Family interventions for schizophrenia
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Authors' objectives
To assess the effectiveness of psychoeducational family interventions for schizophrenia. Sub-questions include:

1. When added to pharmacotherapy, is there evidence that family interventions are effective for reducing patient relapse and for improving functional status and family well-being?

2. Is there evidence that a particular kind of family intervention is superior to others?

3. Is there evidence that patient heterogeneity factors, such as family characteristics, age, gender, race, and phase of illness, influence the effectiveness of these interventions.

Searching
PsycLIT and MEDLINE were searched from 1966 to 1993 using the keywords 'schizophrenia' and 'family intervention' or 'family therapy'. All references related to the keywords were requested using the 'explode' command. The bibliographies of retrieved articles were searched for relevant references and unpublished material was gathered through consultation with experts in the field.

The search strategy examined both reviews and primary research.

Study selection
Study designs of evaluations included in the review
Randomised controlled studies (RCTs) were included.

Specific interventions included in the review
All family interventions tended to share a common set of assumptions: schizophrenia is regarded as an illness; the family environment is not implicated in the etiology of the illness; support is provided and families are enlisted as therapeutic agents; and the interventions are part of a treatment package used in conjunction with routine drug treatment and out-patient clinical management.

Treatment groups received various behavioural conditioning strategies, including: crisis-orientated weekly sessions; behavioural family therapy; education of relatives; education in patient-only and relative-only groups; in-patient family intervention; education in the form of discussion, communication and problem-solving; and behavioural programmes focusing on education, stress-management, problem-solving and goal setting.

Comparison groups received various treatment regimes including: medication, supportive individual psychotherapy, education alone, and social skills training alone.

Participants included in the review
Patients with schizophrenia diagnosed in a systematic fashion were included. Most patients were also resident in a high expressed emotion (EE) environment.

Outcomes assessed in the review
The outcomes were relapse, functional status and family well-being.

How were decisions on the relevance of primary studies made?
The authors do not state how the papers were selected for the review, or how many of the authors performed the selection. All the included studies had to be RCTs involving family members with schizophrenia; the patient group was primarily the persons with schizophrenia diagnosed in a systematic fashion; outcome measures were systematically
Assessment of study quality
The authors do not state that they assessed validity.

Data extraction
The authors do not state how the data were extracted for the review, or how many of the authors performed the data extraction.

Methods of synthesis
How were the studies combined?
The studies were combined by a narrative discussion.

How were differences between studies investigated?
Study differences were investigated by a narrative discussion of the factors that may result in patient heterogeneity, e.g. family characteristics, age, gender, race and phase of illness.

Results of the review
Nineteen studies and one review using a meta-analysis to pool studies were included.

The review set out to answer 3 questions:

1. When added to pharmacotherapy, is there evidence that family interventions are effective for reducing patient relapse and improving patient functioning and family well-being?

Relapse: there is a consistent effect of family interventions delaying, if not preventing, relapse.

Functional status: only modest evidence was found that family interventions may improve patient functioning.

Family well-being: only modest evidence was found that family interventions may improve family well-being.

2. Is there evidence that a particular kind of family intervention is superior to the others?

There is no compelling evidence that family interventions combining the following are superior to one another: taking a positive approach and establishing a genuine working relationship; providing structure and stability; focusing on here and now; using family concepts; working on cognitive restructuring; taking a behavioural approach; improving communication.

3. Is there evidence that patient heterogeneity factors, such as family characteristics, age, gender, race and phase of illness, influence the effectiveness of the reviewed interventions?

There is evidence that patients who have significant family contact (high or low EE) might benefit from family intervention. Multifamily groups may be superior to the single family modality in high EE families; this is not the case for low EE families with white patients, and the evidence is inconclusive for black patients.

Authors’ conclusions
There is substantial evidence that psychoeducational family interventions reduce the rate of relapse. There is suggestive, but not conclusive, evidence that these interventions improve patient functioning and family well-being.

Interventions with multifamily groups that include the patient may be of superior benefit for certain patient subgroups.
More research is needed to determine the critical ingredients of family intervention, to expand the groups of patients included in these studies, and to evaluate a broader range of outcomes.

**CRD commentary**
The authors have tried to bring consensus to an area where it is frequently difficult to draw conclusions from individual research studies. In the end the review is unable to provide firm evidence of effectiveness for several of the key interventions, due to the heterogeneity of the included trials. This is not a fault of the review, but an issue relating to the primary studies. However, the authors could have assessed the validity of each study and assigned more weight to those of better quality; this would have given more strength to the authors' conclusions.

The use of forest graphs or other visual diagrams would have helped to give an immediate indication of the effectiveness of interventions. The decision not to standardise the results between studies, i.e. by calculation of odds ratios and 95% confidence intervals, makes interpretation of the data difficult for the reader.

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**Other publications of related interest**

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