Frequently Asked Questions (FAQ) Concerning Family Psychoeducation

Adapted from the Family Psychoeducation Implementing Evidence-Based Practices Project Workbook *(Contributors to the workbook: William R. McFarlane, M.D., Linda H Jacobson, RN, CS, MAEd., MSN; Donna Downing, MS, OTR/L Kit Perry, LCSW; Mary Beth Lapin Christopher S. Amenson, Ph.D)*

WHAT IS THE SCOPE AND EFFICIENCY OF FAMILY PSYCHOEDUCATION?

The simplest answer is that Family Psychoeducation involves the family in the acute and ongoing treatment and recovery of a person with a severe mental illness, substance use disorder or a co-occurring disorder with the goal of alleviating the disorder, re-integrating the consumer in community life as he or she chooses and helping to set the stage for recovery. Formats vary but the basic approaches are similar. Family members should be involved as soon as possible during psychiatric or substance use crises, inpatient, residential or partial hospital admissions and during longer-term outpatient or Assertive Community Treatment. The other area in which family involvement has proved highly beneficial is in Supported Employment. Some family meetings can replace meetings that may have involved only the consumer with other services. Most outpatient services that have applied Family Psychoeducation on a wide scale have experienced a net decrease in staff time, expense, stress and effort when the family is involved on a routine basis. Family Psychoeducation in multifamily groups is the most cost-effective of the new evidence- based practices and can greatly improve the overall efficiency of mental health, addiction and co-occurring services.

HOW LONG DOES IT GO AND HOW LONG DOES IT TAKE TO WORK?

The outcome research has shown that outcome is almost proportional to the time over which services are offered, with 3 months being the minimum time required to see any effect, 9 months for the clinical effects reported in the literature, 12 months as the recommended minimum and 24 to 36 months for optimal employment and recovery outcomes. On the other hand, the usual approach is simply to ask families to participate for as long as they and the consumer find it useful. With that as the basic contract for participation, it is also the usual situation that once families participate for as little as two or three sessions after the educational session, they choose to participate for up to four or five years, especially in multifamily groups. Though it sometimes takes extra effort to engage a given family or consumer, those same people are likely to request to continue participating several years later.

WHEN SHOULD WORK WITH FAMILIES START?

The two most common points of engagement are:

- when the consumer is experiencing an acute crisis, and
- during community-based treatment.

In the latter situation, both consumer and family will often be encouraged by the prospect of collaborating in the effort to seek a competitive job. Undertaking Family Psychoeducation and Supported Employment at the same time has proven remarkably effective.

Family psychoeducation should be offered as early in the course of treatment as possible, because it can help prevent relapse and disability, while also preserving and enhancing family relationships and social supports for the consumer's recovery. There is perhaps no more cost-effective psychosocial modality that has such a profound effect on the early, and probably the entire, course of treatment.

WHICH FAMILIES AND CONSUMERS SHOULD BE ENGAGED?

Experience, both clinical and research, has not delineated any group among individuals for whom this approach is not effective. The necessary requirement is that at least one person, other than the consumer, is close enough and concerned enough to participate is what we have come to call "sponsors" or "supporters". Most commonly those are family members, but friends, relatives, landlords, and community residence staff and significant others have all proven their value and have benefited the consumer and themselves. As noted above, greater value comes from starting this work as early in the course of treatment as possible, since most consumers and families report the most extreme distress in the first year or two of attempting to cope. As well, it is often in this early period that major rifts develop between consumer and family and/or between family members, rifts that greatly exacerbate symptoms and disability. It is those very rifts that Family Psychoeducation has proven to prevent and often heal, as participants stop blaming themselves or each other and cooperate to assist in the overall treatment and rehabilitation process. Family psychoeducational approaches have been developed for people with major depression, bipolar disorder, borderline personality disorder, obsessive-compulsive disorder, substance use disorder and co-occurring disorder and for those who have no family members available, but who live in community residences. While there is as yet less empirical support for their effectiveness, these other approaches receive the same high praise from participants.

WHO SHOULD PARTICIPATE —FAMILIES, CONSUMERS OR BOTH?

Both consumers and family members should participate in Family Psychoeducation. These models have all involved the entire family, consumer included, because they focus on treating a disorder, not a person. Thus, the consumer needs to be involved not only to receive benefits from the process but also to have a full voice in determining the direction of that process. Also, in psychoeducational multifamily groups, consumers have nearly universally proven to be important resources to family members in other families as well as for other consumers. Families surveyed after participating in groups with or without the consumer present both preferred including consumers, but only after direct experience of one or the other format. On the other hand, there are times, especially during engagement, when separate sessions have an important role. For instance, exploring personal matters, such as romantic entanglements, substance abuse or sexual side effects of medications, are best handled initially in consumer-practitioner meetings. Conversely, time spent in the beginning hearing about the family's frustration and anger about the effects of the consumer's disorder are important, but usually not best done with the consumer present, particularly during an acute crisis. Clearly, without some involvement by a family member or supporter, the approach is more difficult to implement. On the other hand, if at least one supporter is willing to participate, the consumer does not have to participate until he or she gives consent.

CAN SUPPORTIVE PEOPLE OTHER THAN FAMILY BE INVOLVED?

The consumer should be consulted as to whom they would like to have support their treatment and recovery, and in many instances those people can serve as the family in this approach. Frequently, there are no family members available, but a friend, significant other, neighbor, or even concerned residential program staff will be willing to support the consumer's involvement in Family Psychoeducation. In fact, in multifamily groups, up to about a third of the consumers can participate without any support person and still gain a great deal from the process; support comes from other families and consumers. This variation may also be relevant when the consumer is adamant about not involving a family member because of a past history of trauma or abuse.

WHAT IS FAMILY PSYCHOEDUCATION NOT?

Family Psychoeducation is not family therapy. It is nearly the opposite. In this approach, the object of treatment is the disorder and not the family. Thus, the family is considered part of the team, as is the consumer if they are ready to accept such a role. In family therapy, the family itself is the object of treatment. Families do benefit from well-done Family Psychoeducation and family therapy, but for different reasons and with different kinds of problems and diagnoses. Family Psychoeducation is *not* just education. Both in original conception and in the evidence from outcome studies, Family Psychoeducation is a treatment model to achieve recovery, in which the intervening objective is enhancing the coping skills of consumer and family members. That has not proven to be possible with just information or suggestions. These models all provide direct, ongoing guidance, inter-family support (in multifamily groups), and problem solving and modeling to assist in developing individualized coping strategies and skills.

WHAT ARE THE BENEFITS FOR FAMILIES? FOR CONSUMERS?

For families, benefits include enhanced coping skills, greater knowledge and insight into the disorder(s), reduced stress, conflict, isolation and loneliness, satisfaction with support and reduced medical illness, substance use or co-occurring disorders in themselves. Consumers benefit by large reductions in inpatient or residential admissions, more energy and motivation, better family relationships and support, more time spent working or successfully completing schooling and reduced dependence on drugs and alcohol.

WHAT ABOUT CONFIDENTIALITY?

First, remember that the right of privacy always rests with the consumer. The consumer has the choice as to whether he or she is willing to have their practitioner or case manager include the family in treatment. If the consumer refuses to do so after a discussion of the benefits of Family Psychoeducation, that is their choice. However, the engagement process presents to consumers and family members alike a consent process that presents not just problems, but also likely benefits of family members participating in the treatment process. Thus, it is truly *informed* consent. For instance, many consumers are persuaded to allow and even welcome family involvement when it is made clear that the goal is to organize family support for *the consumer's* goals and for them as a person.

WHAT IF THE FAMILY IS ALREADY INVOLVED WITH A NAMI EDUCATIONAL PROGRAM, SUCH AS FAMILY-TO-FAMILY?

These educational programs contain much of the same material as is provided in family psychoeducation, so there is no contradiction and much synergy between them. In fact, one could offer the NAMI course, "Family- to-Family", as the educational intervention in Family Psychoeducation, if some of the teaching was done by the practitioners in concert with the family members leading the course. Family members will also benefit greatly from having access to Family Psychoeducation after they have had a NAMI course. These educational programs do not provide the clinical intervention and skills training and have not been found to benefit the consumer directly, at least in studies to date. On the other hand, there is evidence that families gain a great deal of information and relief from these courses.

The scope of Family Psychoeducation is far greater, with broad treatment and recovery goals that go beyond what can be offered by an advocacy organization. If they have not participated in NAMI or its educational offerings, families should be referred to the local NAMI chapter as an additional resource during the engagement process of Family Psychoeducation and encouraged to become members.