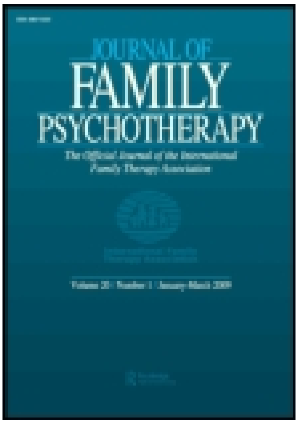

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The Impact of a Dynamic Psychosocial Intervention Group for Caretakers of Individuals With Severe Mental Illness

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The Impact of a Dynamic Psychosocial Intervention Group for Caretakers of Individuals With Severe Mental Illness

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Family members have an important role to play in the caring for their mentally ill relative, and many of them suffer from a significant burden of care. In many cases, these caretakers abandon much of their private and personal space, investing most—if not all—of their time and energy in their caretaker function. The purpose of this study is to evaluate the effectiveness of a short-term, 6-session, dynamic, psychosocial-oriented intervention focusing on the caregiving family and aiming at helping family members regain meaning and control over their own lives, notwithstanding the mental illness of their kin. Thirty-three family group participants and 20 family waiting list control participants took part in the study. They were assessed before and after the intervention on a measure of burden and of caregiving experience. The results show improvements for the caregiving family on both measures, denoting basic social functioning, less disruption in activities, and a reduction in feelings of guilt. Results also showed a significant reduction in the difficulty in coping with the ill family members' negative symptoms and an improvement in rewarding experiences, as well as in the relationship with the family member. By re-nurturing and empowering the caretaker's private space within a group format, it is possible to reduce some of the burden resulting from taking care

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of one's ill relative. Limitations and implications of the study to the field of mental health are discussed.

KEYWORDS caregiving family, group psychotherapy, mental health

INTRODUCTION

In addition to our growing understanding of the impact families (Marsh & Lefley, 2003; Stein et al., 1994) and family interventions may have on the course of mental illnesses (Dixon et al., 2001; Murray-Swank & Dixon, 2004; Pitschel-Walz, Leucht, Bauml, Kissling, & Engel, 2001), there recently has been a renewed interest in the psychological wellbeing of the family members of mentally ill individuals themselves. It is a major burden for a relative to live together with a severely mentally ill person, especially during the acute phases of the illness (Ostman, Wallsten, & Kjellin, 2005). So strong is the reciprocal impact of mental illness on the family that severe mental illnesses may be considered not only a disabling individual disorder, but a family disorder as well (O'Brien, 2008).

Indeed, what have often been damaged in caretaker families are the wide varieties of regular activities present in most families, such as spousal, familial, and social relationships; the vocational environment; leisure time; and other aspects that comprise the human experience. Having a mentally ill individual in care often grows to encompass the entire being of the caretaker, and becomes a lifelong role at the detriment of most other domains of activities.

Psychoeducation, as the major family intervention for kin of individuals with severe mental illness, under its many different versions (e.g., McGill & Lee, 1986; see also Brennan, 1995; Simon, McNeil, Franklin, & Cooperman, 1991), has mainly aimed at improving the care given to the ill person, although it may also alleviate some of the caregiving burden and improve the experience of caretaking. This is usually attained by providing for better means of instrumental and emotional coping, a better understanding of the illness, and removing guilt families may have regarding the course of the illness. Still, psychoeducation—by its focus on the illness—may not offer enough legitimacy for the families to carry on with their own lives. For families to reclaim their own territory, they need a space through which they can process their own life's issues, so as to return to function as a family and not only as caretakers. Dynamically oriented, short-term, psychosocial group therapy may be a good framework for this. This article presents research data assessing dynamically oriented, short-term, group family interventions with family members of patients, aimed at reducing family burden and improving the caregiving experience.

METHOD

Setting

The study was conducted at the Lev Hasharon Mental Health Center, a medium-sized, 280-bed hospital, situated at the center of Israel. The hospital regularly gives psychosocial and family support. The local Helsinki committee agreed to this study.

Participants

The study sample was a non-random convenience sample. One hundred-fifty family members of consecutive hospital clients with severe mental illness were contacted over a period of two years to participate in an open psychosocial dynamic intervention group. Of those, 73 (48.6%) agreed to participate, and were included in the study. Out of this sample, only 33 (family group intervention [FGI]) could come the day the groups were taking place. The 40 remaining family members were considered the waiting list (WL) control group, and were asked if, for the time being, they could fill in a questionnaire twice, at six-week intervals, until we opened another group on another day. Twenty of them agreed.

The intervention: An open psychosocial dynamic intervention group. The intervention was aimed at family members of individuals with severe mental disorders, who were receiving either hospitalization or ambulatory treatment at our hospital. The interventions were held within the confinements of the hospital, and each group was led by two professional facilitators. The team was made up of three social workers and one art therapist, all with master's degrees and well-versed in group therapy.

All four facilitators had worked for more than 10 years in psychiatric settings, and had experience interacting with family members of consumers. The intervention was set up by this group and developed together. There were no fidelity measures, but the team met weekly to discuss the sessions, issues that came up, and the roles that each facilitator took in the meeting. This made it possible to fine-tune and adapt the intervention to newly upcoming issues on a regular basis, as well as provide supervision, support, and guidance for the acting facilitators.

Participants were invited to take part in six 1½-hr sessions. Each group contained between six and eight individuals. The meetings took place at a fixed time and location. Participants were also invited to join in the next course of six sessions. In this fashion, new participants joined together with "veteran" participants, who helped to create continuity and bring their growth experiences to those with less experience in the caring and sharing process. On one hand, this helped veterans to establish their status of being "experienced" and strengthen the change processes experienced in the previous group and in between groups by "giving" and sharing their understandings. On the other hand, it encouraged new participants to open up and share, as well as gain from the information received, be receptive toward hope, and gain a more positive future orientation.

The intervention did not follow a fixed pattern but, instead, a basic principle of targeting the participants, rather than the illness. The group processes focused on family members and on issues brought up by the participants themselves. Group members were encouraged to share and discuss anything that came to their minds. The main message of this approach was that there is life besides the illness of their family kin and beyond being a caretaker. The aim of the groups was to create a space where caregivers could regain the mastery of their own lives and open up to, share, and explore their own personal issues, such as professional and personal relationships, activities, joys and sorrows, successes and disappointments, hopes, and fears.

The first session was devoted to self-presentation and expressing one's expectations from the group. During this session, the facilitator also set the ground rules, as well as explained the aims and general thematic orientation of the meetings. This first session was always concluded with two major take-home messages:

1. Living in the proximity of the illness is just one aspect of life.
2. Although the participants had invested a great deal of energy and emotions into caring for loved ones, this group would be dedicated to help *them* make more place for a private and personal life.

During the next four meetings, participants were encouraged to focus solely on their own needs, wishes, and fears, and were assisted in sharing their experiences and recomposing their personal narratives. This is mainly done by filling in narration gaps, reconstructing time-lines, and with understanding, accepting, and working through past behaviors and events, as well as emotional blockages. Dynamic techniques and approaches toward minimizing stressful components, searching for insight and meaning, enhancing personal experiences, and developing a hopeful approach toward the future were integral parts of each session.

The sixth meeting is an open discussion of the participants' experiences of and within the group. During this meeting, attempts were made to point out potential benefits in behavioral terms. For example, participants could examine the changing levels of their practical involvement in the lives of their ill relatives, the possible reductions in family enmeshment, and changes in approaches and coping that were developed toward handling caring issues differently. At the end of this session, the facilitators invited the participants to join one of the new groups that were to open in the next few months.

Measures

After filling in an informed consent form, family members were administered questionnaires before participating in the groups. They refilled the same forms after the intervention or a period of six weeks (for the WL group).

Demographics. Gender, age, and familial relationship were noted.

Burden. All participants filled in the Burden Assessment Scale (BAS; Reinhard, Gubman, Horwitz, & Minsky, 1994) for families of the seriously mentally ill. The scale contains 19 items that capture both objective and subjective consequences of providing ongoing care to the seriously mentally ill. The scale distinguishes burden from the measurement of the ill relative's disruptive behaviors and the family's caregiving activities. Factor analysis of the BAS (Reinhard et al., 1994) identified five domains—namely, disrupted activities, basic social functioning, personal distress, time perspective, and guilt. Reliability and validity have been assessed and have been found to be satisfying. In this study, Cronbach's alphas were found to range from .72 to.77.

Experience of caregiving. The Experience of Caregiving Inventory (ECI; Szmukler et al., 1996) is a self-report measure of the caregiving experience of a carer of a person with a serious mental illness. The ECI comprises 10 subscales—8 are negative (difficult behaviors, negative symptoms, stigma, problems with services, effects on family, need to backup, dependency, and loss), and 2 are positive (rewarding personal experiences and good aspects of the relationship with the patient)—derived from 66 items in all (52 negative and 14 positive). Each item is responded to on a 5-point scale ranging from 0 (*never*) to 4 (*always*). Good reliability and validity has been observed (Joyce, Leese, & Szmuckler, 2000). In this study, Cronbach's reliability for all sub-factors ranged from .67 to .89.

RESULTS

Forty (75.5%) of the participants were parents of the patient, and 13 (24.5%) had a fraternal relationship with the patient. Thirty-eight were women (71.7%), and 15 were men (28.3%). The average age of the participant was 52.3 years (*SD* = 15.6). There were no differences between the FGI and the WL group. As presented in Table 1, results show that when compared to the control group, caretaker burden significantly decreased. This was due to a significant improvement in basic social functioning, less disruption in activities, and a reduction in feelings of guilt. Results also show a significant reduction in the difficulty in coping with the patients' negative symptoms and an improvement in rewarding experiences, as well as an improvement in the relationship with the family member.

TABLE 1 First and Second Assessment Mean Scores, Main Effects, and Interactions for Caretaker Burden and the Experience of Caregiving Inventory in the Family Group Intervention and Waiting List Group

	First assessment		Second assessment		Main effect for time	Main effect for group	Interaction Time × Group
Measures	*M*	*SD*	*M*	*SD*	*F*(1, 106)	*F*(1, 106)	*F*(1, 106)
Caretaker burden							
Disrupted activities							
FGI ($n = 33$)	2.78	0.60	2.36	0.50	5.50*	2.50	4.50*
WL ($n = 20$)	2.83	0.70	2.81	0.90			
Basic social functioning							
FGI ($n = 33$)	2.75	0.70	1.94	0.60	16.60***	0.03	7.90**
WL ($n = 20$)	2.43	0.70	2.30	0.80			
Caretaker distress							
FGI ($n = 33$)	2.27	0.90	2.10	0.70	1.30	0.30	0.40
WL ($n = 20$)	2.10	0.70	2.10	0.70			
Time perspective							
FGI ($n = 33$)	3.10	0.70	2.85	0.70	10.50***	3.10	0.10
WL ($n = 20$)	3.43	0.50	3.13	0.70			
Feelings of guilt							
FGI ($n = 33$)	1.87	0.70	1.55	0.50	0.40	8.40**	5.90**
WL ($n = 20$)	2.06	0.70	2.25	0.70			
Total burden score							
FGI ($n = 33$)	2.21	0.40	2.57	0.40	10.90**	1.60	7.00**
WL ($n = 20$)	2.52	0.60	2.57	0.50			
Experience of caregiving							
Negative symptoms							
FGI ($n = 19$)	2.16	0.90	1.74	0.70	3.10	4.80*	10.40***
WL ($n = 15$)	1.45	0.80	1.64	1.10			
Difficult behaviors							
FGI ($n = 19$)	2.16	0.90	2.14	0.90	1.10	3.50	1.30
WL ($n = 15$)	1.42	0.70	1.71	1.20			
Fear of stigma							
FGI ($n = 19$)	1.40	0.90	1.29	0.90	0.01	0.50	0.80
WL ($n = 15$)	1.51	1.00	1.61	1.10			
Problems with services							
FGI ($n = 19$)	1.57	0.80	1.53	0.90	0.60	0.60	1.10
WL ($n = 15$)	1.22	0.60	1.45	1.10			
Effects on family							
FGI ($n = 19$)	1.86	0.70	1.81	0.80	0.90	1.40	1.80
WL ($n = 15$)	1.33	0.90	1.70	1.00			
Need to backup							
FGI ($n = 19$)	2.15	0.90	1.93	0.90	6.20*	0.20	0.90
WL ($n = 15$)	2.41	0.80	1.95	1.10			
Weight of dependency							
FGI ($n = 19$)	2.23	0.70	2.15	0.80	3.90	1.20	1.40
WL ($n = 15$)	2.59	0.70	2.32	0.80			
Sense of loss							
FGI ($n = 19$)	1.58	0.80	1.57	0.80	0.10	0.60	0.70
WL ($n = 15$)	1.70	0.70	1.80	0.70			
Rewarding experiences							
FGI ($n = 19$)	2.09	0.60	2.53	0.40	7.30**	1.00	8.10**
WL ($n = 15$)	2.14	0.80	2.12	0.60			

(*Continued*)

TABLE 1 (Continued)

	First assessment		Second assessment		Main effect for time	Main effect for group	Interaction Time × Group
Measures	*M*	*SD*	*M*	*SD*	*F*(1, 106)	*F*(1, 106)	*F*(1, 106)
Good relationship with patient							
FGI (n = 19)	1.72	0.50	2.10	0.40	1.50	4.50*	8.80**
WL (n = 15)	2.34	0.70	2.20	0.70			
Total positive score							
FGI (n = 19)	1.93	0.50	2.34	0.30	6.70*	0.10	13.60***
WL (n = 15)	2.22	0.60	2.15	0.50			
Total negative score							
FGI (n = 19)	1.90	0.50	1.76	0.60	0.01	0.50	2.10
WL (n = 15)	1.62	0.50	1.73	0.90			

Note. FGI = family group intervention; WL = waiting list control group.
$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$.

DISCUSSION

The results of this study are encouraging and promising. They demonstrate a significant improvement in the study group, compared to the control group, both in the overall family burden of the caregiver and in the overall experience of caregiving. This improvement is observable as a significant reduction in distress and guilt and an improvement in social functioning. After the intervention, the caregiving family members were better able to cope with the patients' negative symptoms and developed better relationships with patients. Other improvements were also noted, but did not reach statistical significance, possibly due to the small number of participants. The results support the research assumption that caregiving families can benefit from a group family intervention that is focused on the family, instead of the identified patient.

From earlier literature reviews and meta-analytical studies (Cuijpers, 1999; Dixon et al., 2001; Falloon, Roncone, Held, Coverdale, & Laidlaw, 2002; Lehman et al., 2004; McFarlane, Dixon, Lukens, & Lucksted, 2003; Ohaeri, 2003), as well as from cross-cultural studies (Gutierrez-Maldonado & Caqueo-Urizar, 2007; Magliano et al., 2006; Nasr & Kausar, 2009; Zahid & Ohaeri, 2010), it is clear that psychoeducation may have a significant impact on family burden. So, why change a "winning horse?" A recent study has shown that the impact of these interventions may be short-lived (Wai-chi Chan, Yip, Tso, Cheng, & Tam, 2009). A major reason for this may be that, although caregivers might gain in coping means and understandings regarding the illness of their relative, no lasting change in their own personal lives may have been made. Indeed, such interventions often only provide for "lip service" and short-term improvements as a result of lessening the caretaking burden itself, but they may not engender a profound change in the organization and meaning of one's life. In fact, reducing family burden has not been the aim of the original psychoeducation or clinical interventions; instead, its aim was to better address the patient' illness (Glanville, Denise, & Dixon, 2005). In essence, psychoeducation often does not offer legitimacy for the families to carry on with their lives.

Caregiving for a mentally ill relative is an extremely demanding experience that should not grasp the whole entity of the caregiver. Along with the heavy practical and emotional responsibilities, the caregiver is also a person with his or her own joys and sorrows, often having other children, a work environment, a marital relationship, and other aspects that comprise the human experience. Focusing on the illness only within any therapeutic intervention neglects a whole array of human experiences and preserves the mental illness as the central component in one's life.

Yet, the psychosocial dynamic group approach is not free of questions. Defining family members as primary clients and focusing interventions specifically on them, rather than on the illness, may present ethical issues. Do we, as therapists, have the mandate to "treat" those who come seeking help "for my relative?" Furthermore, if we do intervene at this level, can it be done in the framework of a mental health center or even by the same individuals that may treat the patient? Is there not an inherent contradiction in such a setting?

This psychosocial intervention may also hold some additional value. From caretakers' reports, it seems this intervention may also affect the patients themselves in a positive way. It seems the easing of the family burden by helping caretakers regain a sense of personal and intimate balance may allow caregivers re-develop an array of positive outlooks, such as a healthy sense of compassion, as well as develop more compassion, satisfaction, and ease burnout and compassion fatigue. In short, this intervention may reduce the symptoms of vicarious traumatization following the intensive, often traumatic, caring experiences (Lefley, 1992; Struch et al., 2007; Szmuckler et al., 1996) and, as a result, permit better caretaking on their part.

As was demonstrated in this study, by re-nurturing and by empowering the caretaker's private space, it is possible to weigh down some of the burden resulting from seeing one's relative suffer, coping with the patient's episodes of irrational behaviors, and handling the stigma of mental illness.

The main limitations of this study are the rather small sample taken from a much larger potential population and the fact that family members were not randomly assigned to treatment and control groups. An additional possible limitation is that no manual has been developed for this study, but only a general framework and "philosophy" potentially using all the variants of psychosocial and dynamic techniques.

Future studies should not be limited to assessing burden, but focus also on the changes in quality of life of those attending. It would also be advantageous for future studies to use more objective measures (such as time spent in leisure or familial non-caretaking activities) in trying to assess change. Studies should attempt to understand the active ingredients of the intervention and understand what factors are especially effective in reducing family burden and quality of life. We suggest assessing the impact of moderating variables, such as disclosure and social support, as well. Finally, there might be a need for developing various orientations in such family support groups, differentiating between families according to their ability, willingness, and the source of their motivation to be enlisted in helping the ill family member (Romi & Melamed, 2007). There should also be a need to further develop new ways of reaching out and recruiting the families.These studies would gain strength and explicatory value if they were to be performed in multi-center settings.

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