

# How was it for you? Families' experiences of receiving Behavioural Family Therapy

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**How was it for you? Families' experiences of receiving Behavioural Family Therapy**

The benefits of family interventions for families having to cope with serious mental health problems are well documented but routine implementation of these interventions is often problematic. Despite a wealth of research on the clinical outcomes of such interventions, very little is known about families' subjective perceptions of receiving them. This study reports the findings of a phenomenological enquiry into the lived experience of 10 families who received Behavioural Family Therapy (BFT) as part of a training initiative in the West Midlands Health Region of the UK. The results show that families were very satisfied with the intervention. They reported reductions in the levels of stress within the family, reduction in levels of carer burden, enhanced communication skills and a positive sense of empowerment. They attributed these changes to receiving BFT. The majority of families viewed mental health professionals and services more favourably compared to their experiences before receiving BFT. This is an important finding for service providers, commissioners and mental health workers.

**Keywords:** family interventions, lived experience, phenomenology, psychosocial, qualitative research

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## Introduction

For some years psycho-educational family interventions have been identified as an effective approach to helping families cope with the experience of a relative who has a psychosis (Lam 1991, Dixon & Lehman 1995, Mari *et al.* 1997, Fadden 1998b).

Despite the evidence of effectiveness of family interventions, some studies suggest that their routine implementation in the clinical setting is problematic (Kavanagh *et al.* 1993, Fadden 1997). In a recent systematic review of family interventions in schizophrenia, Pharoah *et al.* (1999) concluded that only moderate benefits were obtained from such interventions and that they required a large investment in time and effort on the part of the families and the therapists. The reviewers suggested that a more valid picture of the benefits may be obtained using a variety of out-

come measures including the subjective reports of families who have received these interventions.

In 1998, a training programme began which aimed to disseminate Behavioural Family Therapy (BFT) across the UK West Midlands region. BFT is a family intervention which includes elements of information giving and skills acquisition. The primary aim is to reduce the rate of relapse by improving communication and problem solving (Falloon *et al.* 1996). Whilst the training programme was aimed at all mental health professionals, the vast majority of those trained were nurses. An evaluation of the programme (now known as the Meriden Programme) demonstrated that front line nurses could be trained in BFT and could subsequently cascade this training to their colleagues (Campbell 2000). Following on from that evaluation a qualitative study of families' subjective experiences of receiving BFT was undertaken. This paper describes that study.

## Literature review

The term 'expressed emotion' or EE has been with us for nearly two decades (Brown 1985) as a way of describing the emotional climate within a care environment. The utility of EE as a meaningful predictor of relapse in schizophrenia is now beyond question (Leff & Vaughn 1985, Butzlaff & Hooley 1998). However, the concept of EE is not without its critics. Atkinson & Coia (1995) noted that high EE is not the only factor implicated in relapse and Solomon (1996) expressed concern that it promotes a blame culture on families.

The research into EE prompted studies into family interventions that might change the status of families from high levels of EE to low levels of EE thus reducing the potential for a relapse. The earliest studies generally supported the conclusion that relapse rates are significantly reduced by family interventions at 12 months and, although the effect is somewhat smaller, relapse rates remained significantly reduced at 2 years (Lam 1991, Dixon & Lehman 1995, Fadden 1998a). Later studies attempted to unravel the effective components (Dixon & Lehman 1995, Fadden 1998b). Whilst the effect size between groups in the later studies was less compared to that found in the earlier studies, the evidence was that family interventions has superior outcomes over routine care (Fadden 1998b).

Few of these studies, however, have contributed anything to our understanding of what it is like to be a carer. As Tuck *et al.* state, 'to support, educate and counsel families as they face the demands of this disease, providers must understand the experience of family caregivers' (Tuck *et al.* 1997, p. 119).

The majority of the literature on family care giving and severe mental illness focuses on the burden of care experienced by the carers (Loukissa 1995, Jones 1996, Tucker *et al.* 1998). Generally the research into caregiving identifies negative aspects of the role of caregiver such as carer burden and chronic sorrow (Loukissa 1995, Jones 1996). However, there are also positive aspects to being a caregiver. For example, in some societies, caregiving is seen as a source of pride and status (Lim *et al.* 1996).

Whilst burden of care is a legitimate topic for research, it is not the only experience encountered. Other experiences have included personal growth (Howard 1994), chronic sorrow (Eakes 1995) and alteration in the family's expectations of the person with schizophrenia (Tuck *et al.* 1997).

Studies looking at the effects of family interventions have mainly considered quantitative outcome data. Few have examined qualitatively what the benefits are from the families' perspectives. McCreadie *et al.* (1991) examining whether families wanted family intervention found that

many families were difficult to engage in treatment but that those who had recently experienced a crisis were more likely to engage with interventions. Van Hammond & Deans (1995) found that participants in psycho-educational support groups experienced positive changes in their beliefs about schizophrenia. The groups had given the families hope and assisted them to adapt to their experiences of schizophrenia.

Budd & Hughes (1997) explored carers' views of the impact of psycho-educational interventions for schizophrenia and found that positive impacts included: increased understanding about schizophrenia, re-attributing problem behaviour to the illness and helping to improve communication within the family. Negative impacts included wanting more information and information being provided too late.

When confronted with dealing with serious mental health problems, most families express the need for more information (Rose 1998). They want continuity of care staff and assistance from professionals to interpret the meaning of behaviours they have observed. They also would like to be introduced to other families and service users in similar circumstances (Rose 1998).

Whilst there is good evidence of the efficacy of family interventions, there is ample evidence that implementing them in routine clinical practice is not easy (Kavanagh *et al.* 1993, Fadden 1997, Campbell 2000). Credible evidence of success is clearly important to the spread of innovative psychosocial interventions (Backer *et al.* 1986). Pharoah *et al.* (1999) suggest that there are insufficient data to definitively state that these interventions are any more effective than other, more accessible, interventions such as assertive community treatment (Marshall & Lockwood 1999).

Despite this cautious assessment, there is good reason to believe that families appreciate family interventions when they are received (Budd & Hughes 1997, Campbell 2000). Exploring the families' perspectives would provide greater depth to the evidence of whether or not such interventions actually benefit families. The provision of such data may help clinicians, many of whom are nurses, to decide whether their struggle to implement family interventions in routine clinical settings is worthwhile. Hearing the consumers' views of family interventions may also assist commissioners of mental health services in weighing up their value (Pharoah *et al.* 1999).

## Method

The primary aim of this study was to describe the lived experiences of families who had received the family intervention of BFT. Two supplementary questions were: what were the benefits as perceived by families and is

there evidence that family behaviours change following intervention?

Whilst the dominant research paradigm in nursing research is the quantitative paradigm (Polit & Hungler 1995), a qualitative approach was taken in this study. Qualitative research approaches are commonly adopted where the researchers are endeavouring to explore or describe the experience of a particular phenomenon rather than to quantify it or generalize findings to a larger population.

Qualitative research has been inextricably linked to psychiatric nursing (Cutcliffe & Goward 2000).

First, the qualitative researcher's use of herself or himself as a research instrument is analogous to the therapeutic use of self in the mental health nurse–client relationship. Second, the qualitative researcher's relationship with participants is analogous to the empathic relationship formed with clients with privileged access to the client's world. Third, by embracing uncertainty and ambiguity the qualitative researcher's dynamic view of the world reflects the realities of nursing people with unique, sophisticated and highly complex problems. Thus, a qualitative methodology was perceived as more able to capture the unique experience of all family members' experiences of BFT and was in keeping with the researcher's affiliation to Cutcliffe and Goward's conceptual arguments.

A qualitative methodology using a phenomenological approach was adopted. The phenomenological researcher believes that, rather than there being a single reality that explains the way the world works, there are multiple realities constructed by those who experience the world (Maykut & Morehouse 1994). The goal is that these realities will be 'describe(d) or rendered into words by people who have experienced the phenomenon and (that) the researcher interprets the words' (Annells 1999, p. 6).

Hedeggerian hermeneutic phenomenology has been adopted in this study (Koch 1999). Here the researcher is seen as an integral part of the research process, entering into the world of the research participants and coming to understand their experience through a process known as the hermeneutic circle (Koch 1995). It assumes that the researcher will bring a level of precomprehension to the study and that, through a circular process, the research participants' knowledge (data) is revisited and elaborated upon, to gain meaningful interpretation of their experiences (Bleicher 1980).

## Sample

A purposive sample of families was recruited from six UK National Health Service (NHS) mental health trusts. The eligibility criteria for recruiting families into the study spec-

**Table 1**  
Demographic details of the interviewees

Interviewees	No. of families = 10 No. of individuals = 27	Mean age in years (range)
Service users	9 <sup>1</sup>	29 (25–38)
Partners of service users	2	42 (34–50)
Daughters of service users	1	29
Sons of service users	1	28
Mothers of service users	8	60 (51–67)
Fathers of service users	4	66 (55–72)
Female sibs of service users	2	25 (16–33)
Ethnicity		
White (British)	24 (89%)	
Asian (Pakistani)	3 (11%)	
Carer employment		
Retired	7	
Professional	2	
Semi-skilled	6	
Unemployed	1	
Mean number of years as carers	7.5 (range 2–23)	
Service user lives with carer		
Yes	6	
No	5	

<sup>1</sup>Eleven service users were involved in the Behavioural Family Therapy sessions but only nine agreed to be interviewed.

ified that at least one member of the family had to have a diagnosis of severe mental illness (schizophrenia, bipolar illness, severe depression); the families had to have received at least six BFT sessions from BFT-trained staff; prospective interviewees had to be over the age of 13 years and all participants had to be able to give informed consent.

At the time of the study 55 clinicians had been trained through the Meriden programme, of whom the majority were nurses (67%). They were asked to supply the names of families who had received BFT. After applying the eligibility criteria, the accessible number of families was 17 with all of those being nominated by nurses. Eventually 10 families were recruited into the study (27 individuals). Table 1 shows the demographics of the participating families.

## Data collection

Semi-structured interviews were carried out, audio-taped and transcribed verbatim by the researcher. A loose interview schedule was used which covered areas such as the global experience of family interventions, the families' thoughts about BFT, thoughts about the therapists' interactions with them and the families experiences of the therapy sessions. Participants were given the option of individual interviews although this was not taken up and assurances of anonymity and confidentiality were given. Multi-centre Research Ethics Committee (MREC) approval was obtained. In addition, approval was obtained

from each of the Local Research Ethics Committees (LRECs) for the participating NHS trusts. Finally, full permission for the study was obtained from the trusts' managers.

### Data analysis

An adaptation of the constant comparative method of analysing qualitative data was employed (Maykut & Morehouse 1994). The transcribed interviews were divided into 'units of meaning' which in this case was sentences. Each unit of meaning was then coded and placed into categories which emerged from the data. Categories were then constantly compared with previous data and refined until the emergent categories accounted for all of the data. The interview transcripts and their coding were then presented to an independent expert in the field of BFT for validation that the categories arose from the data. This step assists in improving the 'trustworthiness' of the research findings (Denscombe 1998). The categories were then examined for common themes running within and across interviews and significant statements relating to the themes were recorded. Through the hermeneutic process the themes were then grouped together into categories of meaning (Maykut & Morehouse 1994).

### Results

The main themes emerging from the interview transcripts were:

- engagement with BFT;
- therapist qualities;
- the practice of BFT;
- perceived gains attributable to BFT; and
- empowerment of service users and family carers.

#### Engagement with BFT

For the majority of families engagement started whilst the service users were either inpatients or soon after a downturn in their mental health. Some service users were initially reluctant to engage but came round to the idea because of the enthusiasm from carers. Families described a process of negotiation of participating in BFT and of being offered real choices to become engaged in BFT or not. For several families the timing of the offer of BFT was an issue in that they felt that it should have been offered sooner. Several of the families commented about the complexities of arranging BFT sessions to suit all members of a family. This was balanced by the families welcoming the flexibility of having the sessions at the carer or service user home at a time to suit them as demonstrated by this comment:

I think them [the sessions] being run in the house was better than going somewhere because I think that if we all had to meet like at the hospital or somewhere . . . at least you feel at ease in your own home. (Interview 4)

The vast majority of families perceived BFT as a collaborative intervention. Many carers expressed the view that being involved in BFT was the first time they felt their views were being taken into consideration by professionals:

. . . I think it's a question of respect on both sides really that with these people like K and this registrar at the hospital and the people at X you felt that they respected your views as well as [us] respecting theirs and this was something quite novel for us. (Interview 7)

#### Therapist qualities

There was unanimity across the families that the therapists were dedicated and professional practitioners. For example, one service user said:

I mean you took to him. It doesn't take long to take to X because it's not like somebody coming and saying "Right well I've got an hour" I don't think he ever looked at his watch, however, long he took. I mean . . . you never got that impression of being hurried with X. (Interview 8)

The therapists were seen as very informed about their role and very able to perform in that role. Family members made numerous positive observations about the style of the therapists including being calm, friendly, and understanding. There were some negative observations made although these were by far in the minority and included patronizing and pedantic styles.

#### The practice of BFT

For all families the consensus view was that participating in BFT had been a useful enterprise. For some, the mere fact that they were having regular contact with a mental health professional was enough to rate BFT highly as one mother commented:

What I think we all valued was the contact with K. Because previously we had no input from a CPN at all. Which I . . . you know we wondered why it hadn't happened. But K has proved in my book anyway to be the most helpful person we've met during the 11 years. (Interview 7)

Families welcomed the fact that BFT was offered to them at their location. They felt that this placed them in the 'driving seat' of the therapy.

The various components of BFT were viewed very favourably. For example, the communication skills train-

ing module was well received. One mother commented that because family communication had improved (as a result of BFT in her view) less problems had arisen. Psycho-educational sessions were another highly valued component of BFT. The provision of up-to-date information in an easy-to-understand format was welcomed by all families.

It was clear from the way the participants used the jargon of BFT that many had internalized the concepts imparted through the intervention. For example, one mother summarizing what BFT was all about said:

How we approached problems, how to talk to each other and how to say nice things to each other and how to say if we'd got a problem. and one of the main things was attentive listening which I think we're still not very good at. (Interview 1)

The appreciation of the BFT process by the participants was not unqualified and several suggestions were made of what might be done differently. For example, therapy sessions could be complemented by audiotapes of sessions to aid retention of information and understanding. Several families expressed a desire for refresher sessions of BFT to help them keep the skills they had learned.

### Perceived gains attributable to BFT

All the families said that one of the main gains from BFT was the contact they had as a result of receiving therapy. They viewed this contact as supportive and valuable. For most families this was a marked change from the service they had been getting. Many carers felt less isolated after receiving BFT. They felt they now had a contact whom they could approach for support. Through BFT, families had obtained a range of information which augmented their existing knowledge.

Many carers felt they had experienced a reduction in their stress levels associated with caring for their ill relative. For example, in this extract in response to a question about changes in the emotional atmosphere in the home, a mother said:

Oh definitely yes there's no tension. I mean there used to be a lot of tension between A and me and my husband. (Interview 2)

Several families felt that they had acquired new skills through BFT and that they were maintaining these skills with the minimum of effort. For example, a mother talking about how she and her son now communicate said:

Yes, definitely. Because – not on some things, but definitely on other things we talk about it, just look at things in a different way. When I want G to do something, or when I say something to G I say it in a different way, not in an argumentative way. (Interview 9)

### Empowerment of users and carers

For all of the carers the BFT outcome that engendered most emotion when discussing it was feeling they now had a say in the way that their loved ones were cared for. BFT had given many of these carers a voice to communicate their concerns to professionals and they felt that their views were now being taken seriously as in this service user's example:

Well what's happened is that the one contact in H (Hospital) has been told and it's been put on my notes that if my family ring up they take notice of my family now, that's actually been written down. It actually says that they need to listen to the family and do something. (Interview 8)

Carers also felt empowered to ask for help for themselves and some felt the family was being treated as a whole and not just the service user. Many participants said being included in drawing up relapse signs and contingency plans was valuable. Service users and their families felt that they were at last taken seriously if they expressed concern about a deterioration in the service user's mental health.

### Discussion

This study has shown that experiencing BFT has a number of positive impacts on families. A consistent theme across all families was that they felt more positively disposed towards mental health services having received BFT. The initial reluctance of some service users to engage in BFT eventually gave way to acknowledgement of its benefits and so the message here for putative BFT therapists is to persevere with the engagement process.

The evidence that families attribute the acquisition of skills and changes in their behaviour to BFT is particularly encouraging and all the more so as the majority of interviews occurred several months after the BFT sessions had ended.

The self reports of families' reductions in stress levels and subjective burden experienced by carers is encouraging. Most of the families attributed the reduction in stress to the improvements in family communication although gaining information about the illness and having contact were other key factors. Whilst it is not possible in this study to make a causal link between BFT and the reduction in stress, the families themselves connected this to their participation in BFT. This echoes the findings of other authors (McCreadie *et al.* 1991, Budd & Hughes 1997).

### Limitations of the study

The sampling procedure was reliant on BFT trainers nominating families. There is the potential for bias in the selec-



tion of families to have been introduced at this stage. The recruiting procedures selected families who actively participated in BFT. By definition these families were prepared to invest time and effort in the intervention and hence were more likely to see BFT in a favourable light. However, the study was not an attempt to see if families liked BFT. It attempted to describe their lived experience of BFT. The small sample size limits any generalizations which can be made. It was never the intention to be able to make wide generalizations from the study findings and this should be borne in mind.

Phenomenology advocates believe that research participants should confirm that the researcher's interpretations have indeed emerged from what they said. Although this stage was omitted from the study, the themes were presented to a Consultant Psychologist with considerable experience in the delivery of BFT who was able to confirm that they did indeed arise from the transcripts.

All the research participants were interviewed within their family groups. Whilst there is the possibility that this may have constrained the respondents from being entirely frank, the researcher believes that this was not the case. BFT seeks to encourage families to communicate more effectively even when there is considerable conflict within the family and by their own admission participants believed that this aspect of the therapy had been successful.

## Conclusion and recommendations

This study has attempted to describe the lived experience of receiving BFT. This is generally a positive one for the families who felt they gained some benefit from BFT and the majority attributed changes in their behaviour to the therapy. To this end the research questions posed have been addressed.

However, receipt of BFT threw these families' earlier experiences of mental health services into stark contrast. Many believed they had somehow missed out by not receiving BFT earlier. The study suggests that BFT which is consistently delivered by skilled therapists in mental health services which are prepared to embrace new collaborative ways of working with service users and their families has very positive impacts upon those families.

Future research might include exploring the experiences of families who were offered BFT but either declined it or dropped out of therapy prematurely. Such a study may provide valuable information on implementing BFT in routine practice.

Some researchers have suggested that the benefits of family interventions are at best moderate (Pharoah *et al.* 1999) but accept that hearing the views of families may

shed more light on the outcomes for those families. The stories of the families involved in this study demonstrate that the benefits of receiving BFT are substantial and that commissioners and providers of services would do well to heed the voices of those families when considering their service priorities for the future.

Many nurses and other mental health professionals may be considering whether to embark on training in BFT or may be struggling with its routine implementation. This study suggests that if they persevere it is likely that both clients and their families will benefit significantly from their interventions in the future and that the families will view the experience very positively.

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