

Impact of Brief Family Psychoeducation on Self-Efficacy

by Phyllis Solomon, Jeffrey Draine, Edle Mannion, and Marilyn Meisel

Abstract

One hundred eighty-three relatives of people with serious mental illnesses were randomly assigned to receive individualized consultation or group psychoeducation or were placed on a 9-month wait list. Analysis of variance and multiple regression revealed that the individualized consultation increased the family members' sense of self-efficacy regarding mentally ill relatives. Group psychoeducation was helpful in increasing self-efficacy of family members who had never participated in a support or advocacy group for relatives of psychiatrically disabled individuals.

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As care of seriously mentally ill adults has shifted to the community, families have been expected to assume increasing responsibility for the care of their ill relatives, a task for which they frequently have no formal training (Lefley 1987; Winefield and Harvey 1994). Families often feel unprepared to manage life with an ill relative (Posner et al. 1992). To assist with this burden, psychoeducation aims to teach family members about mental illness and its treatment and to develop coping and adaptation skills (Leff and Vaughan 1981; Falloon et al. 1984; Anderson et al. 1986; Hogarty et al. 1986, 1991; Zippel and Spaniol 1987).

Psychoeducation's efficacy has largely been based on rigorous research that has found that relapse rates for disabled people whose families participated in a psychoeducational intervention were

lower than those of people who participated in outpatient programs or medication management without family intervention (Falloon et al. 1982, 1985; Leff et al. 1982; Hogarty et al. 1986, 1991; Zippel and Spaniol 1987; Abramowitz and Coursey 1989; Lam 1991). Zippel and Spaniol posit that the various psychoeducational approaches, whether they provide information, support, skill training, or a combination of these, are effective because they all address what families want and need. Furthermore, the interventions engage families as partners, enable families to have some control over intervention, and do not blame families for their relatives' illness or view families as pathogenic units (Zippel and Spaniol 1987; Abramowitz and Coursey 1989). Zippel and Spaniol (1987) suggested that efficacy of the various approaches was similar because recidivism rates were too broad to capture significant differences between approaches and recommended measuring other outcomes such as family satisfaction, client level functioning, family level functioning, and stress.

Generally, prior research of psychoeducation involved families who lived with their ill relatives and who were assessed as having a high degree of expressed emotion (Hogarty et al. 1987). Most of this research has therefore required the participation of ill relatives, either in the family treatment or in treatment of the mental illness. In a number of these studies, re-

Reprint requests should be sent to Dr. P. Solomon, University of Pennsylvania, School of Social Work, 3701 Locust Walk, Philadelphia, PA 19104.

errals were made after the ill relative was admitted to the inpatient unit of a psychiatric facility (Hogarty et al. 1986, 1991) or to either the inpatient or outpatient unit (Falloon et al. 1982, 1985). This study sought to expand the research of psychoeducation interventions to include families whose ill relative did not live with the family and families whose ill relative was not seeking treatment.

The psychoeducation interventions studied here did not require that the ill relative be in treatment or participate in the intervention. Families whose ill relatives were not in treatment or were resistant to treatment could therefore benefit from psychoeducation. Group members benefited by thus being able to share more varied experiences because individuals whose relatives both were and were not in treatment were included. These experiences represented the cyclical and heterogeneous course of serious mental illness. Excluding ill relatives from psychoeducational sessions allowed for candid discussion of coping with mental illness (Pfeiffer and Mostek 1991), and including families whose ill relatives did not live with them allowed their particular concerns to be addressed.

Family advocates and professionals who work with mentally ill individuals and their families designed and implemented the interventions studied in this investigation. Most psychoeducation programs have been designed exclusively by professionals and have been incorporated into the overall treatment of ill relatives. Such treatment has also included prescribed problem solving, skill training, and skill reinforcement monitoring with relatives (Falloon et al.

1982, 1985; Leff et al. 1982; Hogarty et al. 1986, 1991). This study also tests the efficacy of individualized consultation and group psychoeducation as interventions independent of the ill relative's treatment (or absence of treatment). A growing number of family advocates and community agencies are seeking to implement such brief psychoeducation programs, even though examination of their efficacy has been limited (Abramowitz and Coursey 1989; Posner et al. 1992).

Through the collaboration of families and professionals, family input is present from the very inception of the services examined in this study. In the group psychoeducation program, a professional facilitator is assisted by a peer consultant, who is a specially trained family member. Although the consultants in the individualized consultation intervention were professionals, they were accountable to an organization operated as a family-professional collaboration.

This study examined the relative efficacy of two strategies for psychoeducation: individualized consultation and group psychoeducation. Both strategies have been studied as components of more comprehensive treatment programs lasting 9 months to 2 years (Falloon et al. 1982, 1985; Leff et al. 1982; Hogarty et al. 1986, 1991). Individualized consultation with family members with an ill relative had not been previously examined with a rigorous design independent of these comprehensive treatment programs. To meet the growing need for such interventions (Bernheim and Switalski 1988; Posner et al. 1992), the current consultation model was a brief in

tervention that could be implemented by community mental health agencies with existing personnel and a few additional resources. The interventions were conducted in the first 3 months of the family members' participation in the study. The present analysis examined the two interventions' effects on subjective burden, grief, social support, self-efficacy, mastery, adaptive coping, and stress. Satisfaction with intervention services was also measured as a component of service efficacy.

In terms of subjective burden, grief, and stress, the psychological cost to families coping with a mentally disabled relative has been well documented (Doll 1976; Hatfield 1984, 1987; Cook and Pickett 1987-1988; Noh and Turner 1987; Solomon et al. 1988; Miller et al. 1990); the effect on the family's ability to cope has been devastating. Hatfield (1983) concluded from a survey of families in a self-help group that not being able to address problem behavior in an ill relative causes significant strain in family relations. For this reason, both psychological strain, such as grief and burden, and the extent of adaptive coping strategies are used along with self-efficacy as outcome measures in this study.

Because of stigma and the demands of caring for an ill relative, families of psychiatrically disabled individuals frequently experience social isolation and find social support systems to be limited (Noh and Turner 1987). An increasing body of research has demonstrated the important role social support plays as a buffer protecting individuals from chronically stressful events, such as caring for a psychiatrically disabled relative (Noh and Turner 1987). Social network

and social support are therefore included as variables in this study as well.

Methods

Recruitment. Relatives of individuals with severe mental illnesses, living within 50 miles of a large east-coast city, were asked to participate in a randomized clinical trial of psychoeducational services. Subjects were randomly assigned to one of three conditions: individual family consultation, group family psychoeducation, or a 9-month wait list (control group). Recruitment was done through support groups, hospital social service departments, and information programs for family members of psychiatric patients. In addition, an advocate well-known to families was employed to organize a public relations effort that included presentations, radio talk show appearances, and newspaper advertising. The family life columnist of the primary regional daily newspaper featured the project in her column, and an African-American community newspaper also ran a story about it.

The sample represents families with varied levels of involvement with support groups. Of 225 family members, 51 percent ($n = 114$) had never participated in a family support group, and 58.3 percent ($n = 130$ of 223) had never been members of the National Alliance for the Mentally Ill (NAMI), a major advocacy group organized by family members. The ill relatives were not required to participate, though some agreed to be interviewed to assess secondary benefits they may have received from the intervention.

Criteria. To be eligible to participate in the study, family members had to meet the following criteria:

- They had to be the parent, child, spouse, or other relative with major responsibility for an individual diagnosed at least 6 months before study entry as having schizophrenia (295) or major affective (296) disorder per *DSM-III-R* (American Psychiatric Association 1987). Major responsibility was defined as living with the family member, being a contact person for emergencies at rehabilitation residences or agencies, or engaging in frequent monitoring and support of the ill relative in independent living situations.
- They had to have in-person or phone contact with the ill relative at least once a week.
- They, and the ill relative, both had to live within 50 miles of the metropolitan area.
- They, and the ill relative, had to be at least 18 years old.

Every interested family member who met these criteria was asked to participate in the study. If more than one member of the same family was interested, the research subject was selected by coin toss. As a result of recruitment, 244 study candidates were identified, and 225 of these consented to participate. Those who refused ($n = 19$) were more likely to be children of a mentally ill parent ($\chi^2 = 52.04$, $df = 1$, $p < 0.05$) than those who consented.

Sample Description. Most of the participating family members were female ($n = 198$, 88%) and white ($n = 189$, 84%), with an average age of 55.7 years ($n = 225$, standard deviation [SD] = 12.5). A majority had some college education

($n = 122$, 54.2%), and income for the entire group averaged \$36,600 a year ($n = 187$, SD = 26,100); therefore, most subjects could be described as middle class. In addition, most participants were the parents of an adult child with mental illness ($n = 172$, 76.4%). Twenty-five participants (11.1%) were siblings, 10 (4.4%) were spouses, and 13 (5.8%) were adult children. Five (2.2%) had other relationships, such as mother-in-law or long-time companion.

A majority of the ill relatives (63.5%) had a schizophrenia diagnosis. The median number of lifetime hospitalizations was between three and five for ill relatives, with 33.9 percent having more than five lifetime psychiatric hospitalizations. Average age of ill relatives was 35.8 years ($n = 225$, SD = 10.9), and the average length of time from initial diagnosis was 12.7 years (SD = 8.7). By family member report, 35.6 percent of the ill relatives had been arrested in their lifetime, 11.8 percent had alcohol problems, and 9.5 percent had drug problems.

Randomization and Attrition.

Initially, the study design called for 200 persons to be randomized, 60 each to the individual consultation and group psychoeducation interventions, and 80 to the 9-month wait list/control group. More were assigned to the control group because greater attrition was expected for that group. Wait list subjects were paid \$10 for their interviews and were provided either or both psychoeducation interventions free after 9 months, provided they availed themselves of the group service before the individual consultation to prevent contamination of the groups. Inter-

ventions took place in subjects' initial 3 months of participation. Reports of family member outcomes at 3 months are reported here. The results of followup interviews 6 months later (9 months after baseline) will be reported in a later article.

Available time and resources allowed for 225 subjects to be enrolled in the study, 25 more than originally intended. Family members were randomly assigned to one of the three conditions with a random numbers table. Randomization was conducted with families in sets of four to ensure that distribution of families to conditions over the course of the study was equal and that each family had an equal probability of assignment to any condition. Thus, the individual consultation and group psychoeducation programs had a reliable flow of participants. Each referred family was given a temporary random number for assignment purposes. As each subject's identifying number was found in the table, his or her name was entered into the next available slot in a chart divided according to three conditions but with more slots for the control condition than for the others. Because this task had to be done before interviewers approached family members in the field, there was the chance that a family member, once assigned, would refuse participation. We decided that in these cases the slot would be left vacant, to be filled with a name from the next set of family members referred. All identifying information of families who refused participation was discarded. Of the 225 subjects at baseline, 66 were assigned to individual consultation, 67 to group psychoeducation, and 92 to the

wait list.

Forty-two family members dropped from the study before their 3-month interview, 10 from consultation, 12 from the wait list, and 20 from group psychoeducation. Significantly more family members dropped from the group psychoeducation condition ($\chi^2 = 7.97$, $df = 2$, $p < 0.05$). Five were dropped from group psychoeducation because they did not meet the attendance requirement of at least seven group sessions to continue in the study. Dropped subjects were compared to those who remained in the study at 3 months by age, gender, ethnicity, ill relative diagnosis, relation to ill relative, living arrangement with ill relative, income, education, years of relative's illness, and baseline assessment scales, which were also used as outcome measures at 3 months. There were no differences between family members who dropped and those who remained in the study at 3 months on any of these variables. Because 19 tests of statistical significance were used for this comparison, a Bonferroni correction was used ($\alpha = 0.0026$). The remaining 183 subjects were then compared by condition on the same 19 variables. No differences were found in demographic, clinical, or baseline assessment variables by condition among the family members remaining at 3 months.

Interventions. Both interventions were administered by the Training and Education Center (TEC) Network, a collaborative of family members and mental health professionals experienced in providing psychoeducation to individuals with mentally ill relatives. TEC hired, oriented, and supervised ex-

perienced specialists who provided both the individualized consultation and the group psychoeducation. No specialist provided both group and individual psychoeducation services. Subjects in both service conditions were provided with the same instructional materials, though they were used differently as appropriate to the model of psychoeducation provided.

Brief individual family consultation. Fifty-six subjects received individual family consultation. This service consisted of educational assistance provided to the family as a unit or to an individual family member (Bernheim 1982, 1989; Bernheim and Lehman 1985; Kanter 1985). The consultants providing the service were specialists with expertise in teaching family members about mental illness as well as in assessment skills, mediation training, problem management, and resource knowledge. Staff less experienced in this intervention received a 3-hour orientation, followed by ongoing supervision by more experienced specialists.

A minimum of 6 hours of consultation was provided to each family, including a 2-hour initial assessment, at least 2 hours of face-to-face contact, and at least 2 hours of contact that could be face-to-face or over the telephone. A maximum of 15 hours was maintained to ensure comparability of the intervention across all subjects in this condition. Families determined the specific focus of their psychoeducation with their consultant and could access the service as needed over the 3-month period that it was available.

The consultation was thought of as having three phases: feeling or connecting, focusing, and finding. In the feeling and connecting

phase, the consultant provided empathy and support to family members, acknowledging the family's strengths while taking a brief history of the relative's illness. Issues of guilt and blame were addressed, and the consultant assessed educational and skill needs with the family. In the focusing phase, an agenda was developed for the family's psychoeducational work. Problems were clarified or redefined, and a prioritized list of objectives was established. In the final phase, the consultant assisted in developing strategies to meet objectives. The consultant may have assisted the family member in developing and evaluating new skills for relating to the ill relative. Consultants often informed family members about community resources appropriate to their particular needs and occasionally accompanied family members to meetings with other agencies to assist them in getting appropriate services for their ill relatives.

Group family psychoeducation. Eleven psychoeducation groups serving a total of 47 research subjects were each co-facilitated by a mental illness specialist and a family member trained as a peer consultant. Groups, which included some family members not participating in this study, usually consisted of 6 to 12 individuals. Group facilitators were selected based on their expertise in mental illness and professional experience in working with families and groups. Peer consultants were expected to contribute examples from their own experience and to challenge the specialists or group participants if they disagreed with what was being presented or said. Weekly 2-hour sessions were scheduled over a 10-week period.

Some groups took longer because of weather-related rescheduling, but all groups completed the 10 sessions planned.

The groups' objectives were to orient families about serious mental illness and its treatment, to help families to realize that others in their situation have similar feelings and experiences, and to provide guidelines for dealing more effectively with their ill relatives, other family members, and the mental health system. Thirty minutes of each session were devoted to new information about mental illness and its treatment, and 90 minutes to developing coping skills. Homework was usually assigned at the end of each session to help subjects apply what they learned to their interactions with their ill relatives.

The mental illness specialists' and peer consultants' experience in conducting the workshop was based on a 132-page teaching manual. Training consisted of 9 hours of classroom education in attitudes and skills for effective group facilitation and observation of at least two group sessions. Ongoing technical assistance and support was available to group facilitators from TEC staff.

Interviews and Measures. Family members were interviewed by trained research workers independent of those providing the services under study. At the baseline interview, research workers presented the study to family members individually, most often in the home. Research workers explained the study, answered questions, and acquired signed consent. Interviews were conducted again about 3 months later, after those in the service conditions had completed

the psychoeducational interventions.

Baseline interviews included questions about demographics, for example, employment, education, and income. Also included were questions about the history of the relative's mental illness and about their personal history with the relative. Baseline and 3-month followup interviews included measures of burden, grief, self-efficacy, social support, stress, and adaptive coping.

Burden was measured by an adaptation of the interview developed by Pai and Kapur (1981). Family members were asked to describe their experiences in the previous 3 months using standardized statements about typical experiences of objective burden among families with mentally ill relatives. After discussing their burden as it related to each description, family members rated the severity of the burden on a scale of 0 to 2 (0 = no burden, 1 = moderate burden, and 2 = severe burden). Extent of objective burden was not scored. Severity ratings for financial, social, leisure, vocational, health, and mental health burden were totaled to determine the subjective burden. Interviewers also rated the relatives' burden for each item on the same scale, after hearing the family members' description of their burden, but before family members rated themselves. The correlation between interviewer and subject ratings of severity of burden was quite high ($r = 0.96$).

Social support was assessed with the Norbeck Social Support Questionnaire (Norbeck et al. 1981, 1983), which measures instrumental (supportive assistance), affirmative (respect), and affective (empathy)

support. These three subscales were highly correlated (all pairwise correlations higher than 0.9), principally because a significant portion of the variance in scores on subscales related directly to the size of the social network. To enable all subscales to be entered into this analysis in spite of this intercorrelation, the size of the social network was regressed on each of the subscale scores. The residuals of the subscale scores, which specifically excluded variance attributed to the size of the social network, were then entered for these subscale variables in further analyses. No pair of the resulting social support variables—network size, affective support, affirming support, and instrumental support—correlated prohibitively.

Scherer et al.'s (1982) self-efficacy scale was adapted to measure mastery specific to problems encountered by individuals with mentally ill relatives. Internal reliability for the adapted scale was acceptable ($\alpha = 0.85$). Stress was assessed using a scale initially developed to measure stress in families coping with dementia in aging relatives (Greene et al. 1982). Its internal reliability at baseline in this study was acceptable ($\alpha = 0.87$). Grief was measured using an adaptation of the Texas Inventory of Grief (Miller et al. 1990) specifically for families with mentally ill relatives.

The interview also included a self-efficacy scale for coping skills needed by families of persons with mental illness. The scale, developed from guidelines established by Hatfield (1983), was pretested with family members in another study. Test-retest reliability was 0.98 ($n = 10$), and internal re-

liability was 0.84 ($n = 13$). In an analysis of this pretest data, the Hatfield-based scale was closely associated with the adaptive coping behaviors scale modified for coping with a mentally ill relative (Carver et al. 1989) ($n = 16$, $r = 0.923$, $p < 0.001$), which had acceptable test-retest ($n = 12$, $r = 0.91$) and alpha ($n = 16$, $\alpha = 0.84$) reliability.

Satisfaction with the two psychoeducation interventions was measured with nine questions regarding interaction with a mentally disabled relative, the possible responses for which were "very helpful," "somewhat helpful," and "not at all helpful." There were also three questions on global satisfaction with the intervention, the possible responses for which were "to a great extent," "to some extent," or "not at all."

Analysis. The 10 outcome measures at baseline and 3 months were entered into a 2×3 repeated measures multivariate analysis of variance (MANOVA). The dimensions of the MANOVA were time (baseline and 3 months) and condition (consultation, group, or waiting list). Statistically significant interactions of condition by time were attributed to differential efficacy of the service conditions. One-tailed tests ($\alpha = 0.05$) were used because the direction of the results regarding each outcome measure was anticipated by the study hypothesis. No correction for multiple tests of significance was planned, since including the results for individual variables in an overall statistically significant MANOVA (Bray and Maxwell 1985) would protect them from inflated type I error.

Responses to the questions about

satisfaction with service were analyzed by the two service conditions. The "somewhat helpful" and "not at all helpful" categories were collapsed for the chi-square analysis because expected cell frequencies for some items would be well below 5, particularly in the latter category. In the three items measuring global satisfaction with the service, satisfaction "to some extent" and "not at all" were collapsed for the same reason. A Bonferroni correction was used for repeated tests of significance ($\alpha = 0.0041$) because the literature offered no guidance as to the expected degree of satisfaction of families with different aspects of these psychoeducation interventions. Protection was needed against interpretation of a result that could be attributed to chance alone.

Results

Because overall MANOVA, including all outcome measures, was not statistically significant ($F = 1.29$, $df = 20,330$) tests of the individual variables were not protected against an inflated chance of type I error (Bray and Maxwell 1985). Therefore, repeated measures analyses of variance by service condition were performed on all 10 outcome measures using one-tailed tests with a Bonferroni correction. Among the 10 outcome variables, only 1, specific self-efficacy, produced a statistically significant interaction of time and service condition in the expected direction ($F = 7.40$, $df = 2$, $p < 0.05$).

Because just over half of the family members had histories of involvement in support groups or NAMI ($n = 97$, 53%), there was concern that there might be an in-

teraction between support group experience and the psychoeducation service intervention. Further regression analysis was conducted on specific self-efficacy to explore this possibility. The independent variables in this analysis were the baseline measure of self-efficacy, and five indicators for the various combinations of condition and support group participation: (1) individual consultation with support group experience, (2) individual consultation without support group experience, (3) group psychoeducation with support group experience, (4) group psychoeducation without support group experience, and (5) wait list condition with support group experience.

This regression analysis was statistically significant ($F = 17.79$, $df = 6, 171$, $p < 0.001$). As indicated in table 1, both consultation indicators were significant in the expected direction. Of the two group psychoeducation indicators, only the indicator for group psychoeducation with no support group experience was statistically significant in the expected direction. All significance tests were one-tailed.

Analysis of the satisfaction with the intervention items revealed that consultation subjects found them less helpful in understanding medication than group members ($\chi^2 = 8.39$, $df = 1$, $p < 0.0041$). Group members in turn found them less helpful in learning about available community resources than consultation subjects ($\chi^2 = 8.69$, $df = 1$, $p < 0.0041$). The p levels reported reflect the correction for repeated tests of significance at the 0.05 level.

Discussion

Among the outcome variables in this analysis, the only significant improvement attributable to the psychoeducation interventions was in specific self-efficacy, that is, confidence in one's ability to understand mental illness in a relative and to cope with its consequences. As operationalized in this study, specific self-efficacy measurement was taken from Hatfield's (1983) outline of what families want from family treatment. Included in this scale were items related to acceptance ("You are

able to accept the fact that your disabled relative has a mental illness"), assistance for the disabled relative ("You are able to allow your disabled relative to do as much as he/she can for him/herself"), coping with symptoms ("You are able to respond to psychiatric symptoms such as hearing voices, talking to self, or paranoid thinking of your disabled relative"), relations with other family members ("You are able to gain acceptance of your disabled relative by other family members"), and negotiating the mental health system ("You are able to locate needed resources for your disabled relative"). Family members who received the individualized consultation reported a greater sense of self-efficacy at 3 months than control subjects did.

That specific self-efficacy was the only significant outcome immediately after a brief intervention concluded was not totally unexpected. It was the outcome dealing most directly with the focus of the psychoeducation interventions, both in the groups and in individual consultations. These interventions emphasized increasing family members' self-confidence in relating to their ill relatives. Improved outcomes in other areas, such as reduced burden, grief, or extent of adaptive coping behavior, may take more time as family members practice new skills. In addition, using these new skills may benefit the ill relatives in ways not apparent in an immediate assessment of the family member. The hypothesis that psychoeducation of family members may be linked to improvement in the mentally ill will be explored later in this study. Change in the outcomes of the ill relative cannot be expected imme-

Table 1. Regression model: Service condition and support group experience as independent variables explaining self-efficacy, $n = 177$

Independent variable	<i>b</i>	<i>t</i>	<i>p</i>
Consultation without other support group experience	4.07	3.00	< 0.01
Consultation with support group experience	4.20	3.34	< 0.001
Group psychoeducation without other support group experience	4.82	3.21	< 0.01
Group psychoeducation with support group experience	1.65	1.28	NS
Support group experience alone	1.32	1.08	NS

Note.—NS = not significant.

diately at the conclusion of a psychoeducation intervention. However, such change could be evaluated after the family member has had the opportunity to put new skills or knowledge to use.

Both psychoeducation interventions produced desirable outcomes among family members. The interaction of group psychoeducation with prior support group experience, however, may indicate that its usefulness is more limited than individualized consultation. The strong showing for consultation among these family members may indicate that its flexibility is beneficial. Individualized goals are tailored to the needs of family members; thus, those who already know something about the illness and the mental health system will have other goals consistent with their needs.

Group psychoeducation produced an improvement in specific self-efficacy only among family members who did not have support group experience. For these individuals, the group psychoeducation may serve as an initiation into active involvement with their ill relatives' treatment. It may also be their first experience interacting with other relatives of mentally ill people. The benefits of these first-time experiences may be as important as the content of the workshop curriculum.

This analysis supports comments at a roundtable discussion at the 1989 Institute for Hospital and Community Psychiatry (Pfeiffer and Mostek 1991) that retention of information and skills may be helped through more individualized assistance to the family. During individualized consultation, families identified needs and set goals to meet those needs. The

same material was presented in both group and individualized sessions. The retention of confidence in these skills by those in the individualized condition, may have resulted from the presentation of the material and the practicing of the skills specifically relevant to each family. The group experience may be equally important to an individual with a newly diagnosed relative or to one who has never sought out groups of family members with mentally ill relatives.

Though individualized consultation appears to be more immediately effective than group psychoeducation in bolstering the self-efficacy of family members with experience in support groups, it also uses more resources, since specialists must spend more time with each family. Cost-benefit analyses may be needed to provide data to agencies that may be less willing to provide individualized consultation because of resource constraints.

Another option is to use an adapted individual consultation model for groups. For example, family group facilitators could use the three phases of the individual consultation model to structure group discussion. The "feeling or connecting" phase could be adapted to a group model by focusing initial group meetings on providing empathy and support as participants describe their respective predicaments. Subsequent meetings could be spent helping members develop their objectives in managing their personal situations. This focusing phase could provide social support and enable members to learn problem definition skills such as prioritizing and focusing by observing others develop their objective lists. The

"finding" phase could be implemented in remaining meetings by focusing on strategies, skills, and suggestions relevant to the objectives identified by group members. Since individualized attention seems to be a key element of self-efficacy enhancement, group facilitators could use members' actual situations to explain and demonstrate strategies that might help them meet their objectives. As in consultation, members could report their results to the group, so that strategies could be refined or modified. These techniques for structuring family group meetings are similar if not identical to those in McFarlane's model of multifamily group therapy, which has been shown to reduce relapse (McFarlane 1990; McFarlane et al. 1995). Presumably, this group approach could be used by a different cross-section of family members, however, because it does not require participation by the ill relative or a lengthy commitment by the family. Future research is needed to compare the efficacy of more individualized group psychoeducational approaches with other family interventions that do not require the ill relatives to participate.

The differences in satisfaction found between the two services appear to be rooted in the different character of the services provided. In group psychoeducation, sessions on the use and side effects of psychiatric medication are always provided. This information, while provided in material given to the individual consultation clients, may not always have been discussed with the consultant. Consultation, by its nature, may focus on more personal concerns, such as relationship skills with the

ill relative. Alternatively, individual consultation may make the material presented more relevant to specific problems. For example, focusing on available community resources for the specific needs of individual family members may be easier in consultation than in groups.

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The Authors

Phyllis Solomon, Ph.D., is Professor, and Jeffrey Draine, Ph.D., is Research Associate, School of Social Work, University of Pennsylvania, Philadelphia, PA. Edie Manion, M.F.T., is Technical Director, and Marilyn Meisel is Executive Director, Training and Education Center Network, Mental Health Association of Southeastern Pennsylvania, Philadelphia, PA.