kausar, 2009), using a FPE variation translated into Urdu plus medication management, versus medication management alone. The FPE comprised 4 weekly 90-min family-only sessions followed by 5 monthly 30-min problem-solving sessions with both consumer and family member. Those in the FPE condition showed significantly greater reduction in burden 6 months after baseline (i.e., at the end of the intervention) than controls.

Also published in 2009, Kulhara and colleagues randomized 76 consumer-family pairs in India in which the consumer had schizophrenia, to either 9 monthly FPE meetings or 9 months of usual outpatient care. FPE participants showed significantly more improvement in psychopathology, disability, caregiver satisfaction with treatment, and perceptions of social support. There were no significant differences for treatment drop-out, relapse, caregiver-burden, or caregiver-coping. The authors also report that the program was practical to implement and not expensive (Kulhara, Chakrabarti, Avasthi, Sharma, & Sharma, 2009).

*Conclusions regarding randomized trials of FPE for schizophrenia.* Across these various cultures, languages, health systems, methodologies and intervention variations, it is clear both that there is not one “universal” family psychoeducation intervention in use and that the core concepts (see Introduction) across variations have robust effects for some clinical outcomes. Many randomized studies show positive results similar to those in the United States when adapting US-originated FPE models to other cultures, although others find no results. The prevailing US FPE variations may mesh better with certain cultures than others, but variable results may also be due to differences in the quality of cultural adaptations, or to other aspects of the studies’ design, FPE fidelity and delivery, outcome variables or measurement. There are not yet enough randomized international studies to discern global patterns, nor complete cross-cultural meta-analyses. FPE researchers could advance this work by testing cross-cultural hypotheses, perhaps via replication studies of successful cultural adaptations.

As more FPE more research regarding family-member outcomes is conducted, results about “family burden” are mixed. The finding that knowing about consumer suicidality contributes to family member perceived burden (McDonnell et al., 2003), if robust across other studies, could suggest that FPE, through educating participants about signs of suicidality and openly discussing it, can increase family member awareness and thereby *increase* burden. At the same time, FPE offers information, tools, and skills to navigate such stressors, which may potentially cancel out the increase because of greater awareness, leading to null findings. This could potentially be occurring with other burden-related issues as well. Additionally, family burden is not an outcome that FPE was expressly designed to address.

Given the accumulating randomized trials, the time is also ripe for conducting meta-analyses of FPE outcomes. Various meta-analyses of “family interventions” regarding schizophrenia have included types of FPE (e.g., Cuijpers, 1999; Pekkala & Merinder, 2002; Pharaoh et al., 2004; Pilling et al., 2002; Pitschel-Walz, Leucht, Bauml, Kissling, & Engel, 2001). Most conclude unequivocally that family interventions are beneficial and that longer interventions show more effect than shorter ones. However, these have all had to combine quite disparate family interventions, with FPE only one of many considered together. Therefore, separate meta-analysis specifically of FPE is now called for, despite the complexities involved because of variation in FPE interventions, fidelity, and research methods.

*Other outcomes research regarding FPE and schizophrenia.* Aside from randomized controlled trials, other FPE in various settings and countries indicates expanding international



interest in FPE. However, their interpretation is often impeded by methodological weaknesses, especially the absence of a control or comparison group.

Since 2001, two published studies from Japan indicate active inquiry into FPE. Sota et al. (2008) report no differences in the benefits of a shorter versus longer FPE course in post hoc analyses of an uncontrolled study. Second, in new analyses of previously collected data and a non-random usual care comparison group, Mino, Shimodera, Inoue, Fujita, and Fukuzawa (2007; total  $n = 54$ ) found substantial inpatient care cost savings in the 9 months after discharge among people with schizophrenia whose relative completed a 9-month family psychoeducation course, compared with those who did not, but no difference in outpatient care costs.

Weine et al. (2005) reported pre-to-post reductions in medication non-compliance and hospitalization and increases in family mental health services use in a mixed-diagnosis sample of 30 families in post-War Kosovo (comparison group). The authors note that nonetheless the study alone resulted in beneficial policy changes in Kosovo's health service.

Thara, Padmavati, Lakshmi, and Karpagavalli (2005) reported that their 6-session FPE program yielded a significant pre-to-post change only in "occupational disability" among 30 family members of people with schizophrenia in Chennai, India. They reported no changes in burden, depression or anxiety, although both significant and null results are impossible to interpret with no comparison or control group.

Researchers in Thailand also reported improvements in attitudes and knowledge among 91 "family caregivers" of people with schizophrenia after a 1-day FPE workshop (Worakul, Thavichachart, & Lueboonthavatchai, 2007) but again without control or comparison group.

Additionally, Michelle Sherman in the United States has begun to evaluate the SAFE family program she and colleagues developed within the Veteran's Administration (VA). SAFE is a rotating series of 14 monthly cross-diagnosis workshops created within the VA for family members of veterans with serious mental illnesses (Sherman, 2003). As such, it is more education than therapy. Using a (uncontrolled) within group design, she found that the number of workshops attended was positively correlated with improved understanding of mental illness and available VA resources. Further, participant improvement (pre to post) in self-care was positively related to number of workshops attended. Later similar work (Sherman, 2006) confirmed these findings, reported high levels of participant satisfaction and attendance, and found an inverse correlation between attendance and caregiver distress.

#### *Family Psychoeducation Regarding Adults with Bipolar Disorder*

A broad review of family interventions regarding bipolar disorder among adults (Reinares et al., 2002) concluded that published studies recommend them in conjunction with medication to reduce relapses and hospitalizations and benefit functioning. However, it also emphasized that available research at that time had many limitations, such as frequently including no-control designs, and small and biased samples, and lack of follow-up over time. These thoughts were echoed in reviews by Murray-Swank and Dixon (2004) and Sajatovic, Davies, and Hrouda (2004). Miklowitz (2008) concluded that families where one or more members have bipolar disorder should receive 12 weekly sessions of psychoeducation, plus 6 bi-weekly sessions of communication enhancement training, 3 monthly sessions of problem-solving training (total 9 months) and access to a crisis intervention program. Additionally, The American Academy of Child and Adolescent Psychiatry now includes family psychoeducation in its guidelines for the treatment of bipolar disorder (McClellan, Kowatch, Findling, and Work Group on Quality Issues, 2007).

In the 8 years since the previous JMFT review of FPE, three randomized controlled studies have added to this discussion: Miklowitz, George, Richards, Simoneau, and Suddath (2003) randomly assigned 101 people with bipolar disorder to 9 months of FPE plus pharmacotherapy or to a less intensive crisis management intervention plus pharmacotherapy condition. Over 2 years after baseline, family-focused therapy condition participants experienced fewer relapses (35% compared to 54% among controls), longer intervals between relapses, reduced mood disorder symptoms, and better medication regimen adherence (which may have mediated the symptom effects).

Miklowitz et al. (2007) also headed a study of 293 people with bipolar disorder who were randomly assigned to either "intensive psychotherapy" or a "collaborative care" control. The

“intensive” condition provided each participant with one of three forms of therapy, one of which was Family Focused Therapy, a variation in FPE, weekly or biweekly over 9 months. The “collaborative” control condition consisted of three educational sessions over 6 weeks. Those in the intensive condition were significantly more likely to be well during any given study month and had significantly shorter time to recovery. Family-focused therapy showed no more or fewer significant results than the others (CBT, Interpersonal and Social Rhythm Therapy).

Rea, Miklowitz, Tompson, and Goldstein (2003) conducted a small randomized trial, comparing FPE to individually focused treatment over 9 months. They found less re-hospitalization and fewer relapses (across 2 years) among those in the FPE condition.

Additionally, a study from Spain (Reinares et al., 2009) represents a new stage of research regarding FPE and people with bipolar disorder—specifying for whom, under what conditions, in which configurations, does FPE have what beneficial effects. Reinares examined whether consumers’ response to FPE is related to their time since illness onset. In post hoc analyses from a previously published randomized controlled trial of 113 participants, FPE was found to lengthen the time to next relapse for recently diagnosed participants but not for others.

#### *Family Psychoeducation Regarding Adults with Other Conditions*

Since our previous JMFT review, a few studies have been published evaluating FPE for adults with diagnoses other than schizophrenia or bipolar disorder. Methodologies and rigor vary. Below we briefly summarize these by diagnostic category.

*Eating disorders.* Uehara, Kawashima, Goto, Tasaki, and Someya (2001) conducted a pre-to-post (no control group) pilot of MFG-FPE for anorexia among 37 participants. They concluded that the intervention may have improved family-member “mood state” and “emotional over-involvement” but that reduced consumer anorexic behaviors were a result of passing time not FPE.

*Obsessive-compulsive disorder (OCD).* Steketee and Van Noppen’s (2003) review of research on family issues regarding obsessive and compulsive disorders among adults cited three anecdotal reports from the 1990s in which clinicians found FPE to be useful (no data reported) and recommended outcomes research. This review also describes FPE as fluidly related to family-member roles as clinical treatment agents because of the frequent practices of training family members in behavioral techniques for OCD to apply at home. For example, Grunes, Neziroglu, and McKay (2001) reported a small ( $n = 28$  consumer-family pairs) study in which all consumers received individual OCD treatment and half also had a family member participate in a FPE-like “8 week family intervention group” designed to help reduce family accommodation of OCD symptoms. Those in the family condition showed greater reduction in OCD and depression symptoms; their family members showed greater reductions in family accommodation, anxiety, and depression at immediate post and 1 month.

We found no additional studies answering Steketee & Van Noppen’s, (2003) call for rigorous research evaluating FPE for OCD. The only exception was their own (Steketee & Van Noppen, 2003)—a small uncontrolled study of MFG-FPE for families of 19 adult OCD patients, lasting 10–12 weeks with 6 monthly follow-up sessions. They reported that OCD symptoms were significantly reduced and family functioning improved after the intervention, but again the lack of a control group is problematic.

*Dual diagnoses.* Similarly, Moore’s (2005) review notes that there has been very little research on FPE interventions designed for people with both mental illness and substance abuse diagnoses. In its absence, they argue that ample evidence for FPE regarding mental illnesses generally and for various family interventions regarding substance abuse logically imply that FPE would be helpful regarding dual diagnosis. They cite the one published study (Mueser & Fox, 2002) describing and providing pilot evaluation data on Family Intervention for Dual Diagnosis (FIDD), a FPE program specific to dual diagnosis. Since then, Mueser et al. (2009) have reported on engagement and retention correlates in a randomized controlled trial comparing 9–19 months of FIDD to a 6–8 week less structured FPE program but have not yet published outcomes. They found initial engagement quite high and correlated with family-member characteristics (especially perceived benefit of their relationship with the consumer). However,

retention in FIDD was lower and more strongly correlated with consumer factors, especially male gender and less severe drug addiction.

*Posttraumatic stress disorder (PTSD).* Sherman's initial needs assessment work (Sherman, 2003; Sherman et al. 2005; Sherman, Blevins, Kirchner, Ridener, & Jackson, 2008) led her and colleagues to create a 9-month FPE program within the Veterans' Administration (VA) that substantially addresses PTSD (called REACH; Sherman, Fischer, Sorocco, & McFarlane, 2009) based on the McFarlane multiple-family group model. While no outcomes have yet been *published*, the team recently presented initial data showing REACH participation to be significantly associated with increased knowledge, empowerment, coping, improved relationships and reduced symptoms among family members and veterans with PTSD (Sherman et al., 2009). The authors also reported success with a suite of intensive engagement strategies they have developed (Sherman, Fischer, Sorocco, et al., 2009). Interestingly, they report that VA offices of mental health services initiated 19 projects to implement family psychoeducation between 2005 and 2007 (Sherman, Fischer, Bowling, Dixon, Ridener, and Harrison, 2009), but this team is the only group from whom we found published work on FPE and PTSD.

*Traumatic brain injury (TBI).* In a review of evidence for family interventions generally after "acquired brain injury" and several other serious health conditions, Boschen, Gargaro, Gan, Gerber, and Brandys (2007) concluded that "At present there is no strong research evidence supporting any specific intervention method for family caregivers of individuals with TBI . . . although an abundance of anecdotal, descriptive, and quasi-experimental support exists in the rehabilitation literature" (p. 19). A review of TBI rehabilitation (Gordon et al., 2006) came to the same conclusion (both generally and regarding FPE in particular), noting limited efficacy studies and the relative youth of TBI as a specialty field and calling (as does Boschen et al. (2007)) for solid foundational research.

We found only one study addressing FPE outcomes regarding TBI: Rodgers et al. (2007) conducted a mixed-methods evaluation of MFG-FPE (12–18 months long) adapted for people with brain and spinal cord injuries and their families. This study began with a modest sample of 27 injured persons and 28 of their family members. It suffered from serious drop out from both conditions and had no control or comparison condition, so its results are hard to interpret. Rodgers found significant pre-to-post reduction in depressive symptoms and anger, improvement in life satisfaction among the injured individuals, and significant burden reduction among their family members. The qualitative data emphasized normalization, information, coping improvements, and the importance of socializing.

### *Conclusions Regarding FPE for Adults*

Overall, the pattern of findings across this wide range of adult mental health problems speaks to the common functions that family psychoeducation plays in people's lives. While each individual's and family's experience is unique, and tailoring the psychoeducation to certain aspects of a diagnosis, sociocultural group, or setting is important for effectiveness, it is clear that the usefulness of information, skill building, problem-solving, social support, and reducing social isolation are common across these variations. Rodgers et al. (2007) point out that diverse diagnoses involve common personal experiences such as family and personal disruption; changed family roles, boundaries, possibilities and expectations; relationship, role, and economic strain, challenges navigating the mental health system and treatments; social isolation and stigma. FPE may help consumers and families weather these and maximize their quality of life.

### *Family Psychoeducation for Children with Mood Disorders*

Since the previous JMFT review there has been additional research regarding MFG-FPE with children and their parents, differentiating it from general family involvement in their children's treatment (McDonnell & Dyck, 2004). One review supports FPE as helpful in reducing family tensions and dysfunction and fostering more effective use of professional services (Diamond and Josephson, 2005), although there have been null findings as well (Ruffolo, Kuhn, & Evans, 2005).

Most prominently, Mary Fristad and various colleagues have created both individual and multi-family FPE interventions for children with mood disorders and their parents, as adjuncts to



clinical treatment (Fristad, 2006; Fristad, Gavazzi, & Mackinaw-Koons, 2003; Klaus & Fristad, 2005). Their initial evaluation research has been promising. The first, a small randomized trial (35 children + available parents; Fristad, Goldberg-Arnold, & Gavazzi, 2002) reported that families in the MFG-FPE condition (compared to usual care) showed significantly greater improvements in knowledge, skills, support, and attitudes after 6 months of group meetings, and again 4 months later. However, because this study's hypothesis focused on testing differential characteristics of families with a child diagnosed with depression versus with bipolar disorder, details of the treatment effect results are not clearly presented. Similarly, their 2003 randomized trial (Fristad, Goldberg-Arnold, & Gavazzi, 2003) more clearly found increased knowledge, relevant services use, and positive family interactions reported by parents, as well as increased support from parents reported by children, among participants in the MFG-FPE condition.

In contrast, Ruffolo et al. (2005) developed and tested (randomized trial,  $n = 94$ ) a 9-month MFG-FPE intervention regarding children with serious emotional disturbances (SED), using a combined professional and parent leadership model compared with treatment-as-usual. They found that parents in both conditions gained more help from others over time and that overall child behavior significantly improved over time. However, there were no significant differences by condition.

Cummings and Fristad (2007) hypothesized that children with mood disorders and their parents completing a MFG-FPE intervention would show less variance in the number of medications prescribed as the intervention helped them become better consumers of medication related services and information. They randomized 165 such children and their parents to the MFG-FPE intervention or to a 1-year wait list (both in addition to usual care and medication management). The authors report that group variances moved in the hypothesized directions, but the difference was not significant. Also, once the wait-list group completed its (delayed) MFG-FPE treatment, a single-sample test collapsing groups showed significantly reduced variance, but with no control group, it is not possible to attribute it to the MFG with certainty. In separate analyses of the same data (Mendenhall, Fristad, & Early, 2009), families in the MFG-FPE condition showed significantly greater improvement in treatment beliefs and relevant knowledge, and in the children's mood symptoms. There were no differences in parents' ratings of service effectiveness between conditions.

Also recently, Sanford et al. (2006) published results of a modest ( $n = 41$ ) randomized controlled trial of a 24-month home-delivered FPE model based on Falloon's and Miklowitz' models among Canadian adolescents with major depressive disorder. While one site withdrew because of lack of participant engagement, the other had excellent participation. FPE condition participants showed significantly greater social functioning, family relationship improvements, and treatment satisfaction compared with usual care only controls.

In summary, research regarding FPE addressing children's mood disorders shows beginning evidence of positive effects over usual care, but variations in the interventions, their documentation, small samples, research designs, and measurement make conclusions difficult. This area has progressed since McDonell & Dyck's, 2004 review and is promising, but many of the same themes still hold.

### *Early Intervention and FPE*

Continuing a theme evident since the late 1990s, research in schizophrenia has increasingly focused on the earliest phases of onset, elucidating predictors and predictability and effects of early intervention. From the perspective of FPE, some advances have occurred. Work in the 1990s by Hooley and Richters (1995; Falloon (1992) and others indicated that dysfunctional family patterns (including "expressed emotion") tended to develop alongside the family member's illness (usually schizophrenia) rather than precede or cause it. For example, McFarlane and Cook (2007) found a very low level of rejection and a high level of warmth among 100 families of youth in the prodromal phase of psychosis, compared to samples with longstanding illness. The idea that negative family dynamics observed among families where someone has schizophrenia largely result from the stresses and negative consequences of the illness has led a few research groups to include family psychoeducation in clinical approaches to treat early psychosis or to prevent its manifestation after prodromal signs. They reason that providing infor-

mation, support, coping skills and problem-solving resources to consumers and their families at an early point may (a) reduce the trauma of illness onset and (b) prevent development of or ameliorate maladaptive familial patterns, thereby positively impacting outcomes for consumers and family members.

Two Scandinavian studies have thereby incorporated variations in FPE into their respective multisite early intervention studies. In Denmark (Jorgensen, et al., 2000; Nordentoft et al., 2006; Thorupa et al., 2005), the OPUS study recruited a first-episode sample and randomized participants and a family member to MFG-FPE plus family-aided assertive community treatment (FACT, McFarlane, Stastny & Deakins, 1992) or to standard treatment that included neither. Those in the experimental group showed lower suicide rates, negative symptoms, consumer substance abuse and family burden than controls after 2 years (Jeppesen et al., 2005; Petersen et al., 2005). Importantly, in an OPUS subsample of people with schizotypal personality disorder without a previous psychotic episode, those in the intervention condition had half the rate of onset of initial psychotic episodes over 2 years as the control group. Other authors have found family interventions to be beneficial in first-episode situations as well (Addington, McCleery, & Addington, 2005).

In Norway, the TIPS study compared outcomes for adults experiencing their first psychotic episode in counties with early intervention to counties with intervention beginning in a usual (later) manner and timing. The treatment for all participants consisted of multifamily psychoeducation groups with added social skills training, in a quasi-experimental design (Fjell et al., 2007, 2007; Johannessen, Larsen, McGlashan, & Vaglum, 2000). However, fewer than half of 301 consumers participated; reluctance to participate increased with age (Fjell et al., 2007). Though treatment was well received by those who did take part, there was a long (6–12 months) delay in initiating MFG-FPE, largely erasing any advantages of early family intervention. The authors concluded that in the first episode, “care should be taken to prevent a long delay before group commencement at this stressful period.” (Fjell et al., 2007, p. 171) Earlier intervention in the experimental territories was associated with lower symptom levels and fewer severe symptomatic syndromes compared to control (later treatment) areas, suggesting that outcomes might have been improved by earlier family intervention.

Similar FPE work is now being done in the United States. The Portland Identification and Early Referral (PIER) is a community-wide public health system for preventing psychosis. (McFarlane et al., 2010) It shares many elements of the TIPS, OPUS, and other early intervention studies, including MFG-FPE, FACT, psychotropic medications, and supported employment and education. A clinical trial, titled Early Detection and Intervention for the Prevention of Psychosis, is underway to test this model in six U.S. cities among diverse populations representative of the U.S. population for a variety of functional clinical, family, and public health measures are anticipated in 2011 (see <http://www.changemymind.org>).

### *Short Format FPE*

Numerous practitioners have designed shortened variations of family psychoeducation in attempts to make a more attractive, efficient, and feasible intervention. This is a valuable possible strategy for increasing accessibility, but to date, the research evaluating them is sparse, often with poor methodologies that cloud the interpretation of results. Therefore, conclusions about whether and for whom or for what outcomes brief FPE is effective are premature.

For example, in Sweden, Berglund, Vahlne, and Edman (2003) compared Falloon-based Behavioral Family Therapy (BFT) to the hospital’s standard family information sessions, during the consumer’s inpatient psychiatric stay. Via a mix of non-random and random assignment, 14 families received brief BFT and 17 received the usual care for the period the consumer was in the hospital (average 4–6 months). Those who received BFT were significantly more likely to have reduced medication dosage, less likely relapse within 1 year, and less likely to report resigned or rejecting caregiver attitudes.

de Groot, Lloyd, and King (2003) also tested a short-format (one full day + 2 hr every other week for 5 months) FPE intervention ( $n = 27$ ) via an Australian “quasi-experimental study with a matched [comparison] group using a retrospective chart audit and telephone sur-

vey” (p. 20). They reported that the format and content of the group varied over time because of personnel changes. No significant difference was found in the number of psychiatric readmissions over 7 years or in total days spent inpatient.

Yamaguchi, Takahashi, Takano and Kojima (2006) evaluated a very short FPE intervention (three to four 2 hr sessions over 2 months) for relatives ( $n = 46$ ) of individuals receiving inpatient care for schizophrenia in Japan. While they reported decreases in anxiety, subjective burden, distress, and relationship difficulties (pre to post), the absence of a control or comparison group makes it impossible to evaluate whether these changes are because of the intervention, the hospitalization, or other factors.

### *Cost Studies*

Given that relapse is often managed through inpatient hospitalization or crisis services and involves serious life disruption for the consumer and family members, the potential savings in pain, worry, healthcare costs, and lost productivity of reducing relapse are staggering. While distress avoided may be hard to capture, in the past decade, several studies have suggested that FPE is cost-effective: (a) recent analysis of relapse data among people experiencing first episode psychosis found that FPE can be cost neutral or cost savings compared to usual care. This was true for longer-term outcomes, even when the real-life clinical benefits of FPE were assumed to be only 10% of the research effects (Breitborde, Woods, & Srihari, 2009). (b) A 2007 Japanese post hoc study (Mino et al., 2007) reported that average total medical costs were 500,000 yen in the psychoeducation group ( $n = 30$  consumer-family pairs) and 710,000 yen in the non-matched comparison group ( $n = 24$  pairs). (c) Finally, an Australian study compared the cost impact of “routinely introducing [three] family interventions as an “add on” to current practice, compared to current practice” (p. 512): behavioral family management, multifamily groups, and behavioral intervention for families. They calculated that all three were cost-effective in averting disability-adjusted life years if one accepted their posited monetary valuing of clinical outcomes (Mihalopoulos, Magnus, Carter, & Vos, 2004). Thus overall, while cost analyses of FPE are just beginning, initial indications are positive.

Assessing the cost efficiency of FPE is an important determinant of its future use. Many programs or systems worry about being able to afford the professional staff time to organize and lead it. Thus, it would be advantageous if cost were routinely included in FPE effectiveness studies, as a systems level outcome. In particular, cost analysis of large-scale implementation efforts is needed. For example, if a fairly sizeable, self-contained, and vertically integrated healthcare system—such as a managed care organization, a Veterans Health Administration system, or a county or state public system—could implement FPE well *and* track system-wide costs, then actual cost changes across diverse parts of its system in response to FPE could be measured, showing the field under what conditions FPE is cost neutral or cost-effective.

## RELATIONSHIP OF FPE TO THE MENTAL HEALTH RECOVERY PARADIGM

As the recovery model penetrates more thoroughly into mental health services and evaluation, it is becoming clear that the outcomes associated with FPE benefit not only consumers’ clinical profile but also wider quality of life domains. Clinical stabilization is not an end itself, but rather an important foundation for and means toward functional and personal recovery and quality of life (Schooler, 2006). This is embodied in FPE’s goals of equipping family members and consumers with information, skills, problem solving strategies, and ways to optimize “natural supports” to more effectively address the real-life challenges of living with mental illness. For example, Resnick, Rosenheck, and Lehman (2004) reanalyzed data from the initial Schizophrenia PORT client survey (825 persons with schizophrenia) and found that having received family psychoeducation in the past year was significantly related to three of four recovery domains they evaluated (hope, knowledge, and empowerment, but not quality of life as measured).

At the same time, as Glynn, Cohen, Dixon, and Niv (2006) discuss, many family psychoeducation interventions—like many mental health services—retain some aspects of old thinking, particularly via a “patient being treated for a chronic illness” stance, rather than “consumer

assuming as much responsibility as possible for his or her recovery”(p. 451) or implicit assumptions about family constellation and consumer goals. A parallel lag in FPE research is evident in that some recent studies include personal daily functioning and quality of life domains as outcomes while others remain focused on only narrow clinical variables. Future practice and research regarding FPE need to more consistently reflect the mental health recovery paradigm to ensure that the intervention and its evaluation address consumers’ and family members’ real-life concerns and aspirations (Frese, Stanley, Kress, & Vogel-Scibilia, 2001; McFarlane et al., 2003).

## IMPLEMENTATION PARADOX AND FUTURE RESEARCH

A large number of studies have demonstrated decreased relapse and rehospitalization rates among people with mental illnesses who, with their family members, received FPE, compared to those who received “usual care” without FPE (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Dixon, Adams, & Lucksted, 2000; Dixon & Lehman, 1995; Falloon, Held, Coverdale, Roncone, & Laidlaw, 1999; Lam, 1991; McFarlane & Lukens, 1998; Penn & Mueser, 1996; Pitschel-Walz et al., 2001). Other outcomes, especially for certain functional and family results, have growing evidence as well. And, as discussed earlier, therapeutic family interventions broadly defined have shown positive effects across numerous meta-analyses. Currently, the evidence base for FPE is robust and is expanding across multiple continents and new diagnostic and demographic populations. As a result, numerous treatment standards, particularly regarding schizophrenia, have recommended that families of people with serious mental illnesses have ready access to FPE (Dixon et al., 2009; Frances & Kahn, 1996; Herz, Liberman, & Lieberman, 1997; Lehman et al., 1998).

Nonetheless, the non-dissemination and non-accessibility of family psychoeducational interventions is distressing and much discussed (e.g., Cohen et al., 2008; Glynn et al., 2006; Murray-Swank & Dixon, 2004). Almost 10 years after the previous JMFT review, the vast majority of families still have no access to any effective version of FPE. The reasons are multifaceted and parallel problems of integrating new evidence-based practices (EBPs) into “usual care” mental health services more broadly (National Institute of Mental Health, 1991). Some are discussed below.

### *Healthcare Financing and FPE*

Positive clinical outcomes and potential cost-effectiveness have been insufficient to ensure FPE’s widespread availability. Insurers, public or private or commercial rarely reimburse for family intervention (Hogarty, 2003). Economically stressed mental health providers and healthcare systems experience real disincentives to offering FPE (Hogarty, 2003). Even when the Medicare carrier for the northeast U.S. did develop reimbursement codes for FPE (e.g., allowed billing or reimbursement for it), this only promoted implementation when specific regional efforts also actively advocated and supported it (Drake, Becker, Goldman, & Martinez, 2006; McFarlane, McNary, Dixon, Hornby, & Cimett, 2001).

Recent reforms in U.S. health care financing, particularly national mental health parity (Public Law 110–343) and 2010 national healthcare reform, may help the feasibility of widespread FPE implementation in this country. Under healthcare reform, more U.S. citizens should have private health insurance, and parity could induce more insurance providers to cover FPE and other psychoeducational interventions. Healthcare organizations may then be more likely to offer FPE and psychoeducation in general as ways to improve outcomes and lessen the need for more expensive services.

### *Implementation Challenges*

Beyond financing, FPE fits only one of four criteria for innovations likely to be rapidly diffused (Rogers, 1987): although FPE clearly offers a *relative advantage*, it is not *compatible* with many clinicians’ theoretical training; it is more *complex* than standard individual treatment, at least until it has been learned; it is not readily *trialable*; and the outcomes, by design, emerge over the long term and are so not readily *observable*. For example, FPE was one of five clinical practices implemented in multiple states through the SAMHSA National Evidence Based Practices project. McHugo et al. (2007) report that FPE was among the three practices to average

at or above the project's acceptable fidelity threshold. However, as detailed in Bond et al. (2009; table 1, p. 574), only 6 of 53 sites attempted to implement FPE; 3 did so successfully, 1 less than successfully, and 2 discontinued efforts before a full implementation attempt. In another instance, the idea that clinical practice should be guided by evidence was ranked as the least influential factor in practice decisions among more than 500 clinicians in Maine and Illinois (McFarlane et al., 2001). Holding that belief correlated with poor implementation of FPE. A significant proportion of the U.S. mental health system, and other countries (Montero, 2010), is not oriented toward, and perhaps is unaware of, these models and their evidence.

Family psychoeducation also poses psychological and practical barriers for its users. Anecdotally, some family members fear being stigmatized through identification with FPE programs, or lack confidence in mental health providers because of past negative experiences or misconceptions about mental health and recovery. Consumers may be reluctant to further burden family members by asking them to attend. Consumers are also often wary of FPE out of a desire for privacy, discomfort with being talked about when not present, and skepticism of efficacy (Murray-Swank et al., 2007). Families have many competing responsibilities, making scheduling, travel distance, time commitment, and emotional demand considerable factors (Sherman et al., 2008).

Additionally, some families have been coping on their own for many years and misinformation, passivity, or maladaptive patterns may have solidified among them. This highlights the importance of easy access to effective family information, skill and support interventions early in a person's experience with mental illness. It also points out the importance of training and practice in engaging and joining with a diversity of family members and situation among those (therapists, case managers, outreach workers) involved in FPE.

These problems are not limited to the United States. A 2003 postal survey of mental health administrators in Germany, Austria, and Switzerland found that while 86% of the responding institutions reported offering psychoeducation to consumers and family members, only 21% of consumers and 2% of family members had taken part in any psychoeducation sponsored by an institution in the past year (Rummel-Kluge, Pitschel-Walz, Bauml, & Kissling, 2006).

Across diverse efforts, FPE implementation strategies have included academic detailing, motivational interviewing, stakeholder consensus building, and development of multifaceted implementation "tool kits" and assessment of practical barriers (e.g., Bond et al., 2009; SAM-HSA, 2009; Sherman et al., 2008; Sherman, Fischer, Bowling, et al., 2009; Sherman, Fischer, Sorocco, et al., 2009; Torrey et al., 2001). However, there has been too little empirical evaluation of the impact of these and other implementation strategies under various conditions to know their predictive merit (McFarlane et al., 2001; Magnabosco, 2006).

It is likely that no one implementation strategy will suffice. A recent Veterans Administration Forum concluded that multilevel leadership support, training in family psychoeducation models for managers and clinicians, systemic expectations, adequate resources including financing for the implementation process, including ongoing innovation leaders with time to address inevitable real-life operational and psychological barriers are *all* needed for FPE implementation (Cohen et al., 2008). This has have been echoed in other work (Drake et al., 2001; Drake et al., 2006).

In the recent decade, several large-scale FPE implementation efforts seem more successful, although no implementation data or evaluations have been published, so information is only anecdotal. The Scandinavian TIPS & OPUS studies (discussed above) reportedly sparked diffusing of MFG-FPE in Norway and Denmark, via communication of positive experiences among mental health colleagues (W. McFarlane, personal communication, May 2010), but there are no statistics available. Similarly, the New York State Office of Mental Health's (2006) statewide implementation efforts of FPE beginning in 2002 was reportedly successful through a coalition of county and private non-profit mental health centers, and by including NAMI chapters, county mental health administrations, large providers, state associations of provider, and an academic partner (New York State Office of Mental Health, 2006). But this success is measured very modestly: between 2003 and 2006, 37 agencies received training, of which 60% implemented at least one FPE group. In Michigan, initial success in one county reportedly sparked a statewide multifaceted initiative to implement FPE, while in northern California,



healthcare provider Kaiser-Permanente implemented FPE widely (W. McFarlane, personal communication April 2010). There is as yet no publically available documentation or evaluation for either.

Implementation challenges have been a main impetus for the development of FPE short forms (Berglund et al., 2003; de Groot et al., 2003; Yamaguchi et al., 2006, discussed above). As these are more rigorously evaluated and refined, they may contribute to making FPE more accessible. The development of other FPE variations, such as formats that are flexible and/or tailored to a specific family's needs and phone, video, and internet delivery, is also a potentially valuable innovation to increase FPE's reach. However, none have been well tested. Thus, this is an important area of future development and research.

## CONCLUSION

One lesson to draw may be that FPE implementation must be tailored to each situation (Sherman, Fischer, Sorocco, et al., 2009). Healthcare service structures vary considerably among countries and regions, as do consumers, their families, cultural meanings and assumptions regarding mental illness, and the processes of adopting new health care. More successful implementation campaigns seem to be those that attend to multiple levels of implementation, from the "humanity" of how providers approach family members (James, Cushway, Fadden 2006) and participation and support of all stakeholders to the regulatory environment (Isett et al. 2007). The combination that works well in one situation may not succeed in another (Cohen et al., 2008). At the participant level, implementation hinges on whether the content, processes, and structure of FPE offer what consumers and their family members want and need. Thus, targeting FPE implementation to situations where it is wanted, where it fits the organizational ethos, and where families and consumers are asking for it may be fruitful avenues.

In keeping with this, the field is also calling for investigators to develop deeper knowledge about mediators and moderators of FPE's effectiveness, acceptability to participants, and implementation. While international and cross-cultural studies have returned quite consistent effectiveness findings, less is known about engagement factors and processes across ethnic or racial groups (in the United States and elsewhere), and regarding variables such as age, life-stage, SES, time since illness onset, and their interactions. Additionally, determining what specific FPE intervention of what length works best in what situation for which consumers and families will require sophisticated trials, ideally with multiple arms testing well thought-out variations systematically. Qualitative and mixed methods research can also further develop our understanding of the dynamics of implementation, personal responses, cultural factors, and change processes.

Amidst this complexity, the need for empirical evaluation of implementation strategies is also great. Magnabosco (2006) concluded that implementation strategies for evidence-based mental health practices in general need to be more empirically derived and tested—what actually works in a given context and what can that suggest about increasing or preserving gains in that and similar contexts? Similarly, Cohen et al. (2008) wrote "unresolved research questions . . . limit our understanding of how to best structure the intervention to facilitate implementation" (p. 41). In particular, Cohen et al. (2008) draw attention to the fact that variations in FPE program length and format arise in response to local implementation needs (or assumptions) and also make translating implementation and effectiveness research from one situation to the next more complex. Additionally, longitudinal research looking at long-term outcomes of initial FPE and at the impact of ongoing (likely less intensive) access to FPE is sorely lacking and critical for assessing FPE's practical impact for consumers and their family members. Finally, few studies measure or report the effects on FPE of other supports and interventions that a given family (or individual member) may be taking part in, such as individual or family therapy.

Finally, for many mental health interventions, poor fidelity to a core model has been found to compromise outcomes (for example, the study by Bond & Salyers, 2004). One study found a strong relationship between fidelity and positive and negative symptom outcomes for FPE after 2 years (McDonnell et al., 2007). Most FPE studies, however, do not report any information on

the fidelity of their intervention's delivery to whichever model of FPE they are using. This compromises interpretation of their findings. Therefore, fidelity analysis must be integrated into future FPE implementation and outcomes research.

## A CLINICIAN RESPONDS

Curtis Adams

When a person enters psychiatric treatment for a severe mental illness, he usually brings his family with him. His parents, siblings or spouse may be present for a session or sessions. The family members may have engaged willingly or been forced into roles that they had not anticipated. The illness has required somebody to be a case manager, a medication monitor, a financial planner, a housing coordinator, and more often than not, that somebody is a relative of the person with the illness. No longer are they "just" a brother or an aunt, they are a para-professional. Most people who are thrust into these roles have never taken a course to prepare for them. Instead, it's on-the-job training at an accelerated pace.

Alternatively, his family might be completely estranged. In either case, the family is involved—even if the involvement is to avoid involvement. Even if the person with the illness is not present, he is not forgotten. Families may not set a place for their homeless member with bipolar disorder at their Thanksgiving dinner, but his absence does not nullify his existence. It is important for those of us who work with people who have severe mental illnesses to remember their families and then to engage them. How we go about engaging them varies, but the research as demonstrated by this article makes it clear that there are in many instances, evidence-based ways to work with families.

We now have so much more to offer than the past paradigms that blamed families like the now-dead "schizophrenogenic mother." (Fromm-Reichmann, 1948) The research also directs us away from therapy as the first line of engagement. Suggesting family therapy before offering family psychoeducation (FPE) tacitly suggests that we are all in the room together because of something the family did "wrong." Instead we are to direct our interventions toward the "Big Three" as highlighted in the accompanying article: (a) information about the illness, (b) skills to cope with the illness and to manage crises, and (c) support from peers and professional. We must know that every family needs these three offerings. Some families will benefit from therapy, but not all. It goes without saying that information, skills and support will, for many families be therapeutic, but that is not the primary aim of the Big Three.

Knowing that we need to offer the Big Three and proceeding to do it are two very different things. As the research shows, there are a number of ways to provide family psychoeducation, but most of them are lengthy. For example, many of the interventions for schizophrenia and bipolar disorders are most helpful when offered for 9 months. Some families are able to meet with us every other week for 9 months, but many families can't. Further, enthusiastic providers will review the evidence in the Schizophrenia Patient Outcomes Research Team (PORT) (Dixon, 2010) or read a family psychoeducation toolkit and decide that 9 months is not possible. That well-meaning therapist will modify the intervention, but will such modifications render the intervention ineffective? The interventions are efficacious in the randomized control trial, but are they effective in practice? Sometimes the answer is "No," and this leads to one of the major disappointments in family psychoeducation. What we have is effective, but it is very difficult to apply in the clinic.

Then there are other therapists who find the family psychoeducation tool kit for schizophrenia and then use it "off label" for a person with obsessive-compulsive disorder, for example because there is no evidence-based family psychoeducational intervention for this illness.

What we need in family psychoeducation is effective interventions that are brief and less demanding on patients and their families as a complement to the lengthier interventions. Perhaps phased interventions or self-paced interventions might offer broader reach and impact. In the world of smart phones and social media. It is not hard to imagine an "app" that offers the Big Three while providing a virtual support network. Even if the "app" and the associated social network(s) existed, families that lack smart phones or computer literacy would be at a clear disadvantage.

One of the paradoxes of FPE is that 9 months is too long for an intervention but for some families, it's not long enough. They need FPE for as long as the illness is in their lives. There is evidence that NAMI's Family to Family provides this kind of ongoing support. Of note, Family to Family is family-driven, not clinician driven and this may enhance family autonomy outside of the professional realm.

In addition to improving access to family psychoeducation programs that already demonstrate efficacy, we could help more families with more trials on more disorders. At one end of the age spectrum, attention deficit-hyperactivity disorder stresses children and their families. More trials of family psychoeducation will help treatment providers assist families as the child develops. At the other end of the age spectrum, dementias doubtlessly tax families emotionally, financially and in countless other ways. We need more evidence-based guidance about how to approach and help these families.

We have improved how we engage families over the past 50 years. No longer do we point the finger of blame at them or push them into therapy whether they want it or not. Instead we offer information, skills and support. We look forward to more evidence on how to apply the Big Three to more disorders and in ways that keep up with advancing technologies.

## REFERENCES

- Addington, J., McCleery, A., & Addington, D. (2005). Three-year outcome of family work in an early psychosis program. *Schizophrenia Research*, 79(1), 107–116.
- Baucom, D. H., Shoham, V., Mueser, K. T., Daiuto, A. D., & Stickle, T. R. (1998). Empirically supported couple and family interventions for marital distress and adult mental health problems. *Journal of Consulting and Clinical Psychology*, 66, 53–88.
- Berglund, N., Vahlne, J. O., & Edman, A. (2003). Family intervention in schizophrenia: Impact on family burden and attitude. *Social Psychiatry and Psychiatric Epidemiology*, 38(3), 116–121.
- Bond, G. R., Drake, R. E., McHugo, G. J., Rapp, C. A. & Whitley, R. (2009). Strategies for Improving Fidelity in the National Evidence-Based Practices Project. *Research on Social Work Practice*, 19(3), 569–581.
- Bond, G. R., & Salyers, M. P. (2004). Prediction of outcome from the Dartmouth assertive community treatment fidelity scale. *CNS Spectrums*, 9(12), 937–942.
- Boschen, K., Gargaro, J., Gan, C., Gerber, G., & Brandys, C. (2007). Family interventions after acquired brain injury and other chronic conditions: A critical appraisal of the quality of evidence. *NeuroRehabilitation*, 22(1), 19–41.
- Bradley, G. M., Couchman, G. M., Perlesz, A., Nguyen, A. T., Singh, B., & Riess, C. (2006). Multiple-family group treatment for English- and Vietnamese-speaking families living with schizophrenia. *Psychiatric Services*, 57(4), 521–530.
- Breitborde, N., Woods, S., & Srihari, V. (2009). Multifamily psychoeducation for first-episode psychosis: A cost-effectiveness analysis. *Psychiatric Services*, 60(11), 1477–1483.
- Carrà, G., Montomoli, C., Clerici, M., & Cazzullo, C. L. (2007). Family interventions for schizophrenia in Italy: Randomized controlled trial. *European Archives of Psychiatry and Clinical Neuroscience*, 257(1), 23–30.
- Chan, S. W., Yip, B., Tso, S., Cheng, B., & Tam, W. (2009). Evaluation of a psychoeducation program for Chinese clients with schizophrenia and their family caregivers. *Patient Education and Counseling*, 75(1), 67–76.
- Cheng, L., & Chan, S. (2005). Psychoeducation program for Chinese family carers of members with schizophrenia. *Western Journal of Nursing Research*, 27(5), 583–599.
- Chien, W. T. (2008). Effectiveness of psychoeducation and mutual support group program for family caregivers of Chinese people with schizophrenia. *The Open Nursing Journal*, 2, 28–39.
- Chien, W. T., & Chan, S. W. (2004). One-year follow-up of a multiple-family-group intervention for Chinese families of patients with schizophrenia. *Psychiatric Services*, 55(11), 1276–1284.
- Chien, W. T., & Wong, K. (2007). A family psychoeducation group program for Chinese people with schizophrenia in Hong Kong. *Psychiatric Services*, 58(7), 1003–1006.
- Cohen, A. N., Glynn, S. M., Murray-Swank, A. B., Barrio, C., Fischer, E. P., McCutcheon, S. J., et al. (2008). The family forum: Directions for the implementation of family psychoeducation for severe mental illnesses. *Psychiatric Services*, 59(1), 40–48.
- Cuijpers, P. (1999). The effects of family interventions on relatives' burden: A meta-analysis. *Journal of Mental Health*, 8(3), 275–285.
- Cummings, C. M., & Fristad, M. A. (2007). Medications prescribed for children with mood disorders: Effects of a family-based psychoeducation program. *Experimental and Clinical Psychopharmacology*, 15(6), 555–562.

- Diamond, G., & Josephson, A. (2005). Family-based treatment research: A 10-year update. *Journal of the American Academy of Child & Adolescent Psychiatry*, 44(9), 872–887.
- Dixon, L., Adams, C., & Lucksted, A. (2000). Update on family psychoeducation for schizophrenia. *Schizophrenia Bulletin*, 26(1), 5–20.
- Dixon, L. B., Dickerson, F., Bellack, A. S., Bennett, M., Dickinson, D., Goldberg, R. W., et al. (2009). The 2009 schizophrenia PORT psychosocial treatment recommendations and summary statements. *Schizophrenia Bulletin*, 36(1), 48–70.
- Dixon, L. B., & Lehman, A. F. (1995). Family interventions for schizophrenia. *Schizophrenia Bulletin*, 21(4), 631–644.
- Dixon, L., Lucksted, A., Stewart, B., Burland, J., Brown, C. H., Postrado, L., et al. (2004). Outcomes of the Peer-taught 12-week Family to Family Education Program for Serious Mental Illnesses. *Acta Psychiatrica Scandinavica*, 109, 207–215.
- Dixon, L., McFarlane, W. R., & Lefley, H. (2001). Evidence-based practices for services to families of people with psychiatric disabilities. *Psychiatric Services*, 52, 903–910.
- Dixon, L., Stewart, B., Burland, J., Delahanty, J., Lucksted, A., & Hoffman, M. (2001). Pilot study of the effectiveness of the Family-to-Family Education Program. *Psychiatric Services*, 52(7), 965–967.
- Drake, R. E., Becker, D. R., Goldman, H. H., & Martinez, R. A. (2006). Best practices: The Johnson & Johnson—Dartmouth community mental health program: Disseminating evidence-based practice. *Psychiatric Services*, 57(3), 302–304.
- Drake, R., Goldman, H., Leff, H., Lehman, A., Dixon, L., Mueser, K., et al. (2001). Implementing evidence-based practices in routine mental health service settings. *Psychiatric Services*, 52, 179–182.
- Dyck, D. G., Hendryx, M. S., Short, R. A., Voss, W. D., & McFarlane, W. R. (2002). Service use among patients with schizophrenia in psychoeducational multiple-family group treatment. *Psychiatric Services*, 53(6), 749–754.
- Dyck, D. G., Short, R. A., Hendryx, M. S., Norell, D., Myers, M., Patterson, T., et al. (2000). Management of negative symptoms among patients with schizophrenia attending multiple-family groups. *Psychiatric Services*, 51(4), 513–519.
- Falloon, I. R. H. (1992). Early intervention for first episodes of schizophrenia: A preliminary exploration. *Psychiatry*, 55(1), p. 4–15.
- Falloon, I., Held, T., Coverdale, J., Roncone, R., & Laidlaw, T. (1999). Psychosocial interventions for schizophrenia: A review of long-term benefits of international studies. *Psychiatric Rehabilitation Skills*, 3, 268–290.
- Fjell, A., Thorsen, G. R. B., Friis, S., Johannessen, J. O., Larsen, T. K., Lie, K., et al. (2007). Multifamily group treatment in a program for patients with first-episode psychosis: Experiences from the TIPS Project. *Psychiatric Services*, 58(2), 171–173.
- Frances, A. D. J., & Kahn, D. A. (1996). Expert consensus guideline series: Treatment of schizophrenia. *The Journal of Clinical Psychiatry*, 57(50 Supplement 12B), 5–58.
- Frese, F. J. III, Stanley, J., Kress, K., & Vogel-Scibilia, S. (2001). Integrating evidence-based practices and the recovery model. *Psychiatric Services*, 52(11), 1462–1468.
- Fristad, M. A. (2006). Psychoeducational treatment for school-aged children with bipolar disorder. *Development and Psychopathology*, 18(4), 1289–1306.
- Fristad, M. A., Gavazzi, S. M., & Mackinaw-Koons, B. (2003). Family psychoeducation: An adjunctive intervention for children with bipolar disorder. *Biological Psychiatry*, 53(11), 1000–1008.
- Fristad, M. A., Goldberg-Arnold, J. S., & Gavazzi, S. M. (2002). Multifamily psychoeducation groups (MFPG) for families of children with bipolar disorder. *Bipolar Disorders*, 4(4), 254–262.
- Fristad, M. A., Goldberg-Arnold, J. S., & Gavazzi, S. M. (2003). Multi-family psychoeducation groups in the treatment of children with mood disorders. *Journal of Marital and Family Therapy*, 29(4), 491–504.
- Fromm-Reichmann, F. (1948). “Notes on the Development of Treatment of Schizophrenics by Psychoanalytic Psychotherapy.” *Psychiatry*, 11(3), 263–273.
- Glynn, S. M., Cohen, A. N., Dixon, L. B., & Niv, N. (2006). The potential impact of the recovery movement on family interventions for schizophrenia: Opportunities and obstacles. *Schizophrenia Bulletin*, 32(3), 451–463.
- Gordon, W. A., Zafonte, R., Cicerone, K., Cantor, J., Brown, M., Lombard, L., et al. (2006). Traumatic brain injury rehabilitation: State of the science. *American Journal of Physical Medicine and Rehabilitation*, 85(4), 343–382.
- de Groot, L., Lloyd, C., & King, R. (2003). An evaluation of a family psychoeducation program in community mental health. *Psychiatric Rehabilitation Journal*, 27(1), 18–23.
- Grunes, M. S., Neziroglu, F., & McKay, D. (2001). Family involvement in the behavioral treatment of obsessive-compulsive disorder: A preliminary investigation. *Behavior Therapy*, 32(4), 803–820.
- Hazel, N. A., McDonnell, M. G., Short, R. A., Berry, C. M., Voss, W. D., Rodgers, M. L., et al. (2004). Impact of multiple-family groups for outpatients with schizophrenia on caregivers’ distress and resources. *Psychiatric Services*, 55(1), 35–41.

- Herz, M. K., Liberman, R. P., & Lieberman, J. A. (1997). American psychiatric association practice guideline for the treatment of patients with schizophrenia. *American Journal of Psychiatry*, *154*(Suppl. 4), 1–63.
- Hogan, M. F. (2003). The President's New Freedom Commission: Recommendations to reform mental health care in America. *Psychiatric Services*, *54*(11), 1467–1474.
- Hogarty, G. E. (2003). Does family psychoeducation have a future? *World Psychiatry*, *2*(1), 29–30.
- Hooley, J., & Richters, J. E. (1995). Expressed emotion: A developmental perspective. In D. Cicchetti & S. L. Toth (Eds.), *Emotion, cognition and representation* (pp. 133–166). Rochester: University of Rochester.
- Isett, K. R., Burnam, M. A., Coleman-Beattie, B., Hyde, P. S., Morrissey, J. P., Magnabosco, J., et al. (2007). The state policy context of implementation issues for evidence-based practices in mental health. *Psychiatric Services*, *58*, 914–921.
- James, C., Cushway, D., & Fadden, G. (2006). What works in engagement of families in behavioural family therapy? A positive model from the therapist perspective. *Journal of Mental Health*, *15*(3), 355–368.
- Jeppesen, P., Petersen, L., Thorup, A., Abel, M., Øhlenschläger, J., Christensen, T. O., et al. (2005). Integrated treatment of first-episode psychosis: Effect of treatment on family burden. *British Journal of Psychiatry*, *187*, s85–s90.
- Jewell, T. C., Downing, D., & McFarlane, W. R. (2009). Partnering with families: Multiple family group psychoeducation for schizophrenia. *Journal of Clinical Psychology*, *65*(8), 868–878.
- Johannessen, J. O., Larsen, T. K., McGlashan, T., & Vaglum, P. (2000). Early intervention in psychosis: The TIPS project, a multi-centre study in Scandinavia. In B. Martindale, A. Bateman & F. Margison (Eds.), *Psychosis: Psychological approaches and their effectiveness* (pp. 210–233). London: Gaskell.
- Jorgensen, P., Nordentoft, M., Abel, M. B., Gouliaev, G., Jeppesen, P., & Kassow, P. (2000). Early detection and assertive community treatment of young psychotics: The OPUS study rationale and design of the trial. *Social Psychiatry and Psychiatric Epidemiology*, *35*(7), 283–287.
- Klaus, N., & Fristad, M. A. (2005). Family psychoeducation as a valuable adjunctive intervention for children with bipolar disorder. *Directions in Psychiatry*, *25*(3), 217–230.
- Kulhara, P., Chakrabarti, S., Avasthi, A., Sharma, A., & Sharma, S. (2009). Psychoeducational intervention for caregivers of Indian patients with schizophrenia: A randomised-controlled trial. *Acta Psychiatrica Scandinavica*, *119*(6), 472–483.
- Lam, D. H. (1991). Psychosocial family intervention in schizophrenia: A review of empirical studies. *Psychological Medicine*, *21*(2), 423–441.
- Lehman, A. F., & Steinwachs, D. M. (1998). At issue: Translating research into practice: The schizophrenia patient outcomes research team (PORT) treatment recommendations. *Schizophrenia Bulletin*, *24*(1), 1–10.
- Magliano, L., Fiorillo, A., Malangone, C., De Rosa, C., & Maj, M. (2006). Patient functioning and family burden in a controlled, real-world trial of family psychoeducation for schizophrenia. *Psychiatric Services*, *57*(12), 1784–1791.
- Magnabosco, J. L. (2006). Innovations in mental health services implementation: A report on state-level data from the U.S. Evidence-Based Practices project. *Implementation Science*, *1*(13). Available from <http://www.implementationscience.com/content/1/1/13>.
- McClellan, J., Kowatch, R., Findling, R. L., & Work Group on Quality Issues. (2007). Practice parameter for the assessment and treatment of children and adolescents with bipolar disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, *46*(1), 107–125.
- McDonell, M. G., & Dyck, D. G. (2004). Multiple-family group treatment as an effective intervention for children with psychological disorders. *Clinical Psychology Review*, *24*(6), 685–706.
- McDonell, M. G., Rodgers, M. L., Short, R. A., Norell, D., Pinter, L., & Dyck, D. G. (2007). Clinician integrity in multiple family groups: Psychometric properties and relationship with schizophrenia client and caregiver outcomes. *Cognitive Therapy and Research*, *31*(6), 785–803.
- McDonell, M. G., Short, R. A., Berry, C. M., & Dyck, D. G. (2003). Burden in schizophrenia caregivers: Impact of family psychoeducation and awareness of patient suicidality. *Family Process*, *42*(1), 91–103.
- McDonell, M. G., Short, R., Hazel, N. A., Berry, C. M., & Dyck, D. G. (2006). Multiple-family group treatment of outpatients with schizophrenia: Impact on service utilization. *Family Process*, *45*, 359–373.
- McFarlane, W. R., & Cook, W. L. (2007). Family expressed emotion prior to onset of psychosis. *Family Process*, *46*(2), 185–198.
- McFarlane, W. R., Cook, W. L., Downing, D., Verdi, M., Woodberry, K. A., & Ruff, A. (2010). Portland Identification and Early Referral: A community-based system for identifying and treating youths at high risk of psychosis. *Psychiatric Services*, *61*(5), 512–515.
- McFarlane, W. R., Dixon, L., Lukens, E., & Lucksted, A. (2003). Family psychoeducation and schizophrenia: A review of the literature. *Journal of Marital and Family Therapy*, *29*(2), 223–245.
- McFarlane, W. R., & Lukens, E. P. (1998). Insight, families, and education: An exploration of the role of attribution in clinical outcome. In X. F. Amador & A. S. David (Eds.), *Insight and psychosis* (pp. 317–331). New York, USA: Oxford University.



- McFarlane, W. R., McNary, S., Dixon, L., Hornby, H., & Cimett, E. (2001). Predictors of dissemination of family psychoeducation in community mental health centers in Maine and Illinois. *Psychiatric Services, 52*(7), 935–942.
- McFarlane, W. R., Stastny, P., & Deakins, S. (1992). Family-aided assertive community treatment: A comprehensive rehabilitation and intensive case management approach for persons with schizophrenic disorders. *New Directions for Mental Health Services, 53*, 43–54.
- McHugo, G. J., Drake, R. E., Whitley, R., Bond, G. R., Campbell, K., Rapp, C. A., et al. (2007). Fidelity outcomes in the National Implementing Evidence-Based Practices project. *Psychiatric Services, 58*, 1279–1284.
- Mendenhall, A. N., Fristad, M. A., & Early, T. J. (2009). Factors influencing service utilization and mood symptom severity in children with mood disorders: Effects of multifamily psychoeducation groups (MFPGs). *Journal of Consulting and Clinical Psychology, 77*(3), 463–473.
- Mihalopoulos, C., Magnus, A., Carter, R., & Vos, T. (2004). Assessing cost-effectiveness in mental health: Family interventions for schizophrenia and related conditions. *Australian and New Zealand Journal of Psychiatry, 38*(7), 511–519.
- Miklowitz, D. J. (2008). *Bipolar disorder: A family-focused treatment approach* (2nd ed.). New York, NY: The Guilford.
- Miklowitz, D. J., George, E. L., Richards, J. A., Simoneau, T. L., & Suddath, R. L. (2003). A randomized study of family-focused psychoeducation and pharmacotherapy in the outpatient management of bipolar disorder. *Archives of General Psychiatry, 60*(9), 904–912.
- Miklowitz, D. J., Otto, M. W., Frank, E., Reilly-Harrington, N. A., Wisniewski, S. R., Kogan, J. N., et al. (2007). Psychosocial treatments for bipolar disorder: A 1-year randomized trial from the systematic treatment enhancement program. *Archives of General Psychiatry, 64*(4), 419–427.
- Mino, Y., Shimodera, S., Inoue, S., Fujita, H., & Fukuzawa, K. (2007). Medical cost analysis of family psychoeducation for schizophrenia. *Psychiatry and Clinical Neurosciences, 61*(1), 20–24.
- Montero, I. (2010). Training and dissemination of family intervention in Spain. *Journal of Schizophrenia Research, 2*, 120–121.
- Moore, B. C. (2005). Empirically supported family and peer interventions for dual disorders. *Research on Social Work and Practice, 15*(4), 231–245.
- Mueser, K. T., & Fox, L. (2002). A family intervention program for dual disorders. *Community Mental Health Journal, 38*(3), 253–270.
- Mueser, K. T., Glynn, S. M., Cather, C., Zarate, R., Fox, L., Feldman, J., et al. (2009). Family intervention for co-occurring substance use and severe psychiatric disorders. *Addictive Behaviors, 34*(10), 867–877.
- Mueser, K. T., Sengupta, A., Bellack, A. S., Glick, I. D., Schooler, N. R., Xie, H., et al. (2001). Family treatment and medication dosage reduction in schizophrenia: Effects on patient social functioning, family attitudes, and burden. *Journal of Consulting and Clinical Psychology, 69*(1), 3–12.
- Murray-Swank, A. B., & Dixon, L. (2004). Family psychoeducation as an evidence-based practice. *The International Journal of Neuropsychiatric Medicine, 9*(12), 905–912.
- Murray-Swank, A., Glynn, S., Cohen, A. N., Sherman, M., Medoff, D. P., Fang, L., et al. (2007). Family contact, experience of family relationships, and views about family involvement in treatment among VA consumers with serious mental illness. *Journal of Rehabilitation Research and Development, 44*(6), 801–812.
- Nasr, T., & Kausar, R. (2009). Psychoeducation and the family burden in schizophrenia: A randomized controlled trial. *Annals of General Psychiatry, 8*(17), 1–6.
- National Institute of Mental Health. (1991). *Caring for people with severe mental disorders: A national plan of research to improve services*. Washington, DC: Supt. of Docs., U.S. Government Printing Office.
- New York State Office of Mental Health. (2006). *The New York State family psychoeducation initiative, Final report*. Albany, NY: New York State Office of Mental Health.
- Nordentoft, M., Thorup, A., Petersen, L., Øhlenschläger, J., Melau, M., Christensen, T. O., et al. (2006). Transition rates from schizotypal disorder to psychotic disorder for first-contact patients included in the OPUS trial. A randomized clinical trial of integrated treatment and standard treatment. *Schizophrenia Research, 83*(1), 29–40.
- Pekkala, E. & Merinder, L. (2002) Psychoeducation for schizophrenia. *Cochrane Database of Systemic Reviews, 2002, 2*:CD002831.
- Penn, D. L., & Mueser, K. T. (1996). Research update on the psychosocial treatment of schizophrenia. *American Journal of Psychiatry, 153*, 607–617.
- Petersen, L., Nordentoft, M., Jeppesen, P., Øhlenschläger, J., Thorup, A., Christensen, T. O., et al. (2005). Improving 1-year outcome in first-episode psychosis\*OPUS trial. *British Journal of Psychiatry, 187*, s98–s103.
- Pharaoh F., Mari, J., Rathbone J., Wong, W. (2004). Family intervention for schizophrenia. Cochrane Database of Systematic Reviews 2010, Issue 12. Art. No.: CD000088. DOI: 10.1002/14651858.CD000088.
- Pickett-Schenk, S. A., Cook, J. A., & Laris, A. (2000). Journey of Hope Program Outcomes. *Community Mental Health Journal, 36*(4), 413–424.

- Pilling, S., Bebbington, P., Kuipers, E., Garety, P., Geddes, J., Orbach, G., et al. (2002). Psychological treatments in schizophrenia: I. meta-analysis of family intervention and cognitive behaviour therapy. *Psychological Medicine*, 32, 763–782.
- Pitschel-Walz, G., Leucht, S., Bauml, J., Kissling, W., & Engel, R. R. (2001). The effect of family interventions in relapse and rehospitalization in schizophrenia: A meta-analysis. *Schizophrenia Bulletin*, 27(1), 73–92.
- Ran, M., Xiang, M., Lai-Wan Chan, C., Leff, J., Simpson, P., Huang, M., et al. (2003). Effectiveness of psychoeducational intervention for rural Chinese families experiencing schizophrenia. *Social Psychiatry and Psychiatric Epidemiology*, 38(2), 69–75.
- Rea, M. M., Miklowitz, D. J., Tompson, M. C., & Goldstein, M. J. (2003). Family-focused treatment versus individual treatment for bipolar disorder: Results of a randomized clinical trial. *Journal of Consulting and Clinical Psychology*, 71(3), 482–492.
- Reinares, M., Colom, F., Martínez-Arán, A., & Vieta, E. (2002). Therapeutic interventions focused on the family of bipolar patients. *Psychotherapy and Psychosomatics*, 71, 2–10.
- Reinares, M., Colom, F., Rosa, A. R., Bonnin, M. C., Franco, C., Sole, B., et al. (2009). The impact of staging bipolar disorder on treatment outcome of family psychoeducation. *Journal of Affective Disorders*, 123(1–3), 81–86.
- Resnick, S. G., Rosenheck, R. A., & Lehman, A. F. (2004). An exploratory analysis of correlates of recovery. *Psychiatric Services*, 55(5), 540–547.
- Rodgers, M. L., Strode, A. D., Norell, D. M., Short, R. A., Dyck, D. G., & Becker, B. (2007). Adapting multiple-family group treatment for brain and spinal cord injury intervention development and preliminary outcomes. *American Journal of Physical Medicine & Rehabilitation*, 86(6), 482–492.
- Rogers, E. M. (1987). The diffusions of innovations perspective. In N. D. Weinstein (Ed.), *Taking care: Understanding and encouraging self-protective behavior* (pp. 79–94). Cambridge: Cambridge University Press.
- Ruffolo, M. C., Kuhn, M. T., & Evans, M. E. (2005). Support, empowerment, and education: A study of multiple family group psychoeducation. *Journal of Emotional and Behavioral Disorders*, 13(4), 200–212.
- Rummel-Kluge, C., & Kissling, W. (2008). Psychoeducation in schizophrenia: New developments and approaches in the field. *Current Opinion in Psychiatry*, 21(2), 168–172.
- Rummel-Kluge, C., Pitschel-Walz, G., Bauml, J., & Kissling, W. (2006). Psychoeducation in schizophrenia—results of a survey of all psychiatric institutions in Germany, Austria, and Switzerland. *Schizophrenia Bulletin*, 32(4), 765–775.
- Sajatovic, M., Davies, M., & Hrouda, D. R. (2004). Enhancement of treatment adherence among patients with bipolar disorder. *Psychiatric Services*, 55(3), 264–269.
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2009). *Family psychoeducation: How to use the evidence-based practices KITS*. HHS Pub. No. SMA-09-4422. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, available at 1-877-726-4727 or Retrieved September 13, 2011, from <http://store.samhsa.gov/product/Family-Psychoeducation-Evidence-Based-Practices-EBP-KIT/SMA09-4423>.
- Sanford, M., Boyle, M., McCleary, L., Miller, J., Steele, M., Duku, E., et al. (2006). A pilot study of adjunctive family psychoeducation in adolescent major depression: Feasibility and treatment effect. *American Academy of Child and Adolescent Psychiatry*, 45(4), 386–395.
- Schooler, N. P. (2006). Relapse prevention and recovery in the treatment of schizophrenia. *Journal of Clinical Psychiatry*, 67(5), 19–23.
- Schooler, N. R., Keith, S. J., Severe, J. B., Matthews, S. M., Bellack, A. S., Glick, I. D., et al. (1997). Relapse and rehospitalization during maintenance treatment of schizophrenia: The effects of dose reduction and family treatment. *Archives of General Psychiatry*, 54, 453–463.
- Sherman, M. D. (2003). The SAFE program: A family psychoeducational curriculum developed in a veteran affairs medical center. *Professional Psychology: Research and Practice*, 34(1), 42–48.
- Sherman, M. D. (2006). Updates and five-year evaluation of the S.A.F.E. program: A family psychoeducational program for serious mental illness. *Community Mental Health Journal*, 42(2), 213–219.
- Sherman, M. D., Blevins, D., Kirchner, J., Ridener, L., & Jackson, T. (2008). Key factors involved in engaging significant others in treatment of Vietnam veterans with PTSD. *Professional Psychology: Research and Practice*, 39(4), 443–450.
- Sherman, M. D., Fischer, E., Bowling, U. B., Dixon, L., Ridener, L., & Harrison, D. (2009). A new engagement strategy in a VA-based family psychoeducational program. *Psychiatric Services*, 60(2), 254–257.
- Sherman, M. D., Fischer, E. P., Sorocco, K., & McFarlane, W. R. (2009). Adapting the multifamily group model to the veterans' affairs system: The REACH program. *Professional Psychology: Research and Practice*, 40(6), 593–600.
- Sherman, M. D., Sautter, F., Lyons, J. A., Manguno-Mire, G. M., Han, X., Perry, D., et al. (2005). Mental health needs of Cohabiting partners of Vietnam veterans with combat-related PTSD. *Psychiatric Services*, 56, 1150–1152.

- Sota, S., Shimodera, S., Kii, M., Okamura, K., Suto, K., Suwaki, M., et al. (2008). Effect of family psychoeducational program on relatives of schizophrenia patients. *Psychiatry and Clinical Neurosciences*, *62*(4), 379–385.
- Stekete, G., & Van Noppen, B. (2003). Family approaches to treatment for obsessive compulsive disorder. *Revista Brasileira de Psiquiatria*, *25*(1), 43–50.
- Taylor, T. L., Killaspy, H., Wright, C., Turton, P., White, S., Kallert, T. W., et al. (2009). A systematic review of the international published literature relating to quality of institutional care for people with longer term mental health problems. *BMC Psychiatry*, *9*(55). Retrieved October 3, 2011 from, <http://www.biomedcentral.com/1471-244X/9/55>.
- Thara, R., Padmavati, R., Lakshmi, A., & Karpagavalli, P. (2005). Family education in schizophrenia: A comparison of two approaches. *Indian Journal of Psychiatry*, *47*(4), 218–221.
- Thorup, A., Petersen, L., Jeppesen, P., Øhlenschläger, J., Christensen, T. O., Krarup, G., et al. (2005). Integrated treatment ameliorates negative symptoms in first episode psychosis—results from the Danish OPUS trial. *Schizophrenia Research*, *79*, 95–105.
- Torrey, W., Drake, R., Dixon, L., Burns, B., Flynn, L., Rush, A., et al. (2001). Implementing evidence-based practices for persons with severe mental illnesses. *Psychiatric Services*, *52*(1), 45–50.
- Uehara, T., Kawashima, Y., Goto, M., Tasaki, S., & Someya, T. (2001). Psychoeducation for the families of patients with eating disorders and changes in expressed emotion: A preliminary study. *Comprehensive Psychiatry*, *42*(2), 132–138.
- Weine, S., Ukshini, S., Griffith, J., Agani, F., Pulleyblank-Coffey, E., Ulaj, J., et al. (2005). A Family Approach to Severe Mental Illness in Post-War Kosovo. *Psychiatry*, *68*(1), 17–27.
- Worakul, P., Thavichachart, N., & Lueboonthavatchai, P. (2007). Effects of psycho-educational program on knowledge and attitude upon schizophrenia of schizophrenic patients' caregivers. *Journal of The Medical Association of Thailand*, *90*(6), 1199–1207.
- World Schizophrenia Fellowship. (1998). *Families as partners in care: A document developed to launch a strategy for the implementation of programs of family education, training, and support*. Toronto: World Schizophrenia Fellowship.
- Yamaguchi, H., Takahashi, A., Takano, A., & Kojima, T. (2006). Direct effects of short-term psychoeducational intervention for relatives of patients with schizophrenia in Japan. *Psychiatry and Clinical Neuroscience*, *60*(5), 590–597.
- Zygmunt, A., Olfson, M., Boyer, C. A., & Mechanic, D. (2002). Interventions to improve medication adherence in schizophrenia. *The American Journal of Psychiatry*, *159*(10), 1644–1653.