Family psychoeducation as a treatment for schizophrenia was developed 40 years ago almost simultaneously and independently by investigators who at the time were not family therapists. Although the original goal was to decrease high expressed emotion as a means of preventing relapse, later variations have gone beyond to focus on social and role functioning and family well-being. Explicitly disavowing the earlier assumptions that family pathology caused relapse and deterioration, family psychoeducation seeks to engage family members as more sophisticated partners, complementing interventions by clinicians with specialized interactions and coping skills that counter the neurologic deficits inherent to the disorder. It has proved to be one of the most consistently effective treatments available. Reports on outcome studies now number more than 100, while meta-analyses put relapse rate reduction at 50–60% over treatment as usual. The most recent application in first episode and prodromal psychosis, combined with other evidence-based interventions, is yielding perhaps the most promising results yet achieved—substantial return of functioning and avoidance of psychosis altogether. Reviewed here are its scientific, theoretical, and clinical sources, a description of the most commonly applied version—the multifamily group format, selected clinical trials spanning those four decades, international and ethnic adaptations, and studies on mechanisms of efficacy.

Keywords: Family Intervention; Schizophrenia; Psychosis; Psychoeducational Multifamily Group; Family Psychoeducation; Early Intervention

Family psychoeducation (FPE) for the psychotic disorders has been established as one of the most effective psychosocial treatments ever developed. It is a structured method for incorporating a patient’s family members, other caregivers, and friends into acute and ongoing treatment and rehabilitation. The descriptor “psychoeducation” can be misleading: FPE includes cognitive, behavioral, and supportive therapeutic and rehabilitative elements, utilizes a consultative framework, and shares some characteristics with structural family therapy. The model most commonly used today is an amalgam of FPE (Anderson, Hogarty, & Reiss, 1986), behavioral family therapy (Falloon, Boyd, & McGill, 1984), and multifamily group therapy (McFarlane, 2002). Based on a family–patient–professional partnership, the most effective models are essentially cognitive-behavioral therapy with consistent inclusion of family members as collaborators. As a substitute for a family member, it can include any friend or para-professional person who is providing support to persons with a severe mental illness. In contrast to most family therapies, the family is not the object of therapy but rather a key implementer, as an indispensable colleague with
differing expertise and potential skills. 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 severe mental illness. Within this range of potential resources, this review will address only the clinical intervention of FPE and its effects for the psychotic disorders.

As a group of related models with common characteristics (World Schizophrenia Fellowship, 1998), FPE:

- 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 often severe challenges posed to the family system.
- Assumes that the way in which relatives behave toward and with the person with mental illness can have important effects, both positive and sometimes negative, on that person’s well-being, clinical outcomes, and functional recovery.
- Combines informational, cognitive, behavioral, problem solving, communication, and consultative therapeutic elements.
- Is initiated and led by mental health professionals.
- Is offered as part of a clinical treatment plan for a specific patient/consumer.
- Focuses primarily on benefiting consumer/patient outcomes, but improvements for family members (e.g., reducing confusion, exasperation, and emotional distress) are also essential to achieve those outcomes.
- 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 and instruction;
  - implementing individualized coping and rehabilitative strategies;
  - expanding social support networks; and
  - explicit crisis planning with professional involvement.
- Are generally diagnosis specific, although cross-diagnosis models have been developed and are often the de facto practice.

Around these core elements, FPE programs vary considerably: FPE may take place with just one family (single-family psychoeducation, SF-PE) 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 (for maximum efficacy, for months or even 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 patients 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 dysfunction etiological theories of the past” (Jewell, Downing, & McFarlane, 2009).

Evidence that FPE benefits the most important clinical outcomes has been established, particularly regarding people with schizophrenia. Family psychoeducation has been empirically demonstrated in a large number of clinical trials to improve outcomes in schizophrenia and bipolar disorder to the same or greater degree as antipsychotic medication, complementing but doubling its treatment effects. Family intervention is particularly

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beneficial in the early years of the course of a mental illness, when improvements can have a dramatic and long-term effect and while family members are still involved and open to participation, change in attitude, and interaction with the patient. Patients who experience frequent hospitalizations or prolonged unemployment benefit substantially and often dramatically, as do families who are especially exasperated or confused about the illness or even hostile toward the patient.

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, Schizophrenia Patient Outcomes Research Team (PORT) (Dixon et al., 2009), and the Presidents New Freedom Commission (Hogan, 2003). The goals are to improve clinical and functional outcomes and quality of life for the patient and to reduce family stress and strain as an indispensable means of achieving those outcomes. It combines the complementary expertise and experience of family members, patients, and professionals. Given the depth of empirical evidence for efficacy, it should be applied as widely and as routinely as medication, whenever there is a family member available. Unfortunately, this does not mean it is commonly available or fully utilized.

Background and History

Family psychoeducation originated from several sources in the late 1970s. Perhaps the leading influence was the growing realization that conventional family therapy, in which family dysfunction is assumed and becomes the target of intervention for the alleviation of symptoms, proved to be at least ineffective and in many cases damaging to patient and family well-being. Awareness also grew, especially among family members themselves and their rapidly growing advocacy organizations, that living with an illness such as schizophrenia is demoralizing, frustrating, and confusing for patients and families alike. In a reciprocal process, the resulting stresses on families often lead to persisting patterns of interaction that can have equally devastating effects on the patient and the course of the disorder over time. It became increasingly clear that to adapt under these circumstances, the family must have the available knowledge about the illness itself and coping skills specific to a particular disorder, skills that are counterintuitive to most families and many clinicians. It became clear that it was unrealistic to expect families to understand such mystifying disorders and to know what to do about them, independent of professional guidance. The implication was that clinicians are a crucial source of that information, guidance, and emotional support.

As to coping skills, families sometimes develop methods of dealing with positive, negative, and mood symptoms, cognitive deficits, functional disabilities, and the desperation of their ill relative, although usually through painful trial and error. These successes, however, are rare. Furthermore, the MFG-FPE model assumes that families need to have access to each other to learn of other families’ successes and failures and to establish a repertoire of clinically effective coping strategies that are closely tailored to the disorder, to the specific family, and to the individual person. Furthermore, family members and significant others often provide emotional and instrumental support, case management functions, financial assistance, employment, advocacy, and housing to their relative with mental illness. Doing so can be rewarding but poses considerable burdens. Family members often find that access to needed resources and information is lacking. Too often, the end result is a family that is so anxious, confused, exasperated, demoralized, or even hostile that their interactions with the patient become risk factors for relapse, exacerbation of functional deficits, family disruption, and eventual deterioration. Given that perspective,
clinical investigators began to recognize the crucial supportive role families played in outcomes after an acute episode of schizophrenia and endeavored to engage families collaboratively, sharing illness information, suggesting cognitively sophisticated interactions and strategies that promote recuperation, and teaching coping strategies that reduce their sense and experience of burden. The group of interventions that emerged became known as FPE.

These approaches recognize that schizophrenic and mood disorders are brain disorders that are only partially remediable by medication, and that families can have a significant effect on their relative’s recovery. Functional deficits and behavioral changes in these disorders are exacerbated and even induced by stress. Nevertheless, those deficits are often the most confusing and burdensome for family members because they usually do not identify them as part of the disorder, while also finding themselves trying to compensate for those deficits. The psychoeducational approach shifted away from attempting to get families to change their “disturbed” communication patterns toward educating and persuading families that their interactions with the patient can facilitate recovery by compensating for those deficits and sensitivities specific to the disorder. For example, some families interfere with recuperation if in their natural enthusiasm to promote and support progress they create unachievable demands and expectations, but the same family could have a dramatically positive effect on recovery by gradually increasing expectations and supporting an incremental return of functioning. This strategy is much like that which is now standard practice after a heart attack.

Research conducted over the last three decades has supported evidence-based practice guidelines for addressing family members’ needs for information, clinical guidance, and ongoing support. This research has demonstrated that altering key types of negative interaction and promoting disorder-specific interaction styles and recovery skills dramatically improve patient outcomes, while improving family well-being and meeting their members’ needs. FPE focuses on building on inherent family resiliency and strengths. Several models have evolved to address the needs of family members. They include:

1. Individual family consultation (Wynne, 1994);
2. Family psychoeducation (Anderson et al., 1986; Falloon, 1984; Miklowitz & Goldstein, 1997) in single-family format;
3. Psychoeducational multifamily group (Kopelowicz et al., 2012; McFarlane, 2002);
4. Modified forms of more traditional family therapies (Marsh, 2001);
5. A range of professionally led models of short-term family education (sometimes referred to as therapeutic education) (Amenson, 1998);
6. Family-led information and support classes or groups such as those of the National Alliance for Mental Illness (NAMI) (Dixon et al., 2004, 2011; Pickett-Schenk, Cook, & Laris, 2000); and
7. Open dialogue, a modern adaptation of systemic family therapy (Seikkula et al., 2006).

Of these models, professionally led FPE has a deep enough research and dissemination base to be considered an evidence-based clinical practice, especially in the earliest phases of the psychotic disorders (Dixon et al., 2001a; Lehman, Carpenter, Goldman, & Steinwachs, 1995; Lucksted, McFarlane, Downing, & Dixon, 2012; McFarlane, Dixon, Lukens, & Lucksted, 2002). Described here are the theoretical background for this treatment model, major components and technical methods and evidence for its efficacy, effectiveness, and key mediating processes.
MAJOR THEORETICAL AND RESEARCH-BASED CONSTRUCTS

Although the scientific evidence is increasingly strong that the major psychotic disorders are based in genetic, neurochemical, inflammatory, and/or neurodevelopmental defects involving brain function and structure, there is also abundant evidence that the first onset, progression, and relapse of psychotic or severe mood symptoms are the result of psychosocial stress. The stress-diathesis or stress-vulnerability model provides a widely accepted, empirically supported, and useful framework for describing the relationships among provoking agents (stressors), vulnerability and symptom formation (diathesis), and outcome (Zubin, Steinhauer, & Condray, 1992). Thus, a genetically or developmentally vulnerable person, whose inborn tolerance for stress is incompatible with exposure to either excessive internally or externally generated stimulation, may experience an episode of psychotic illness. This principle underlies the Biosocial Theory, which states that major psychotic and mood disorders are the result of the continual interaction of specific biologic disorders of the brain with specific psychosocial and other environmental factors (McFarlane, 2002). Specifically, episodes are induced in biologically vulnerable individuals by major stresses imposed by role transitions and other life events, social isolation, family expressed emotion, trauma, chronic anxiety, conflict, criticism, separation from family of origin, intense sensory stimulation, and experienced stigma, among many others. Most of these stresses lead to neurochemical alterations, leading to activation of the hypothalamic–pituitary axis, and subsequent elevations in dopamine, noradrenaline, and glutamatergic neuronal systems. This causal biosocial theory yields an interactive, feedback-based model for the final stages of onset and subsequent relapse, as compared to a simpler linear-causal model. In this conceptual framework, subtle symptoms, behavioral changes, and functional deterioration induce anxiety, anger, rejection, confusion, withdrawal, and other reactions in family members, friends, and fellow employees or students, which in turn exacerbate those same symptoms by inducing psychological and ultimately physiological and neurochemical reactions in the vulnerable person. The end result is a positive feedback process that leads to deterioration of both the patient and the family.

Prospective Studies of Family Interaction Prior to Onset

Tienari and his colleagues, and Goldstein and his colleagues earlier, have shown in two landmark prospective studies that family expressed emotion (EE) and communication deviance (CD), especially negativity directed toward the at-risk young person, predict onset of psychosis, interacting with genetic (having a biological mother with schizophrenia) or psychiatric risks (already having nonpsychotic symptoms and behavioral difficulties) (Goldstein, 1985; Tienari et al., 2004). In support of the stress (environmental risk) part of the biosocial theory, Goldstein demonstrated that onset of psychosis in disturbed adolescents seeking psychological treatment could be predicted by in vivo assessment of negative family affective style (a form of EE) and deficiencies in clarity and structure of communication (CD). The results in the Tienari study indicated that risk for development of schizophrenia spectrum disorders was much higher—37% versus 6%—among genetically at-risk adoptees reared in families in which there were higher levels of negativity, family constrictedness, and family boundary problems. There was no increase in incidence among genetically at-risk adoptees reared in less distressed families. Thus, not only were certain types of common family interaction implicated in triggering the onset of schizophrenia in genetically vulnerable children but also healthier family interaction played a protective role against onset of an illness in genetically predisposed individuals.

These studies imply a more complex but more precise model of etiology, but one that is more clinically useful. In essence, negative family interactional patterns are as potent and indispensable factors in onset as are genetic and neurodevelopmental factors, but only
when those predisposing biological factors are themselves present. This model reflects a growing literature that documents gene–environment interaction as a mutually causal process powerfully affecting mental and physical health (Felitti et al., 1998; Reiss, Neiderhiser, Heatherington, & Plomin, 2000; Repetti, Taylor, & Seeman, 2002). The current empirical conclusion is that severe psychiatric and medical disorders are the result of (negative family) nurture acting on (genetically or developmentally abnormal) nature, specifically defined in each disorder but heavily and equally dependent on both sets of influences. Furthermore, and in strong disagreement with schizophrenogenic theories, almost all of the negative family interaction is reactive to the developing or continuing illness itself. Family psychoeducation thus targets one of the two fundamental etiological domains in major psychotic disorders.

**Expressed Emotion (EE)**

High levels of criticism and emotional overinvolvement are strongly predictive of exacerbation or relapse of psychotic symptoms (Brown, Birley, & Wing, 1972). In an extensive meta-analysis, Bebbington & Kuipers (1994) cite the overwhelming evidence from 25 studies for a predictive relationship between high levels of expressed emotion and relapse of schizophrenia and bipolar disorder. Cook, Strachan, Goldstein, and Miklowitz (1989), Strachan, Feingold, Goldstein, Miklowitz, and Nuechterlein (1989), and Goldstein, Rosenfarb, Woo, and Nuechterlein (1994) found that expressed emotion is a reflection of transactional processes between the patient and family, supporting the conclusion that family functioning is strongly and negatively affected by aspects of the illness in the patient. That conclusion is supported by several studies indicating that EE is less pronounced in the earliest phases of psychosis, and increases over time. Hooley and Richters (1995) found that criticism and hostility rates rose rapidly in the first few years of the course of illness: in 14% of families with less than 1 year of illness, and in 50% after 5 years. EE differs widely across prodromal and chronic patient samples. Parental scores for rejecting attitudes and emotional overinvolvement were all but identical in two independent established disorder samples, but were markedly higher than scores in a prodromal sample (McFarlane & Cook, 2007). These studies strongly suggest that expressed emotion is largely reactive to cognitive deterioration, disabilities, and emerging negative behavior manifested by the young person developing a psychotic disorder.

**Attribution**

Relatives’ beliefs about the causes of illness-related behavior have been associated with expressed emotion. Relatives described as critical or hostile misperceive the patient as somehow responsible for unpleasant, symptomatic behavior, whereas more accepting relatives saw identical behaviors as characteristic of the illness itself (Brewin, MacCarthy, Duda, & Vaughn, 1991; Dominguez-Martinez, Medina-Pradas, Kwapił, & Barrantes-Vidal, 2014). This is an especially acute risk in the prodromal phase, during which symptoms and deficits often develop gradually, sometimes imperceptibly, appearing to be emerging personality or behavioral faults (McFarlane & Lukens, 1998). As a result, family members are more likely to respond with emotional intensity, criticism, or hostility.

**Communication Deviance**

Communication deviance, a measure of distracted or vague conversational style, has been consistently associated with schizophrenia. It was the other factor in the prospective long-term outcome study that predicted the onset of schizophrenic psychosis.
Studies have demonstrated that it is correlated with cognitive dysfunction in the relatives, which is of the same type, but of lower severity, as is seen in patients with schizophrenia (Wagener, Hogarty, Goldstein, Asarnow, & Browne, 1986). This suggests that some family members have an inherent and probably genetically derived difficulty holding a focus of attention, with important implications for treatment design.

**Social Isolation**

The available evidence across several severe and chronic illnesses indicates that ongoing access to social contact and support prevents the deterioration of such conditions and improves their course (Penninx, Kriegsman, van Eijk, Boeke, & Deeg, 1996). Family members of the most severely ill patients were isolated, preoccupied with, and burdened by the patient. Brown et al. (1972) showed that 90% of the families with high expressed emotion were small in size and socially isolated. In addition, social support buffers the impact of adverse life events (Lin & Ensel, 1984) and is one of the key factors predicting medication compliance (Fenton, Blyler, & Heinssen, 1997), adherence to treatment, schizophrenic relapse, quality of life (Becker et al., 1998), and subjective burden experienced by relatives (Solomon & Draine, 1995). Social network size decreases with number of episodes, is lower than normal prior to onset, and decreases during the first episode (Anderson, Hogarty, Bayer, & Needleman, 1984).

**Effects of Psychosis on the Family**

The psychotic disorders exact an enormous toll on family members, in anxiety, anger, confusion, received stigma, rejection, and exacerbation of medical disorders (Johnson, 1990). The organization of most families undergoes a variety of changes, including alienation of siblings; exacerbation, or even initiation, of marital conflict; severe disagreement regarding support versus behavior control; even divorce. Almost every family undergoes a degree of confusion, demoralization, conflict, and self-blame, which may be reinforced by some clinicians. Because some family members share subclinical forms of similar mood control deficits and cognitive abnormalities, treatment for psychotic disorders must be designed to compensate for those difficulties. Those deficits lead to diminished coping ability in some family members.

**A Model of Reciprocal Causation**

These critical family and psychosocial factors lead to onset and relapse of psychosis via (a) a general and biologically based sensitivity to external and internal stimulation and (b) a major discrepancy between stimulus complexity and intensity and cognitive capacity. These processes converge, generating external stresses that induce a spiraling and deteriorating process that ends in a major psychosis or onset of a major mood episode. This larger process is the potential target for FPE and multifamily groups, altering critical environmental influences by:

- Reducing ambient social and psychological stresses;
- Reducing stressors from negative and overly intense family interaction;
- Building barriers to excess stimulation;
- Buffering the effects of negative life events;
- Promoting patient- and family-specific coping skills; and
- Enhancing social networks and social support.
Thus, the core elements of this treatment are relevant education, training, enhanced coping skills, and support to family members, friends, and other caretakers—those who provide support, protection, and guidance to the patient/consumer.

**RESEARCH OVERVIEW**

A large number of controlled and comparative clinical trials have demonstrated markedly decreased relapse and rehospitalization rates among patients whose families received psychoeducation compared to those who received standard individual services, reductions of 20–50% over 2 years. Since 1978, with the publication of Goldstein’s study showing dramatic short-term effects of educational and coping skills training intervention, there has been a steady stream of rigorous validations of the positive effects of this approach on relapse in schizophrenic disorders. Overall, the relapse rate for patients provided FPE has hovered around 15% per year, compared to a consistent 30–40% for individual therapy and medication or medication alone (Baucom, Shoham, Mueser, DaIuto, & Stickle, 1998). It is important to note that medication is not a variable in these studies: The design of family psychoeducational approaches includes medication adherence as key to promoting recovery. Therefore, medication is provided in both the experimental and control conditions in almost every instance.

At least 13 literature reviews have been published regarding FPE in schizophrenia, all finding a large and significant effect for this model of intervention (Baucom et al., 1998; Dixon, Adams, & Lucksted, 2000; Dixon & Lehman, 1995; Dixon et al., 2001b; Falloon, Held, Coverdale, Roncone, & Laidlaw, 1999; Jewell et al., 2009; Lam, 1991; McFarlane & Lukens, 1998; Murray-Swank & Dixon, 2004; Penn & Mueser, 1996; Pitschel-Walz, Leucht, Bauml, Kissling, & Engel, 2001; Rummel-Kluge & Kissling, 2008; Taylor et al., 2009; Zygmunt, Olifton, Boyer, & Mechanic, 2002). For example, in an aggregate analysis of 11 studies of family interventions for schizophrenia, Baucom et al. (1998) found that an (unweighted) average of 25.5–28% of individuals with schizophrenia suffered a symptomatic relapse or rehospitalization while receiving a family intervention as compared to 63.6% of individuals who received routine treatment alone, an effect size comparable to that for antipsychotic medication versus placebo. Taylor’s (2009) review was broad in scope, surveying evidence for all services used by people with “longer term mental health problems” in the British system, and concluding that FPE should be a central component of effective treatment of schizophrenia. Zygmunt’s (2002) is the narrowest, reviewing only literature testing for medication adherence effects and published between 1980 and 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 U.S. Department of Health and Human Services’ Substance Abuse and Mental Health Services Administration includes McFarlane et al.’s (2002) multiple-family group model as an evidence-based practice and has released a “tool kit” developed by U.S. leaders in the field to promote its widespread implementation (U.S. Department of Health and Human Services, 2004). In addition, PORT treatment recommendations regarding schizophrenia state that family interventions should last at least 6–9 months and include illness education, crisis intervention, emotional support, and
training for coping skills. They add that if delivery of this long an intervention is impossi-
ble or unacceptable, adults with schizophrenia and their family members then be offered a
program of at least four sessions (Dixon et al., 2009; Lehman et al., 1998). Other best
practice standards (American Psychiatric Association, 1997; Frances, Docherty, & Kahn,
1996; Frances, Hoffman, Pass, & Andrews, 1987) have also recommended that families
receive education and support programs. In addition, an expert panel that included clini-
cians from various disciplines, families, patients, and researchers emphasized the import-
ance of engaging families in the treatment and rehabilitation process (Coursey, Curtis, &
Marsh, 2000a,b).

Three studies found no effect for FPE, providing additional insights into the necessary
components and processes (Kottgen, Sonnichsen, Mollenhauer, & Jurth, 1984; Linszen
et al., 1996; Telles et al., 1995). In the Kottgen study, the ongoing sessions were oriented
toward exploring psychodynamic and dysfunctional aspects within the families’ dynamics,
now considered contraindicated for nearly all families of patients with schizophrenia. In
the Telles study, conducted in a Spanish-speaking immigrant sample, there was a
reversed effect for behavioral family management among those from a less acculturated
subgroup and no effect for those from the more acculturated subgroup. Other recent stud-
ies in Spain have demonstrated the same robust effects as the prior studies in English-
speaking countries, suggesting that it was the sample’s immigrant status that may have
negated the effects of family intervention. In the Linszen study, the control group received
individual therapy that was well designed and also achieved low relapse rates comparable
to those in the family intervention sample (15–16% in both conditions). This study tested
family intervention only during an inpatient admission and not during outpatient treat-
ment, for which it was designed. The Linszen study illustrates a general finding: Pro-
grams lasting longer than 3 months had more robust effects. In fact, consistent efficacy
has only been demonstrated in those studies in which intervention was provided on an
ongoing basis, lasting at least 6 months, and incorporated problem solving, coping skills
training, expanded social support, and communication skills training. Thus, the noncon-
firming studies tend to suggest that core elements make a difference, but also that some
patients and families may require cultural and/or contextually specific adaptations of the
approach, and that other methods may also achieve comparable short-term effects.

It has become clear that education alone has at least short-term salutary effects for
family members (Dixon et al., 2011; McFarlane, Link, Dushay, Marchal, & Crilly, 1995a),
but other studies have found that there is no lasting effect on patient clinical or functional
outcomes (Abramowitz & Coursey, 1989). That might be expected given the long-term
course of illness of schizophrenia, eroding gains in understanding under the influence of
the persisting deficits, symptoms, and burdens. Thus, the critical elements include those
that involve changes in behavior and ongoing training in diagnosis-specific and clinically
oriented coping skills training. Increasingly, as the focus of intervention has shifted to
functional aspects, especially employment, the patient has been included in these skills
training and behavioral interventions. In the multifamily group approaches, there is
another element added—ongoing social support and social network expansion—for family
members and the patient.

U.S. RANDOMIZED TRIALS

Previous reviews have documented the significant effects of single FPE (Hogarty et al.,
1986) and family behavioral management (Falloon et al., 1985). MFG-PE has been found
to be superior to SFT-PE in two studies conducted by this author (McFarlane et al.,
1995a; McFarlane et al., 1995b). Across seven sites in New York and New Jersey, relapse
rates were significantly lower by one third in the multifamily format, even though the

Fam. Proc., Vol. x, xxxx, 2016
content delivered in the two conditions was identical. Positive symptoms at baseline markedly influenced relapse outcome in MFG-PE and SFT-PE \( (p < .05) \) (McFarlane et al., 1995b). Remarkably, for each one-point increase in the score on the baseline Brief Psychiatric Rating Scale (BPRS), the risk of relapse increased by 39\% in SFT, but, in stark contrast, decreased by 42\% in multifamily groups. Moreover, these effects were durable with continued participation in MFG. For example, in the first study (McFarlane et al., 1995a), benefits for relapse prevention were maintained across all years of a 4-year study of MFG for schizophrenia. Among patients who continued in treatment after the 4-year trial, non-relapers averaged over 7 years in remission, most having been in low-intensity treatment for the duration. The average period of remission was 59 of a possible 90 months. The MFG-PE effect was validated in a randomized trial of 97 adults with schizophrenia and their family members study conducted by a Washington state team of researchers. They compared 2 years of MFG-FPE against standard care (Dyck, Hendryx, Short, Voss, & McFarlane, 2002; Dyck et al., 2000). They found significant effects for relapse and negative symptoms. In later analyses, they reported that the MFG-FPE condition participants showed significant decrease in consumer hospitalizations with no net increase in outpatient services use over the 3 years after baseline (Dyck et al., 2002; Michael G. McDonell, Short, Hazel, Berry, & Dyck, 2006), and significantly reduced family member distress but no reductions in family burden and no increase in family member active coping or perceived social support (Hazel et al., 2004).

Mueser and colleagues published analyses from the randomized Treatment Strategies in Schizophrenia study \((n = 528 \text{ consumers + family members})\) (Mueser et al., 2001; Schooler, 1986). This large study compared (a) 2-year supportive family management (SFM; monthly multiple-family information/support meetings) with (b) more intensive applied family management (AFM) involving individual in-home behavioral family therapy. Both ran alongside three medication regimens. They found: (1) there were equal rates of relapse between the two conditions; (2) there was no effect in either condition on family burden; (3) consumer social functioning improved equally in both; (4) AFM was associated with family member perceptions of lower family friction and rejecting attitudes toward consumers; and (5) there was no medication-condition interaction. This was, in effect, a test of MFG without PE against SFT-PE, suggesting that the social interaction across families in groups by itself produces an effect comparable to that of SFT-PE.

Kopelowicz and his colleagues documented a significant effect among Latino families for MFG enhanced by a module to enhance medication adherence (Kopelowicz et al., 2012). MFG-PE with adherence was associated with higher medication adherence than MFG standard or treatment as usual. The MFG-PE adherence participants had a longer time to first hospitalization and were less likely to be hospitalized than those in MFG standard and treatment as usual. Increased adherence accounted for one third of the overall effect of treatment on the reduced risk for psychiatric hospitalization. The authors concluded that multifamily group therapy specifically tailored to improve medication adherence through a focus on the beliefs and attitudes of the target population was more effective than MFG-PE alone, which was more effective than treatment as usual.

**INTERNATIONAL RANDOMIZED TRIALS**

Internationally, FPE research has been proliferating, most recently focusing on family member outcomes as its effectiveness regarding consumer relapse is accepted. Recent reports have only added to the strong validation of the effects on relapse, particularly because these later studies have been conducted in a variety of
international and cultural contexts. Reductions in relapse for family intervention, compared to the control conditions, have been demonstrated in China (Ling et al., 1999; Zhang, Wang, Li, & Phillips, 1994; Zhao, Shen, & Shi, 1999; Zhao et al., 2000), Spain (Montero, Gomez Beneyto, Ruiz, Puche, & Adam, 1992; Muela Martinez & Godoy Garcia, 2001; Tomaras et al., 2000), Scandinavia (Rund et al., 1994), and Britain (Barrowclough et al., 2001). For instance, 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. 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 medication only group (37.8%), and approximately one quarter of the rate of the control group (61.5%) \( (p < .05) \). Chien and Wong (2007) compared 36 weeks of MFG-FPE to usual care, enrolling 84 family members of people with schizophrenia. MFG-FPE participants showed greater improvement in both family and consumer functioning, family self-perceived burden of care, and the number and length of participants’ rehospitalization. In a separate trial, Chien randomized 76 primary family caregivers of adults with schizophrenia attending one of two participating outpatient psychiatric clinics (Chien, Thompson, & Norman, 2008). 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 to a control group. A model has been developed specifically for Asian Americans, designed to fit this population’s different value orientations and cultural characteristics (Bae & Kung, 2000). These trials suggest that FPE confers benefits over usual care participants in China, whereas results regarding treatment compliance and medication adherence remain unclear. That these effects are additive to, but not substitutive for, antipsychotic medication was illustrated in a German study (Wiedemann et al., 2001). The investigators found that behavioral family management did not compensate for the increased risk of relapse posed by “targeted” drug treatment, in which the patient did not use medication unless experiencing prodromal signs or symptoms of relapse.

Beyond China and the United States, there are six randomized studies, some the first from their country. Reported as the first evaluation of MFG-FPE in Australia, Bradley et al. (2006) compared outcomes for English-speaking (34 consumer–family member pairs) and Vietnamese-speaking (25 pairs) participants in schizophrenia spectrum disorders, in part to investigate the feasibility of using the MFG-PE model cross-culturally and cross-linguistically. Participants were randomized to case management versus case management plus MFG-PE delivered with minimal cultural adjustments advised by an experienced Vietnamese therapist. There was significantly less relapse in the MFG-FPE condition (3 people (12%) vs. 9 (36%)) during the year of intervention, and a large difference 6 months after it ended (6 people (25%) vs. 15 (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 was not significantly different.

Two Italian studies showed similar results. Magliano, Fiorillo, Malangone, De Rosa, and Maj (2006) had 34 clinicians trained in FPE select 71 families of consumers with schizophrenia to be randomized to a 6-month SFT-PE 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. Carra, 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 MFG-PE. Only compliance with standard care was significantly greater in the FPE group at 1 year, but this diminished by 24 months. Although expressed emotion was more often reduced among those in the experimental condition, this effect also had dissipated after an additional year. This may illustrate the limitation of efficacy for education-only intervention.

In Pakistan, a randomized study of primary family members for 108 persons with schizophrenia was performed, using a SFT-PE variation translated into Urdu plus medication management, versus medication management alone (Nasr & Kausar, 2009). The SFT-PE condition showed significantly greater reduction in burden 6 months after baseline (i.e., at the end of the intervention) than controls. 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 (Kulhara, Chakrabarti, Avasthi, Sharma, & Sharma, 2009). FPE participants showed significantly more improvement in psychopathology, disability, caregiver satisfaction with treatment, and perceptions of social support. However, there were no significant differences for treatment dropout, relapse, caregiver burden, or caregiver coping. The authors also report that the program was practical to implement and not expensive.

The universality of this approach seems to have been demonstrated in contexts different enough that further generalization in other cultures and countries appears to be likely to succeed. However, given results that were less than optimal in some of these countries, further attention to the necessary adaptations appears to be necessary.

**EFFECTS ON FUNCTIONING AND WELL-BEING**

These and other studies have demonstrated significant effects on other areas of functioning, thereby addressing a frequent criticism of the clinical trials: Relapse is only one dimension of outcome and course of illness. Many consumers and their family members are more concerned about the functional aspects of the illness, especially housing, employment, social relationships, dating, marriage, and general morale and well-being than about remission, which tends to be somewhat abstract as a goal. Several of the previously mentioned models, particularly the American versions—those of Falloon, Anderson, and McFarlane—have used remission as both a primary target of intervention but also as necessary to achieve recovery. In addition, these models all include major components designed to achieve functional recovery, and the studies have documented progress in those same domains, as investigators have shifted focus to targeting these more human aspects of life. Other effects have been shown for:

- Improved family member well-being (Cuijpers, 1999; Falloon & Pederson, 1985; McFarlane, Dushay, Stastny, Deakins, & Link, 1996; Shi, Zhao, Xu, & Sen, 2000; Solomon, Draine, Mannion, & Meisel, 1996; Wang et al., 1999; Zhao et al., 1999);
- Increased patient participation in vocational rehabilitation (Falloon et al., 1985);
- Substantially increased employment rates, when combined with supported employment (McFarlane et al., 1995b, 1996, 2000);
- Decreased psychiatric symptoms, including deficit syndrome (Dyck et al., 2000; Falloon et al., 1985; McFarlane et al., 1995b; Zhao et al., 2000);
- Improved social functioning (Montero et al., 2001);
- Decreased family medical illnesses and medical care utilization (Dyck et al., 2002), and reduced costs of care (Cardin, McGill, & Falloon, 1985; McFarlane et al., 1995b; Rund et al., 1994; Tarrier, Lowson, & Barrowclough, 1991).
CONCLUSIONS: RANDOMIZED CLINICAL 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” FPE intervention in use, and that the core concepts across variations have robust effects for many clinical outcomes. Many randomized studies show positive results similar to those in the United States when adapting U.S.- or U.K.-originated FPE models to other cultures, although others find no results. The prevailing U.S. 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, or complete cross-cultural meta-analyses. FPE researchers could advance this work by testing cross-cultural hypotheses, perhaps via replication studies of successful cultural adaptations.

OTHER QUASI-EXPERIMENTAL OUTCOMES RESEARCH TESTING FPE IN SCHIZOPHRENIA

Aside from randomized controlled trials, other studies of FPE have tested applications in various settings and countries, providing data on effectiveness in routine applications. However, their interpretation is often impeded by methodological weaknesses, especially the absence of a control or comparison group.

Two published studies from Japan indicate active inquiry into FPE. Sota and colleagues report no differences in the benefits of a shorter versus longer FPE course in post hoc analyses of an uncontrolled study (Sota et al., 2008). Mino and colleagues found substantial inpatient care cost savings in the 9 months after discharge among people with schizophrenia whose relative completed a 9-month FPE course, compared to those who did not; but no difference in outpatient care costs, which yielded a positive benefit/cost ratio (Mino, Shimodera, Inoue, Fujita, & Fukuzawa, 2007).

Weine and colleagues reported pre-to-post reductions in medication noncompliance and hospitalization and increases in family mental health services use in a mixed-diagnosis sample of 30 families in postwar Kosovo, using a comparison group (Weine et al., 2005). The authors note that the study resulted in beneficial policy changes in Kosovo’s health service.

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

Sherman in the United States has evaluated 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, 2006). As such, it is more education than therapy. Using an 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. Furthermore, participant improvement (pre- vs. posttreatment) in self-care was positively related to number of workshops attended. Later evaluation reported high levels of participant satisfaction and attendance, and found an inverse correlation between attendance and caregiver distress (Sherman, Fischer, Sorocco, & McFarlane, 2011).
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 effects of early intervention, while widening the diagnostic scope to include all psychoses. From the perspective of FPE, many advances have occurred. Work in the 1990s by Hooley (1995), Falloon (1992), and others indicated that dysfunctional family patterns (including “expressed emotion”) tended to develop alongside the family member’s illness rather than precede or cause it. For example, a very low level of rejection and a high level of warmth were found among 100 families of youth in the prodromal phase of psychosis, compared to samples with longstanding illness (McFarlane & Cook, 2007). The idea that negative family dynamics observed among families largely result from the stresses and negative consequences of the illness has led a few research groups to include FPE in clinical approaches to treat early psychosis or to prevent its manifestation after prodromal signs. Providing information, 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 interaction patterns, thereby positively impacting outcomes for consumers and family members.

In the New York State comparative trial of SFT vs. MFG formats, the relapse rate among individuals receiving MFG was significantly lower for individuals experiencing their first episode of psychosis as compared to more chronic patients (19% vs. 44% at 2 years) (McFarlane et al., 1995b). Among the original and early clinical trials of psychoeducation or behavioral family intervention, a substantial proportion of subjects were having their first episodes (e.g., Hogarty: 23% (Hogarty et al., 1986); Falloon: 36% (Falloon et al., 1985); Leff: 44% (Leff et al., 1989); Montero: 70% (Montero et al., 2001)), suggesting specific efficacy in first-episode psychosis.

That laid the foundation for two Scandinavian studies that incorporated variations in MFG-FPE into their respective multisite early intervention studies. In Denmark (Thorup et al., 2005; Jorgenson, et al., 2000), the OPUS study recruited a first-episode sample, and randomized participants and family members to MFG-FPE plus family-aided assertive community treatment (FACT; McFarlane, Stastny & Deakins, 1992) or to standard treatment which included neither (Nordentoft et al., 2006; Thorup et al., 2005). 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 (Nordentoft et al., 2006). Other authors have found family interventions, especially MFG-P, to be beneficial in first-episode situations as well (Addington, Collins, McCleery, & Addington, 2005; McCleery, Addington, & Addington, 2007). An international survey concluded that, both as an international consensus of opinion and by evidence levels, MFG-FPE ranked only behind antipsychotic medication for efficacy in first-episode psychosis (Addington, McKenzie, Norman, Wang, & Bond, 2013).

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 the usual (i.e., later) manner. The treatment for all participants consisted of MFG-FPE with added social skills training, in a quasi-experimental design (Fjell et al., 2007; Johannesssen et al., 2001). However, fewer than half of 301 consumers participated in the MFGs; reluctance to participate increased with age. Although treatment was well received by those who did take part, there was a long (6–12 months) delay in initiating MFG-FPE, erasing many advantages of early family intervention.

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Similar early psychosis 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, 2014). It shares many elements of the TIPS, OPUS, and other early intervention studies, including MFG-FPE, FACT, psychotropic medications by symptom indication, and supported employment and education. A clinical trial, titled Early Detection and Intervention for the Prevention of Psychosis, tested this model in six U.S. cities among diverse populations representative of the United States for a variety of functional, clinical, family, and public health measures (McFarlane, Cornblatt, & Carter, 2012; McFarlane et al., 2015). The experimental cohorts included both those at clinical high-risk (prodromal) and very early (i.e., duration less than 30 days) first-episode psychosis (FEP). There were significant results for psychotic, negative, disorganized and general symptoms, global outcome, and increase in participation in school and work. Results for social and occupational functioning were not statistically significant, but both cohorts’ mean scores were in the normal range after completion of 2 years of treatment, matching outcomes for the low-risk comparison group receiving community standard or no treatment. Post hoc analysis disclosed that results for psychotic symptoms were associated with exposure only to MFG-FPE, but not antipsychotic or antidepressant medications.

Another multisite clinical trial tested family-focused therapy (FFT) against enhanced care (three sessions of family education) in prodromal youth \((n = 129)\) (Miklowitz et al., 2014). Participants in FFT showed significantly greater improvements in attenuated positive symptoms over 6 months than in the control condition. Negative symptoms improved independently of psychosocial treatments. Changes in psychosocial functioning depended on age: Participants more than 19 years of age showed more role improvement in FFT-CHR, whereas control participants between 16 and 19 years of age showed more role improvement. The results were independent of concurrent pharmacotherapy. Bechdolf et al. (2004) found a significant prevention effect for conversion to psychosis in a randomized clinical trial of brief MFG-PE combined with cognitive therapy. Based on this and other early psychosis intervention studies, it is likely that future recommendations for psychosocial intervention to prevent onset of psychosis will include MFG-PE and psychosis-specific versions of CBT.

A recent multisite effectiveness trial in first-episode psychosis, RAISE, included SFT-PE, but found no differences in psychotic or negative symptoms or rehospitalization rates, although there were effects for retention in treatment and quality of life (Kane et al., 2016). This result contrasts with the superiority of MFG-PE specific to the first episode of schizophrenia noted previously.

**MEDIATING EFFECTS**

From a theoretical standpoint, this broad spectrum of effects is mediated either by numerous intervention components or a smaller number of nodal alterations whose secondary effects ramify throughout the family system and biological processes within the affected individual. The second option is strongly supported by the finding that all the efficacious family psychoeducational models reduce family expressed emotion and that doing so is directly associated with the reduction in relapse found in clinical trials. This linearity of effects is reassuring, because the intent of the early models, that developed by Leff particularly, was to reduce expressed emotion. Tarrier, Sommerfield, and Pilgrim (1999) isolated reduction in EE as the key mediator of relapse, and that active involvement of the relatives in learning new behavioral approaches was essential for reducing EE and alleviating negative outcomes.
However, the better known variants—FPE, family behavioral management, and psychoeducational multifamily groups (PMFGs)—have deliberately added important new dimensions of intervention, tending to support the first theoretical possibility that these models have several different domains of effect. These include good general clinical management strategies and empathic engagement of patient and family members in Anderson’s model, problem solving, communication skills training, and in-home sessions in Falloon’s model and multifamily participation in problem solving and expanded social networks and social support in the MFG-FPE format. Each of these components is designed to impact specific and somewhat separate aspects of the illness and the family system, as well as expressed emotion. A key instance is Falloon’s demonstration that successful mastery of problem solving by family members was more directly associated with relapse prevention than reductions in expressed emotion (Falloon et al., 1985). When a very similar version of FPE is incorporated, multifamily groups lead to lower relapse rates and higher employment than single-family sessions (McFarlane et al., 1995a,b). The parsimonious explanation is that enhanced social support, inherent only in the multifamily format, reduces vulnerability to relapse, and that effect owes to a reduction in anxiety and general distress (Dyck et al., 2002). Both of these empirical results strongly suggest a multidimensional effect as the explanation of improved clinical outcomes. That argument is strengthened further by recent studies showing dramatic improvements in employment among people with schizophrenia, especially when combined with supported employment that is designed to achieve functional goals (McFarlane et al., 1996, 2000). Therefore, both theoretical possibilities are supported by present evidence. Many of the effects of these models are mediated by reductions in expressed emotion, but that effect is enhanced by elements that focus on general empathic support for families and patients, problem-solving, coping, and communication skills training and enhanced social networks and support.

Delivery of the appropriate components of FPE to patients and families appears important in determining outcomes of families and patients. Several studies (e.g., Greenberg, Greenley, & Kim, 1995) have demonstrated that programs fail to reduce relapse rates if they present information without also providing family members with skills training, ongoing guidance, and problem solving regarding illness management and rehabilitation, and emotional support. Information-only interventions also tend to be quite brief; a meta-analysis of 16 studies found that family interventions of fewer than 10 sessions had no important effects on relatives’ burden (Cuijpers, 1999); there have been no studies that found that brief, education-only interventions reduce relapse rates. However, the number of sessions could not explain completely the differential outcomes; length of total time, allowing for refinement of coping skills and strategies by the family and patient, rather than number of sessions, may be a factor, as may be the therapists’ styles of dealing with the emotional reactions of patients and relatives to the educational material. The behaviors and disruptions of schizophrenia, in particular, require more than education to enhance patient outcomes.

An exhaustive review of 729 publications including analysis or data on mediating or moderating factors was published recently in this journal (Gracio, Goncalves-Pereira, & Leff, 2016). While definitive conclusions that allow attribution of specific mechanisms to FPE appear to be lacking, the authors gleaned several consistent findings across these studies. In responses from family members and patient participants, it is clear that engagement and relationship building, trust, and collaboration are key, as in almost all psychotherapies and even in prescribing psychiatric medications. Other factors include education, almost regardless of the method of delivery. Levy-Frank, Hasson-Ohayon, Kravetz, and Roe (2011) found that both strong therapeutic alliance and PMFG with problem solving led to equally positive outcomes, including reduction in EE, which in itself appeared to be correlated with reduction in psychiatric symptoms. FPE is effective
because it provides, at a minimum, a therapeutic alliance with family members and the affected person, extensive education, and guidance and coping skill training (Gracio et al., 2016; Kuipers, 2006). The relatives who have experienced MFG-PE and other group family interventions invariably attribute positive outcomes to sharing concerns, burdens, and ultimately coping strategies across family lines, which can be subsumed under expanding social networks and social support. These are perhaps the most powerful variables known for predicting not only psychiatric outcomes but also death rates and other key outcomes from many chronic medical disorders (Putnam, 2000).

These variables may be the explanation of the results claimed by the open-dialogue approach developed in Lapland by Lehtinen, Seikkula et al. (2006). In spite of having been tested in only one clinical trial with mixed results, it has been posited as an alternative to FPE, given its emphasis on engagement, receptiveness, conceptual flexibility, dismissal of the therapist’s expertise, and positive reframing. The developers appear to be unaware of controlled trials of SF-PE or MFG-PE in the United States, or of the vast research base for FPE. This may be the result of the model being based historically on systemic family therapy and psychodynamic individual therapy concepts, in which the family is seen inevitably as a pathological influence, nearly the theoretical opposite of FPE. It is, like many applications of SF-PE, usually done in the home, with the provision of some education about psychosis. Interestingly, one outcome was a reduction in incidence of first-episode psychosis in Western Lapland, as was documented in the PIER study in the United States. This approach in its current form, which de-emphasizes universally dysfunctional family pathology, may offer a way to accommodate and assist families that are not easily engaged in FPE, although it may be at the cost of some reduced reliability of outcome.

The other key mediating variable is fidelity of the intervention itself, relative to the models designed and tested originally by developers. For instance, McDonell et al. (2007) documented a nonlinear decline in outcome as fidelity to the MFG-FPE model declined; only high fidelity MFG implementation replicated relapse results, unlike even moderate, let alone low, fidelity. Clearly, as in other advanced methods in medicine and technology, advances in outcomes require adherence to the methods used originally to achieve them. The evidence strongly suggests that casual modifications and short-cuts lead to diminished chances for recovery, often to the level of usual care. For a number of historical reasons, the mental health field has been slow to recognize the importance of precise, scientifically validated methods, as they are in most other fields of modern human endeavor.

**CONCLUSION**

Abandoning the assumption of family pathology, FPE has accumulated a remarkable record of efficacy, even while being applied in settings and populations vastly different than those in which it was developed. Meta-analyses have demonstrated reductions in relapse rates for persons suffering from schizophrenia to 40% of those in control groups, comparable to, if not larger than, the effect for antipsychotic medication versus placebo. The multifamily group format reduces those rates by another one third. This record is not matched by many treatments for any disorder, but does support the efficacy of directive, cognitive, and behavioral therapies when applied in severe psychiatric syndromes. The instances in which studies have not replicated those results tend to have deviated substantially from the methods recommended by previous successful clinical trials or, in the case of some international trials, may have suffered from inadequate adaptation to the regional culture. That is suggested by the evidence that some culturally specific adaptations of psychoeducational multifamily groups, for example, to Latino populations in the United States or the Vietnamese population in Australia, have been remarkably effective in more
rigorous trials. Recent applications in first-episode psychosis and the prodromal phase of psychoses have shown promising results, leading to increasing dissemination in the United States and internationally. A partial failing is to fully study and document exactly the mechanisms by which the approach is effective. It is clear that reducing expressed emotion, the original goal, is necessary but not sufficient; improvements in functioning and family well-being, when they occur, appear to be related to modifications intended to focus on coping strategies to address stressors and cognitive impairments. Ultimately, the challenges in the future are two: to fully implement this approach for the people who will benefit and to continue to seek and test adaptations that might further improve outcomes.

REFERENCES


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