Review of the Literature

A complete review of the family education programs is beyond the scope of this manual. However, good review articles exist (e.g., Atkinson & Coia, 1995; Lam, 1991; Pickett-Schenk, Lippincott, Bennett, & Steigman, 2008; Simon, McNeil, Franklin & Cooperman, 1991) and the Best Practices in Family Intervention for Serious Mental Illness website (w3.ouhsc.edu/bpfamily) summarizes many available programs. A few of the major variables involved in programs are briefly discussed below.

Family education programs vary in format, target population, duration, goals, and mode of intervention. Programs may have an educational focus, a skills-building approach, a strictly supportive focus, or some combination of the three. Many programs focus on a specific mental illness, typically schizophrenia (e.g., Abramowitz & Coursey, 1989; Amenson, 1998; Atkinson & Coia, 1995; Posner, Wilson, Kral, Lander & McIlwraith, 1992; Simon & Birchwood, 1987), while others focus on the major mental disorders (e.g., Baker & Landwehr, 2003; Bisbee, 1991; Burland, 1993; Mannion, Mueser & Solomon, 1994). Programs have also been developed specifically for consumers with both a psychiatric disorder and substance abuse, including Family Intervention for Dual Disorders (Mueser, et al., 2003) and Behavioral Couples Therapy for Alcoholism and Drug Abuse (O'Farrell & Fals-Stewart, 2000; Rotunda, et al., 2001).

Some programs include consumers in the interventions (e.g., Moller & Wer, 1989), but most do not, as consumer involvement can have an inhibitory effect on the educational process (Reilly, Rohbaugh & Lachner, 1988). Most programs include all adult family members (parents, siblings, adult children, etc.), and a few focus specifically on the needs of a particular relative (e.g., program for spouses in Mannion et al., 1994). The growing recognition of the importance of sibling relationships in the context of serious mental illness (Smith & Greenberg, 2008) may indicate a need for specific outreach to and services for this group. Family interventions range from a single-session educational workshop (e.g., Pollio, North, Reid, Miletic & McClendon, 2006) to intensive programs of 15 classes or more (Burland, 1993; Cuijpers, 1999).

Although many courses are facilitated by mental health professionals, some programs train family members to teach the classes (e.g., Burland, 1993). The National Alliance on Mental Illness (NAMI) has endorsed the Family to Family Education Program, a 12-week family member-led education program focused on serious mental illness. Preliminary research of this program has found that participants had a significantly greater sense of empowerment and lessened worry and distress about their family member; further, these positive outcomes were sustained at a 6-month follow up (Dixon, Stewart, Burland, Delahanty, Lucksted et al., 2001). Family to Family participation has also been associated with improved knowledge of mental illness and the mental health system (Dixon, et al., 2004). Research on another popular family-led education program, Journey of Hope, has found participation to be associated with less depression and improved perspectives on their relationships with their loved ones (Pickett-Schenk et al., 2006). A recent randomized clinical trial of Journey of Hope found that participants reported improved understanding of

mental illness and a decreased need for information when compared with wait-list controls (Pickett-Schenk, Lippincott, Bennett, & Steigman, 2008).

Regarding content of family programs, some investigators have asked families directly how the mental health system could provide assistance in dealing with their loved ones. Family members report that they need education about the diagnosis and treatment of mental illness, opportunities to share their stories, reassurance that they are not alone in struggling with their stressful family situations (Gaskill & Cooney, 1991-1992; Gasque-Carter & Curlee, 1999), resources for coping, and help with family relationships (Pollio et al., 2006). Family members also need to learn realistic expectations about the prognosis of their loved ones (Atkinson & Coia, 1995). Approximately 60% of families in a survey reported wanting more contact with professionals (Spaniol, Jung, Zipple & FitzGerald, 1984). Family members need adaptive coping skills (both for themselves and for their loved ones) and emotional support. When families feel better able to cope with the consumer's behavior, they report fewer psychosomatic symptoms and a lower level of burnout (Cuijpers & Stam, 2000). As families learn about the biological etiology of many mental illnesses, their feelings of guilt can lessen.

No programs examined in this review had specific information on coping with PTSD in a family member, which is a notable gap in the family education literature. Some couples therapy models have been applied to PTSD, such as Susan Johnson's emotion-focused therapy (EFT, Johnson, 2005), behavioral family therapy (e.g., Glynn et al., 1995), and cognitive behavioral couples therapy (e.g., Monson, Stevens, & Schnurr, 2005). However, there has been a notable gap in family education programs dealing with PTSD. Given the high prevalence of PTSD symptoms in the veteran population, a workshop specifically on this disorder was important to include in this manual.