A Mental Health Professional Opinion on Family Involvement During the Treatment of Severe Mental Illness: A Multiple Case Study

Vanessa Perocier
*Antioch University of New England*

Follow this and additional works at: [https://aura.antioch.edu/etds](https://aura.antioch.edu/etds)

Part of the [Marriage and Family Therapy and Counseling Commons](https://aura.antioch.edu/etds), and the [Occupational Therapy Commons](https://aura.antioch.edu/etds)

**Recommended Citation**
Perocier, V. (2023). A Mental Health Professional Opinion on Family Involvement During the Treatment of Severe Mental Illness: A Multiple Case Study. [https://aura.antioch.edu/etds/949](https://aura.antioch.edu/etds/949)

This Dissertation is brought to you for free and open access by the Antioch University Dissertations and Theses at AURA - Antioch University Repository and Archive. It has been accepted for inclusion in Antioch University Full-Text Dissertations & Theses by an authorized administrator of AURA - Antioch University Repository and Archive. For more information, please contact hhale@antioch.edu.
A MENTAL HEALTH PROFESSIONAL OPINION ON FAMILY INVOLVEMENT DURING THE TREATMENT OF SEVERE MENTAL ILLNESS: A MULTIPLE CASE STUDY

A Dissertation

Presented to the Faculty of
Antioch University New England

In partial fulfillment for the degree of
DOCTOR OF PHILOSOPHY

by

Vanessa L. Perocier
ORCID Scholar No. 0000-0001-7278-1529

August 2023
A MENTAL HEALTH PROFESSIONAL OPINION ON FAMILY INVOLVEMENT DURING THE TREATMENT OF SEVERE MENTAL ILLNESS: A MULTIPLE CASE STUDY

This dissertation, by Vanessa L. Perocier, has been approved by the committee members signed below who recommend that it be accepted by the faculty of Antioch University New England in partial fulfillment of requirements for the degree of

DOCTOR OF PHILOSOPHY

Dissertation Committee:

Denzel Jones, Ph.D., Chairperson
Tomoyo Kawano, Ph.D.
Stewart Gilbert, M.D.
While severe mental illness (SMI) is extensively studied, less attention focuses on the relationship between people with SMI and their families and the impact this may have on treatment. Bronfenbrenner’s (1979) ecological systems theory conceptualized the treatment and recovery of people with SMI and their families. This study proposes that if family members getting social support contribute to a person’s treatment plan, the individual’s treatment outcome will improve rather than the individual enduring the treatment process individually. By applying ecological systems theory, mental health professionals and policymakers can better grasp the systemic nature of individuals, their family members, and surrounding external circumstances. Future research implications and recommendations aim to increase knowledge and awareness of family involvement during SMI treatment approaches. This dissertation is available in open access at AURA (https://aura.antioch.edu) and OhioLINK ETD Center (https://etd.ohiolink.edu).

*Keywords*: Severe mental illness, family, treatment, ecological systems theory
Acknowledgment

I want to acknowledge everyone who helped and supported me from start to finish. The work cited throughout this project started well before my acceptance into a Ph.D. program, and putting it into writing for the greater good could not be done without you. Suppose this topic interests you, and you find yourself reading this discussion. In that case, you are also involved and help the system function at its best.

My Christian faith has played a vital role in the process of this project. Therefore, my faith in God has brought me to this point. I further acknowledge my parents, Steve and Rose, Perocier, for their unconditional support and encouragement. Without their reinforcement, maintaining academic focus would have been more challenging. They are always my biggest cheerleaders. Additionally, I acknowledge my friends and family who are also strong support – especially those also participating in doctoral programs along with me.

I also acknowledge colleagues who participated in my study; my helpful research assistants, Victoria Quitevas and Sanjana Parikh who helped me make sense of the data I collected; and my many teachers and professors who encouraged me to pursue higher education and always make a difference. Thank you, everyone. Honestly, it really helped.
Dedication

This dissertation is dedicated to my parents, Steve and Rose Perocier, and both sides of my family, the Perocier and Mucker families. I am the first to get a Doctor of Philosophy (Ph.D.) degree. This dissertation and degree are generations of their commitment to God, African American and Puerto Rican heritage, human rights, and anti-slavery mindsets that pushed me to continue my education to the highest academic level and enhance my service to others – as they have taught me. My accomplishment results from their steadfast work ethic, love, and dedication to themselves and the people they have served. This dedication is to say you are welcome and, more importantly, thank you. We did it together.
# Table of Contents

Table of Contents .......................................................................................................................................... 7

Chapter One — Introduction ...................................................................................................................... 13

References ................................................................................................................................................... 23

Chapter Two — Critical Literature Review .................................................................................................. 28
  Schizophrenia and Bipolar Disorders ...................................................................................................... 28

Treating Mental Health Disparities ................................................................. 29
  The Medical Model ................................................................................................................................. 30
    Psychopharmacotherapy ..................................................................................................................... 31
  Psychotherapy ......................................................................................................................................... 32
    Community Behavioral Health Services and Treatment ..................................................................... 32
    Relational Concepts .............................................................................................................................. 33

Recovery ...................................................................................................................................................... 34
  Recovery-Oriented Treatment .................................................................................................................. 34

Ecological Framework .................................................................................................................................. 35

Figure 2.1: Ecological Family Systems Model ........................................................................................ 36
  Microsystem ............................................................................................................................................ 37
    The Family Role ................................................................................................................................... 37
  Family Goals and Recovery ..................................................................................................................... 39

Treatment and Program Involvement ......................................................................................................... 40
  Mesosystem ............................................................................................................................................ 40
    Mental Health Professionals and Family Treatment ........................................................................... 40
    Recovery-Oriented Family Interventions .............................................................................................. 41

Exosystem ................................................................................................................................................... 41
  Peer-Led Family Education ...................................................................................................................... 41
  Psychoeducation ......................................................................................................................................... 42
  Family Consultation .................................................................................................................................. 42
  Symptom Management and Recovery Intervention .............................................................................. 43

Macrosystem .............................................................................................................................................. 43
  Social Roles .............................................................................................................................................. 43
  Resources .................................................................................................................................................. 44
  Chronosystem .......................................................................................................................................... 44
Appendix G — Research Assistant Application Google Form ................................................................. 115
Appendix H — Research Assistant Application Questions ................................................................. 116
List of Table

Page 69 Table 1: Participant Demographics
List of Figures

Page 36  Figure 2.1: Ecological Systems Model
Page 102 Figure 4.1: Ecological System Model
Chapter One — Introduction

Approximately 8.8 million adults in the United States are diagnosed with schizophrenia and bipolar disorder in 2016 (U.S. Department of Health and Human Services, 2016). The consequences of non-treatment of those illnesses lead to relapses in the treatment process and results in homelessness (Solari et al., 2016), time in jail or prison, suicide attempts and death by suicide, homicides of other people with mental illnesses, family homicides, and mass killings (U.S. Department of Health and Human Services, 2016). Relapse occurs when the person becomes ill repeatedly and re-experiences their symptoms after recovery (Belete et al., 2020).

Non-compliance to antipsychotic medication regimens occur in 50% of people diagnosed with schizophrenia, with 78% discontinuing medications altogether (Altamura & Goikolea, 2008), resulting in a relapse. For treating schizophrenia, treatment regression includes social withdrawal, difficulty concentrating, and increased paranoia (Iliades et al., 2014). A community-based study in Ethiopia indicates a 65.9% relapse rate over 2.5 years among men and women (Belete et al., 2020). Decompensation for people diagnosed with bipolar disorder includes frequent, sudden changes in mood and energy levels, impulsive behaviors, an exaggerated perception of self-worth, and decreased ability to think clearly (Andrews et al., 2017). Family burdens (Peters et al., 2011), re-hospitalizations, suicidality, and hindered psychosocial recovery (Belete et al., 2020) increases each time someone with Severe Mental Illness (SMI) experienced a relapse.

Medications for decreasing physical and psychiatric symptoms are the primary treatment for SMI (Maidment et al., 2022). For example, antipsychotic medications are effective in reducing relapse rates among 50% of people experiencing their first episode of schizophrenia (Rettenbacher et al., 2004), and 36% of adults who use antidepressant medications to manage depressive symptoms of bipolar I disorder experience relapse after discontinuing their prescription against medical advice (Belete et al., Legas, 2020). Treatment methods are dictated
mainly by phenomena deriving from psychiatry, social work, and nursing fields (Sim, 2006). Factors like family history, employment status, adverse events, or unmanaged psychiatric symptoms like poor insight and cognitive deficits (Altamura & Goikolea, 2008) lead to partial or no compliance with treatment. Psychotherapy and pharmacotherapy generally take place in community mental health settings, inpatient and outpatient facilities, state hospitals, and within the criminal justice system in jails and prisons (Sim, 2006).

Previous research on SMI primarily consists of an individual's biomedical responses and psychosocial factors (Spaulding et al., 2003), individual characteristics (Young et al., 2005), and substance abuse (Wood & Buttaro, 2013). When considering occurrences of partial compliance to treatment, researchers examine multiple sociodemographic factors, such as the family or caregiver's attitudes toward the illness or the family's contribution to adverse events experienced by the family member diagnosed with the illness (Rettenbacher et al. 2004). Positive attitudes from the patient's support network on living conditions associated with the illness and having enough resources are significant protective factors for encouraging the healing experience (Pernice-Duca, 2010).

Family involvement in research is defined as the frequency of appearance and participation activities (Irving, 2015) and the family ownership and management (Ashwin et al., 2015) of the consumer's experience. Added research on family involvement during treatment has increased our understanding of a family's desire to appear during treatment, their ownership of the process, management, and experience together supporting their member with the illness. Family-focused psychoeducational interventions are a practical addition to pharmacotherapy to prevent relapse (Belete et al., Legas, 2020). Observing benefits through the lens of treatment providers aids an understanding of how family interventions influenced the treatment of schizophrenia and bipolar disorders.

Topar et al. (2006) suggests that people diagnosed with SMI prefer feeling whole, meaning they desire an increased sense of belonging and companionship within their social
relationships and networks. Their quality of life improved when the illness was unassociated from their identity. The individual could retain a sense of self when their social network contributes to their recovery process (Topor et al., 2006). Vital members of the support network are the individual's family. Family members experience vulnerability when relapses or adverse events happen to the family (Spaniol & Nelson, 2015). The individual's family had pressure to acquire more patience and confidence in their choices during daily treatment functions. They were stressed by learning new things about the person diagnosed with the illness, and their lives were significantly altered (Spaniol & Nelson, 2015; Doornbos, 1996). Positive, healthy coping methods within families resulted in higher abilities to adapt to the stressors of managing daily life (Doornbos, 1996).

Surveying mental health professionals (MHP) from varying professional groups is a start to examining family involvement when treating people with SMI. MHPs are fundamental in the treatment process and daily facilitation of the treatment plans (Topor et al., 2006; Wahl & Aroesty-Cohen, 2010). They are also more vocal about mental healthcare policy, protocols, and treatment recommendations. MHPs are ideal candidates to consult regarding treating SMI because they could provide valuable insight on strategies, malpractice warnings, and how to retain family involvement.

The present study offers a plan for researching MHPs and their professional opinions and judgments on whether family involvement is a noteworthy addition to pharmacotherapy (i.e., medical model, psychiatric medications), particularly in community mental healthcare settings with disadvantaged groups. The purpose of the qualitative study is to present MHP case studies to give insight into current challenges and future recommendations for clinical and organizational improvements when providing care to people diagnosed with SMI treatment and whether family involvement is a workable approach to recovery and stabilization.
Statement of the Problem

Family psychotherapy models demonstrate family inclusion when addressing emotional distress, relapse, and similar family demands. The literature for SMI is primarily biological and psychiatric focusing on the central nervous system, cognitive dysfunctions, age-related deterioration (Tamminga & Medoff, 2000), structural and functional brain activity, and inflammation (Harrison et al., 2018). Such research is less likely to include familial and social information for recovery and wellness.

Mulud and McCarthy (2017) highlighted that family research on this topic consists of caregiving and family burden from monitoring medication adherence and daily living needs. This study addresses the impact of family experiences and involvement in treating family members with severe mental illness during the treatment process through the lens of mental health providers. It is necessary to conduct this study for a greater understanding of family support and its influence on treatment practice and outcomes.

Rationale for the Study

Overall, current literature appears to concentrate on cognitive processing of SMI, psychotropic drug trials, violence prevention, caregiver burdens and needs, and youth programs for psychosis with the intent to examine the individual experiences of the illness or caregiver mental health. However, this study highlights the processes of MHPs engaging with families participating in treatment and the effects of family contribution and togetherness (Cohen et al., 2013; Price-Robertson, 2017).

The study aims to consult with professionals on daily clinical outcomes, techniques, and methods for family involvement and retention in treating SMI. MHPs provided a helpful understanding and insight of recovery and treatment compliance and insight to clinicians seeking to work with this population and hoping to gain the family's interest and support. Examining such increased an understanding of individual recovery goals. Correspondingly, planning council members and administrators may find the results valuable when designing
mental health programs for this population and decreasing adverse reactions to partial
treatment compliance.

**Rationale for Qualitative Methods**

This qualitative research study attempts to gain an understanding and explanation of the
disadvantages and advantages of family involvement during the treatment of SMI. Qualitative
research gathers, organizes, and analyzes contextual data (Bowen, 2014). Therefore, the
participants' responses highlight an underlying phenomenon through ethnographical qualitative
research examining their viewpoints.

Ethnography is a qualitative research method used to observe participants' observations
described in the interview transcript (Have, 2004) and captures the intricacy of their dynamics
and cultural contexts (Gehart et al., 2001). Qualitative research allows for purposeful sampling;
therefore, the researcher chose participants with relevant characteristics and criteria (Gehart et
al., 2001). The thematic analysis provides extended awareness of the coded and themed data
(Hsieh & Shannon, 2005).

Qualitative research allows professional voices to speak for vulnerable clientele and their
families. The current study does the following:

- Obtains information about methods useful for involving the families in treatment,
- Describes issues preventing successful community mental health treatment of SMI,
- Describes the evidence regarding usefulness in community settings.

**Research Questions**

The study aims to answer the central question of how mental health professionals
clarify the importance of family involvement in the treatment in community settings among
individuals diagnosed with SMI. The research study addresses the following sub-questions:

1. Per your professional opinion, is there a positive relationship between family involvement
   in treating SMI and individual recovery in community settings?
2. What are the most important factors influencing a family's decision to participate in treatment for those diagnosed with SMI?

3. What has been your experience working with this population?

4. How would you describe your experience working with family members?

5. What have been the changes you observed when families were involved in treatment?

6. What was your communication with family members during the duration of treatment?
   
   Was it frequent? Strained? Forthcoming? Brief?

7. What are your overall thoughts on family involvement when treating SMI?

8. What family approaches would you use if treatments with family were more accessible?

9. How would you incorporate families into therapy or treatment measures for this population?

10. What would recovery look like for diagnosed persons?

**Significance of the Study**

Ralph & Corrigan (2005) describes recovery as a process rather than an outcome of services. It is multifaceted, multidimensional, and not adequately measured with a single classification system. Through this research, gaining awareness from expert opinions on respected clinical judgment for the approach to mental health treatment for individuals and families may influence how insurance companies, grant providers, and related stakeholders redefined medical necessity and their approach to treatment implementation in the community.

This study is a descriptive study that attempted to acquire information measuring and clearly defining family involvement with SMI cases in community settings. A descriptive research model is chosen over an exploratory model because I hoped to gain insight into the characteristics and functions of family involvement and not merely for general inquiry.

Specifically, it was vital to understand how family involvement and recovery were subjective and varied for this population because their family's welfare was important. Moreover,
the analysis suggested future research and factors associated with family decision-making for mental health treatment in community settings. A therapist is an active part of recovery for the client and family (Ruddick, 2008). The treating mental health professional facilitates a positive correlation between the family support network size and the overall recovery experience (Pernice-Duca, 2010).

**Definition of Terms**

Below is a list of terms used throughout the dissertation and their definitions:

- **Family recovery** – Recovery was a process by the family that typically occurs in phases to gain or regain insight into oneself, others, and public life after or during the negative impacts of the mental illness (Spaniol & Nelson, 2015).

- **Medical model or Biomedical System** – A system used by medical professionals to conduct clinical work and research; it examines the assessment of patients, their presenting problems and classification, and recommended interventions (Huda, 2021).

- **Clinical Judgement** – Often cited in the nursing field, defined as the compilation of knowledge and skills over time, resulting in the ability to analyze and synthesize the client's presentation at the time of services, objective, and subjective data. After, the professional gathers enough knowledge or evidence on the client to determine the treatment's interventions to deliver the desired treatment outcome (Embler, 2021).

- **Mental Health Providers (MHPs)** – Providers deemed eligible at a state or national level by licensure or certification to treat a range of mental health conditions within their scope of practice and competencies (National Alliance on Mental Health, n.d.)
  - LCSW – Licensed clinical social worker
  - LMFT – Licensed marriage and family therapist
  - LMHC/LPC – Licensed mental health counselor / Licensed professional counselor
- Psychologist – Doctor of Philosophy (Ph.D.) in clinical psychology or Doctor of Psychology (Psy.D.) in Clinical Psychology licensed as a mental health provider
- PMHNP – Psychiatric mental health nurse practitioner
- Psychiatrists – Medical doctors certified to practice psychiatry
- Psychiatric P.A.s – Physicians Assistants registered to practice psychiatry

- Severe Mental Illness – An emotional, mental, or behavioral disorder resulting in severe functional impairment that interferes with or limits a person’s daily activities (U.S. Department of Health and Human Services, 2016)
  - Psychotic-related disorders: Schizophrenia or schizoaffective disorder
  - Bipolar-related disorders: Bipolar I/II

**Theoretical Assumption**

The present study is grounded in Bronfenbrenner's (1979) ecological systems theory to describe the position of family involvement and SMI treatment in the individual's life. As a systems theory, it recognizes that factors could cut across multiple levels in a person's life based on cumulative and intersectional experiences, including a person's geographic and biophysical makeup (Cumming, 2014). This framework is originally known for its biophysical-environmental orientation, yet it is applied to a social context to guide this study. The five-systems structure is: microsystem, mesosystem, exosystem, macrosystem, and chronosystem. Each system is interconnected. The influence of one system depends on its relationship with the other systems (Guy-Evans, 2020).

The premise of the ecological model is that each ecosystem experiences waves of change. For people to live and interact within each ecosystem for survival and natural interaction, adaptation must occur based on their environment. Similarly, for families (a nested ecosystem) to participate in treating severe mental illness, they need to adapt to current changes of intersecting ecosystems that would compete with their decision to partake in treatment with
family members. Organized interactions occur between people based on their environments, and each ecosystem has a niche that helps people function by increasing their adaptability and performance to allow them to adapt adequately to life circumstances (White et al., 2019).

**Summary of Methodology**

The present study empirically investigates how families could be helpful during treatment through multiple case studies (MCS) using semi-structured interviews with MHPs. MCS helped me view the phenomenon in real-life contexts (Woodside, 2017) and make future inferences to collectively treat individuals and their family members. MCS assists me with gaining a deeper understanding of the "sensemaking" processes, interviewees' perceptions, problem-solving perspectives, systems thinking, and other system dynamics (Woodside, 2017). A limitation of MHP case studies is that they represented the context from a professional standpoint, not the position of families or diagnosed people directly. Thoughtfully, presenting multiple cases describes more than one setting and client-provider interaction, which allowed for a more comprehensive discovery (Gustafsson, 2017).

**Outline of Dissertation**

This dissertation includes this introduction, two academic article manuscripts, and a chapter summary detailed across four chapters. Chapter two consists of a thorough and critical literature review supporting the principal views of severe mental illness and family participation in treatment, and the third chapter critically assesses the findings from the research study, including each participant's case study, primary themes, methodology, analysis, validation strategy, ethical issues, and future directives.

The articles align with guidelines from the chosen journal for publication. The fourth chapter consists of the study's discussion and conclusion, summarizing the analysis, research experience, and recommendations for future research. The appendix includes a copy of the internal review board (IRB) approval for the study from Antioch University New England (AUNE),
the informed consent form for participants, interview protocols, a demographic questionnaire, and a table.
References


Chapter Two — Critical Literature Review

Severe Mental Illness (SMI) is a common phrase describing mental disorders and symptoms that gravely impair daily functioning in an individual life (American Psychiatric Association, n.d.). The severity of mental illness is measured based on the duration, frequency, and number of symptoms experienced during an episode or past episodes (American Psychiatric Association, 2022). Acute symptoms are often treated in hospital settings (American Psychiatric Association, n.d.) until a person can live daily without psychiatric interruptions. However, severe psychiatric symptoms exhibited in the community outside of hospital settings affect many social factors ranging from family issues to a lack of gainful employment options, which interfere with individual wellness and society's definition of success or recovery (Whitley & Campbell, 2014).

Research on these two illnesses indicates that people who experience symptoms are at a higher risk for chronic diseases and compromised welfare than the public or those diagnosed with other mental disorders. A cohort study of $5.9 million participants from a Danish Civil Registration database conducted by Davydow et al. (2016) indicates that individuals diagnosed with schizophrenia and bipolar disorders (SMI) experienced an increased risk for ambulatory care-sensitive conditions like diabetes, cardiovascular disease, and lung disease. Additionally, people with bipolar disorders and schizophrenia score lower on quality-of-life outcomes in a study conducted by Berghöfer et al. (2020) studying the World Health Organizations Quality of Life Instrument with people diagnosed with various mental illnesses.

Schizophrenia and Bipolar Disorders

Schizophrenia is a psychotic disorder defined as impaired perception and thought processing. Psychotic disorders include other related conditions such as schizoaffective disorder, schizophreniform, and brief psychotic disorder (American Psychiatric, 2022). Like those disorders, schizophrenia is an individual disorder with shared symptoms of hallucinations
and delusions, in which people with the diagnosis typically experience a distortion of their reality through such negative symptoms. Individual psychomotor behaviors and volition decline, making the person unable to make clear decisions (Heckers, 2013). Other criteria include disorganized thought, losing interest, and losing motivation (American Psychiatric Association, 2013).

Bipolar disorder has symptoms of frequent shifts in mood, energy, activity levels, and concentration (U.S. Department of Health and Human Services, n.d.). There are three types of bipolar disorders: Bipolar I, Bipolar II, and Cyclothymia disorder. Additionally, an unspecified version of the condition exists when symptoms do not meet the usual criteria. Each one shares symptoms yet ranges in severity (American Psychiatric, 2022). Twenty percent of people experiencing symptoms are diagnosed within the first year of onset (Phillips & Kupfer, 2013).

Schizophrenia is often treated in the community using a standard approach called Assertive Community Treatment (ACT) that reduces hospitalizations and symptom severity in people diagnosed with the disorder; it is also frequently used for improving functioning and well-being (Peritogiannis et al., 2020). Similarly, Michalak et al. (2016) explained that research on bipolar disorder diagnoses is plentiful among genetics, neurobiological, and clinical fields yet could benefit from more remarkable empirical studies examining the development of new medication and psychological-social treatments, prevention, and productive and positive features of the condition.

Treating Mental Health Disparities

In 1933, the International Congress on Mental Hygiene gathered to discuss how to conserve mental illness and treat the mentally sick. The mental health hygiene movement (Mandell, 1995) continued into the World War II (WWII) era. The motion supported the idea that mental health issues arise from maladjustments and poor behaviors – contrary to modern belief. Additionally, the training helped incorporate mental health principles into social work, public
health administration, government, and education. A psychiatrist named Paul Lemkau taught at John Hopkins, and he introduced wartime psychiatry into the academic setting after joining the military and running a psychiatric clinic. Lemkau observed that patients given rapid, short-term treatment were less likely to develop neurotic disorders.

After, local health departments and clinics were placed in neighborhoods to alleviate community stress. In 1955, Lemkau published that local clinics would heal the sick and prevent mental disorders. Mandell (1995) added that Lemkau saw the need for mental health professionals to integrate into community clinics and not operate like traditional psychiatric clinics. Lemkau believed mental health professionals needed new skills in changing public attitudes through media outlets that provided in-service education to clinic personnel (untrained staff and human services personnel). Mental health professionals also offer consultations with community leaders and other community groups.

**The Medical Model**

Clinical treatment models best conceptualize a recovery paradigm (Gehart, 2012). Instead of a therapist operating under the lens of a therapeutic model or structure, recovery also is utilized as an alternative to the commonly used medical model. Research shows a low utilization of the recovery approach across mental health settings. However, the medical model presents SMI as a mental, behavioral, or emotional disorder diagnosable by a mental health professional that causes severe clinical and functional impairment, significantly interfering with daily activities. It attempts to treat SMI with pharmaceutical drugs, interdisciplinary treatment, and adhering to an inflexible treatment plan (Perrin et al., 2018).

The medical model intends to "fix" an individual's issue, while support groups and peer education present a relational healing method for coping and family recovery (Maybery et al., 2013). Gehart (2012) states that the medical model conceptualized mental illness instead of approaching mental illness using the social concept of disability that hinders psychosocial
functioning over medical symptomatology. Price-Robertson et al. (2017) explained the medical model as a biological view of mental illnesses such as schizophrenia and bipolar disorder. It foresees mental illnesses as incurable conditions not conducive to brain functioning. The medical model defines recovery by deficient-based interventions that do not directly promote a healthy relational means of recovery of SMI. The medical model aims to monitor behaviors measured by the remission of mental health symptoms (Price-Robertson et al., 2017).

**Psychopharmacotherapy**

Psychopharmacotherapy is a medication-assisted treatment used to regulate severe symptoms of mental disorders (American Society of Clinical Psychopharmacology, 2022), including schizophrenia and bipolar disorder. Common medications for schizophrenia symptoms are categorized as antipsychotics and include Risperidone, Clozapine, Seroquel, Geodon, and Haloperidol, also known as Haldol (Bhandari, 2021). Joint mood stabilizers used to treat frequent shifts in mood caused by bipolar disorder include Lamotrigine, Valproic Acid, Lithium, Aripiprazole, or Abilify, and Lurasidone is known as Latuda (Bhandari, 2022). Some psychotropic medications have a high comorbidity rate with epilepsy, and renal impairments, among other medical comorbidities. However, psychotropics also relieve sleep disorders, nausea, and poor appetite among patients seen for cancer-related care (Uguz, 2017).

Haram et al. (2018) highlight a downside of using medication as the only form of treatment. Doing so could cause a one-sided modality that leaves the patient victim to expert care with a minimal say in their treatment outcomes and increased stigma. Haram et al. (2018) also indicated that newer studies focused on the significance of studying a person’s developmental and interpersonal circumstances through supportive interventions like music therapy and family interventions, which antipsychotic medications alone do not do.
Psychotherapy

Pathophysiology research informs and refines new therapy approaches for people diagnosed with schizophrenia (Gaebel & Zielasek, 2015). Ruffalo (2019) summarized that advancing biological processes to treat schizophrenia minimized psychotherapy's role, yet it tends to be educational and supportive. People with schizophrenia often undergo therapy with a psychiatrist, which is brief, to obtain medications, and the client may not always experience warmth and security (Ruffalo, 2019).

Historically, psychoanalytic psychotherapy treated bipolar disorders. It focused on transferences and developing insight to change the person's life (Swartz & Swanson, 2014). Psychotherapy also helps people with bipolar disorder regulate mood fluctuations, cope with stress, and improve social skills (Sylvia et al., 2015) since medications partially relieve symptoms (Swartz & Swanson, 2014). Much of the literature on psychotherapy is on individual treatment using behavioral modalities.

Community Behavioral Health Services and Treatment

Community-based services provide an alternative to inpatient services for people needing psychiatric treatment (Kowalski, 2020). Priorities of community-based programs consist of social inclusion, empowerment, and inclusion of people diagnosed with severe mental illness (Atterbury & Rowe, 2017) and the provision of traditional treatment modalities. Frequent re-admissions into community-based programs are reduced with regular monitoring of the client's symptoms and the cooperation or involvement of their family members in conjunction with local services (Peritogiannis et al., 2020).

Community organizations coordinate mental health education and peer and family support for the public experiencing mental health issues (Mentalhealth.gov, n.d.). Sometimes, individualized treatment in the communities is insufficient despite their intention to embolden
patients. Community services provide opportunities to rehabilitate, educate, employment, and housing. For example, mobile crisis unit care teams aim to provide collaboration between mental health and medical professionals, community authorities, and family members to gather information and coordinate the care of those with severe mental illnesses (Peritogiannis et al., 2020). Also, they assist impoverished people and those who experience racism and are otherwise socially excluded.

However, community programs could improve on helping people who experience severe illness integrate into society as citizens and not merely assist with social resources. Atterbury and Rowe (2017) indicated that psychosocial intervention help connects people to resources, while citizenship education alleviates personal deficit and a community member's inability to join society independently, emotionally, and interpersonally. Some community programs focus their clinical assessments on the needs, strengths, and challenges experienced by the client and encourage collaborative decision-making between the client and staff. Such programs aim to customize clinical activities so that the client and their family can increase the continuity of care (O'Donoghue et al., 2016). Providing a personalized and collaborative framework for education, such as calling it a project instead of an intervention; removing the technical language from community treatment, could also result in better use of community programs (Atterbury & Rowe, 2017).

Relational Concepts

As stated by Rasheed et al. (2010), theorists and researchers want to understand better mental disorders and the relationship between the condition and the self. One relational concept addressed by the conclusion that treating the person's relational self ought to be a standard method for managing illness. Mental illnesses confirm that individuals are relational and communicative; their interpersonal selves derive from their relational networks, such as their
family unit or close circle. Rasheed et al. (2010) adds that including each human or relational self to address disorders is Family Therapy. Early family therapists followed the notion that each family carries some need to organize and sustain an intervention to help them cope with fluctuations of inner-city living. The dominant culture promotes treatment among individuals and aims to become more self-reliant; however, family therapists are starting to challenge the individual viewpoint and advocate that individuals undergoing quality of life issues could better examine their problems holistically and within the framework of their relationships: family, communal, social, governmental, and economic involvements (Rasheed et al., 2010).

Recovery

Recovery, defined as a process rather than an outcome of services (Ralph & Corrigan, 2005), is multifaceted, multidimensional, and not adequately measured with a single classification system. The field relays on the absence of symptoms and objective criteria to determine whether someone is "recovered" and omits the overall recovery experience. Moreover, the overall experience is subjective, including improvements in the person's various areas of functioning regardless of presenting symptoms (Pernice-Duca, 2010).

Recovery can have multiple definitions and depictions of what a person with SMI must do to recover from their illness. Maybery et al. (2013) explained that recovery refers to the ability to access mental health services. An individual can access recovery with the lived experience of the illness. Additionally, individuals are primarily reported in statistics, yet rarely are parents, families, or children written as recovered (Maybery et al., 2013).

Recovery-Oriented Treatment

Gehart (2012) reinforces that having a recovery theory is not an anti-medical model or against medical interventions such as medications; however, the medical model is secondary to the recovery approach and autonomy. The recovery approach promotes individualism and egocentrism, promoting a self-sufficient and self-determining entity (Price-Robertson et al.,
Family recovery of SMI involves multiple components. Not all family members experience each phase of treatment simultaneously, and some family members could never share certain parts of the treatment stages. Each treatment phase can involve various tasks, experiences, barriers, mental health providers, and personal grievances or shifts (Spaniol & Nelson, 2015).

**Ecological Framework**

Perocier (2022) calls for an ecological approach to treating SMI in practice and through research, followed by a brief statement of why that approach benefits treatment and the field. Public mental health research commonly references a socio-ecological lens and its uses for analyzing concerns in mental health among various populations (Purgato et al., 2017); however, the use of a contextual model among the severely mentally ill is minimal. Bronfenbrenner (1979) viewed child development as a system of relationships affected by the child's surrounding environment. Similarly, people struggling with SMI may also experience a mentally disabled life as a system of relationships affected by their surroundings.

Per the Ecological Systems Theory (Bronfenbrenner, 1979), development occurs in five systems: microsystem, mesosystem, exosystem, macrosystem, and chronosystem. Areas of distress for a person with SMI spread throughout those five systems. Family distress influences the microsystem, unemployment is part of the mesosystem local government is part of the exosystem, poverty is part of the macrosystem, and their overall diagnosis impacts all stages of their life as the chronosystem. Figure 1 provides a graphic model of ecological family systems displaying the components of each sub-system.
Figure 2.1: Ecological Family Systems Model

Note. This model depicts how the client's systems intersect and at what level.
These social factors and systems impact a person's ability to participate in community activities and resources, let alone successfully participate in a mental health treatment plan that does not effectively reflect social and daily functioning (Purgato et al., 2017). Greater emphasis on the family influence during the treatment process and the social-economic makeup may assist with obtaining better rehabilitation efforts and treatment outcomes in every system of the person's life.

Tanhan and Francisco (2019) confirms that recovery or healing from mental health issues is not one-sided but multisided. The solution is to collaborate with everyone influential in the person's life. They examined Muslim college students' perceptions of mental health and treatment. Some students saw mental health providers as professionals who only focused on individual needs, not community issues. Findings suggested that an individualistic approach did not fit the students' worldview. Therefore, it was not practical for them and their communities.

**Microsystem**

The present study seeks to describe how close relationships influence the person with SMI. The microsystem illustrates a pattern of activities, roles, and relationships conducted in a person's life (Onwuegbuzie et al., 2013). This system involves family, peers, friends, and anyone with direct contact with the individual.

**The Family Role**

The family of origin (e.g., parents, siblings, adult consumers, caregivers, and spouses) is part of the family constellation (Reupert et al., 2015) and experience the client's symptoms of SMI in their ways. Haselden et al. (2018) report that family members often support relatives with SMI. Assisting a family member with SMI may involve several areas of need and responsibility, including watching an individual's instability in symptoms, helping with medication adherence,
providing transportation and financial backing, or helping with vocational needs like obtaining benefits and finding a job.

Mowbray and Oyserman (2003) explain that recovery or increased stability for a family generally involves families with children. Parents with SMI or substance use admit to treatment more often than those without children. Additionally, children are at more risk of developing a mental illness or mental health-related problems than other children (Gehart, 2012). Moreover, (Price-Robertson et al., 2017) confirmed that families play a prominent role in negative and positive recovery processes, irrespective of the research's focus or treatment model.

Price-Robertson et al. (2017) explained that social roles valued by the client and the ability to have positive interpersonal relationships could shape the client's view of self and identity. Topor et al. (2006) noted characteristics or roles that helped clients feel supported. Aspects usually came from their family and friends, including those who stood alongside them or demonstrated being there during recovery. Family and friends who could bear witness to the client's hardship and recovery showed a form of acceptance of who the client was despite their diagnosis. Additionally, the family or friend's ability to remain present during recovery helped the client feel minimized due to stigmatization from surrounding environments.

Clement et al. (2015) explained that individuals in the family unit diagnosed with SMI tend to avoid seeking community help outside the family unit; therefore, the family had no role in treatment for reasons linked to stigma or shame. Their research includes a community sample not involved in clinical programs for treatment showed a greater likelihood of having subthemes associated with weakness, rejection, and difficulty communicating with professionals or confidential services due to feelings of dishonor. Clement et al. (2015) added that samples currently receiving mental health treatment at the time of such studies had subthemes associated with craziness and non-disclosure of symptoms or situations and yet were less likely to have subthemes related to difficulty talking to professionals compared to their counterparts not currently seeking mental health care (Clement et al., 2015).
Family Goals and Recovery

Family goals and their vision of recovery for the family and the individual with SMI (Oltean et al., 2020) start with family functioning from a healthy context. The ability of family members to effectively meet basic needs and manage conflicts throughout the treatment process is different from unhealthy means of functioning. Strained relationships create violence, distress, and low cohesion among family members. Family-oriented care includes family members actively participating in the care and decision-making process for the adult or child's mental health needs alongside the mental health professional. Family involvement aids in the planning and evaluation, ongoing care, recovery, and the influences of the quality and delivery of care (Planner et al., 2014; Oltean et al., 2020).

A family-informed recovery approach, also known as a recovery-oriented treatment, improves overall family functioning. Treatment goals consist of the identified patient's (IP) origin and background, preferences of medicine use, and evidence-based practices. When attempting to include family members in treatment, Doornbos (1996) emphasized that families feel burdened when caring for a family member with SMI. Specifically, family members caring for a family member with SMI experienced anxiety, heightened stress and tension, resentment, depression and hopelessness, powerlessness, and a sense of entrapment, affecting the family dynamic's ability to cope. Families emphasize disruption in their relationships and experience financial difficulties, physical health disparities, trouble, and limitations with social activities. Overall, families share a decreased quality of life due to caring for a family member with SMI (Doornbos, 1996).
Treatment and Program Involvement

Mesosystem

The mesosystem involves the interaction between two or more settings (Onwuegbuzie et al., 2013). The overall experience between those settings is vital in understanding how families approach treatment. For example, the relationships between the person with SMI, treatment facility, and resource centers are examples of the mesosystem for a person with SMI.

Mental Health Professionals and Family Treatment

The medical model aims at clinical recovery, as evidenced by reducing mental health symptoms (Price-Robertson et al., 2017). Despite the illness's symptoms and limitations, recovery consists of personal or familial empowerment, satisfaction, and hope. Social Justice and stigma are also pragmatic in recovery-oriented therapy, which is also not addressed by the medical model (Gehart, 2012; Price-Robertson et al., 2017). Perversely, recovery-oriented approaches promote the idea of personal recovery and allow for the IP or family to define what those entail. Generally, collaboration involves actively working together to assist persons with mental health disabilities (Gehart, 2012). Therapists find recovery-oriented work exciting and are less likely to experience burnout when families are involved in treatment (Gehart, 2012). Moreover, family collaboration builds connections for planning, implementing, and monitoring the treatment process. The family and therapist can discuss cooperation from their standpoint (Gehart, 2012).

Gehart (2012) emphasizes that barriers to collaboration include: a) the lack of boundaries supporting the recovery, b) utilizing problem-focused therapy models, c) involving family members who do not want to be a part of the recovery process, d) overall negative mindsets and biases, e) hopelessness from all involved (i.e., mental health professional, families, IPs, and anyone experiencing burnout), and f) confidentially as opposed to innovation.
Gehart (2012) notes that it is critical to encourage the family and the member with the disability during treatment. The mental health professional can join the collaborative efforts and family recovery.

**Recovery-Oriented Family Interventions**

There are various family treatment interventions developed over the past 20 years. They vary by theoretical orientation, duration, and settings. Treatment programs generally inform families about mental health and symptom management, increase life satisfaction, and reduce family stress. Such models intend to form collaborative relationships between treatment teams and their families (Mueser et al., 2003).

**Exosystem**

The exosystem is the process and order of social settings indirectly involving the person (Onwuegbuzie et al., 2013). The exosystem informs how organizations or treatment centers external to the person with SMI influence their direction and treatment.

**Peer-Led Family Education**

Spaniol and Nelson (2015) suggest that family members are generally confused by treatment protocols with little readiness to navigate laws and procedures. The idea of coping can indicate that the family has reached a problem and does not acquire adequate knowledge of treatment experience, creating a stigma in the family's investment (Maybery et al., 2013). Support from extended family members can be an option; however, it usually does not equate to the psychoeducation received from mental health professionals. However, peer-led education helps families relate to each other and best teaches families to cope with how to care for a member with severe mental illness undelivered by mental health professionals. Studies have
concluded that family- and peer-led education increases the family's knowledge, level of empowerment, and skills and lowers emotional burnout (Dausch et al., 2012).

**Psychoeducation**

Behavioral approaches successfully develop effective coping strategies with symptoms, severity, and distress (Mueser et al., 2003). Psychoeducation effectively improves knowledge about mental illness and does not negatively affect treatment outcomes (Mueser et al., 2003). Psychoeducation also educates families on the biological nature of bipolar disorder, controlling disease, and the ongoing importance of family engagement in treatment (De et al., 2013). Family psychoeducation for patients with schizophrenia helps to increase medication compliance and treatment adherence (Budiono et al., 2021). Cognitive behavioral modalities are also effective with medication compliance and identifying relapse warning signs.

**Family Consultation**

A wrap-around variation supports the family unit to increase self-sufficiency. For example, Dausch et al. (2012) discussed the importance of family consultation, a brief intervention to help join the IP and family members. Consultation assesses the needs and goals of the family. Likewise, it discusses resolving the identified problem and barriers to treatment, such as resistance or change. Dausch et al. (2012) add that family consultation increases members' self-efficacy and recovery. Consultation assists with referring long-term services and incorporates a plan for education and support. Also, educational resources provide information on mental illness and emotional support topics.

An assemblage theory, also known as family unity or Family Assemblage, helps families think outside the social norm and broaden the idea of recovery (Price-Robertson et al., 2017). The family assemblage comprises family associations, lifestyles, stories, and interactions. These family definitions form over time, creating dependent relations that form a collective
identity. The family assemblage changes treatment focus to the more significant unit away from the IP, making treatment an "open-ended project."

Symptom Management and Recovery Intervention

Mueser et al. (2003) emphasizes that recovery is a platform for managing symptoms of mental illness, but recovery also aids personal accomplishments in areas critical to the consumers. Conjunctively, symptoms management and recovery helps the person diagnosed gain helpful information and skills to collaborate effectively with family and mental health professionals. Collaboration with family assists them with minimizing the effects of mental illness, relapse prevention skills, and the desire to pursue personal goals using psychoeducation (Mueser et al., 2003).

Macrosystem

The macrosystem is societal beliefs surrounding the person with SMI and their environment. This system is ever-changing and evolves (Onwuegbuzie et al., 2013). Future studies could aim to understand how people with SMI and their family's values and beliefs leverage their decision-making.

Social Roles

Gehart (2012) explains that postmodern and recovery-oriented approaches assume that societal discourses apprise the IP's experience of mental illness and personal identity. The therapist's primary task is to connect the family's strengths and resources to encourage a future vision. Gehart (2012) adds that therapists must ensure that they promote communities for social change. Understanding these aspects of treatment helps mental health professionals view mental illness symptoms as part of a societal process—contrary to the medical model—and defines acceptable and unacceptable social norm standards (Gehart, 2012).
Price-Robertson et al. (2017) note that developing valuable social roles and engaging in positive interpersonal relationships between family members facilitates healthy identity development. The notion of identity aids recovery from an interpersonal standpoint and acknowledges the connection between the IP’s sense of self and family members. Price-Robertson et al. (2017) adds that multiple randomized clinical trials illustrated that long-term family programs reduce relapse or rehospitalization after two years.

**Resources**

Recovery can also stem from the utilization of community resources. Assertive Community Treatment (ACT; Mueser et al., 2003) teams are beneficial resources for consumers with severe mental illness. ACT initially started as a service offered to eligible consumers but positively improves symptoms in those with SMI. Consumers expand their capacity for independent living and successfully transition to less intensive mental health services. Mueser et al. (2003) added that families have requested to become more involved in their members' treatment. Incorporating psychoeducation and involvement in family recovery can help facilitate family collaboration in community mental health interventions.

**Chronosystem**

The chronosystem is the fifth and final system and involves time and the overall course of development (Sincero, 2012). It is the overarching system of all the systems of methods listed above (i.e., micro, meso, exo, and macro). All socio-historical contexts fall within the chronosystem. More research is needed to understand better the effects of the person’s diagnosis on their growth and understanding of themselves and those around them.
Research

Ample research exists discussing the oppositions of SMI. Research studies address many subtopics like comorbidities, stigma, caregiving, staff attitudes, and vocational outcomes. However, the literature on family cohesion could improve. Pearson et al. (2022) indicates that people diagnosed with SMI were likelier to suffer from social deficits, including loneliness. Pearson et al. (2022) notes that the population experiences socioeconomic factors and sedative effects from medications, leading to a lack of motivation in daily functioning, posing as an individual and mesosystemic issue.

A family impact perspective acknowledges that events affecting specific family members and events outside the family influence the nature and caliber of family interactions and decisions. The ecological model of human development is a foundation for this concept (Cadigan & Alberts, 2009). It is an underresearched area to bridge the gap between understanding illness etiology, societal beliefs, and the effort to address factors that increase mental well-being for those diagnosed.

Current research attempts to recognize the involvement of families in solving problems that determine wellness outcomes. The effects of research acknowledging that there are various family structures and that different families may respond to mental health treatment differently could assist with addressing the requirements for vulnerable families with SMI in economic and social contexts (Cadigan & Alberts, 2009). As in the biopsychosocial model, one source of disagreement about these factors is differing perspectives on what causes SMI, including whether it is predominantly biological, psychological, social, or mixed.

For example, the National Institute of Mental Health (NIMH) in the United States is currently focusing on funding research on biological etiology and intervention (Hawthorne & Williams-Wengerd, 2022). In contrast, the goal of researching the individual and family chronosystems of the Ecological Systems Construct — changes in patterns of environmental
events (Lau & Ng, 2014) — in the context of this text is to understand better how changes (and continuities) over time in the environments in which people with SMI and their families live affect their development (Neal & Neal, 2013).

Individually-Focused Research

Despite many subtopics in SMI research, a primary focus was on individual recovery rather than family or community rehabilitation. According to Boucher et al. (2019), recovery is a process that solely includes the individual's function, and ethnocultural backgrounds influence how they recover. Reupert et al. (2015), on the other hand, agrees that there is a void in the research that highlights individuality but claims that it clashes with some cultures that some individuals tends to accept the mainstream treatment method incompatible with their upbringings and beliefs. Study and application need to be more comprehensive in examining or attempting to recognize the interconnectedness and durability of familial ties, notwithstanding any potential for conflict in such connections.

Neal and Neal (2013) emphasize that empirical studies have employed ecological systems theory to uncover environmental variables or intervention areas outside the individual. They participate in or directly interact with policy-making. Still, such governing policies influence their program and treatment experiences (Neal & Neal, 2013).

Caregiver-Focused Research

Another significant bias in research centers on caretakers. Most family-focused research refers to family members as carers, implying a separation in the literature between individuals and their caregivers rather than a unified family unit. Reupert et al. (2015) and Saunders (2003) explain that family caregivers report high-stress levels, a high burden, and frequently receive little support from mental health experts. Therefore, ample research acknowledges caregiver burnout and overinvolvement, leading to ineffective results. Mainly, family research addresses
coping, caregiver load and psychological distress, caregiver resilience, depression, social support, client behavioral difficulties, and family functioning.

Saunders (2003) notices that current research clearly describes SMI caregiving more than in prior research, which covered three decades and was brief. Caregiver research has become better and is equally important to recovery efforts; however, research about family togetherness in addition to caregiving may help the recovery process for all involved and increase the family’s healing with a greater focus on how their ecological systems interact throughout the process.

Acri et al. (2017) suggested more research on developing peer support models for caregivers and family members and carefully examining familial outcomes and family-level mediators of client outcomes. Doing so could reconnect families and individuals to areas of the ecological systems. The primary roles of families should be encouraged and supported rather than hindered or replaced.

An ecological systems theory could be used in the early stages of policy or program creation to stimulate critical thinking about the potential policy or program for people experiencing SMI and the potential impact on families (Cadigan & Alberts, 2009). Additionally, programs and their mental health staff could aid in promoting family membership, mental and emotional health, and stability to the unit collectively and deliver positive reinforcement (Cadigan & Alberts, 2009). Researchers could evaluate the consequences of this method and utilize it more regularly to aid in more fruitful research.

Increasing Necessary Research

Hawthorne and Williams-Wengerd (2022) highlighted that the overall purpose of research for SMI is to concentrate on the effectiveness of care and treatment. However, primary research foci were controversial and needed more endpoints immediately applicable to treatment individually and with family members. There were many differences in how efficacy
was measured because there was a wide range of therapeutic schools and models for treating disorders.

Research is varied and focuses on medical, behavioral, recovery, and humanistic models, that emphasize symptom management, function, hope, and well-being at different degrees, making it difficult to identify a single, trusted treatment idea (Hawthorne & Williams-Wengerd, 2022). Patterns change in the understanding of people's social interactions over time, and these changes have a direct impact on the diagnosed person and their family, leading to the idea that changing the configuration of their ecological system (Neal & Neal, 2013) is one way to resolve the research controversy.

Little research suggest options for individual and family solutions combined. The article Mental Health and Well-being Ecological Model (Micheals et al., 2022) mentions that areas of additional focus appear to include the need to highlight interpersonal relationships between caregivers and individuals, social connections, and skill-based learning to orient families for appropriate care methods — in addition to psychoeducation — coordinated mental health prevention on governmental levels, and advocating funding for mental health promotional research and are some areas where research is lacking. A slower rate of providing additional studies on etiology, effectiveness, and stressors could open possibilities for more organized action steps in research.

Discussion

While most of the literature is present about several mental illnesses like schizophrenia and bipolar-related disorders and how the illnesses manifest from a medical and psychiatric context, the current review may be the most comprehensive review across mental healthcare that includes qualitative and literature studies on how the illnesses officials treated mental illnesses historically, family roles, goals, recovery, and education. This current review demonstrates the importance of family unity concerning recovery from SMI in more recent times.
(Cohen et al., 2013; Price-Robertson, 2017). Few studies expressly compare, including those published in gathering mental health provider information concerning families' engagement in severe mental illness recovery attempts (Have, 2004) to capture cultural contexts and authenticity (Gehart et al., 2001) using an ecological systemic framework.

The primary evidence of related studies is qualitative research conducted in mental facilities to assess the influence of family participation and visits. Nursing journals contained such investigations (Reupert et al., 2015; Saunders, 2003; Sim, 2006) while research in public health typically refers to socio-ecological perspectives for assessing and resolving mental health challenges in various communities (Purgato et al., 2017). The same technique might uncover possible benefits to family well-being, recovery, and involvement in SMI (Perocier, 2022). On the other hand, family psychoeducation groups and consultations enhance awareness about mental illness without negative treatment results, which is a beneficial current type of family participation in overall recovery (Mueser et al., 2003).

In community mental health, recovery for individuals and their families was an often measured ideology with varied degrees of identification. Overall, recovery has several forms, and its definition is dependent on the client and their family. It is frequently a process rather than a single consequence (Ralph & Corrigan, 2005) of treatment and occurs in stages (Spaniol & Nelson, 2015). Another notable recovery paradigm includes mental health specialists actively in the healing process. They are credentialed individuals who guide clients and their families through the process (Ruddick, 2008; Pernice-Duca, 2010). The research has an increasing inspiration to assist individuals in developing useful social roles, and engaging in strong interpersonal relationships among family members helps healthy identity formation.

**Implications**

Stronger social functions and interpersonal ties for this population will alleviate problems within the socio-ecological network of each individual and family. To assist people with SMI in
expanding their social roles, research, treatment agencies, and clinical practice can aim to provide more practical solutions, such as redesigning psychoeducational groups and content, family involvement measures in community mental health, or treatment centers specific to the system or family therapy practices and producing research that is not comprehensive to biological or psychiatric contexts (Hawthorne & Williams-Wengerd, 2022). In addition to present measures for community mental health treatment, a new implementation of learning aids for families that advance psychoeducation protocols and efforts can be made available.

**Future Directions**

People with SMI will remain underrepresented in literature until funding is made available to programs that emphasize collective individual and family treatment rather than programs determined to treat using only a medical model, limiting the opportunity to expand treatment possibilities, decrease partial participation in treatment, and disrupt reoccurring psychotic episodes by assisting additional individual protective factors. Research for this population could take multiple forms such as exploring interactions between family members and their involvement with the treatment team; how workplace norms affect clients and their families; a person’s community and the general relationship between the two while the person is in treatment; the larger mental healthcare system as it relates to family treatment, while looking at how challenges, supports, and solutions cultivates a more sustainable mental healthcare system; or how economic shifts and new laws for treating SMI affects families. Administrators managing community-based programs might use this data to improve their programs, while policymakers could use it to help with policy change and improve family advocacy with insurance providers and lawmakers. New mental health professionals could use the data for professional development and incorporate it into their practices.
Conclusion

Involving family during the treatment of SMI, the medical model and primary care, family recovery interventions, and the social systems affecting the lives of diagnosed clientele have the potential to become more thoroughly understood by mental health professionals and families alike. All parties interacting with a person diagnosed with SMI could benefit from a greater understanding of a recovered lifestyle and awareness of local and state issues and aim to assist with collaborating on inclusive treatment plans.

Community-based programs may continue to set precedence by considering social inclusion and helping to establish healthy social connections and behaviors, enablement among people diagnosed with severe mental illness for the individual incorporating natural supports. Psychosocial intervention appears to be utilized by mental health professionals to an extent. It helps connect clientele to resources and educational materials that promote independence, emotional health, and a greater connection to self.

Advocating for stronger research efforts on family participation and relationships to promote mental health could benefit how society sees SMI treatment. Doing so could improve broken relational dynamics, poor communication skills, and partial healthcare practices, and policymakers can consider restructuring family mental health programs and reducing possible relapses. The medical model could continue treating SMI as a collection of severe mental disorders causing scientific and functional impairment and altering a person's daily events. However, the recovery approach could help better address self-empowerment and interconnection between many affiliated ecological systems, enhancing satisfactory and influential outcomes in recovery.


https://doi.org/10.1016/j.healthplace.2019.01.008


https://doi.org/10.3390/ijerph18147522


https://doi.org/10.1017/S0033291714000129

https://doi.org/10.1176/appi.ps.2012000176

https://doi.org/10.1080/15487768.2012.655223

Rehospitalizations for Ambulatory Care-sensitive Conditions in Denmark: A Nationwide Population-based Cohort Study. *Medical Care, 54*(1), 90–97.  
https://www.jstor.org/stable/26418105

https://doi.org/10.1111/acps.12007


https://doi.org/10.1111/pcn.12322


https://doi.org/10.1080/17522439.2018.1460392


Lau, J., & Ng, K.-M. (2014). Conceptualizing the counseling training environment using Bronfenbrenner's ecological theory. *International Journal for the Advancement of Counselling*, 36(4), 423–439. [https://doi.org/10.1007/s10447-014-9220-5](https://doi.org/10.1007/s10447-014-9220-5)


https://www.mentalhealth.gov/talk/people-mental-health-problems


Severe illnesses like schizophrenia and bipolar disorders have changed the perspectives of mental health clinicians. They seek more holistic practices that aid the social functioning of their clients. Research has carried a tone of unwillingness to research social well-being among those diagnosed with SMI. The social functioning of people diagnosed with extreme mental conditions was criticized in previous research, stigmatizing family members (Aldersey & Whitley, 2015) and conceptualizing SMI using the biomedical model (Elliott & Ragsdale, 2023).

Despite the societal and academic judgment, support programs offering psychoeducation, family therapy, and community interventions have been seen as successful in improving treatment adherence (Adeponle et al., 2009). Contrarily, hindering treatment adherence and family support could be the pertinent issue of provider burnout, which arises due to demanding relationships with clients and family members; challenging work with colleagues, client suicide, and other legalistic frameworks (Zaninotto et al., 2018); and overall prolonged work stress (Thuynsma & de Beer, 2017) — which can be alleviated by self-compassion (Rooney, 2020).

**Family Involvement**

Family member involvement while treating SMI has several effects. Aldersey and Whitley (2015) emphasize that families can bring warmth and nurture or rejection and condemnation to the treatment regarding their members with SMI. Sometimes family member relationships are strained, and families are uninterested in participating in treatments, or experiencing distress from caregiving (Crowe & Lyness, 2013). Adeponle et al. (2009) conducted an observational study at a Nigerian psychiatric hospital that showed greater post-discharge appointment adherence when family members were involved in treatment. In addition, Aldersey and Whitley (2015) includes that families assisting with treatment, which aids in housing, chores, and meals for the client. Families provide support that is interpersonal and a
source of encouragement. Aldersey and Whitley (2015) conclude that more than 30 randomized clinical trials highlight reduced relapse rates and improved client recovery when clients and their families participated in Family Psychoeducation (FPE) programs.

**Burn and Self-Compassion among Professionals**

Thuynsma and de Beer (2017) emphasize that every job has unique characteristics that comprise the placement’s demands and resources. Job demands derive from the emotional contribution when an employee completes their duties and are a primary contributor to people experiencing burnout. Such requests could be in physical, organizational, and social forms. Occupational research refers to the Jobs Demands and Resources theory or JD-R model, theorizing how corporate environments influence employee well-being and productivity (Thuynsma & de Beer, 2017; Tummers & Bakker, 2021). Generally, job demands are not harmful to employee well-being but may become stressors that lead to energy drainage and result in burnout, causing an occupational health concern (Thuynsma & de Beer, 2017) or an impediment to successful client-family mental health treatment.

Ahola et al. (2005) reviewed 12 studies highlighting correlations between depressive symptoms and burnout and summarizes that emotional exhaustion, depersonalization, and personal accomplishment stemmed from burnout. However, Rooney (2020) counteracts the idea of burnout with the act of self-compassion. They explained that compassion alleviates the inability to empathize or sympathize with self-compassion, defined as compassion directed at oneself with a kind attitude. Rooney (2020) adds that challenges with self-compassion may derive from the current pattern of using the biomedical model in professional settings and healthcare — the model detaches healthcare workers from their job duties.
Stigma

Mentally ill individuals experience internalized stigma from the public (Kalisova et al., 2018), which diminishes well-being and leads to hopelessness (Elliott & Ragsdale, 2023) and low self-esteem (Santos et al., 2016). Santos et al. (2016) defines stigma as an undesired difference and intolerance between people that causes fear of the unknown and generates false beliefs. The authors report that an Italian deinstitutionalization movement in Brazil during the 1970s sought to remove psychiatric institutions and promote alternative mental healthcare services—the shift aimed to focus on respecting people with SMI and their rights and encouraged those diagnosed to become more social and promote family reintegration.

Likewise, regarding the societal stigma of mental illness, Kalisova et al. (2018) mentions self-stigma as the internalized stereotypes and attitudes originating from societal stigma. At the same time, Santos et al. (2016) emphasizes that a sense of citizenship and integral care alleviated stigma. The individual holds captive the thought or feeling of being part of a devalued group and self-stigmatizes because of societal stigma. Notably, Kalisova et al. (2018) iterates that emerging into social networks and people groups is a protective factor and reduced self-stigma, creating desirable outcomes of welling for diagnosed individuals and their families.

The Present Study

Based on the literature review, how mental health professionals clarify the importance of family involvement in community settings to treat people diagnosed with SMI in community mental healthcare has been ill-addressed. As Elliott and Ragsdale (2023) convey, incorporating environmental dressing into genetic and biomedical literature may reduce societal stigma. Additionally, Elliott and Ragsdale (2023) highlight that social inconveniences that families experience could help the public or future academic research lessen the fear of violence assumed by symptoms associated with SMI and increase social interaction; hopefully changing the public’s attitudes towards people with SMI, even within their families.
Additionally, psychosocial influences are understudied, and how to prepare families for managing and co-living with persons diagnosed with SMI is unclear. Thus, the purpose of the present study is to gain counsel from mental health professionals who previously or currently work with the population to share their methods, techniques, and outcomes of family involvement during the treatment of their clients in community mental health settings to increase our understanding of how to enhance research and practice.

Methods

Research Design Overview

A multiple-case study design featuring seven cases was the design for this study, using a reflexive thematic analysis to analyze the data collected. Schmidt (2010) explains that cases are past or current situations about a decision, challenge, or opportunity. They figuratively invite the reader to be present in the situation of the person or organization the case is studying. Cases have three main objectives: a) focus on the issue or topic, b) expose enough information for the reader to conclude, and c) state no conclusion of their own (Schmidt, 2010). Multiple case studies help researchers understand differences and similarities between the cases regarding the proposed phenomenon, as opposed to one case study that presents a single perspective. Multiple case studies also allow the researcher to analyze information within each case study and between case studies, making the data more reliable (Gustafsson, 2017).

Each participant was invited for a video-recorded interview to answer questions about their experience working with individuals with SMI and their families. Recorded interviews were transcribed by software notetaking were each edited into first and second-person summaries to represent the participant’s case. The purpose of the cases was to focus on Schmidt’s (2010) objectives that focus on family involvement during the treatment of people with SMI, expose
enough information for the readers to conclude the phenomenon, and state no additional conclusion for the reader.

**Sampling Procedure and Recruitment**

Participant recruitment started after receiving approval from Internal Review Board (IRB; see Appendix A). Criterion sampling methods helped select licensed mental health clinicians practicing in California. Working with SMI populations for at least five years was also required to keep potential participants similarly relevant to the field's population trends. Participants received an email invitation (see Appendix B) from the researcher or another colleague detailing the study's goal and the ethical requirements for research before volunteering their participation. They responded to the email with their consent, and the researcher saved the response to the university's Google Drive and then planned an interview meeting. Participants in the final sample were mental health professionals, at least 18-year-old, from marriage and family therapy, social work, and psychiatry working with SMI populations for at least five years.

**Data Collection and Interview Process**

Participants were interviewed using an interview guide of 11 questions with two sub-questions (see Appendix C). The interview process consisted of seven 90-minute semi-structured individual online interviews. All interviews were conducted online via Zoom video conference platform, with an optional 10-minute break midway to prevent study fatigue, burnout, and attrition. The questions occurred in three sections: Case History, Present Observations, and Future Recommendations and suggestions. Participants were asked the same questions during their interviews to receive the opportunity to provide authentic answers relevant to the topic. They answered the questions based on their professional experience and training, which diversified the findings (see Appendix D).
Analysis

Otter.ai web cloud and automatically transcribed and stored interview data on the paid cloud network. The researcher handwrote additional notes on an observation form (see Appendix E). After, ATLAS.ti software assisted with the organization for familiarizing, reviewing, and coding. The primary researcher recruited two research assistants to aid the process by sending an invitation email (see Appendix F) to undergraduate psychology programs.

Two undergraduate-level students submitted applications to partake as research assistants and interviewed with the researcher. The application consisted of a brief description of the role’s expectations and an interview-style questionnaire to submit (see Appendix H and I). They completed one hour of training in videos and readings from YouTube and online articles on conducting thematic coding, sorting, and peer debriefing qualitative data. The research assistants and primary researcher met weekly, including three meetings in-person and the remainder virtually, to review and debrief the data and sort it as a team. The researcher recorded discussions and ensured the team stated tasks and thoughts aloud to validate the thought processes.

Researcher Reflexivity

I was this study's primary investigator and researcher as part of my Ph.D. research in Couple and Family Therapy. The lack of structure for enhancing family involvement in community mental healthcare services was why I enrolled in a Ph.D. program to produce research in this area and analyze relevant factors. All the licensed mental health professionals interviewed in this study knew this aspect of the study.

Being an insider researcher, I also watched and understood that families living with or having a family member SMI undergo stressors unique to the challenging symptoms faced by the disease. Therefore, the idea for this study stemmed from my interest in including other
clinicians’ input on the personal experiences of people experiencing SMI in community mental health settings. My goal to do so started when I was a clinician in community mental health settings and experienced challenges working with the population and their families. My professional beliefs and opinions as a fellow community member, therapist, prior administrative assistant, and case manager influenced the data collection for this study.

As a registered associate marriage and family therapist assisting people with severe mental illnesses like schizophrenia and bipolar disorder, I noticed the complexities involved in conducting treatment and providing community services. I needed additional support from higher-power providers who often were unsure how to support me. Also, all families coped differently based on their cultural and social backgrounds and beliefs. I firmly believe that families influenced by their diagnosed family member’s illness, and their responses, can affect the family’s attempt to receive treatment interventions.

My caseload frequently lacked family support or understanding of their challenges, and my master’s program did not teach such information. I was disappointed by the lack of support found among supervisors to promote better guidance and family involvement for interested clients, and what I learned in higher education was not enough. I witnessed that systems of oppression were enormously endorsed when my underserved clients lacked adequate support. This population was disadvantaged and challenged socioeconomically, educationally, and racially. Families also were challenged by the need to balance other life stressors and the need to care, or the decision to care for, their mentally disabled family members.

I remember families expressing concerns for neighborhood safety, childcare expenses, health expenses, or workplace stressors, in addition to coping and caring for their family member with SMI. Sometimes they projected their adverse responses to systemic issues onto the family member diagnosed with SMI, which would worsen symptoms and influence the treatment outcome. Therefore, not all families were healthy or focused enough to support their members’ mental health treatment. As a result, I tried other approaches to family inclusion for
interested clients and attempted to collaborate more with families while working in the field. The idea was to apply more collaborative clinical practices since most mental health programs focused solely on the individual, with little room to invite families into the treatment.

Therefore, I wanted to illuminate the problem and present important considerations in my research for mental health professionals and administrative bodies. While many providers work with people in clinical settings, assembling a shared understanding of how to offer feedback to a specific population was my goal. Thus, I wanted to recruit clinicians with similar work histories and allow their authentic experiences to capture the content of the interviews and data collection deeply. I wanted to recruit multidisciplinary participants since community mental health care usually consisted of professionals from multiple backgrounds to care for one region. I model my study this way to provide consultation and insight into clinical improvements for people with severe illnesses on communal and societal levels to achieve population-level change.

I hope the added attention persuades policymakers to become more family-centric regarding community mental and family healthcare for the severely mentally ill. I wish that treatment program designs have protocols that cater more closely to healthy family functioning, leading to greater individual function and not contrariwise. My data aims to gather feedback from my colleagues about community-based programs and whether families could effectively help treat individuals and state potential next steps for the field to consider.

**Researcher-Participant Relationship**

Out of seven participants, the researcher had a professional relationship with two, one of which was a professional and personal relationship. All remaining participants were friends or colleagues of one another. Three of the participants worked for the same organization.
Credibility and Trustworthiness

Data synthesis was done through qualitative triangulation using multiple methods or data sources to understand a phenomenon better (Carter et al., 2014). My research assistants and I used the Critique Appraisal Skills Programme (2018), researcher reflexivity journals, and weekly video-recorded peer-debriefing meetings discussing the nuances of the data to increase analysis validity.

Findings

Participant Demographics

The study consisted of seven clinicians, two males and five females aged 33-66. Four participants held a license as marriage and family therapists, two as licensed clinical social workers, and one medical doctor board certified as a psychiatrist. All participants held at least a master’s degree in their respective fields, while one of the marriage and family therapists held a Doctor of Psychology degree. In total, two participants had doctorate degrees. All participants had 6-23 years of experience working in the mental health profession. Participants are referenced using pseudonyms rather than their full identities to protect private and personal information as shown in Table 1.
<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Gender</th>
<th>Credentials</th>
<th>Age</th>
<th>Level of Education</th>
<th>Years Practiced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reine</td>
<td>Female</td>
<td>LCSW</td>
<td>44</td>
<td>Masters</td>
<td>21</td>
</tr>
<tr>
<td>Nora</td>
<td>Female</td>
<td>LMFT</td>
<td>35</td>
<td>Masters</td>
<td>9</td>
</tr>
<tr>
<td>Christi</td>
<td>Female</td>
<td>LCSW</td>
<td>35</td>
<td>Masters</td>
<td>8</td>
</tr>
<tr>
<td>Zach</td>
<td>Male</td>
<td>LMFT</td>
<td>33</td>
<td>Masters</td>
<td>6</td>
</tr>
<tr>
<td>Leah</td>
<td>Female</td>
<td>LMFT</td>
<td>34</td>
<td>Masters / Doctorate</td>
<td>11</td>
</tr>
<tr>
<td>Pierce</td>
<td>Male</td>
<td>Psychiatrist</td>
<td>49</td>
<td>Doctorate</td>
<td>16</td>
</tr>
<tr>
<td>Dina</td>
<td>Female</td>
<td>LMFT</td>
<td>66</td>
<td>Masters</td>
<td>23</td>
</tr>
</tbody>
</table>

*Note.* This table demonstrates participant demographics, including their pseudonym, gender, credential, age, degree type, and experience working in the field.

**Case Studies**

Findings were obtained by transcribing audio recordings of participants during their interviews — each case is listed in the order of the interview.

**Reine**

Reine was a 44-year-old female licensed as a clinical social worker with 21 years of experience. Her work settings included intensive outpatient programs (IOPs), a day treatment program, and full-service partnerships (FSP).

**Case History.** Reine began working with the population around 2003. She was a student interning for the IOP program at a large medical hospital. She described the program
structure as brief and light touch – meaning it covered surface-level mental health topics for patients. Some of the people were living with schizophrenia and sometimes depression.

Reine encouraged clients to get emotional support from other providers when working with families because sometimes families were frustrated and had unhelpful personal challenges in supporting family members with a healthy mindset. Family members carried a mentality that they had to care for their ill family members and would often forget about themselves. Reine expressed that working with people was challenging as a student. She was new to the work and newly exposed; she also explained having an introverted personality and was quiet.

Field Observations. In Reine’s professional opinion, a positive relationship existed between family members and treating SMI. Family meetings were useful because family members often could recall specific, important information that her severely ill client could not remember and provide about their history and condition. She also indicated that family involvement in sensitive situations was good, depending on the family dynamic. Some changes Reine observed when families were involved included the results of psychoeducation — sometimes helping clients decide to take medications for their symptoms or consider a treatment modality that would assist with families being affected. Psychoeducation helped the client feel like their family system was supportive and accepting of whatever decision they wanted to make to navigate their health.

Additionally, Reine reported a general sense that families needed assistance. She proposed additional peer assistance for family members and clients. Reine alluded that assisting families and clients was critical if professionals wanted to involve and keep family members involved because they were first involved in the caregiving process at some time in the participant's journey before formal treatment with mental health professionals. When family
members were present, treatment or involvement in a person's life may be because they required additional assistance and resources.

**Future Recommendations.** Reine mentioned supporting that client by also considering non-biological family members. Whomever the client deems safe to contribute to their healing is an asset to their well-being and treatment progress in a program. Reine said she would incorporate families or other support systems into treatment when the client is most comfortable. Her idea of recovery did not look one kind of way and that a person was much bigger than their mental health problem. A person’s identity could be influenced by working, volunteering, caring for themselves, other influential partnerships, and parenthood. Another essential component of recovery that Reine mentioned was the client’s ability to have natural and professional support.

**Nora**

Nora was a 35-year-old female licensed as a marriage and family therapist with nine years of experience in the field. She had a history of working in long-term, outpatient programs lasting 1 – 3 years that were non-profit and billed Medi-Cal healthcare insurance; therefore, clients needed to meet the medical necessity to qualify for services.

**Case History.** Nora stated that she has been working with SMI at her current workplace for three years at the date of this study. Before that, she was a child therapist. Nora’s role as a therapist for adults with SMI included supporting them with basic tasks, doctor’s visits, connecting with family members, identifying stable and secure housing, and eliminating barriers to food insecurity. Nora confirmed primarily working in the Quality Assurance department on insurance documentation but had experience conducting direct services.

Nora's work consisted of having an initial intake appointment to get historical and other pertinent information from the client and learn their natural and professional supports as part of the clinical assessment. The following works consisted of overall therapeutic support and case
management, which included check-ins, linking clients to their psychiatrist on video chat, playing board games for mental stimulation, going on walks for physical activity, decreasing isolation, supporting with activities for daily living, accompanying them to the bank, teaching them basic budgeting skills, and coaching on basic hygiene.

Nora’s communication with family members depended on the client, and some clients experienced estrangement from their family members. She suspects that when on the brink of a psychotic episode, the client’s behaviors became problematic for family members and potentially caused families to disconnect from the client. Nora also suspected that the client could have been disorganized and chaotic, and the family may not have contacted them because the client was not in a space to communicate. They were highly involved in the care. Nora confirmed that family involvement at her job site varied from person to person.

Field Observations. Nora noticed that her communication with family members during treatment was with families who wanted to be involved in caring for their loved ones. They would reach out to her to establish a relationship to get support from her with appointments or medications. She explained that having clients who did not live with their family members, the families would call her to make sure of the client’s needs. Family members also provided her with the information she had not received from the client. Nora asserted that there is a positive relationship between family involvement and treating SMI. She stated that family members are more withdrawn, frustrated, or losing patience; however, the catching approach could validate the family’s experience.

Nora acknowledged that families tended to deflect and internalize stigma from their surrounding environments, such as society or other family members. She highlighted that her communication with such family members did not detract from the treatment or make matters worse — or benefit treatment. Her thoughts on family involvement were that it was a valuable part of the treatment. She ensured, “I think it should be incorporated as much as possible, whenever possible.” Secondly, addressing the family of estrangement and reconnecting with
people who have not spoken for years was a therapeutic tool. Nora emphasized, “We should utilize it because the amount of relief that a person can experience makes such a huge difference in terms of their well-being.”

**Future Recommendations.** Nora reported that misunderstandings and miscommunications between family members influenced recovery for a diagnosed person due to the client’s mental illness. She suggested helping families develop acceptance and positive communication skills to help meet the client’s needs. In an ideal world, Nora would focus more on their family members. Therefore, creating a weekly parent support group to give educational tools to family members and help them understand common themes and challenges. Additionally, a family advocate or partner in the treatment team could conceptualize the family as another client. Another team member would have an additional caseload to manage family involvement.

Another concern mentioned by Nora was how “clinician turnover impacts families and treatment outcomes.” She stated that she worked with a client and their sibling very closely, and she, as the provider, ended up leaving the treatment team. Nora mentioned that the experience left the client to start over with a new provider. Advocating for staff retention could help clients and families not feel like they are restarting their treatment with a new person. Nora added that clients were left to re-explain traumas from childhood and their experiences. She concluded, “Keep staff involved and on board with their positions and roles so that the daily connection can be maintained.” She confirmed that she shifted roles because she had 40 clients.

**Christi**

Christi was a 35-year-old female with a master’s degree, licensed as a clinical social worker in California. Her experience working with the population ranged from Full Service Partnerships (FSP), a Mobile Crisis Team, and a university clinic. Christi started her career
working for a foundation that aimed to prevent the spread of HIV through Wellness Recovery Action Plan services. As a behavioral health intern at the time, she served on a multidisciplinary team with medical doctors, nurses, and housing and employment staff.

**Case History.** Christi’s first client with schizophrenia managed symptoms with medications. She recalled that the client’s primary focus for treatment was to address his medical diagnosis, not his schizophrenia diagnosis. Likewise, the client was a pregnant young adult in a domestically violent relationship. Christi conveyed that although the client’s main concern may not have been the client’s mental health diagnosis, she still saw value in helping them manage their symptoms as it affected other areas of the client’s life.

Christi reported that with her experience working in the field, she considered Bipolar disorder, Schizophrenia, and schizoaffective disorder the primary severe psychiatric diagnoses. She also added that she grew up with a parent with a severe mental illness and learned from personal experience. For example, Christi recalled being unsure what schizoaffective disorder was as an intern and associated it with trauma since her clients were young, Black, and had experienced substantial trauma. She explained witnessing symptoms from an understanding of trauma.

**Field Observations.** Christi endorsed soothing the family’s emotions sometimes more than the identified. She explained that families needed comfort from feeling scared; she rarely found a balanced approach to how families interacted with her as the primary provider. Christi substantiated that families either micromanaged and carried a hands-off stance or would wait for her to approach them while treating their family members.

Christi agreed that a positive relationship existed between family involvement and treating SMI. Christi reported that families are present in the person’s life because they care, and their care can be challenging to manage. They often feel like they must be present to advocate because their family members cannot advocate for them. However, she alluded that
nothing made her happier than when a family member was involved and that it was critical to the individual's health.

Psychoeducation was another important component that could assist the family in learning and understanding the person's diagnosis. Christi expressed confidence that psychoeducation that oriented a family influenced the long-term treatment outcome for the individual and the family unit. Christi strategized teaching families the difference between diagnosis and specifications — for example, Bipolar I and II. Then, she suggested presenting coping and management strategies – safe words – or a strategy that could help family members communicate the next steps leading to or during an episode when feeling anxious, nervous, paranoid, delusional, or scared.

Christi added that education for families could be an opportunity for families to acquire knowledge and tools to develop more helpful skill sets; teach typical medications and side effects. Courses could be an opportunity to brainstorm or present common questions for medical providers or review options for tracking devices if appropriate.

**Future Recommendations.** Christi confirmed that most of her experience was with intensive case management. However, she still offers a smaller version of family therapy and helps people find ways to community with each other. Alternatively, having family respite services could be beneficial. Christi explained that families experience much burnout and that additional support groups could be helpful. She included transportation services as a possibility since family members often lack adequate transport, preventing them from participating in treatment as desired.

About technology, Christi suggested that permissible family members' access to the client’s medical chart could help them remain informed about their family member’s treatment, access schedules and calendars, medication changes, and negative or positive reactions — to reduce stress within the family unit, increasing transparency and communication between
clientele and provider. Doing so could allow the family to be more collaborative with each provider on the treatment team — serving as a central database to help families involved.

**Zach**

Zach was a 33-year-old male licensed marriage and family therapist with six years of experience. His previous work experience occurred in non-profit agencies like FSP, which offered a lifetime of support to clients diagnosed with SMI, and a housing program that assisted clients with housing needs.

**Case History.** Zach reported that his first clients with schizophrenia were in their late teenage years and early 20s. His current job provided services to people with severe mental illness with years of admissions in the healthcare system — frequently diagnosed with schizophrenia. The program he worked at started in 2019 and targeted clientele experiencing psychosis, the first time he could remember working with the population. Zach recalled his first practicum at a middle school working with children as a Housing Navigator. The job had a mental health component, but his primary work was not considered clinical, yet some of the clients experienced features of a psychotic disorder.

Zach’s interactions with family members varied. He described them as sometimes involved. When he met with them, he explained what the program was about, its process, and the informed consent. Zach inquired with the client whom they wanted to be involved in their treatment and wanted the clinician to contact. Family members, with permission, were helpful to Zach when he lost contact with the client due to a disconnected phone number.

Contrarily, families also experienced burnout with the client. Zach added that his team would try to do as much as he could for the client. However, their workdays were busy. The clinical team engaged in Team Decision Meetings (TDMs) where they invited the client and
whomever they were close to, 3 – 4 primary members of the team, and talked about the client’s progress, thoughts, and feelings about treatment.

**Field Observations.** A necessary experience that Zach shared was the high turnover rate among psychiatrists. He stated that the agency hired a psychiatrist the clients enjoyed seeing; however, he emphasized that the agency saw seven or eight different psychiatrists in the four years he has worked at his job site. Clients met one psychiatrist and followed up with a different psychiatrist without knowing how long that person would last before the next new psychiatrist. Zach exclaimed, “I wish the system would recognize that more — than if we as workers or human beings would not like something, our clients probably would not like it. They are the same as us.”

In Zach’s professional opinion, a positive relationship existed between family involvement and treating SMI in community settings. He believed that the more support people had, the better. He also reflected on clients who had no support and recalled a particular client whose family were deceased or whose families were disinterested in involvement and stated that not all clients could have a natural support system. Likewise, some clients preferred to undergo treatment alone without family or friends.

**Future Recommendations.** Zach advocated for TDMs, which provided strength-based approaches used if families become involved in treatment. However, he wondered how they could use support from the family members, which most meetings primarily served the client alongside family members. Zach also emphasized wanting to incorporate couples therapy into his role at the community agency. He stated that agencies could consider focusing more on couples and families and less on individuals and that plenty of his clients would benefit from such services to heal old wounds.

Zach added that facilitating new or underutilized approaches for including more natural supports in treatment could begin with having more family advocates in programs and personnel
trained in family systems. He clarified that his work as a therapist was smoother when a family advocate was part of the clinical team.

**Leah**

Leah was a 34-year-old female licensed marriage and family therapist in California. She also obtained a Doctor of Psychology degree and was registered as a psychological associate in Idaho with 11 years of experience in the field. Leah reported relevant work experience in Intensive outpatient programs (IOPs), FSPs, and a community counseling center. Programs were non-profit and for-profit organizations lasting between 2 – 6 months.

**Case History.** Leah noted seeing her first client diagnosed with bipolar disorder in a counseling center. The client previously engaged in medication management at another facility. Leah recalled not initially seeing signs of bipolar disorder in the client’s behavior after only seeing the client for 1 – 2 visits. After 40 visits, Leah learned that the client had many extenuating circumstances, and she could see patterns in her behavior, which led Leah to research her observations further.

Leah noticed an obvious occurrence of the client’s bipolar episodes ranging from mania to depression, yet, the client appeared to have positive responses to their medication. Likewise, Leah’s initial experience of schizophrenia was also at a community clinic. The county referred the clientele, and each client experienced varying disorder severity. Full participation in the clinic was affected. Leah was puzzled about how to treat the population that did not consistently meet the full Diagnostic Statistical Manual (DSM-5) criteria for a diagnosis.

**Field Observations.** Leah mentioned that she and her colleagues would do all they could to involve families in an individual’s treatment when appropriate. She stated that treatment comprised case management, social services, and research. Leah explained the limitations experienced by mental health professionals. Leah validated that when families show a genuine interest, clients reported feeling less alone during treatment. She added that the client had more
buy-in to work towards healthier outcomes. Leah suggested that greater psychoeducation for families occur to help the family understand treatment options, medications, and biological responses after metabolizing prescribed medications — connecting those responses to the behaviors shown within the family and assisting the family in weighing the pros and cons.

Leah verified that family involvement in treatment helps, and involvement could be as simple as coming into the treatment with care and compassion. Involvement could also support the individual client in learning to advocate for themselves. She highlighted that clients appear not to know when they enter a manic episode; however, the people around them could have better insight. She declared that family members could learn to suggest positive next steps for the person and guide them to healthier coping behaviors. Leah added that having family members in the client’s safety plan could be beneficial. She reported that helping family members to recognize the onset of manic and depressive episodes and even suicide could assist them with supporting their family members as part of the person’s safety plan.

**Future Recommendations.** Leah suggested a parenting group for parents of any age with children of any age, including adults. She suggested a topic congruent with, “How do you parent when you have multiple children, work a hon, and have a parent,” as when parents consider how to parent toddlers or newborns. Leah also suggested that classes address parental burnout and mental health. She concluded that such courses could aim to remedy the attachment disparity known by mental health professionals.

Classes could help families and parents learn more than how to cope but how to address and manage. Leah suggested that in an ideal world, family members would come into clinics to learn more about their loved one’s mental health condition and how to advocate for the person diagnosed with the disorder to benefit the entire family unit. Leah stressed that she could be a better provider if her caseload were light, without serving over 40 people per week who need
services. She added that maintaining efficient work also meant helping her colleagues as a team player; however, they were overloaded with severe clients.

**Pierce**

Pierce was a 49-year-old male. He was a board-certified medical doctor practicing psychiatry with 16 years of experience working in the field. Pierce has worked in various clinical spaces, including county behavioral health clinics and similar non-profit and county-contracted agencies. He previously worked within a private practice, yet, at the time of the interview, he worked for a non-profit, community-based organization.

**Case History.** Pierce encountered his first patient diagnosed with a SMI in 2006 during his clinical residency at a county Department of Behavioral Health clinic. He was interested in integrating mental health treatment into the public health department, so he moved to their department because many of his patients suffered from experiencing physical symptoms that did not receive proper treatment. Pierce had previous training at the University of Washington, learning their Collaborative Care model that integrated mental health into primary care by placing consulting psychiatrists in settings with clinical therapists. Psychiatrists would screen and collaborate with primary care to better facilitate treatment, which he was involved with for nine years.

Pierce explained that professionals often disregarded clients because their mental health problems or their mental health problems prevented them from seeking treatment or a trusted provider. He concluded, “Part of my goal as the main medical director for my job now and in my career is to find an area I can make an impact, anywhere that I can shape how mental health treatment is provided. That is what I value.” Pierce highlighted having good mentors and proper training that helped him understand how to care for delusional or severely symptomatic patients in primary care.
Unfortunately, Pierce reported that colleagues would take an “elimination of symptoms” approach to treating mental illness, where prescribing physicians assigned heavy sedative medications that put them to sleep, making them less functional and not adding to their quality of life. He exerted importance on the patient’s goal. If they liked hearing comforting voices, maybe the patient wanted to keep them. Therefore, if Pierce automatically assumed that eliminating the symptom was something the patient wished to do, it was an error on his part.

Pierce’s experience communicating with family members during treatment ran on a spectrum. He explained that some parents and families were extremely involved and enmeshed. Sometimes, the families would have agendas that did not align with the patient’s agenda. Pierce explained being in a position where he would attempt to help families understand and support the patient. In contrast, some families had given up on the patient and did not care anymore. Alternatively, the families saw mental illness as a character flaw of the person, especially if substance abuse was involved or the family and patient had an estranged relationship.

**Field Observations.** Pierce stated that, in his professional opinion, a positive relationship existed between family involvement and treatment. He expressed that families could experience an inborn stigma or belief regarding mental health, which could influence their participation. Families were more resistant to treatment and potentially believed that mental illness was a character flaw or an issue of having good will or intelligence. In contrast, participatory families appeared open-minded and accepting of alternative ideas and possibilities like other treatment models (i.e., spiritual, medical) conjunctive to the medical model.

Overall, Pierce reported having a positive perspective on family involvement during treatment. He said that family involvement was a spectrum and that some families were more involved than others. Moreover, Pierce emphasized that families functioned well with the right tools; this way, there would be no need for his services as a psychiatrist should a family be
equipped. Productive engagement in treatment meant starting a healing process and having aligned tools.

**Future Recommendations.** Pierce stated that he would identify and refine family agendas. Showing families how different they are and finding a way to bring them closer together. He reiterated the importance of healing and not feeling as though they have failed their family members while attempting to cope and manage the symptoms of the illness.

Pierce’s next approach is a team-based care approach in place of the standard care of a psychiatrist. He stated that the population’s standard of care appeared poor and could improve, even influencing IRB standards and how the research was approved and conducted would improve the field. Pierce suggested a collaborative care model that allows systems to work together, supporting patients and providers. Pierce also emphasized greater training for medical doctors in residencies.

Pierce explained that regardless of what specialty a physician works with, more training with SMI could help them make better clinical decisions for the patient with the disorder, even regarding their visit. For example, greater activity on SMI could result in greater diabetes management or benefit patients with poorly managed hypertension struggling with a psychiatric diagnosis and ultimately support families in treatment-seeking professional, psychiatric, and medical support.

**Dina**

Dina was a 66-year-old female with a master's degree, licensed as a marriage and family therapist with 23 years of experience. Dina worked with non-profits ranging from 2 months to 3-year periods. All non-profit organizations required that clients be medically necessary to receive services, and sometimes organizations were Medi-Cal-based programs.

**Case History.** Dina reported working for a non-profit shortly after graduating with her graduate degree and earning board-eligible hours. There is where she remembered working
with an individual who presented with features of schizophrenia, recently discharged from a psychiatric hospital. Dina recalled little awareness of schizophrenia and felt ill-equipped to treat the client. The client did not want to consume medication and was hyper-focused on religion.

Dina also mentioned a percentage of the population coping with trauma-related conditions. Most clientele experienced auditory or visual hallucinations. Dina stated that people with severe mental illness have trouble caring for their needs and often encounter law enforcement and crisis response teams. Sometimes the issues are because of family conflict, yet the laws for grave disability are insufficient to properly seek help for people in crisis with severe mental illness.

Dina explained that it is challenging to know how to help this population, and involving family members does sometimes help because they may want to heal their family system. For that reason, she reported encouraging the family to set boundaries for their safety to gently guide the person diagnosed with SMI into understanding healthy and safe family dynamics. She emphasized that family involvement in treatment aftercare is beneficial.

Field Observations. Dina emphasized that the family wants connection. She shared that she has witnessed a lot of family pain. Also, families showed a willingness to mend broken bonds among family members is an excellent segway to treating SMI and associated social challenges. Contrarily, Dina added that some families desire no connection, and the client coped without familial influence. When families were involved, Dina witnessed situations like a threatening client getting proper mental healthcare because an elderly parent collaborated with her team, parents learning the importance of their safety and how to manage their feelings during psychotic episodes.

Future Recommendations. Dina’s overall thoughts on family involvement included having a family advocate present in community programs, which is essential to the work. The advocate connects with families and brings peer experience, yet differs from a Peer Advocate.
Dina added that using an empowerment model would better assist families, especially after they receive support and education to keep them motivated throughout their family member’s treatment. Dina noted that the parents or supporting family members could often benefit from treatment to strengthen the family system.

Dina strategized to incorporate more education around family systems, the identified patient in the family, and the role of enablement, enabling, and improving family awareness of illnesses of what is occurring to the family now throughout their experience. Dina would strengthen the system and how family members communicate and interact with each other. She disclaimed that some clients are too severe to do so; therefore, her approach would be most useful once symptomatic clients are stable to begin efforts to stabilize the family. Dina suggested that having more family support groups, time with family members, and sessions where the clinician could see how the family interacts with each other and acknowledge their strengths within the system would be ideal in community mental health settings.

**Data Analysis**

Clinicians assist families in navigating mental illness and strengthening family relationships. According to interviewees, individual results improved when family members partook in treating SMI. Furthermore, aiding families with the experience of mental health care, such as symptom management, vocational support, and overall system navigation, had difficulties and downsides. Four key themes emerged from the analysis of the findings: a) Methods, b) Techniques, c) Outcomes for involving the family in treatment, and d) Systemic Problems; each with several subthemes (see Table 2). The primary concepts offered in this analysis address the methods, reasonings, and obstacles of incorporating family members in treatment to reduce routine symptom management and improve recovery outcomes for persons seeking services from community mental health treatment programs.
<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-themes</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process of Family Involvement</strong></td>
<td>Methods</td>
<td>“How do we get specialized family advocates or peers, as part of the team, as part of what we offer, and have it be standardized? It is like this is what we do, we are going to reach out to families, if families encounter us, we have professionals in place to work with them.” – Reine</td>
</tr>
<tr>
<td><strong>Family Advocates</strong></td>
<td>“The client’s sister told me that they really enjoyed listening to The Beatles, and I had no idea, and so anytime I would pick them up to go to the doctor's office, I started turning the Beatles on, and we would drive to the doctor's office.” – Nora</td>
<td></td>
</tr>
<tr>
<td><strong>Establishing Trust and Validating</strong></td>
<td>“It does go more smoothly when we have a family advocate.” – Zach</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“Work with the family to set some boundaries around their safety and that it was important.” – Dina”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“Giving information about resources or normalizing that it is very challenging to have a loved one who is very symptomatic, and encouraging people to get their support or to be in therapy or to let people know that caregiving requires a lot of your support and taking steps towards your well-being.” – Reine</td>
<td></td>
</tr>
<tr>
<td>Techniques</td>
<td>Psychoeducation</td>
<td>Family Dynamics</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------</td>
<td>-----------------</td>
</tr>
<tr>
<td></td>
<td>“Provide realistic expectations too and help people to advocate for their care.” – Leah</td>
<td>“We pulled in the parent if we needed support around getting the client to do something that they did not want to do, or they had to encounter a situation that was going to be very challenging for them. The parent involvement was beneficial.” – Reine</td>
</tr>
<tr>
<td>Professional Opinion</td>
<td>“You have much better outcomes with family involvement.” – Dina</td>
<td>“Generally, yes. There is a positive relationship between family involvement and treating SMI. I think that there are family members who’s initial involvement is a little more withdrawn, frustrated, or they are at their wit’s end – but I think in general, if the approach can validate their experience and we can coaching them around symptoms and provide psychoeducation around a diagnosis, normalizing their responses to mental illness, and the ways that mental wellness manifest. I think that it can be a very useful tool.” – Nora</td>
</tr>
<tr>
<td>Outcomes</td>
<td>“It helps to have a care, compassion, and to help the person to advocate for themselves, because a lot of folks do not really know when they are getting ready to go into a manic episode” – Leah</td>
<td>“In general, when caregivers or family members were participatory, the client felt more held. There are professional supports in place, but the natural supports are also addressing their needs.” – Nora</td>
</tr>
<tr>
<td>Individual Stability</td>
<td>“My capacity is limited because of the intensive case management part of my job, but I am often doing smaller versions of family therapy and helping them find ways to communicate with each other.” – Christi</td>
<td></td>
</tr>
<tr>
<td>Family Stability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systemic Problems</td>
<td>Lack of Resources and Burnout</td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“I wish there was a way to make it more system focused. When we are just working with one person, and there are all these family dynamics behind it, we can only tackle one piece of it. We know that balance is hard in our studies. Then we go and work for agencies that are doing insurance billing, and the system is just really not set up in that way.” – Zach</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“I do not think there’s enough programs and supports for people living with SMI, but I also think there is even fewer resources for family members.” – Reine</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Stigma</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>“Awareness of stigmas is not enough by itself. There needs to be much more training, and that needs to start in medical schools” – Pierce</td>
</tr>
<tr>
<td></td>
<td>“Minimize stigma as much as possible.” – Nora</td>
</tr>
</tbody>
</table>

**Methods for Involving Family**

**Process of Family Involvement**

The active participation of family members in treatment processes, activities, and appointments is a subtheme related to the benefits of family involvement. Involvement denotes that the family or a family member had some level of involvement. In contrast, active participation implied investment status and a team approach to accomplishing a certain goal or outcome. According to Nora, Leah, Reine, Dina, and Zach, family connections mediated by mental health experts resulted in smoother family engagement during treatment.

Pierce indicated that collective decision-making reduced reactive responses across all involved in the treatment. When family members participated in treatment, he emphasized that the family process was part of a professional's position in treatment. He noted, “You know, we kind of in this position where we are trying to help them understand and support the patient.” As a result, mental health specialists are continually working with the family unit to process the process on behalf of the client's well-being goals. He also mentioned that the process necessitated managing family expectations, which sometimes differed from those of the clients.
or facilitating mental health professionals, where he had to navigate and provide additional assistance and planning.

**Family Advocates**

Several times during the interview process for working in community mental health, some participants indicated the function of family advocates. Dina, Reine, Nora, and Zach stressed the importance of the role in working with families. A team member dedicated to family involvement enabled them to perform clinical tasks promptly. They claimed that the clinical team could function more efficiently.

**Validation and Establishing Trust**

All participants underlined the significance of building trust, which is common practice in many therapeutic contexts. However, each expressly stated the elevated level of trauma from earlier experiences among family members, which confirms the need to create trust with clients and family members as the sole facilitator in the treatment.

**Techniques for Involving Family**

**Psychoeducation**

All participants used psychoeducation frequently, and Dina, Reine, Nora, and Zach noted it openly. Psychoeducation educates family members about mental illness, particularly in community mental health settings. Christi and Leah, on the other hand, indicated that psychoeducation procedures could improve by being more comprehensive. Rather than general education on symptoms and treatment options, provide an orientation to family members, similar to other life courses such as parenting and birthing programs. Both participants underlined the importance of educating families on practical life skills for living with or engaging mentally ill family members.
**Family Dynamics**

Family dynamics, according to all participants, were critical in the treatment. Dina and Leah noticed that family relationships, whether for safety or support, frequently decide the treatment route. Reined and Nora noted that the client's family sentiments could sometimes help encourage the client to take steps toward obtaining a goal. Christi described how she participated in a group text with a client's siblings because they wanted to include her in their dynamic and purpose of caring for their sister. Pierce remarked that he rarely met families with strong and supportive relationships because the families supported each other and did not necessitate intensive psychiatric treatment. Often, families from broken relationships needed psychiatric and therapeutic care, and Zach also mentioned that working with the family was “an opportunity to heal old wounds” or weaker dynamics.

**Outcomes**

**Professional Responses to Family Involvement**

All participants reported better results with family participation, showing a relationship between family involvement and individual healing for clients. On the other hand, they accepted client autonomy and acknowledged those who did not favor family engagement during treatment. Nonetheless, the following quotations highlight the professional opinions on family participation for everyone in this study:

- “I think so, definitely. I mean, the more support people have, the better.” (Zach)
- “I think it has been helpful to have family involved for the participant that I was talking about where we had that family meeting.” (Reine)
- “You have much better outcomes with family involvement.” (Dina)
- “Generally, yes. There is a positive relationship between family involvement and treating SMI.” (Nora)
- “Whatever level that I can impact the family and provide some healing.” (Pierce)
- “There is always a benefit to having your family around as long as their intentions are good.” (Christi)

- “I also think that when families are involved, and they show a genuine interest in being part of the support, folks tend to feel better, and they feel less alone on this journey.” (Leah)

**Family Stability**

Christi saw a rise in the constant establishment of boundaries among the participants, such as constant reminders of family responsibilities and frequent validation of feelings and decisions. She observed that each family member played a role in the treatment, yet, the functions frequently proved burdensome for family members, removing their ability to focus on their natural family needs. Christi underlined her approach to helping families keep true family roles and stabilizing their experience. She stated:

> It re-establishes order in the family where many family members have had to take on roles that are not necessarily there is, lawyer, advocate, doctor, physician's assistant, or nurse. It allows families to be families. [For older adults], it is imperative in healing. It is their last opportunity to heal and be together.

**Individual Stability**

Nora highlighted, "But I think that when parents, caregivers, or family members were participatory, the client felt more held, right? Professional support is in place, but these natural supports also address their needs." In addition to professional experience and expertise as a mediator, active family participation is a good effect of family involvement. Family members participating in treatment provided emotional support and stability for the client, who struggled with controlling their emotions and connecting with others due to their psychiatric condition and occasionally substance addiction.
Systemic Problems

Lack of Resources and Burnout

Despite the benefits of family involvement, physicians acknowledged difficulties supporting families in navigating the field's administrative processes and how agencies and boards delegate guidelines for clinical treatment. Zach said, "I wish there were a way to make it more system focused. When I only work with one person, all these family dynamics are behind it. I am only really tackling one piece of it." According to Reine, people with SMI have fewer resources to support them and fewer resources for their families. Pierce added that the standard of care for people with SMI could improve.

According to Pierce and Leah, treating SMI causes clinician burnout, extended waitlists for medical experts, and an increase in partial or unfinished treatment outcomes. They watched colleagues overworking to complete treatment goals and increase productivity. Pierce and Leah frequently had little client-family interaction due to mental health programs concentrating on the client as the identifiable person and billable hours for insurance and payment.

Leah stressed, "I can be a better provider if I do not see 40+ people weekly. My colleagues can be way better and more efficient providers if they are not seeing 40 people a week, right?" Clinicians desired more familial and personal stability, but job constraints hampered burnout at work. Pierce also stated that an improved curriculum for teaching new medical practitioners would benefit the field when treating SMI regardless of medical specialty. He explained, “For people doing 12-week surgery rotations, about 90% of them will never do surgery again, but every single one will see a psychiatric patient,” emphasizing the need for additional help in the field.
**Stigma**

Reine, Pierce, and Leah validated having a compromised relationship with the treatment process due to societal stigma, evident among peer providers, in addition to professional productivity and inadequate resources, which resulted in elevated professional beliefs and job expectations. Pierce explained, "Either clients are written off as part of their mental health problem, or their mental health problem prevents them from seeking treatment or trusting other providers." Dina stated that clients and possibly their families refuse mental health treatment due to the stigma and shame they have suffered. She went on to say that in some populations, families choose not to connect with their family members due to underlying assumptions or beliefs about the condition, which limited or stopped the advantages of their involvement.

**Discussion**

Previous research suggested that involving family members in treating people with SMI was a good idea. The body of research does not explain how family participation is beneficial in practice or how to incorporate it more into future practice initiatives for families. It also does not expressly use mental health providers to provide input from real-life field experience.

Previous literature notes homelessness, relapse, and recidivism as challenges faced among people diagnosed with SMI (U.S. Department of Health and Human Services, 2016). It does not, however, comment on specific systemic barriers encountered by people with the diagnosis and their support networks, nor did it highlight practical implications for family engagement or natural support as a help.

The current study strongly supports current research demonstrating that family engagement is a beneficial practice; however, it may benefit from additional support by interviewing more medical doctors and nurses from the medical field, who primarily determine treatment methods for the population in psychiatric facilities and occasionally in community
settings. This research could include surveys or interviews with family members or people diagnosed with illnesses to gain first-hand knowledge and recommendations for improving the profession. Involving families fully in the treatment process, which includes and aids in restoring each person's relationship, may assist the diagnosed individual by minimizing their need for treatment or ongoing intervention and enhancing their independence in interconnected networks (Adeponle et al., 2009; Aldersey & Whitley, 2015).

This set of case studies implied that if program treatment methods and structure specifically addressed family estrangement collectively with the primary client, the need for mental health experts such as psychiatrists and psychotherapists would reduce, which does not appear in current literature. Findings from this study also revealed that the structure of therapy modalities utilized in the field's exosystem hindered the benefits that would have otherwise stabilized individuals and their families and another overlooked point in the literature. According to Santos et al. (2016), stigma from professionals contributed to some systemic issues professionals face. Additionally, this study also discussed stigma among family members.

Participants said that limited training addressed stigma and burnout for arriving or new practitioners, nor was it thoroughly included in agencies' training for new staff members, resulting in low staff retention rates, which is consistent with the research (Thuynsma & de Beer, 2017). The lack of understanding and prevention of employment burnout and stigma did not help with family involvement in treatment, especially if mental health professionals, as the main facilitators, did not confront preconceptions against their clients experiencing SMI and family estrangement.

Nonetheless, continuing professional fatigue hindered care and whether clients and families received appropriate support and mental health treatment, consistent with previous literature (Zaninotto et al., 2018). Constructive family participation, process, and decision-making assisted by mental health practitioners proved useful in involving family members and supporting more preferred treatment outcomes for clients who consented.
**Implications for Practice**

These results imply that, despite unforgiving organizational obstacles, involving family members in treatment was made possible by validating procedures and building trust with all parties involved to support family strengths and promote the success of individual clients with SMI. This study has implications for how harnessing family strengths might improve treatment outcomes in line with past research, how current healthcare professionals feel about doing so, and the applicability of the concept using a socio-ecological perspective.

**Limitations**

All studies have constraints regarding validity and applicability over which the researcher has little to no control. The study had participants from several disciplines gather information from a multidisciplinary, cross-functional perspective; however, four of seven professionals were marriage and family therapists, which skewed the data. Collectively, the MFT participants added relational depth to the data because of their emphasized relational training. Surprisingly, regardless of their academic school of thought, every participant demonstrated some understanding of relational concepts in their clinical judgment. Therefore, the data was not wholeheartedly skewed by having more MFT participants, yet impacted in some way. One possible participant had to cancel their visit so that the data would be slightly more diverse. Fortunately, all participant interviews were 90 minutes long. Thus, there was no time constraint due to the length of each session.

**Future Directions**

Findings show that more research and implementation efforts are needed to improve treatment completion rates among clients through family participation and more burnout and employee relief training to encourage a healthier mesosystem and exosystem for mental healthcare. Future research efforts could utilize the findings from this study to conduct
comparative or interventional studies with families to measure before and after treatment for this population, using the input provided by the participants.

The study’s findings did not include knowledge from non-credentialed professionals such as peer counselors, drug and alcohol counselors, clergy, or administrators, even though they played an important role in treatment, as noted by at least three participants. Non-credentialed mental health workers appear overlooked and seldom mentioned in literature. Future studies may provide a clearer picture of the responsibilities of credentialed and non-credentialed mental health professionals and how they each contribute to family involvement in therapy.

The objective is to distribute the contents of this multiple case study design to mental illness advocates who may utilize them to address the issues identified and to support families in need. This study was planned and carried out with numerous stakeholders in mind. Administrators and stakeholders in community-based programs might use this data to improve their programs. In contrast, policymakers could use it to help with policy change and family advocacy with insurance providers and lawmakers. New professionals working with SMI clients and their families, as well as new physicians, nurses, and therapists, could use the data for professional development and incorporate it into their practices.

**Conclusion**

Since most studies revealed a reluctance to address social well-being among persons diagnosed with SMI (Topor et al., 2006), mental health clinicians seek more comprehensive techniques that help improve their clients’ social functioning (Gehart, 2012). Families with SMI members might provide comfort or disapproval of the treatment process based on their expectations. Sometimes family members are in distress (Crowe & Lyness, 2013), and families prefer not to participate in treatment. Some studies have revealed that including family members in treating seriously mentally ill patients is useful. The multiple case studies provided tried to
illustrate why or how family participation was effective in practice and related to results for families and persons.

A challenge for mental health professionals was finding work that did not lead to burnout. Demands did not always jeopardize employee well-being. Nonetheless, they may become stressors, resulting in energy depletion and burnout, posing an occupational health risk, and negatively influencing the client's and their family's treatment experience by eroding faith in providers. Heavy caseloads and personal stigmas towards the population caused burnout.

Lastly, the psychosocial influences on patients with SMI have received little attention in the literature. It was unknown how families might prepare or what experiences mental health providers had while caring for the group. As a result, mental health professionals who have previously or are currently dealing with people with SMI could offer feedback based on their experience with family engagement during their clients' treatment in community mental health settings. The key themes of the study addressed their experiences, which included methodologies, techniques, and outcomes for involving families in SMI treatment, as well as the systemic problems they experienced, which will be valuable for many audiences to better the field.
References

https://doi.org/10.1192/bjp.bp.108.052217


https://doi.org/10.1188/14.ONF.545-547

Critical Appraisal Skills Programme (2018). CASP qualitative studies checklist. Available at: 
https://casp-uk.net/casp-tools-checklists/

https://doi.org/10.1177/1066480713513552

https://doi.org/10.1177/01902725231175279

Gehart, D. R. (2012). The mental health recovery movement and family therapy, part I: Consumer-led reform of services to persons diagnosed with severe mental illness. *Journal


https://doi.org/10.1016/j.psychres.2018.03.076
Chapter Four — Discussion

This qualitative multiple-case research aims to observe and review the current literature on mental health professionals' methods, techniques, and suggestions when assisting clients with severe mental illness to include family members in their treatment.

My review of literature on SMI for this study focuses on schizophrenia and bipolar disorders because both are serious psychiatric disabilities, I came across during my experiences working with this population in the mental healthcare system. Schizophrenia is a psychotic disease characterized by poor perception and thought processing, while bipolar disorder affects mood, energy, activity level, and attention swings. Historically, professors understood mental health problems from observing maladjustments and poor behavior.

Historically, local health departments and clinics were placed in neighborhoods to relieve community stress, help heal, and prevent future problems, much like community treatment settings today. Presently, researchers aspire to better understand mental diseases and their relationship to the person’s self, while this study aims to expand the understanding of relationship between SMI and other structures within a person’s ecological network. The inference that treating the person's relational self is recommended by me to be a regular technique for managing the sickness treatment.

The medical model is the usual treatment model in community mental health settings. It defines SMI as a mental, behavioral, or emotional disorder diagnosed by a mental health professional, and causes severe clinical and functional impairment, interfering with daily activities, and treats SMI with pharmaceutical drugs, interdisciplinary treatment, and strict adherence to a rigid treatment plan. Mood stabilizers and antipsychotic medications are examples of medication-assisted treatment used to treat mental problems. However, similar therapeutic approaches appear ineffective without involving the client's familial relationships, assuming they are open to it.
Summary of Key Findings

The ecological systems theory describes four subsystems that facilitate family involvement in treatment for this study: a) microsystem, b) mesosystem, c) exosystem, d) macrosystem, and e) chronosystem (see Figure 1). Each system used as a framework for the study illustrated how the overarching system affected each environment or subsystem an individual encountered. The chronosystem is the outermost system, mirroring societal change between each system over time, while each system after that reflects levels of an individual's everyday interactions and influences. These levels contributed to a more comprehensive understanding of how SMI treatment affected an individual and family living with external, intersecting stressors while engaging in mental health treatment.

Seven cases from this study found that clients with SMI who consented to family contact benefited from it. The benefits of family involvement included enhanced validation and trust between client and practitioner and increased family participation. Furthermore, the case studies highlighted numerous flaws in the framework that facilitates SMI treatment. Overarching issues included a lack of programs for people with SMI diagnoses, high caseloads among practitioners, which led to fatigue, and a lack of support or family advocates to integrate the family with the treatment team's therapeutic goals to provide treatment to their family members.
Figure 4.1: Ecological Family Systems Model

Note. This model depicts how the client's systems intersect and at what level.
Interpretation of Findings

The purpose of the multiple case study is to determine how various mental health professionals explain the significance of family involvement in the treatment of people with SMI in community settings by sharing their experiences, professional opinions about the phenomenon, and methods, techniques, results, and challenges for doing so. During the interview, I asked 11 questions to get more information on the tactics employed, key elements considered, and changes seen throughout the treatment.

The nine subthemes connect to the four primary themes found in the data. Each was a method, methodology, or result from the interviewee's experience. The data occasionally shows a lack of method or technique, influenced by a more serious systemic problem. However, the tactics and procedures are things participants employ or wish they had access to when trying to help their clients and family with SMI treatment.

Major Themes and Subthemes

The themes mentioned in the study reflected how mental health professionals collaborate with the family of people with SMI. The interviews carry a common thread where all participants attempt to include families in treatment when allowed by the client. All participants agree that family involvement is positive when incorporated into treatment. An overarching theme of the data is the challenge of encountering systemic problems, which makes treating these illnesses difficult with or without family involvement.

Methods. The participant employs different strategies to interact with the family or the client through the family.

Process of Family Involvement. Processes that the participants permit to develop to aid the family in processing the involvement, particularly for estranged families with a history of violence or disability.
**Family Advocate.** A representative who works for the organization acted as a bridge between the family and the treatment team. Additionally, during several interview situations, relatives advocated on behalf of the client to the mental health expert.

**Establishing Trust and Validating.** Like the family process, building trust and validating treatment concepts is necessary to present the idea to the family, who is struggling with their family member's mental illness and occasionally have negative experiences with mental health programs or treatments.

**Techniques.** Specialized techniques or procedures to engage family members.

**Psychoeducation.** Standardized courses in community mental health to inform clients and families. It is helpful to families, according to five out of seven participants. According to two of the five, it may be better by becoming more thorough in future designs.

**Family Dynamics.** Family members' behavior and attitudes at the time of engagement. Every participant who interacts with family members must learn how to navigate the current family dynamic. Beyond the standardized clinical abilities, they acquire through their master's or doctoral degrees, there is no other technique for the demand, yet it is mentioned commonly as to be aware of when involving the family.

**Outcomes.** The outcomes of involving families, according to skill and judgment.

**Professional Opinion.** Throughout the meeting, participants express their thoughts on whether involving clients' families impedes or helps treatment. Everyone who took part in the study approves of the phenomenon.

**Individual Stability.** At least four participants remember a scenario in which family support helped a client achieve stability. Because a family member was supportive, educated, or helpful to the treatment team, the client continued treatment more independently.

**Family Stability.** SMI treatment for a person frequently helps the whole family unit heal together. They learn how to navigate the mental health system, and stability lessens family
stress. One participant observed that few people use his services when families were stable and healthy.

**Systemic Problem.** Larger-scale problems that stem beyond the control of the treatment team. Systemic Issues impact the client's treatment due to the organization, policies, or laws regulating the course of care and staff employment.

**Lack of Resources and Burnout.** At least two participants cite burnout and a lack of resources as obstacles to providing good care, achieving desired results, and reducing frustration among staff, families, and clients.

**Stigma.** At least three participants mention stigma as a barrier for the client. It is difficult for professionals to become involved because family members stigmatized their loved ones diagnosed with the condition. The participant's coworkers also contribute to client stigma, which accelerates burnout. One interviewee asserted that there is a stigma around SMI in the profession and that new practitioners would receive better, more extensive training for SMI if the stigma did not exist.

**Implications for the Field**

The findings suggest that stronger social functions and interpersonal ties for people with SMI will lead to more favorable outcomes in community settings. Only when healthcare measures address structural problems can people with SMI expand their social responsibilities with the assistance of mental health experts skilled in navigating complicated family dynamics. A person's or a family's mesosystem influences their microsystems, making it difficult for them to work together in treatment settings. Staff members’ mesosystems and macrosystems also directly affect how well they can care for patients.
Suggestions for Future Research

Each participant suggested how to move forward involving families when treating SMI, provided the client consents, to advance the state of the field on a mesosystemic and exosystemic level. Each participant is doing this because it positively affects the family and the mental health of the individual with SMI.

Systematic research into this topic would improve our knowledge and methods, reducing the difficulties in treating this population. Future research may examine the interactions between family members of people who are engaged in programs and collaborate with a treatment team compared to people who are not on a microsystemic level. Research may examine the evolution of families and how families are defined in different eras. Other forms of families, such as non-relative family members may be research such as faith-based communities, work-based settings, or social clubs where members hold family-like relationships could advance research. A mesosystemic approach might consider how workplace norms affect clients and their families or how job policies and regulations affect staff members' productivity when working with this group, which has been described as difficult to serve without experiencing workplace stress.

Research on the person's community and their family, the general relationship between these communities while undergoing treatment, could be included in an exosystem-level study. The larger mental healthcare system as it relates to this demographic and family treatment for SMI symptoms could be the subject of a macro-level study.

Macrolevel research could examine challenges, supports, and solutions for sustainable mental healthcare for this group and their families. Finally, chronosystemic research would look at how significant occurrences like economic shifts, the implementation of new legislation, or similar things affected the timing of the client and their family's life stressors.
Conclusion

A primary gap in the research foci for this population showed that an improved regulatory initiative for staff retention and burnout could result in better treatment outcomes, helping more clients and reconciling divided family members was an issue. Additionally, including family members may increase treatment compliance among participants in community mental healthcare programs. Engagement throughout treatment for people with SMI does not complete treatment yet adds to already existing methods. Mental health professionals and treatment teams have trouble with assisting families due to exhaustion. Healthcare professionals observed changes in treatment throughout this study when explaining outcomes for enabling family participation for their clients. To better design options for more financing resources, higher leadership requirements, and insurance policies to close the gap in our community healthcare system.
Appendix A — Internal Review Approval

Dear Vanessa Perocier,

As Chair of the Institutional Review Board (IRB) for 'Antioch University, I am letting you know that the committee has reviewed your Ethics Application. Based on the information presented in your Ethics Application, your study has been approved. Renewal is not required, however, any changes in the protocol(s) for this study must be formally requested by submitting a request for amendment from the IRB committee. Any adverse event, should one occur during this study, must be reported immediately to the IRB committee. Please review the IRB forms available for these exceptional circumstances.

Sincerely,

--

Kevin P. Lyness, Ph.D., LMFT
Professor, Dept. of Applied Psychology
Director, PhD Program in CFT
Antioch University New England
40 Avon Street
Keene, NH 03431
Appendix B — Informed Consent

A Mental Health Professional Opinion on Family Involvement during the Treatment of Severe Mental Illness: A Multiple Case Study

I invited you to participate in a research study about family involvement during treating severe mental illness (SMI). I am inviting mental health professionals over 18, licensed or registered in California, who has worked with clients diagnosed with schizophrenia or bipolar disorder sometime within the past five years (2018-present) in a community mental health or public community clinic or setting. The practitioner need not work with the population currently.

The researcher for this study is Vanessa Perocier, a doctoral candidate at Antioch University New England, Couple and Family Therapy Ph.D. program. You may have gained access to this study through an organization that agreed to participate in assisting in recruiting potential participants. This form is part of the Informed Consent process to allow you to understand this study before deciding whether to participate.

Background Information: This study aims to gain professional insight from clinicians or practitioners on their understanding of the advantages and disadvantages of family involvement while treating severe mental illnesses, particularly schizophrenia and bipolar disorder.

Participants must hold a state or national credential as one of the following:

- LCSW – Licensed clinical social worker
- LMFT – Licensed marriage and family therapist
- LPCC – Licensed professional clinical counselor
- Psychologist (Ph.D./PsyD degree) – Doctor or philosophy in psychology or Doctor of Psychology professional
- PMHNP – Psychiatric mental health nurse practitioner
- Psychiatrists/M.D.s – Medical doctors
- Psychiatric P.A.s – Physicians Assistants

Additionally, the clinician has practiced with this population in a community setting.

Procedures: If you agree to be in this study, I ask for you to:

- Email the researcher at [redacted] to schedule an interview date and time for a 90-minute interview
- Interviews are virtual or in-person, video and audio recorded talking about:
  - Your history working with the population
  - Your observations on those experiences
  - Any recommendations for future directions involving family members in the treatment process.

Here are some sample questions:

11. Per your professional opinion, is there a positive relationship between family involvement in treating SMI and individual recovery in community settings?
12. What are the most important factors influencing a family’s decision to participate in treatment for those diagnosed with SMI?
13. What has been your experience working with this population?
14. How would you describe your experience working with family members?
15. What have been the changes you observed when families were involved in treatment?

Voluntary Nature of the Study: This study is entirely voluntary. Everyone will respect your decision of whether to be in the study. No one associated with this survey will treat you differently if you decide not to be in the study. Additionally, this study is entirely anonymous, and no one will know if you did or did not participate other than the chair and research assistant. If you decide to join the study, you can change your mind later. You may stop at any time.

Risks and Benefits of Being in the Study: This type of study involves some risk of minor discomforts encountered during interviews, such as nervousness. Being in this study would not pose a threat to your safety or well-being. This study aims to provide general knowledge about the clientele who have received services from you as the clinician and facilitator of their treatment. The benefits of the study include voicing your thoughts and concerns regarding a family’s involvement in the treatment process.

Compensation: Interviewees can provide their email addresses for a $60 Amazon digital gift card. A completed interview is required to receive the total amount. If the interview is interrupted, at least 50% (45-minutes) must complete to receive a $15 Amazon digital gift card. Interviews lasting less than 45 minutes do not receive compensation.

Privacy: Any information you provide will be kept anonymous. The researcher will not use your data outside this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. Your credential type will be public for an accurate description of the data. Data will be kept secure by password protection and data encryption.

Contacts and Questions: If you have questions now or later, you may contact the researcher, Vanessa Perocier, via [phone number reacted]. You can ask any questions you have before you begin the interview.

Please print or save this consent form for your records.

Statement of Consent
I have read the above information. I feel I understand the study well enough to decide about my involvement. I understand and agree to the terms described above by clicking the scheduling an interview date and time. Please indicate your consent by replying with written permission to this email.

Vanessa Perocier, M.A., LMFT
Department of Applied Psychology
Antioch University New England
Keene, NH
Dissertation Chair: Denzel Jones, Ph.D., LMFT
Appendix C — Interview Protocol and Guide

Date: Click or tap to enter a date.  
Participant pseudonym: Click or tap here to enter text.

Introduction
♦ Introduce yourself
♦ Provide an overview of how the interview will continue
♦ Start recording
♦ Provide the structure of the interview (audio recording, taking notes, and use of pseudonym)
♦ Discuss the purpose of the study
♦ Review informed consent from email invitation
♦ Ask if they have questions
♦ Test audio recording equipment
♦ Start the interview with demographic questionnaire and interview questions

Interview Questions

Case History
1. When was your first client(s) diagnosed with schizophrenia or bipolar disorder?
2. Can you please describe your work setting at that time?
3. What has been your experience working with this population?
4. What was your communication with family members during the duration of treatment? Was it frequent? Strained? Forthcoming? Brief?

Present Observations
1. Per your professional opinion, is there a positive relationship between family involvement in treating SMI and individual recovery in community settings?
2. What are the most important factors influencing a family’s decision to participate in treatment for those diagnosed with SMI?
3. What have been the changes you observed when families were involved in treatment?
   a. What about lower-functioning families? What did you observe?

Future Recommendations
1. What are your overall thoughts on family involvement when treating SMI?
2. What family approaches would you use if treatments with family were more accessible?
3. How would you incorporate families into therapy or treatment measures for this population?
4. What would recovery look like for diagnosed persons?
   a. In an ideal world, how could community settings facilitate this?
Appendix D — Demographic Questionnaire

Date: Click or tap to enter a date.

1. Gender Choose an item.

2. Age Click or tap here to enter text.

3. Highest Educational Level Choose an item.

4. Type of Credential
   a. □ LCSW □ LMFT □ Psychologist (Ph.D./Psy.D.) □ LMHC
   □ Psychiatrist (M.D./O.D.) □ Nurse (LMHNP) □ Physician Assistant (PA)

5. Years practicing in the field Click or tap here to enter text.

6. In what kind of community setting did you practice with this population? Click or tap here to enter text.
Appendix E — Observation Protocol

Date: Click or tap to enter a date.

Participant Pseudonym: Click or tap here to enter text.

<table>
<thead>
<tr>
<th>Observation</th>
<th>Reflection</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Dear [name of organization],

My name is Vanessa Perocier, and I am hosting an assistantship for my dissertation project on involving family member in the treatment of severe mental illness, namely schizophrenia and bipolar disorder. One undergraduate student can gain the opportunity for mentoring in coding, analyzing, validating qualitative data, gaining additional research experience, and the chance for personal and professional development.

If your student is eligible for field credits and would be happy to oblige. All undergraduates in your program are welcome to apply by completing my Google Form.

I will provide more information about my study or submit an additional IRB to your department if needed. Please pass along the information to colleagues. Thank you!

Sincerely,
[signature]
Appendix G — Research Assistant Application Google Form

Section one
Description:

Vanessa Perocier, a Ph.D. candidate at Antioch University, is hosting a research opportunity for analyzing and validating qualitative research on family involvement during the treatment of severe mental illnesses (i.e., bipolar disorder and schizophrenia) for a dissertation study. The opportunity suits an undergraduate student looking for hands-on experience with qualitative research.

Qualifications:

• The candidate should have a working knowledge of psychology or family studies and be able to apply these concepts to data analysis
• Additionally, they will need an eye for detail and excellent verbal and written communication skills
• The candidate shall thrive in a self-paced environment, adapt to ongoing research objectives, and operate independently with frequent check-ins
• Enrolled in a bachelor’s of science or bachelor of arts degree in psychology, sociology, family studies, or related field or equivalent related experience
• Knowledge of qualitative research (i.e., organize, analyze, code, interpret)
• Comfortable learning ATLAS.ti computer-assisted qualitative data analysis software (CAQDAS).
• Located in California

Benefits:

• Gain hands-on experience and increase your research skills by interpreting analytics in qualitative research
• Advance your analytical knowledge as an entry-level social science researcher
• Grow your professional network
• Experience one-on-one mentoring with a Ph.D. Candidate
• Enhance your job applications and resume/CVs
• Potential for letters of recommendation
• Possible credit hours (depending on your university's requirements)

Hours and compensation:

• Flexible work arrangement (remote)
• 10-15 hours a week for two months or until duties are complete (whichever comes first)
• The researcher is offering a $100 gift card after the assistantship

Let’s work together! Apply by completing the attached Google Form
*Please allow 30-45 minutes to complete

Questions? Email at [redacted]
Dissertation Chairperson: Denzel Jones, Ph.D.
Appendix H — Research Assistant Application Questions

Section two (Section one is the role’s description in Appendix D)
First name
Last name
University

Section three – Research interest and capabilities
What do you find exciting about research?
What is your overall impression of your research experience?
In your opinion, what three skills are the most critical in serving as a research assistant?
How have you demonstrated the above skills in your career or previous endeavors? Which skills would you need to improve to excel as a research assistant?
Why do you see yourself continuing to pursue research in the future?
Describe a time when your organizational skills helped you succeed in a project. Clearly state the skill(s) and how they helped you.

Section three – Technicalities
Do you have a reliable internet connection and access to a computer? Y/N
Are you able to meet virtually at least once a week? Y/N