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Counselling the Relatives of the Long-Term Adult Mentally Ill

I. Evaluation of the Impact on Relatives and Patients

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The efficacy of implementing a clinically feasible psychosocial intervention which addresses the needs of carers of the long-term mentally ill is reported. All the relatives of patients in continuous high contact with one clinical team in a local day-care facility were offered the intervention. An interactive education session at home was followed by a monthly relatives group which aimed to reduce components of expressed emotion and to alleviate burden. Patients and relatives were assessed. The controls were the patients in contact with the other teams in the day-care facility, and their relatives. The intervention was effective at reducing EE and improving family relationships. Offering this kind of support to people who are providing long-term care for the severely mentally ill can contribute significantly to the quality of life of both supporters and patients.

Family atmosphere, and the attitudes of family members towards a mentally ill person are believed to influence that person's ability to remain relatively free of positive symptoms of disorder and to function well outside hospital (Freeman & Simmons, 1963; Vaughn & Leff, 1976*a*). This claim has been strengthened by the success of interventions designed to modify the attitudes and behaviour of family members in caring roles (Leff *et al*, 1982, 1985; Falloon *et al*, 1985; Hogarty *et al*, 1986).

As community-care policies increasingly shift the main day-by-day responsibility for long-term aftercare from the state to spouses, parents, and other available kin, these findings assume particular importance. Nearly 60% of a series of first-onset cases of schizophrenia were living with relatives when they became ill, and most returned home after discharge from hospital (MacMillan *et al*, 1986). About half of first-onset cases are likely to develop a chronic, recurrent or persistently disabling psychotic illness (Bleuler, 1978), and at least one-quarter of patients with affective disorder will have persistent symptoms which are to some extent incapacitating (Bebbington, 1982). It has been estimated that 139 people in 100 000 of the population will need a high level of long-term day care for a psychiatric illness (Wing, 1982). Of this high-dependency group, nearly half continue to live with relatives (Brugha *et al*, 1988). Thus, the number of relatives supporting severely disabled patients in the community is substantial.

When mental illness is long standing and disabling, the requirements of both patients and their relatives will be of a special type. In contrast to acute or intermittent cases, the concept of relapse is less relevant, since in many cases fluctuations in level of disturbance occur against a background of more continuous disability (Falloon, 1983). In such circumstances, the quality of life of patients and supporters is likely to depend less on minimising active psychiatric symptoms than on maintaining levels of functioning and reducing the negative symptoms that are persistent sources of stress and conflict in the family (Creer *et al*, 1982). For patients, the preservation of independence and self-help skills is of key importance if they are to retain a more than nominal role in the community. Supporting relatives appear to be severely burdened but rarely articulate their difficulties (Gibbons *et al*, 1984; Fadden *et al*, 1987). Frequently, they try to preserve barely tenable situations that impose undue stress on themselves or provide disabling environments for the patient. Some families continue to support patients only by making adjustments that can be seen as maladaptive since they arise from undue self-sacrifice or apathetic disengagement. Such families may need encouragement to change this kind of pathological equilibrium or to separate altogether. Appropriate care in the community for this population must therefore include efforts to prevent or reverse a loss of skills in the patient, to alleviate the subjective and objective burden experienced by relatives, and to facilitate individuation and some degree of separation when needed.

Evidence from consumer groups suggests that relatives lack support from, and easy communication with, professional mental health personnel. Although they need information and advice, they also have less specific requirements from their relationships with professionals; for example, for continuity and trust (Hatfield, 1983). However, their attitudes to services can vary from frank antagonism and suspicion to high dependency and demandingness (Birley & Hudson, 1983). Many relatives develop fixed beliefs or ways of coping which superficially seem maladaptive, but are functionally important for them, and have proved difficult to modify (Barrowclough *et al*, 1987). For the long-term severely ill population, a highly structured and intensive training programme for relatives may therefore be neither feasible nor appropriate in many clinical settings.

Interventions with families have been shown to be effective in reducing relapse in recently discharged groups. Some of the recipients had a long history of recurrent illness, and three large trials have successfully improved patients' social performance as well as having reduced active symptoms (Falloon *et al*, 1985; Hogarty *et al*, 1986; Tarrier *et al*, 1988). However, in these trials, specialised teams have been able to offer relatively intensive help for about one year. Generally, samples in each trial have been homogeneous: the families have been supporting a person with a psychotic illness, and at least one of the relatives has been high in expressed emotion (EE). These circumstances do not reflect the reality of a clinical setting, where typically diagnoses are varied or hard to determine, and available staff time is limited. Further, such sampling may prematurely exclude other groups of relatives who could benefit from support (Hogarty, 1985). Implementing this kind of intervention with unselected groups of supporters of the long-term, continuously mentally ill has not been evaluated previously, although the recent findings referred to above suggest both that it may enhance patients' social functioning and that a wider range of relatives should be included than has so far been acknowledged.

The relationship that the parameters of expressed emotion bear to levels of functional disability has not yet been tested thoroughly (Falloon, 1988). However, the measure does provide a reliable way to assess variations in family atmosphere (Kuipers & Bebbington, 1988). Further, some of the attitudes and types of behaviour characteristic of families rated as high-EE seem intuitively likely to be associated with poor levels of functioning in both acute and long-term populations (MacCarthy *et al*, 1986). Measuring expressed emotion therefore seems to be a legitimate means of summarising aspects of the family situation and pin-pointing areas in which professionals working with such relatives might look for change.

We were anxious to avoid facilitating a model of family functioning in which relatives so reduce both their expectations and the amount of contact they have with the patient that the home becomes a markedly unstimulating environment which cannot capitalise on the patient's functional assets. Fears have been expressed that this kind of 'low engagement' model of functioning may characterise some families rated as low-EE (Hogarty, 1985). This style of interaction is likely to be particularly detrimental for the long-term population. Consequently, we attempted to assess other aspects of both the relatives' and patients' behaviour such as coping style and social role performance which seemed relevant to the needs of this population, and in which we anticipated achieving some change as a result of the intervention.

In the study reported here, therefore, we evaluated the effect of implementing a counselling and support group for relatives of patients who were receiving regular day care and who had severe and long-term psychiatric and social disabilities. The design of the intervention took account of the constraints imposed by a typical clinical situation. During the intervention, we aimed to reduce relatives' EE and the amount of time that relatives spent with patients where necessary. However, we also aimed to alleviate the burden on these relatives, improve ways of coping, and reduce the recognised tendency among relatives to blame patients for the symptoms or course of their illness. We speculated that if relatives could be helped to feel more in control of the problems presented and aware of the value of their own coping efforts, at the same time as gaining an accurate appraisal of the difficulties of the task they were confronted with, by learning about problems experienced by others in similar circumstances, this might help to reduce levels of EE. In view of the chronic and persistent difficulties which characterised the patients in this setting, our aspirations for achieving a substantial reduction in the positive symptoms of their illnesses were limited. However, we hoped that enhancing relatives' coping skills and reducing their distress would in turn improve the social functioning of the patients.

Method

Subjects

All patients receiving day care from a specialised service designed to meet the varying needs of the long-term mentally ill in the local community were surveyed. The service is organised to offer continuity of care, structured daytime activities, and residential and drop-in facilities. Staff are divided into three care teams, whose approach is very similar. Those day patients were identified who suffered from a non-organic psychiatric disorder attended the centre at least 2½ days a week, and lived with or spent at least one whole day per week with relatives. Those whose relatives also attended the day-care service as patients were excluded from the study. Out of 78 high-contact attenders, 33 met all the study criteria. Relatives of patients in one of the three teams were invited to attend a monthly support group. Out of a potential pool of 13 patients in this group, the relatives of 4 could not be engaged in the intervention, leaving 9 patients with 13 relatives to make up the experimental group. The remaining 20 patients and their relatives in the other two teams served as controls. Of these, 3 patients or their relatives refused to complete the assessment procedure, leaving 17 families in the control group.

Diagnostic classifications obtained from structured clinical interviews showed that the patients were suffering from a range of problems characteristic of those receiving long-term day care. All were currently severely disturbed and had been continuously disabled by their symptoms for at least one year before they were interviewed. The relatives, therefore, were offered this intervention at a time when neither they nor the disturbed family member were experiencing a crisis or major change. Only one patient in the experimental group and two in the control group had never experienced psychotic symptoms. All but two patients (one in each group) were prescribed neuroleptic medication, and four were taking either antidepressants or minor tranquillisers in addition.

Assessment

All patients and their relatives underwent an assessment procedure twice. The first assessment was at the beginning of the study. The second assessment took place after the relatives had attended the group for one year; in the case of the control group, it took place approximately nine months after the start of the study.

Assessment of patients

The patients' clinical status was assessed using the development version of PSE-10, a structured clinical interview which yields detailed data on psychiatric symptoms, including negative symptoms. Three summary scores were obtained: total subjective disturbance, total negative symptoms, and observed behavioural disturbance. Diagnostic classifications (see Table I) were obtained from computer analysis, using the version of the Catego program which has been developed to accompany PSE-10 (Wing *et al*, 1989). These interviews were conducted by two members of the research team (AS and JH), who were blind to the results of all relatives' assessments. Throughout the study period the patients' clinical state was monitored for signs of relapse or exacerbation of symptoms, and changes in medication or attendance patterns were also noted. When indications of deterioration were present, patients were again interviewed with PSE-10 to establish the severity of the deterioration in their clinical state. All patients were re-assessed at the end of the study period.

Relatives' responses to structured checklists provided ratings on three-point scales of the patients' symptoms and behaviour problems (SBP) and their ability to perform normal domestic and self-help functions at home (role-performance). The reliability of these measures had been established previously (Brewin *et al*, 1987). The SBP item scores were added to give an overall indication of level of behavioural disturbance, and four subscores, of neurotic behaviour, slowness and apathy, social skills deficits, and disruptive behaviour, were also computed. A measure of role-performance was derived by dividing each subject's total score by the maximum number of functions they had the opportunity to perform. Relatives were also asked how the patient would fare if he or she had to cope without support at home for a week.

TABLE I
CATEGO classification of patients

Classification	*Experimental group (n = 9)*	*Control group (n = 17)*
Schizophrenia	4	11
Asperger	1	1
Manic-depressive	3	3
Psychotic depression	1	–
Unsure/no diagnosis	–	1

Assessment of relatives

The relative with whom the patient spent most time, or who took major responsibility for care, was identified as the key informant. This relative was interviewed at home at the beginning and end of the study period, using a form of the Camberwell Family Interview (Vaughn & Leff, 1976*b*) adapted for use with a chronically ill population. These interviews were conducted by one researcher (BM), who was blind to the results of the patients' assessments and was not involved in the running of the group. The interviews lasted 1½–2 hours and were audio-taped and rated for indices of expressed emotion: critical comments, hostility, emotional over-involvement and warmth. Relatives were classified as high-EE if they made six or more critical comments during the interview, or if they were rated as showing hostility or over-involvement greater than 3 on a 0–5 scale (Leff & Vaughn, 1985). The time relatives and patients spent in face-to-face contact was calculated from detailed questioning about usual household routines. In the course of the interview, structured questions were used to assess relatives' perceptions of restrictions on their social life and the emotional strain imposed by their care-taking role, the level of intimacy and reciprocity achieved in their relationship with the patient, and their attributions about the causes and course of the patients' problems. Relatives were also asked to complete a 28-item self-report checklist of coping strategies, described by MacCarthy & Brown (1989). Responses were scored Yes or No. Each relative was given a coping change score by tallying the number of strategies that he or she had either started to use or discontinued by the second assessment.

Where, in the experimental group, there were two parents in the household, the other parent was also interviewed with the full package of assessment measures, and invited to attend the group. Of the nine patients, four had both parents living in the household.

Education package

Previous attempts to provide relatives with information have shown that the acquisition of facts alone does little to change relatives' fundamental attitudes or beliefs (Berkowitz *et al*, 1984; Smith & Birchwood, 1987). Relatives appear to be less receptive to different information when the illness is more chronic (Barrowclough *et al*, 1987). However, preliminary education sessions do seem to enhance relatives' ability to co-operate with and benefit from further interventions. We did not expect, therefore, to modify the beliefs of our patients' relatives through an education component. Instead, we aimed to devise an instrument which would be short and easily comprehensible to all participants, which would allow relatives to make their beliefs and attitudes explicit, and which could form a basis for future discussion.

The instrument – the Knowledge Questionnaire – assessed the relative's knowledge of the particular diagnosis, aetiology, course and treatment of the patient's disorder. Equivalent versions of the questionnaire were designed to cover the various diagnoses represented in the group. All relatives in the experimental group were seen on two further occasions before they attended the support group. During the first assessment session they had been asked to complete a Knowledge Questionnaire before the interviewer's next visit. During the second visit, the interviewer used their responses to the questionnaire as a basis for education and discussion. During the third visit, two weeks later, the interviewer oriented relatives to the group's aims and approach, finalised arrangements for their attendance, and answered further queries arising from the previous education session. A second copy of the Knowledge Questionnaire was left with the relatives at this point, which they were asked to complete and bring to the first session of the group. The experimental-group relatives completed the Knowledge Questionnaire for the third time after the final group session. Thus the effect of this short and simple education procedure on relatives' beliefs about their patients' problems could be assessed independently of the impact of the group.

Further self-report measures established how much control the relatives in the experimental group thought they and the patient had over the patient's general state of mental health and over the main problems they had, how well they thought they coped compared to others in similar circumstances, and how difficult they thought it would be for anyone to cope with their situation. The Knowledge Questionnaire and these additional assessments were not administered to the control group.

The experimental group were invited to attend a monthly group at the day hospital for approximately a year. The group lasted for 1½ hours and was run by the team's clinical psychologist (LK) and social worker (RH). Neither worker had been involved in the assessment and education procedures, and they were blind to the results of the assessments. Relatives were encouraged to discuss the practical problems and feelings which arose in the course of living with family members with a long-term psychiatric illness. The group focused on issues relating to expressed emotion, in order to reduce critical or over-involved attitudes and the level of face-to-face contact where these appeared to be unduly high. Relatives were also encouraged to share their experience of successful coping strategies and to ventilate some of the distress, grief and frustration known to be common in this group. A detailed account of the approach used in the group and of its efficacy is given in the following paper.

Patients and relatives in both the experimental and control group continued to receive routine day care throughout the period of the study. The centre is well-staffed, and attenders participate in a moderately intensive programme of community meetings and occupational and industrial therapy. Patients' medication and clinical state are closely monitored, while the daily programme focuses on patients' self-help skills and independence. Relatives typically have contact with care staff at about six-monthly intervals, but the system is intended to be responsive to need, so that contact can readily be increased at times of crisis.

Results

The patients had a mean age of 36.1 years (range 22–66). Sixteen were men and ten were women. The experimental and control groups of patients did not differ significantly in age or sex. Seven members of the experimental group and 12 of the control group had never been married; however, since two of the relatives who refused to attend the group were spouses, the two groups were originally matched for marital status. The relationship of the relatives to the patient is shown in Table II. The sample had been ill for a long time: the mean length of contact with services was 15 years for the controls (range 2–50) and 19.5 years for the experimental group (range 9–40).

Four relatives refused the invitation to attend the group. Of the remaining 13 who attended at least one session, the majority came to all the sessions which were practically feasible for them. The mean number of sessions attended was nine. One pair of parents and one spouse proved to be intermittent attenders: these relatives were living with patients with rapid-cycling manic depression, whose clinical state varied much more widely than that of the other patients in the study.

The scores of the experimental and control groups within and between assessment periods were compared by use of χ^2 tests and *t*-tests. When the data was at least ordinal, change scores were computed by subtracting the scores

TABLE II
Relationship between supporters and patients

Supporter	*Experimental group (n = 13)*	*Control group (n = 17)*
Mother	6	8
Father	5	3
Spouse	1	4
Friend	–	1
Sibling	1	1

obtained in the second set of assessments from those obtained during the first assessments.

Patients' measures

The control group of patients was not matched for disturbance with the experimental group, and the latter showed a considerably higher level of subjective symptoms at the initial assessment, although the difference was not statistically significant ($t = 1.28$, $P = 0.10$). The level of disturbance in both groups was high (mean 26.9 in the experimental group and 15.9 in the control group). The mean number of symptoms fell in the experimental group (mean 22.8) and actually rose slightly in the control group (mean 17.1). However, although these changes suggested an effect of the intervention, the difference between the two groups in the amount of change which occurred was not statistically significant ($t = 0.90$, $P = 0.19$). Differences between the groups at the second assessment were also not significant ($t = 0.59$, $P = 0.28$). The groups were more evenly matched on objective symptoms and negative symptoms, and there appeared to be no effect from the intervention in these areas. No differences were found in the rate of relapse or exacerbation, which was low in both groups: two patients in the experimental group and four in the control groups experienced an episode of marked exacerbation.

Using relatives as informants, the experimental and control groups were compared on the behavioural measures. There was a significant and appreciable improvement in the independent role-performance of the experimental group over time ($t = 1.91$, $P < 0.05$). The overall level of behavioural disturbance fell, in comparison with a slight increase in the level of disturbance shown by the control group, although these changes did not reach significance. Examining changes in each subscale separately showed that the trend was for most of the scores for the experimental group to show some improvement, compared with no change or deterioration in the control group. The most sizeable difference in change occurred in disruptive behaviour ($t = 1.82$, $P < 0.05$). Change scores on other subscales did not reach statistical significance.

Relatives' measures

The results of the EE ratings at first and second assessments are shown in Table III. There was no initial difference in the proportion of relatives in the two groups who fell into the high-EE or low-EE category ($\chi^2 = 0$). However, after the intervention a change had occurred: three of the experimental-group relatives moved from high-EE to low-EE, in contrast with one relative shifting into the high-EE category in the control group ($\chi^2 = 3.39$, $P = 0.06$). The experimental group's mean frequency of critical comments decreased as much as the control group's increased: the difference between these change scores was significant at the 5% level. However, there were no significant differences between or within groups in the rating of warmth or over-involvement. The amount of face-to-face contact per week changed in the opposite direction to that expected, although not significantly: the experimental-group relatives and patients were spending an average of six hours more together by the end of the intervention, while the control group reduced the time they spent together by an average of five hours.

TABLE III
Changes in relatives' attitudes over time

Attitude measures	*Experimental group* (n = *13)*	*Control group* (n = *13)*	
Expressed emotion			
Initial assessment: number of relatives			
Low-EE	6	7	$\chi^2 = 0.07$, NS
High-EE	7	10	
Final assessment: number of relatives			
Low-EE	9	6	$\chi^2 = 3.39$, $P = 0.06$
High-EE	4	11	
Critical comments			
Initial	9.00	6.52	NS
Final	6.69	9.11	NS
Difference	−2.31	+2.59	$t = 1.66$, $P < 0.05$

Relatives' perceptions of the restrictions on their own freedom of action, and their feelings of strain arising from coping with the problems of the disturbed family member showed no significant differences. However, the experimental group reported a significant improvement in intimacy and reciprocity in their relationship with the patient ($t = 2.42$, $P < 0.05$). A smaller, non-significant change in the same direction occurred in the control group.

The experimental group showed more changes in coping style than the control group. The strategies which were either abandoned or adopted by at least three relatives in each group are listed in Table IV. The experimental group abandoned a number of strategies which seemed likely to be unhelpful, and their efforts to cope became less diverse. The control group made fewer changes, although they were in a similar direction to those of the experimental group.

All the relatives appeared to be at least moderately well informed about the nature of their relative's disorder: the mean score on the first Knowledge Questionnaire was 6.37 out of a possible 10, and all but two relatives scored more than 50% correct. However, the scores changed little either before or after the intervention: the mean change score was less than 1 at both assessment points, and as many relatives scored fewer correct responses as increased their score at each re-assessment. There was no relationship between scores on the Knowledge Questionnaire and any EE indices, nor between EE indices and change scores.

One of the aims of the intervention had been to reduce the recognised tendency among relatives to blame patients for the symptoms or course of their illness. We also speculated that if relatives could be helped to feel more in control of the problems presented and aware of the value of their own coping efforts, at the same time as gaining an accurate appraisal of the difficulties of the task by learning about problems experienced by others in similar

TABLE IV
Changes in relatives' coping styles

	Experimental group	*Control group*
Strategies abandoned		
Putting off action	Yes	–
Preparing for the worse	Yes	Yes
Asking for advice	Yes	Yes
Trying to make plans	Yes	–
Passive acceptance	Yes	–
Keeping feelings to self	Yes	–
Criticising and blaming self	Yes	–
Wishful thinking	Yes	Yes
Strategies adopted		
Taking up other activities	Yes	–
Calm discussions with patients	Yes	–

circumstances, this might serve to reduce levels of EE. However, relatives' appraisal of their own level of control over, or ability to cope effectively with, the problems presented was low: few scored items to indicate they felt they had much control at all, either before or after the intervention. Nevertheless, five of the ten who responded to the item concerning confidence in their ability to cope with their feelings about the situation did report an improvement. By the end of the intervention, six of the relatives thought the patients had more control over how well or ill they were generally, and five thought they had more control over major specific problems.

Relatives were asked informally about their experience of the group: whether they had found it helpful, and which aspects had been positive or negative. All but one person had found the group supportive, and a welcome opportunity to sort out many issues. The exception was the relative of the only patient with a neurotic disorder, who stated that he could not identify with most of the problems brought up by other relatives. The factor most commonly mentioned as helpful was the opportunity to discover that there were other people with similar problems, who also found the situation very stressful and bewildering at times. Opportunity to learn new ways of behaving was not referred to by any relative, either as part of the positive experience of the group, or as something they would have liked more of. Similarly, no group member expressed a need for more information.

Discussion

Relatives of the long-term mentally ill were offered a regular, although infrequent, opportunity to meet others in similar circumstances, in order to share problems and ideas about successful ways of coping. Our results show that this kind of minimal, clinically feasible, intervention can have a positive effect at several levels, even on top of an energetic and well staffed day-hospital service. Patients' clinical status showed a trend towards improvement and, perhaps more relevantly for this group, their ability to perform independently a range of domestic and self-help skills improved significantly. Relatives became less critical and reported improvements in the rewardingness of their relationship with the patient. Coping also seemed to change for the better, leaving several of the relatives more confident about how well they handle their feelings about the situation.

These trends are encouraging, since they suggest that the approach used in the intervention, which included efforts to lower levels of EE, but did not focus exclusively on this issue, can contribute positively to the process of rehabilitation in the long-term mentally ill. It has been suggested that, in this population, there may be a balance or pay-off between disability and illness, such that the cost of improving social functioning may be an increase in relapse rates and that, conversely, attempts to minimise the risk of positive symptomatology may enhance levels of social disability (Liberman, 1986). We had hoped to achieve some reduction in the very substantial levels of disability in the patients, and to this end were wary of facilitating a low-engagement style of coping in the relatives. The improvements in aspects of the patients' social functioning, the increase in the amount of time the family spent together, and the relatives' reports of increased intimacy and recognition of the patients' own potential to control their behaviour all point to the success of our efforts in this respect. The trend towards a decrease in positive symptoms, shown by the PSE results, was an additional, somewhat unexpected change.

The results frequently failed to achieve statistical significance, despite showing apparently substantial changes and between-group differences which seem likely to be clinically important. In part this was due to the small size of the sample, coupled with the large variation in the variables measured. In view of the fact that we were dealing with an unselected group, our positive findings must be treated with caution. A replication of this study with much larger numbers, to take account of this considerable variation, is necessary before we can be confident of the significance of our findings.

However, the patients were chronically and severely disabled, showing islands of competence amid a sea of problems, and substantial improvements in such patients occur only occasionally in traditional services (Bleuler, 1978). Further, both the experimental group and the comparison 'no treatment' controls were receiving a well staffed, intensive service, which may be beyond the power of many day-care facilities to offer. Therefore we had to show a treatment effect which exceeded that already achieved as a result of receiving this routinely high level of day care. Thus the odds were weighted against our being able to demonstrate any effect at all. Despite this, improvements were achieved, testifying that regular support offered to relatives as an adjunct to traditional services, and deploying merely three hours of professional time each month, is an effective use of resources.

Since the relatives' own ratings were used to estimate the patients' performance of domestic and social roles, the improvements indicated by the results cannot necessarily be taken at face value: they may reflect a lowering of expectations on the relatives' part, rather than a real increase in the patients' level of functioning. However, in either case, the results indicate a change for the better in the home environment.

The EE scores of relatives who attended the group were substantially reduced without the use of explicit or sophisticated behavioural techniques. Provision of a supportive and accepting environment where relatives have an opportunity to ventilate some of their more difficult feelings about their situation seems to facilitate these desirable changes without the necessity for more structured techniques. This unchallenging approach may be better adapted to meet the needs of supporters of the long-term mentally ill, who are likely to have long-established, entrenched attitudes and methods of coping which may be resistant to change, and who are no longer actively searching for information or advice, but who feel a need for support and reassurance to cope with their sense of burden.

As anticipated, offering these relatives education based around the Knowledge Questionnaire was not effective in changing their ideas about the disorder. For some this was because there was little room for improvement, and perhaps reflects their long familiarity with the problems, and the generally good contact between relatives and staff maintained by this particular service. For others, it appeared that the incorrect information they had about the disorder represented a set of personal beliefs rather than a deficit in knowledge, and as such could not be easily modified by simple instruction (Barrowclough *et al*, 1987).

The group was a positive experience for almost all the members, as was demonstrated by their regular attendance rates and the views they expressed afterwards. They found the opportunity to meet others in similar situations was particularly beneficial, and they came to realise that their problems were not unique, nor was their situation necessarily as bad as others. The therapeutic effects of discovering universality (Yalom, 1975) and making positive social comparisons (Wood *et al*, 1985) have been reported in other populations.

The patients themselves were a diverse group, and the family relationships were diverse in quality. Some relatives who attended the group had unique problems and would have benefited from more intensive, individual input, probably as an adjunct to the group meetings. Although specific diagnoses might seem less important than the disabilities evident in these patients, diagnosis does have relevance in enhancing the coherence and commitment of the relatives' group. The perceptions and reactions of relatives of those patients who were not suffering from schizophrenia posed particular problems. They identified less with the interests of the group as a whole, and their emotional responses to the patient seemed to be more volatile, possibly reflecting the greater volatility of the patient's clinical state. Indeed, the two relatives who became more critical fell into this subgroup. In view of this, it is impressive that the group, meeting rarely as it did, was able to establish and profit from considerable cohesiveness. It seems, therefore, that this kind of group cannot offer sufficient support to meet the needs of all the relatives who may be encountered in an ordinary clinical setting. Separate groups for the relatives of patients with schizophrenia, cyclical affective disorders and neurotic disorders may be preferable when feasible.

Those who rejected the offer of the group completely present a different problem. The baseline measures do not suggest that their needs differed from those of the participants in the group. However, their previous experience of contact with services may partly account for their reluctance to participate: either the care team had previously failed to gain their co-operation in planning the patient's treatment programme, or they had a history of conflict with services which might have led them to reject the idea of attending a regular group. Evidence points to the importance of close and consistent liaison with relatives from the point of first contact with services (Birchwood & Smith, 1986; MacCarthy, 1988), and the necessity of taking the relatives' own beliefs and requirements into account in offering services, if subsequent relationships are to achieve the desired level of collaboration.

Finally, our sample, who were prepared to accept a high level of contact with the day-care facility, may be unrepresentative of the long-term mentally-ill population as a whole. However, it is perhaps a truism that it is impossible to treat people who are not there to be treated. Those patients who are poor or minimal attenders at day-care centres are an important subgroup who present particular management difficulties (Compton & Brugha, 1988). Indeed, working with the relatives of such patients may be the only feasible option open to care staff. However, such relatives will face particular problems and burdens not necessarily shared by the group we worked with. The intervention reported here aimed to supplement the efforts of the day-care staff in providing a coherent and integrated service to the family as a unit. Part of what was being 'treated' therefore, was the relationship between the day-care team and the family unit.

We would argue that this sort of specific, time-limited group needs to become a routine part of the clinical service offered by community care facilities, even if relatives and patients have achieved an equilibrium in the context of persistent chronic and severe difficulties. Ideally, this should be initiated earlier in a patient's career, to avoid the development of persistent failures of communication between the clinical team and carers. Guidance about attitudes and coping styles is also indicated before these settle into maladaptive but entrenched patterns. However, detailed information and explicit behavioural guidance may not be as crucial a requirement for relatives coping with really long-standing problems. The opportunity to acknowledge and share some pent-up feelings with others in similar circumstances seemed particularly welcome to this group, and may be the best focus for intervention with relatives of the long-term group, who cope with a diverse range of disabilities and deficits.

Acknowledgements, references, and authors' details are given at the end of the following paper, on page 782.

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Counselling the Relatives of the Long-Term Adult Mentally Ill
II. A Low-Cost Supportive Model

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A psychosocial intervention is described geared to the needs of carers of the long-term mentally ill, which is feasible for a busy clinical team to implement: relatives were not selected for the group by patient diagnosis or motivation and little extra staff input was required. An interactive education session at home was followed by a monthly relatives group which aimed to reduce components of expressed emotion (EE) and to alleviate burden. The group facilitators adopted a directive but non-judgemental style, and constructive coping efforts were encouraged. The intervention was effective at reducing EE and improving family relationships. The study offers a realistic model of how to offer support to people providing long-term care for the severely mentally ill.

The emotional demands on relatives who provide support for those in continuous and intensive contact with psychiatric services may continue for years. Relatives of the mentally ill have voiced much dissatisfaction with services, and with clinicians who have traditionally blamed or exploited them without recognising that they are an important community resource with needs of their own (Kuipers & Bebbington, 1985). Carers need to have ready access to sympathetic staff who are familiar with their situation and who can help them to ensure that patients maintain and develop skills and independence despite their residual disabilities. Such help needs to be long-term, supportive and geared to maintaining gains rather than to treating symptoms.

In the project reported here, we were interested in developing a psychosocial approach which suited the specific needs of supporters of the long-term