



# Family psychoeducation and therapeutic alliance focused interventions for parents of a daughter or son with a severe mental illness

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## ABSTRACT

This study compared the effectiveness of a family psychoeducational intervention (FPEI) and a therapeutic alliance focused intervention (TAFI) for parents of daughters and sons with severe mental illness (SMI). A process-outcome model was used to compare the effectiveness of the two interventions and to evaluate how they achieved their outcomes. Extent of effectiveness was assessed in terms of the family burden (FB) of the parents and the quality of life (QoL) and psychiatric symptoms of the daughters and sons. This study did not uncover a difference in effectiveness between the two interventions. However, at post-treatment, the participants in both interventions reported statistically significant less FB and attributed more QoL and less psychiatric symptoms to their daughters and sons than at pre-treatment. In addition, these pre- and post-treatment differences were mediated by specific mediating variables. These results are discussed in terms of the great psychotherapy debate (Wampold, 2001) as to the relative effectiveness of technique oriented interventions as compared to context oriented interventions.

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## 1. Introduction

Such severe mental illnesses (SMI) as schizophrenia generally emerge between the ages of 16 and 30 years old (Almeida et al., 1995). This age range involves significant challenges to the person with the SMI and that person's family with regard to establishing personal and interpersonal independence (Malla et al., 2005). Therefore, SMI tends to influence and to be influenced by the child–parent relationship and family quality of life (QoL) and the QoL of the individual with the SMI. On one hand, research has shown that family members, especially parents, can impact both positively and negatively on the treatment and the rehabilitation of persons with a SMI (Birchwood and Smith, 1990; DeChillo et al., 1994; East, 1992). On the other hand, many investigations of the families of persons with a SMI indicate that these families experience extreme burden (Coyne et al., 1987; Gibbons et al., 1984; Spanoil, 1987). Subsequently, over the last two decades, various interventions for family members of persons with SMI have been developed both to facilitate the treatment and rehabilitation of these persons (McFarlane et al., 2003) and to ameliorate the negative consequences of these persons' illness for the family.

Several studies have been carried out to evaluate the effectiveness of the various interventions that have been developed for family

members of persons with SMI (Barlow, 1996; Chambless, 1996; Chambless et al., 1998; Lehman and Steinwachs, 1998). In particular, evidence has accumulated in support of the contention that various forms of family psychoeducation interventions (FPEI) are effective in reducing family burden and in improving both the communication between parents and their children and the QoL of the family and of the individual with the SMI (Jewell et al., 2009; McFarlane et al., 2003; Montero et al., 2001; Mueser and Glynn, 1999; Nasr and Kausar, 2009). Therefore, these interventions are considered evidenced based practices (EBP) in the field of psychiatric rehabilitation (Dixon et al., 2001). However, other studies have not replicated the findings that showed psychoeducations to be effective (Pekkalä and Merinder, 2001).

The psychoeducation approach, because it is problem focused (McFarlane et al., 2003) emphasizes the techniques it uses as a major determinant of change (Barlow, 1996; Chambless, 1996). According to Wampold's (2001) conceptualization of what he terms the great psychotherapy debate between those theoreticians who attribute the effectiveness of psychotherapy to specific techniques and those theoreticians who attribute this effectiveness to a set of common factors, family psychoeducation would be most consistent with the medical model of psychotherapy. A medical model orientation to such psychosocial interventions as psychotherapy assumes that these interventions consist of sets of techniques designed to remediate specific problems, symptoms or complaints (Wampold, 2001). Those theoreticians who claim that a set of common factors are the principle

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determinants of the effectiveness of different interventions argue that specific techniques contribute little to these interventions' effectiveness (Teyber and McClure, 2000; Wampold, 2001).

The quality of the therapeutic alliance established between a client and a clinician is a major common factor that has been shown to underlie the effectiveness of different psychosocial interventions (Fancher, 1995; Frank and Frank, 1991). Bordin (1975, 1976, 1980) is accredited with identifying the therapeutic alliance as a core ingredient of psychotherapy. According to Bordin (1975, 1980), the therapeutic alliance enables the client to accept and comply with treatment. He claimed that the therapeutic alliance consists of establishing an affective bond between therapist and client and achieving agreement between therapist and clients on the goals of therapy and on the means of attaining these goals. Evidence has been uncovered showing that the therapeutic alliance contributes significantly to positive change in psychotherapy in a variety of settings (i.e., individual psychotherapy (Beutler, et al., 2004; Horvath and Bedi, 2002) family therapy (Sprenkle and Blow, 2004), group therapy (Marziali et al., 1997), and family group therapy (Brown and O'Leary, 2000).

The present study applied a process–outcome research design to examine two family interventions that are aimed at achieving a positive change in the lives of parents of persons with SMI and in the lives of these parents' daughters and sons with a SMI. These interventions were a family psychoeducation intervention (FPEI) and a therapeutic alliance focused intervention (TAFI). Thus, these studies compared an intervention that applies techniques designed to remediate specific problems, symptoms and complaints to an intervention that emphasizes the establishment of a relationship between the client and clinician assumed to be conducive to engendering positive change.

The effectiveness of the two interventions was evaluated in terms of their differential impact on common outcome variables that could be affected by either intervention. Furthermore, intervening variables theoretically associated with the processes by which the interventions were expected to achieve these outcomes were examined. Certain of these processes could be theoretically linked to either of the interventions whereas other processes appeared to be theoretically associated specifically with one of the interventions. The outcome variables were QoL, psychiatric symptoms and family burden, and the mediator variables were hope, internalized-stigma, therapeutic alliance and expressed emotion.

Thus, in terms of outcome, both the FPEI and the TAFI could reduce the family burden of the parents and the symptoms of the daughters and sons with a SMI and to increase these sons' and daughters' QoL. However, if the component of intervention most responsible for these improvements consisted of the psychoeducation techniques, this improvement should be significantly greater for the FPEI than for the TAFI whereas the opposite results were expected if the therapeutic

alliance was the more effective therapeutic component. In addition, each of the interventions was assumed to achieve the above outcomes due to their impact on different processes represented by different intervening variables. For the FPEI, variables such as parent's expressed emotions and internalized stigma were assumed to be related to the psychosocial educational technique applied by the intervention whereas for the TAFI, variables such as the quality of the therapeutic alliance and hope that were assumed to reflect factors common to effective therapy should be the intervening variables. The FPEI was expected to reduce expressed emotion and self-stigma whereas the TAFI was expected to create a more positive therapeutic alliance and to increase hope (see Fig. 1).

## 2. Method

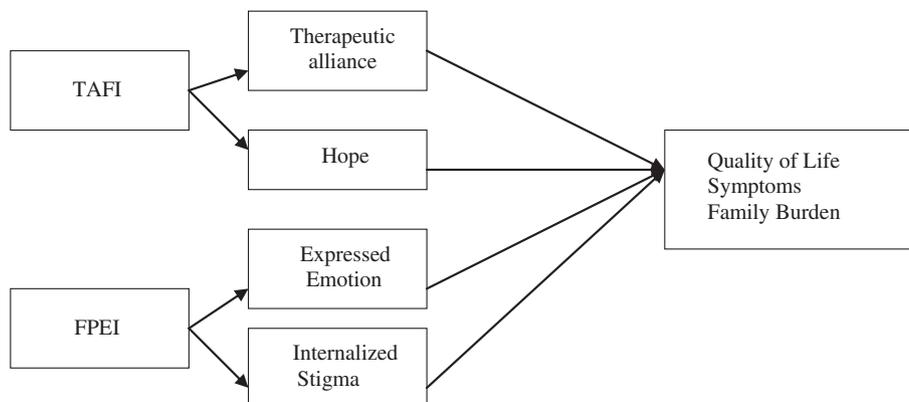
### 2.1. Research setting

This study was carried out in five counseling centers offering family therapy for parents of a son or daughter with SMI. These counseling centers are funded by the rehabilitation unit of the Ministry of Health. The centers are located in five central cities in Israel. Group leaders were all women, social workers and/or rehabilitation counselors, employed by each center with a year or more of experience working with the parents of daughters and sons with SMI. Each center implemented the interventions.

### 2.2. Research participants

Research participants were parents of a son or daughter with a diagnosed SMI that a professional committee of Israel's National Health Insurance administration had assessed as constituting at least a 40% disability. After applying to the Ministry of Health for counseling, these parents had been assigned to one of the counseling centers. Inclusion criteria were: (1) parents of a daughter or son with SMI; (2) the son or daughter lives with the parents or communicates with them on a daily basis; and (3) parents sufficiently competent to provide informed consent with regard to their participation in the study. All of the parents who participated in the study received the same set of rehabilitation services from the parent organizations that provided the opportunity for them to receive group counseling.

One hundred and twenty-seven persons who met the above criteria initially agreed to participate in the study. In each of the five counseling centers the interventions were carried out serially with the choice of the initial intervention determined randomly. Once that choice was made, the parents who applied for services at these centers were assigned to the particular intervention that was being carried out at the time. Although in each of the research sites the choice of the initial intervention was random, the current study was not a random control study since participants were based on convenient sample, and no control group was used. The parents were informed that they were taking part in a study of psychiatric rehabilitation interventions. However, they were not told that the study consisted of the comparison of two interventions and, due to the serial format according to which the interventions were carried out, the likelihood that they could become aware of their participation of one of two interventions was very low. While this raises ethical issues, informing them that the study compared two interventions, could have created demand characteristics. Thirty-four (26.8%) persons participated in less than 12 of the 15 intervention sessions and, thus, were not included in the study. Eight of the above persons belonged to one of the TAFI groups that had to be discontinued early into the intervention because of the group leader's death from cancer. Thus, ninety-three persons participated in the



**Fig. 1.** Mediating models for TAFI and FPEI. According to these models, TAFI achieves its effect by impacting positively on the quality of the therapeutic alliance and on hope whereas FPEI achieves its effects by reducing expressed emotion and internalized stigma.

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