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Mental Health Professionals and Family Burden: Ways to Improve Training and Treatment

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This is to certify that the doctoral dissertation by

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Abstract

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MPhil, Walden University, 2020

MA, Georgia School of Professional Psychology, 1996

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Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
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Abstract

During deinstitutionalization, schizophrenia treatment shifted from state facilities to communities and families. This change stressed families. This study investigated mental health professionals' (MHPs) knowledge and training about this stress also called family burden (FB). The study had three research questions. These addressed MHPs' view of FB, what barriers exist in treating FB, can multiple viewpoints define FB, and if these views influence MHPs to reduce it. This grounded theory study used 22 MHPs in seven focus groups (FGs). The participant recruitment process included email, list serves, phone calls, and one state conference. The participants were MHPs licensed for 3 years with 2 years' experience working with families with a loved one with schizophrenia. The questions in the FGs imbedded concepts of Ken Wilber's Integral Theory (IT) to create a new theory of what MHPs know about Harriett P. Lefley's, FB. The MHPs created mind maps and answered 8 FG questions related to FB via Zoom. This study analyzed, open coded, and categorized the mind maps and transcripts leading to themes. MHPs defined FB as a problem with a lack of resources. Lack of resources causes strain inside and outside of families, causing pressure, stress, and a lack of awareness. These issues worsen due to family size, lack of family support, family discord, treatment failures, family fragmentation, and guilt. Recommendations suggest teaching FB, IT, parenting skills, and advocacy in graduate schools. Further research should occur with families and patients as FG members. This study and its findings have the potential to provide positive social change by improving the quality of life, freedom, and dignity of families and patients with schizophrenia.

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Dedication

I dedicate this dissertation to Aunt Niece. I saw you endure mental illness most of my life. Your condition caused a burden for you. When you called me several times to talk, I did not have all the answers to support you when you had a bad day. I gave you all I had to listen to your pain. When you left this world in 2019, I pray you knew I did my best. I hope the journey I am about to finish will help others like you.

Additionally, I dedicate this to all the families I have worked with in Georgia while doing community and private counseling. I heard you. I hope to have more answers and provide them to you in the future. Thanks for trusting me with your personal stories.

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I need to thank God. Although I thought the MD route was my plan, you had another and chose the Ph.D. route. I further want to thank my family for their support. My family extends further than mom, dad, and sister. I want to thank two men. The first is Stephen Futch, an enslaved person from Africa who started the paternal-maternal side of my family. The second is Hamp Spann, a pivotal member of my maternal-maternal side of my family. You men and your descendants gave me life. Thanks.

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Last, my faculty/committee rebuilt me into a social change agent. Thanks Chair Dr. Benedict DeDominicis, member Dr. Karel Kurst-Swanger, and URR Dr. Victoria Landu for imparting wisdom. I appreciate the time you gave me. My original committee member was Dr. Marcia Kessack; she left Walden but was invaluable in getting my proposal approved. The other is Lillian Chris Taylor. The writing class I took from you was insightful. Thanks.

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Chapter 1: Introduction to the Study

The study involved using focus groups (FGs) comprised of mental health professionals (MHPs) to investigate their understanding of family burden (FB) as they treat families with a loved one dealing with schizophrenia. The field needs this study because MHPs do not receive this training in graduate school.

This study will influence mental health because it will involve methods to better train providers to treat schizophrenia. This study may change amounts of money Georgia spends on mental health services for those with schizophrenia if there is a cost savings from better treatment interventions. Recommendations derived from results can influence training of other professionals, as findings may generalize.

Study results could lead to decreased family problems from FB and decrease money spent on treatment. FB suffering comes from prolonged pain this condition puts on patients and families if untreated. As treatment conditions improve, Georgia may allocate fewer funds to mental health budgets allowing money to go to other budget services. Recommendations could apply to MHPs including licensed professional counselors, social workers, and licensed marriage and family therapists. This study can lead to social change by addressing dignity of patients suffering from schizophrenia and families dealing with FB. Research questions involve improving training of MHPs treating FB in Georgia.

Chapter 1 includes an introduction, background information, problem statement, study purpose, research questions, theoretical framework, nature of study, definitions, assumptions, scope and delimitations, significance, and a summary.

Background

A lack of resources influences treatment of the mentally ill in the United States of America. These resources may worsen in rural areas because they have cultures which create barriers (Jensen et al., 2020), poorly trained emergency room doctors, and primary care doctors (Johannson et al., 2019), and non-professional staff leading to ineffective and inappropriate treatments (McCabe & Macnee, 2002). Issues involving resources, ineffective, and inappropriate treatments in rural areas, worsened since deinstitutionalization because of minimal planning and preparing for deinstitutionalization (Osborn, 2009), problems providing individualized treatment, attempts to use assertive treatment approaches, continual on-going care (Test, 1981), stigma, and families not accepting the illness (Welton, 2006). Deinstitutionalization also left treatment professionals in state facilities but not with families who had to rely on non-professionals as providers. Deinstitutionalization made resources scarce because families could not find them in Georgia. Treatments are also contradictory because fragmented levels of care provided families with different information from different sources.

Deinstitutionalization started in 1955 to remove people from large state hospitals and to provide treatment in communities (Frontline, n.d.; Kliewer et al., 2009; Yohanna, 2013). Community refers to in-home treatment or outpatient settings but not in state facilities. This study focused on Georgia.

At the start of deinstitutionalization, about 560,000 individuals with severe mental illness resided in state-run facilities (Marshall-Lee et al., 2019). Similarly, the deinstitutionalization movement has occurred across the world. In Sweden, deinstitutionalization resulted in using Assertive Community Treatment (ACT) teams to care for those with schizophrenia (Markström, 2014). In Spain Saz-Parkinson et al., (2011), researched the deinstitutionalization movement from 1980 to 2004 and they determined rates of days of hospitalization decreased from 148 days in 1980 to 35 days in 2004.

Because of deinstitutionalization, schools that train MHPs need new training models (Harrison & Stupak, 1993). These training models do not exist because the mental health field has not standardized qualifications, training, or ongoing competency evaluation of providers conducting services (Morris & Stuart, 2002).

Molefi and Swartz (2011) interviewed 10 families of patients receiving treatment in a hospital in the Western Cape of South Africa. They found family exclusion in treatment planning, families had issues communicating with treatment team, and families did not get a clear explanation of schizophrenia, and needed more family support. Lippi (2016) found similar complaints from families receiving treatment along with poorly trained police and a lack of support groups.

Treatment providers need new training methods for MHPs because deinstitutionalization made families and communities primary arenas for treatment. Families serve as caregivers and need new strategies from providers to address the issues of FB. Prior to deinstitutionalization in 1955, treatment occurred in state-level institutions and hospitals. A lack of strategies to help MHPs work with FB is the gap in literature. As family members care for more loved ones with schizophrenia, incidences of FB will increase.

The use of MHPs in research studies is common. Jackson (2017) interviewed 11 MHPs to determine actions they undertook to decrease hospitalization rates for stabilization. Riebschleger (2001) did convenience sampling of 73 MHPs and 4 FGs of 37 MHPs to assess their interaction with families testing two hypotheses on their perceptions on family pathology. Smith (2008) used 188 MHPs to investigate how their training influenced their view of stigma in patients with trauma histories. Stock (2002) asked MHPs about their views of clients with childhood sexual abuse histories. These studies and others in literature never asked about MHPs' understanding of FB. This present study adds these new perspectives about MHPs.

Currently in-patient treatment for schizophrenia occurs due to concerns of dangers to self or others. This problem influences citizens of Georgia because it increases costs of emergency department visits, incurs transportation costs to treatment facilities, raises costs and number of hospital admissions, and decreases liberty, rights, and freedom. Policy corrections from this study may improve delivery of services, save money, decrease transportation costs, decrease hospital admissions, and increase freedom.

Problem Statement

The goal of this study was to develop insights into MHPs' knowledge of FB to improve delivery of services in Georgia. The study used FGs comprised of MHPs to assess their level of understanding about FB as they treat families with loved ones dealing with schizophrenia. Georgia needs this information to improve treatment outcomes because MHPs do not receive this training in graduate school.

Caregivers deal with many stressors when caring for family members diagnosed with schizophrenia. DeTore et al. (2018), gave 41 first episode individuals dealing with schizophrenia rating scales to assess their level of burden, social adjustment, and symptoms. This was a longitudinal study lasting 1.5 years. The families had assessments to measure burden. The study determined at baseline (start of study) burden does not correlate with family work status. However, as FB increases family members cannot work leading to financial issues and more burdens. Villalobos et al. (2017) studied how Mexican families in Southern California dealt with FB and said when caregivers were more responsive to relatives' symptoms; they were less critical and warmer. If caregivers had negative emotions, they were unsupportive, but if they had positive emotions, they were supportive of families with schizophrenia. Both studies showed how FB influences finances and emotions in families.

Kusaba et al. (2016) studied caregiver management of chronic diseases at six primary care centers. Kusaba used the Index of Family Dynamics for Long-term Care (IF-Long) to assess family dynamics. This scale developed by the researcher, measures disengagement, scapegoating, transfer of problems across generations, and undesirable behavior. Kusaba et al. (2016) included 199 caregivers of frail elderly individuals in long-term care. The researchers concluded family dynamics correlates more to burden than care receivers' level of cognitive impairment. Caregiving relationships must enter into care planning as Kusaba showed. Jagannathan et al. (2011) investigated 30 caregivers of in-patient family with schizophrenia using FGs in India and found families knew little about mental illnesses of their loved ones. Because of lack of knowledge, providers needed new interventions to address this problem. This lack of knowledge can affect family dynamics and relationships. Jagannathan et al. (2011) showed six major themes that emerged in these were management of illness behavior, managing social-vocational problems, addressing health needs for providers, education, rehabilitation, and managing sexual and marital problems of patients.

Defining FB is difficult due to lack of specificity in terms of how the literature defines family caregiver burden. Tamizi et al. (2019) searched databases from 1940-2018. Their methodology included data analysis with narrative approach thematic synthesis. This work was inconclusive because of a lack of clarity in literature in terms of how to define caregiver burden. Since literature is unclear about how to define FB, providers, and family have difficulty recognizing it. Despite its unclear definition, FB stresses families as they cope with family members and schizophrenia. This burden becomes a significant issue. Das et al. (2019) found for families in Karachi, Pakistan, FB was severe in 32%, moderate in 14.7%, mild in 11%, and had little or had no effect in 42% of cases. These numbers showed that in over half of families FB was a significant concern. Zhang et al. (2014) said in China, 73% of patients dealing with burden, met criteria for a disability. Factors improving treatment outcomes were to target symptoms and disability via treatment approaches and rehabilitation training. Zhang et al. also revealed families needed financial, educational, and social support. FB in families has objective and subjective components.

Overtime FB can affect families if the disease is treatment resistance. Velligan et al. (2019) studied FB with those who care for family members with treatment resistant schizophrenia (TRS) and determined caregivers of those with TRS spent 61 hours compared to 40 hours for families with non-TRS patients. These families also spent $490 per week vs. $373 for non-TRS family caregivers. TRS families need support to decrease the burden. Nuttal et al. (2019) conducted longitudinal study to assess families' perceived burden and clinical correlates of first-episode schizophrenia patients over 24 months. The assessment of the families done at baseline, 6-months, 12-months, 18-months, and 24-months occurred with the Burden Assessment Scale (BAS), Quality of Life Scale (QLS), Positive and Negative Syndrome Scale (PANSS), Calgary Depression, Scale for Schizophrenia, Oral Antipsychotic Medication Adherence Review, and Services Utilization Monthly. For FB, the decrease in burden was 71% from baseline to 6-months, 13% from 6-12-months, and 11% from 12-18-months. The slopes revealed higher levels of burden at baseline resulted in sharp declines.

The QLS testing showed declines 62% from baseline to 6-months, 2% from 6-12-months, and 17% from 12-18-months. The slopes of the lines from the QLS testing revealed baseline quality of life is not associated with increases quality of life.

The PANSS showed a 90% from baseline to 24-months occurred in the first 6-months. However, the slopes of lines between quality of life and increases in positive symptoms are not related.

The researchers used a Multivariate Latent Growth Curve Model with Quality of Life Unstandardized Estimates (Multivariate LGCM) to find female patients seemed to enjoy a better quality of life than males. Multivariate LGCM also determined when patients remained compliant with medication quality of life were better at 12-months from the beginning of the study.

The researchers used a Multivariate LGCM to reveal if depression was high; it resulted in a decrease in quality of life. The greatest improvement occurred at the 6-month interval. All results for FB, and quality of life, and positive symptoms revealed improvements with the greatest from baseline to 6-months from the start of the study.

Nuttal et al. (2019) found quality of life for patients and families will improve with sharpest increase in the first 6-months. The early stage of treating schizophrenia might provide the best time to treat this disease in first-episode patients. Therefore, I examined from the perspective of MHPs FB as related to schizophrenia using grounded theory (GT) FG research. This methodology involved understanding MHPs' views of FB. If their new view, knowledge, and training occur in the first 6-months, this may decrease the consequences of FB.

This research involved addressing lack of training MHPs receive in graduate school to deal with FB. If FB persists, then this might cause more expensive in-patient treatments. To address these training needs, systems need changing. Systems only change with new policies. Understanding the policy making process is vital in order for long-standing changes to occur. Families and patients dealing with schizophrenia find themselves in crisis often. In order to decrease crises, the system must address policies to improve crisis management. Policies must address barriers involving integrated services, advocacy awareness, and including MHPs in Medicare coverage.

Satcher (2006) said, “Central to all functions of government or public health is policy development” (p. 554). In order for governments or other entities to know if a policy needs changing, it takes public health researchers to show the need for a new policy. To show need according to Garrison et al. (2017), public policy involves connecting political influence and pressure. Political influence and pressure arises from citizens asking for change. Advocacy is when organized citizens and interest groups unite to influence public policy. One public policy concern this study found is advocating for more training to help MHPs learn about FB.

In 1977, President Jimmy Carter attempted during his presidency, to create the first presidential commission on mental health (Grob, 2005). As Georgia Governor, he created the Commission to Improve Services to the Mentally and Emotionally Retarded, since deinstitutionalization reduced hospital admissions 30%. First Lady, Rosalyn Carter hoped to replicate the Community Mental Health Centers (CMHCs) created in Georgia on a national level. CMHCs are smaller regional facilities providing care to patients closer to their home and not in large state families.

Grob (2005) found the Presidential Commission on Mental Health had a diverse but nonprofessional group of members, which led to a lack of focus. The commission comprised 20 people with interest in the mental health of minorities and the underserved, unemployed, those discriminated against, and the poor. The demographic make-up of the commission was 12 men and 8 women, with three being African America, six being Caucasian, two Hispanic, and one Native American. The professional background of the group included psychiatrists, academics, lawyers, human rights advocates, mental health activists, a minister, and labor leader. The report from the commission focused on delivery of services, funding, general knowledge base improvements, and prevention strategies. The commission had recommendations for CMHCs, federal agencies coordinating programs among agencies, coordination of state group homes, funding for CMHCs, and training programs.

A second problem area involved ensuring coverage of mental health benefits in public and private insurance plans. Patients need coverage in plans so they can afford to receive treatment. Third, the commission provided funding to help educate the U.S. public about mental illness. Last, the commission recommended national strategies on prevention. When addressing the issue of prevention, the commission had problems deciding if the plans define mental illness as a mental health disorder or disability.

Grob (2005) said the diverse nature of the commission made recommendations difficult because of multiple interest groups. Grob (2005) suggested changes to the composition of future commissions to avoid competing individual issues. These included first not implementing ideology based on an ungrounded empirical reality. These empirical realities comprise how the diverse nature of the commission saw the problem without focusing on a cohesive definition of how to address mental illness. The second recommendation involved understanding bureaucratic rivalries with and between governments. The third recommendation was to understand how to deal with rivalries between MHPs and knowing and identifying implications of interest group politics. Another recommendation was to study and know the role of poverty, racism, elitism, stigmatization, and unemployment and their effects on the etiology of mental disorders.

Grob further suggests research on preventing mental disorders. This research should determine if prevention strategies reduce an illness or a disorder.

After policy creation, the next task is implementation. Implementation is similar at state and federal levels. The Lanterman-Petris-Short (L-P-S) Act in California in 1967 created mental health reforms with the goal of restoring civil liberties of mentally ill persons and deinstitutionalization. Bardach (1982) said policymakers when passing legislation had to be aware of these facets of the implementation process when creating law: intergovernmental relations, interagency relationships, relationships between government and private contractors, professional participation among providers and overseers, interprofessional rivalries, regulatory and service delivery actions, intrabureaucratic politicking, interfaces with other public areas, and continuing legislative oversights and interventions. If policy makers ignore these issues, then the implementation of new law regarding mental illness is difficult. The issues in implementing the L-P-S act and Carter's commission can serve as guides to implement state and federal level recommendations of this study. Legislation change does not occur without addressing barriers in the legislative process.

Copper-Bolinskey (2020) noted some barriers social workers faced trying to get state level legislators to change practice laws included social workers not knowing the political climate. Another barrier was not understanding legislation takes time or educating legislators about professional licensing. Social workers should also eliminate barriers in understanding their professional organization's financial constraints and their scope of practice. Social workers should educate policymakers and the public about licensure, learn about accreditation standards, and know the opposition. If the profession is to have success in influencing policy makers on practice laws, then solutions may include working on inter/intra-agency collaboration. Other changes are, working with players and legislative champions, engaging supporters or those who believe in your issue, building relationships with potential supporters of legislation, improved education on policy issues, advocating for causes of organizational importance, narrowing focus of the issue advocated for, knowing the political climate, and willingness to compromise on legislation.

One additional policy issue confronting families dealing with mental illness is utilizing an integrated health care (IHC) system. An IHC works on a biopsychosocial approach treating the whole individual. These settings are multifaceted and involve different services, professionals, and settings. Kaur et al. (2022) said IHC systems have barriers and the following policy changes through advocacy must occur: counselor must have license portability, funding must change from agencies to the IHC system, mental health counselors in groups must collaborate between related health organizations, changes in modes of service delivery and management, and changes to limited billing for Medicare. When addressing the modes of delivery of services and management, CMHCs must address issues around client confidentiality impeding the free flow of client information in CMHC. Service delivery must also address barriers to duty to warn constraints when clients become suicidal during treatment. To enhance services, professionals at CHMCs must receive training on what an integrated team is and researchers must research the CMHC model to improve delivery.

Fullen et al. (2019) conducted an interview with nine MHPs with experience with the Medicare coverage gap. The MHPs described problems with Medicare to include, ineffective policies, difficult transitions, undue burdens, and confounding regulations. MHPs expressed confusion when many in their community did not know professionals like LPCs could not accept Medicare. They also expressed issues with inconsistencies in some states allowing MHPs to accept Medicare but not Medicaid. Participants further noted the undue burden on clients and MHPs when a client qualifies for Medicare by age or disability, the client may have to find another provider for care. If the mental health system is integrated, it must address these barriers and create a uniform crisis response system.

Hogan and Goldman (2021) said there is no organized crisis mental system in the U.S. Frank and Wachion (2022) noted in a blog, the poor crisis system puts people with serious mental illness including schizophrenia in jail. The general population only has 5% of people with serious mental illness but in jail, it is 26% and prison 14%. Because there is no coordinated crisis system, this leads to distress for families in a crisis, overuse of police and emergency departments, increased suicide rates, overuse of in-patient facilities, more violence toward the mentally ill, and death, neglect, and personal societal costs. The lack a crisis system in the U.S. does seem to add to FB. In this study, participants noted crisis and management of crisis as a problem among families.

If the mental healthcare system of Georgia addresses policy changes and training needs, then it may reduce severity of the FB, reduce in-patient treatment costs, lessen caregiver costs, and improve Georgia's treatment of those with the illness.

Purpose of the Study

The purpose of this GT study was to determine how MHPs understand FB and how this influences families caring for loved ones with schizophrenia. To address this, I used FGs with MHPs to determine their knowledge of and training involving FB. From FG data, I then developed a model defining FB. If training of MHPs improves, then FB will lessen for families. For those professionals now practicing, it is important to understand what barriers they see in treating FB.

I used GT to address what MHPs know about FB. According to Creswell and Poth (2018), GT is used when complex understanding, empowering subjects, literary flexibility and follow-up explanations of findings, and a theory is needed to explain a gap, in addition when quantitative studies are not appropriate. Creswell (1998) stated the use of GT to study interactions, take actions, or engage a process of a phenomenon.

This study defines FB as stress families endure when caring for loved ones with schizophrenia. This study developed recommendations to improve graduate training needs for MHPs in FGs. By examining perspectives of professionals like licensed professional counselors, licensed marriage and family therapists, and licensed clinical social workers, I suggested new graduate school coursework to improve outcomes of families dealing with FB in Georgia.

First-episode early timeframe of schizophrenia is critical to reduce harmful effects of the disease. Nuttal et al. (2019) showed the importance of treatment in the first 6-months of treatment with the largest decline in burden occurring in the first 6-months of treatment. It is during this time; some patients have symptoms but are unaware of them.

If patients and family are educated in early stages, FB may lessen. Some family members see unique behaviors but are unaware it is a symptom of schizophrenia due to a lack of awareness of symptoms. MHPs with proper training and skills can intervene to address these problems early and reduce harmful effects.

Without these skills, this may lead to delays in treatment. Delays in treatment result in crisis hospitalizations, burdens families, overwork healthcare delivery systems, and diminish the freedom of patients due to involuntary treatments. This study may fix some of these problems.

Research Questions

The study involved addressing the following research questions:

RQ1: How do mental health professionals define FB?

RQ2: What do mental health professionals think are barriers for families dealing with FB?

RQ3: How can multiple viewpoints and perspectives assist in defining FB and influence formal education of mental health professionals to reduce FB?

Theoretical Frameworks of the Study

Theoretical Framework

This study involved investigating training of MHPs for clients and families they serve in Georgia. MHPs learn how to counsel families in universities and colleges. Typically, topics for these students include ethics, cultural diversity, human growth, and development, career development, counseling and helping relationships, counseling theory, group counseling and assessment, research, and program evaluation. The problem with current school curricula is it misses other perspectives influencing human behavior. One such theory to address patients and families is Wilber's integral theory (IT).

Ken Wilber created integral-transpersonal psychology. Integral–transpersonal psychology comes from "integer" or whole and "trans" meaning beyond the person. Therefore, it is psychology, which goes beyond the whole person. IT has five elements. These are quadrants, states, types, levels, and lines of development (Ingersoll, 2007). Lines represent the total of a person's existence. Quadrants are the exterior and interior of both people and groups in society, which people belong. States are multiple levels of consciousness such as waking, dreaming, and sleeping. Types are ways people filter their experiences. More in-depth information about IT appears in Chapter 2.

If MHPs learn IT and the five elements of how client's and families experience FB, this new insight may improve treatment outcomes. This study addressed what MHPs know about clients and families dealing with FB from multiple perspectives. Theses perspectives included their training, experience of FB, verbatim transcript statements, and mind maps about FB.

Conceptual Framework

Harriett P. Lefley is the originator and creator of FB (Lefley, 1989). The central phenomenon of this study is FB. FB is physical, emotional, social, and economic costs families endure when taking care of a loved one with schizophrenia (Lefley, 1989). The literature includes research on FB but there is a lack of information regarding how to teach MHPs about FB.

GT research involves developing new theories from data and studying processes, actions, or interactions with participants, and grounding theory from the view of participants (Creswell, 1998; Creswell & Poth, 2018). There is no current theory to explain what MHPs know about FB.

Ken Wilber’s IT involves four quadrants. These four quadrants are the upper right exterior-individual quadrant, upper left interior-individual, lower left interior-collective, and lower right exterior-collective. These quadrants represent the interior-exterior experiences of patient and groups. Groups include family, country, society, city, or state and explain patient’s interactions with these groups. It is not a mental health exclusive theory, but does have implications to help those who suffer from FB. The implications of IT is its ability to describe FB more than by symptoms of schizophrenia but answering how FB influences patients of different SES, ethnicities, or symptom severity. The only way to do this is to use GT methodology to gain perspectives of MHPs.

FB was in the questions in FGs and was the concept this study investigated. Instruments used to obtain data were the FG protocol and mind mapping exercises. The FG protocol was eight questions used in FGs to ask all participants questions to obtain data for analysis. The mind map exercise in the FGs helped participants define FB in a diagram form to help them express a concept via illustration when they might find words difficult. This concept helped me to see how many ways varying viewpoints and perspectives saw FB. These instruments derived data and formed a new theory. Later in the study, I present a new theory created from this research.

GT qualitative research develops when a researcher seeks to understand inner experiences of participants in order to explore their meaning. Meaning in a study is how participants understand a phenomenon from their vantage point. These points or areas are variables for future qualitative studies (Corbin & Strauss 2008, 2015). This may help MHPs view clients in a different way. New knowledge may lead to new training techniques to lessen FB and improve recovery.

Nature of the Study

This study involved addressing MHPs' knowledge of FB using a GT approach. The study occurred virtually with FGs recorded via Zoom. Each FG used questions from the FG protocol to understand MHPs' knowledge of FB and ways to teach MHPs about FB. FGs discussed graduate coursework needs in order to improve how MHPs can learn new skills to help families deal with FB.

One reason GT was suitable for this study was because I obtained lived experiences of MHPs. Neal (2009) asserted GT's use when no hypothesis exists, when a study uses participants and not subjects, and data and research in a study produces theory. Literature shows few studies asking MHPs about FB. MHPs in FGs were participants in research. Grbich (2013) noted use GT when there is little knowledge regarding a subject, interactions need explaining, or to form a new theory from empirical knowledge. An assumption of GT is symbolic interactionism. Symbolic interaction assumes social interactions can change among people. Interactions derive meaning from symbols, signs, and types of language people use to interact with each other. Blumer (1969) said three assumptions help explain symbolic interactionism: human beings act on knowledge, concepts, or ideas based on meanings, meaning comes from social interactions, and the interpretative process modifies meaning. In this study, MHPs interacted in FGs and used symbolic language to explain their understanding of FB. Participants in FGs provided material in order to create a new theory.

This conscious material derives from two sources, the “I” of the uninhibited self, and the “Me” under social control. Participants came to the FG with two conscious sources, “I”, and “Me”. In FGs conscious material interacted with that of other participants and myself to form new theory. GT then looked at the empirical life of participants, how they interacted with other participants, interacted with me, and interacted with past families to create a new theory.

Corbin and Strauss (2015) said GT comes from data collected during and not prior to research, analysis, and data collection. GT is the way to allow relationship examination and allows for analysis and data collection. Interrelation allows theory to contain components of data collected. GT allows people to explain and take actions to alter, contain, or change situations. This study had data from mind maps and transcripts collected from MHPs. The mind maps were visual symbolic drawings of how MHPs define FB. No data collection occurred beforehand, and data collection informed analysis. Further, all data collection occurred virtually via Zoom with recordings of FG discussions to record verbatim transcripts.

This study used Zoom as a natural setting to collect data. The setting was familiar because participants have used Zoom before. Lincoln and Guba (1985) said of natural settings, “we suggest that inquiry must be carried out in a ‘natural’ setting because phenomena of study, whatever they may be-physical, chemical, biological, social, psychological- *take their meaning as much from their contexts as they do from themselves* (p. 189). In this study, MHPs in FGs discussed a topic they were familiar with because of their professional work.

In natural study settings, humans act as instruments and as participants (Lincoln & Guba, 1985). Natural studies involve using tacit (intuitive, felt) and propositional (expressed in language) knowledge. Naturalistic setting studies often involve qualitative research methods such as purposive sampling to increase transferability. Naturalistic studies involve using inductive data analysis methods to move from specific to general claims. Studies provide tentative application results with focused boundaries. Tentative applications apply because results apply only to this study and these participants. As new data, interviews, or FGs occur results may change. Since study results are tentative, results apply only to the limits and boundaries of this study. Natural studies show trustworthiness via credibility, transferability, dependability, and confirmability of results.

This study used MHPs' views of FB in a virtual environment of Zoom. Data collection involved my participation with participants, and participant interactions with each other to influence data results. Data collected came from FG transcripts and mind maps. What MHPs felt (tacit) and knew (propositional) was in transcripts. This study was inductive and involved using the GT method. In Chapter 4, I will show what theory the study created. This theory again is tentative and changeable as new interviews produce new transcripts and mind maps. This changing tentative nature is a basic assumption of GT.

Glaser and Strauss (1967) said, “Researchers’ job is not to provide a perfect description of an area, but to develop a theory that accounts for much of the relevant behavior” (p. 30). Theories described by Glaser and Strauss are of two types substantive or formal. Substantive theories are empirical and cover sociological inquiry. Substantive theories are also broader. Formal theories cover a narrow specific concept. Substantive and formal theories are mid-range because they are more powerful than minor theories. Formal theories start with loose conceptual frameworks. The loose framework I used for this study was my lack of formal training on FB. I saw a problem and I used my lack of knowledge to create and inform this study.

Glasser and Strauss noted GT is trustworthy because the researcher’s long engagement of data in the field, the researcher’s use of evidence from data, and having multiple comparison groups to compare data. GT further allows for predictions and explanations of behavior, the advancement of theory in sociology, practical application, new perspectives on behavior, and it can guide research in particular behaviors. Predictions of behavior in this study occurred when MHPs’ described interactions with families and how these interactions can predict possible improved treatment outcomes with new training. New theory produced advances MHPs’ knowledge on FB and allowed others to add to the literature. This study had a practical application in understanding new perspectives on FB and it looked at particular behavior related to FB.

My prior training and literature show why the profession needs this study. There are numerous barriers interfering with how families receive services related to FB. One of these barriers is shame (Shamsaei et al., 2018). Over 24 million people worldwide suffer from schizophrenia (Oloniniyi et al., 2019) with a worldwide prevalence of 0.54% (Zhang et al., 2018). Schizophrenia was a factor in 0.38% of emergency department (ED) visits in 2005 and 0.88% in 2011 (Lombardi et al., 2020). Some ED visits occur because clients and families stop medications. Medication noncompliance leads to increased hospitalizations and hospitalization costs (Kovács et al., 2018). In the U.S., between 2005 and 2015, psychotic disorders were involved in 28.4% of ED visits for homeless individuals as opposed to 5.4% for non-homeless populations. Ayano et al. (2019) analyzed 31 studies of 51,925 homeless people from developed and developing countries. The study included developing countries like the US, Canada, Germany, Spain, France, Scotland, the UK, Japan, and Australia and developing countries like China, Ireland, Ethiopia, and Serbia. The research found homeless populations on average comprised 2.48% with schizophrenia disorder, 3.53% with schizoaffective disorder, 9% with a psychosis not otherwise specified, and 21% with psychotic disorders.

Globally, healthcare systems spend 1.5% to 3% on schizophrenia and 22% on mental health costs (Marcellusi et al., 2018). FB increases over time when families do not work (DeTore et al., 2018), causes harm to patients when they are put in jail (Harki, 2019), and is difficult to define by a lack of clarity on defining FB (Tamizi et al., 2019). These factors have implications on caregivers. These implications make this study relevant and timely.

I obtained data from persons who helped families deal with FB: MHPs. I looked at best ways to train MHPs to help families and patients deal with FB. If recommendations from this study lead to state-level system changes, this will lead to legislation passage in Georgia. Even more importantly, the mental health system of Georgia needs legislation in order to create a national crisis system to prevent families dealing with FB from entering crises. This is where the skills of a public policy professional with knowledge of policy and mental health issues like FB can influence policies and systems to make changes to improve FB.

Definitions

Action-Interactions: In this study, actions are main issues in the mental health system, which are either productive or nonproductive strategies in treating schizophrenia (Corbin & Strauss 2008, 2015).

Conditions: Conditions in a paradigm answer questions of why, when, or how a situation in a study occurs (Corbin & Strauss 2008, 2015).

Consequences: Consequences in a paradigm show anticipated or actual outcomes or action of interactions (Corbin & Strauss 2008, 2015).

Family Burden (FB): FB is caregiving, psychosocial, and financial burdens associated with family member medical conditions. Many physical and mental conditions lead to significant demands on caregiver resources, and this can result in care providers becoming depressed, socially isolated, and/or physically ill (Schulz & Beach, 1999).

First episode schizophrenia: First-episode schizophrenia describes patients who formally presented with symptoms and received the diagnosis. This is a clinical and research term identifying and emphasizing special issues with this population (Khamker, 2015).

*Mental Health Professionals (MHPs):*Professionals who work in inpatient facilities, such as general hospitals and psychiatric facilities, as well as outpatient facilities such as community mental health clinics, schools, and private practices (National Alliance on Mental Illness, n.d.). In this study, I excluded psychiatrists, psychiatric pharmacists, certified peer specialists, and pastoral counselors. This study included psychologists, licensed professional counselors, licensed marriage and family therapists, and license clinical social workers.

Mind map: A brainstorming memory process using diagrams to build, arrange, and discuss activities or concepts radially around a central concept or idea. Connectors, arrows, and lines with different colors used to show relationships (Creativity Web, n.d.; Dunn, 2020; Ungvarsky, 2019; Smith, 2019).

Paradigm: A paradigm is a tool to show axial coding or coding around a category (Corbin & Strauss 2008, 2015). The paradigm is comprised of conditions, actions-interactions, and consequences or outcomes.

Schizophrenia: A disease which lasts at least 6 months and must include at least 1 month of two or more active phase symptoms. Active phase symptoms include disorganized speech, hallucinations, grossly disorganized or catatonic behavior, negative symptoms, and delusions (American Psychiatric Association [APA], 1994; APA, 2013).

Systems Theory: A theory of an organization as a complex set of dynamically intertwined and interconnected elements, including inputs, processes, outputs, feedback loops, and environment in which it operates and with which it continuously interacts (Shafritz & Russell, 2005).

Assumptions

Qualitative research involves paradigm assumptions that are essential for this study. These include ontological, epistemological, axiological, methodological, rhetorical, and purpose assumptions. In this study, MHPs viewed a phenomena and interpretations of their reality in FG transcripts. I gained knowledge from direct interactions with participants. I asked questions during FGs, participants responded, and I commented on their statements. From an axiological perspective, I used direct statements and mind maps to collect data. GT is inductive and allows theory formation where no theory existed before.

I asked all participants if they were qualified for the study. Inclusion criteria for this study were licensed MHPs, with a license for three years, who cared for families with a loved one with schizophrenia for two years. Consent documents included inclusion criteria. All study subjects voluntarily participated in the study. There was an explanation in the informed consent document involving voluntary participation. I assumed all answers given during FGs were honest. When subjects gave answers, there were no indications of deception or dishonesty. Therefore, I assumed honest answers. An important factor needed to conduct engaging and enlightening FGs is trust between the moderator and participants. I developed trust with all participants by building rapport with them to improve gathering of information.

Participants in the study were voluntary. FGs must be honest, and if not, findings might be invalid. If trust is not established, participants may not give insightful answers to create a new theory.

Scope and Delimitations

This study involved interviewing MHPs with at least 2 years of experience working with patients and families with schizophrenia. I excluded professionals with less experience. I did this to ensure participants had enough experience to provide rich information during FGs.

I did not ask participants about cognitive behavior or person-centered therapy. I also did not focus on topics like ethics, counseling skills, counseling theory, human development, professional development, or helping relationships, which MHPs know well. Instead, I explored FB and addressed how to improve recovery of patients with schizophrenia and families dealing with FB.

In this study, I had experience as a MHP. This allowed rapport to build. Research had credibility due to following GT principles of line-by-line coding, category formation, and paradigm creation. Study results derived only from transcripts, mind maps, and interactions between participants and me.

Limitations

One limitation in this study is that all participants came with biases and prejudices. Biases might influence ways MHPs answered questions during FGs. I tempered discussions and provided modifying follow-up questions if biases surfaced during FGs. Biases might have entered this study if MHPs had preconceived notions about their training or were unable to be objective and listen to viewpoints of others. I allowed all viewpoints in discussions, including minority views.

I came to all FGs with biases. My biases were my belief in my inadequate training. I also had biases in believing the mental health system is not doing enough to help families dealing with FB. I controlled for these biases by only asking follow-up questions based on participant responses, not ones based on my own opinions.

Participants in this study were MHPs. They brought relevant knowledge during FGs. Participants randomly agreed to be in the study and participated if they met inclusion requirements. I only admitted MHPs in the study who met the requirements.

However, there were some liabilities involved with this study. Howe and Eisenhardt (1990) said there are five standards to apply to all research. These include allowing research questions directly to influence data collection. Another is a researcher should allow questions to drive analysis. Additionally, data collection must remain technically appropriate and the researcher should make objective assumptions to ensure research is necessary and based on theory. Studies should add something to the literature and have scholarly merit, protects client confidentiality, and is honest in terms of participant information.

The greatest liability of GT is threat of a lack of consistency. In this study, I maintained consistency by using the same questions and materials to gather data. If consistency does not develop, then FGs will not include accurate information to develop standards, leading to a new theory. Using MHPs to obtain answers to interview questions is a limitation, because the view this theory creates is only from the perspective of MHPs in the inclusion criteria. If the study included psychiatrists, nurses, or mental health techs results could be different. Additionally, the eight questions asked in FGs were a limitation, if different questions asked a different theory could emerge.

Researchers like me bring some level of bias based on their own experiences in life. According to Corbin and Strauss (2015), some ways to reduce biases are to keep a journal and write notes when collecting data in FGs involving reactions, and by following GT principles. Another way to limit biases is by using study process notes to address nonverbal and verbal interactions. By looking at these interactions, I could judge if participants' statements matched body language. This type of documentation was not difficult to produce since I am a licensed professional counselor and document sessions in this manner. GT also helps in terms of avoiding biases by using the constant comparison process. Constant comparison involves matching existing data categories to new ones created until no new data categories develop.

Significance

I used FGs comprised of MHPs to define FB, identified barriers to treat FB, and coursework requirements to reduce FB. This research suggested changes to coursework during master's level courses. I created a theory to add to literature regarding new skills and courses MHPs may need to reduce FB. Theory recommendations occurred in FGs as MHPs discussed FB.

Therefore, this study involved better ways of training MHPs to deal with FB. It can also ultimately affect state legislative budgets for schizophrenia expenditures in Georgia by having a better-trained mental health community, possibly decreasing patient crises rates, and leading to fewer crisis hospitalizations. Recommendations apply to MHPs in Georgia. This study can lead to social change by improving the dignity of those suffering from schizophrenia because families will be better able to deal with family member symptoms.

Summary

Families are the main source of care for patients. When families care in rural areas, these areas lack providers. These shortages stem from these rural areas creating distinct cultures causing barriers (Jensen et al., 2002), containing poorly trained PCP and emergency room doctors (Johannson et al., 2019), and containing non-professional staff implementing poor treatments (McCabe & Macnee, 2002). These problems worsened after deinstitutionalization because the small number of providers in rural areas saw more patients after discharge from facilities. In 1950s when deinstitutionalization began, 560,000 individuals received treatment at state facilities in the U.S. (Markström, 2014). This number dropped to 200,000 in 1975 and 35,000 in 2014. As discharged individuals sought treatment, they found poorly funded CMHCs (Marshall-Lee et al., 2019). Services provided after deinstitutionalization showed minimal planning for community services, care failed to meet the expectations of professionals, and patient safety not addressed in the community (Osborn, 2009).

Deinstitutionalization in Spain, from 1980 to 2004 showed patients with schizophrenia stayed in hospitals shorter times but, rates of admission increased from 3.71 per 10, 000 in 1980 to 5.89 in 2004 (Saz-Parkinson et al., 2011). Deinstitutionalization in Spain only decreased times in hospitals but increased the number of admissions. As patients moved from hospitals to outpatient settings, treatment needed to include individual approaches, assertive approaches, and continual on-going care (Test, 1981) but many times did not. Patients receiving treatment dealt with more stigmas, needed more skills in relapse prevention, and dealt with families not accepting their illness (Welton, 2006).

Deinstitutionalization led to FB. FB contains objective and subjective components causing strains on family relationships, finances, and time constraints (Chan, 2011). FB can be severe in some cases. Das et al. (2019) studied FB in Karachi Pakistan for 150 caregivers of a patient with schizophrenia using the Zarit Burden Interview and found burden severe in 32 %, moderate to severe in 14.7 %, mild to moderate in 11.3%, and little or none in 42%. FB and quality of life is inversely related (Nuttal et al., 2019). Velligan et al. (2019) studied 177 caregivers in the US found patients with TRS had families with greater FB. Zhang et al. (2014) in Sichuan Province China investigated 101 patients and families dealing with schizophrenia. Results revealed 73% of patients had clinically significant disability correlating to early age of onset, longer illness duration, and more severe clinical symptoms.

If training improves, better methods can develop to address this costly disease for caregivers, and society. Barbosa et al. (2018) found in Brazil 85% of medical coast and 25% of direct care cost was due to schizophrenia. Kovács et al. (2018) in a literature review of European countries found decreasing hospital stays and focusing on relapse prevention decreased costs. Sruamsiri et al. (2018) studied 171 caregivers in Japan and determined 19% had to quit work to care for family but if family had long-acting injectable medication family productivity loses became minimized. FB has indirect costs in societies like Europe (Fasseeh et al. 2018), and schizophrenia increases the mean cost per patient per month (PPPM) for commercial claims in the U.S. from $419 for non-schizophrenia clients to $1806 for those with schizophrenia.

Literature shows many studies used MHPs in dissertations but there is a lack of information about MHPs' knowledge of FB. This study involved examining how MHPs viewed FB and their level of training to help families deal with FB. I used FGs to identify coursework needs for MHPs in order to treat FB. I determined what types of training providers received.

Chapter 2 includes an introduction and literature search strategies. I then address theoretical foundations involving GT, as well as IT and FB. Chapter 2 includes a literature review with variables and concepts as well as a summary and conclusion.

Chapter 2: Literature Review

Researchers have examined causes of schizophrenia and addressed effects on first-episode individuals and proper treatment for the illness. First-episode individuals are those who have their first encounter or episode with this disorder. I investigated how FB influences families. What is missing in the literature is MHPs' knowledge of or training involving FB.

The purpose of this study is to address MHPs' knowledge of FB using the GT approach. GT was suitable for this study because this study had no hypothesis, used participants, research returned to the field to gather more data, and new theory created came from the data. Neal (2009) supported using GT when the previous conditions exist. Grbich (2013) said use GT for studies with little knowledge of a concept, those that rely on interactions between people to explain phenomena. This study had little prior knowledge of MHPs' view of FB and the interactions between participants and family helped in theory formation. Glaser and Strauss (1967) said GT provides a way to analyze a thought or a belief when no other method exists. Corbin and Strauss (2015) said GT helps when no prior data exists on a subject and a connection exists between data collection and analysis.

I found studies about schizophrenia's effect on patients and families, but none addressed how to train MHPs to treat FB. Studies dealing with families came from Taughter (1997) with Hispanic/Latino families and Lobana et al. (2001) with families in India. Families in Lobana et al. (2001) wanted patients to remain on medications to control symptoms. Pyne et al. (2006) studied the relationship between patients and providers on medication compliance.

Mountain (1998) and Tooth et al. (2003) looked at how patients recover and how to facilitate recovery. Recovery can occur in rehabilitation programs and Prouteau et al. (2004) studied patients with schizophrenia in outpatient setting and their level of cognitive dysfunction.

FB depends on the caregiver’s response to it. The literature does show numerous studies about caregivers. Wancata et al. (2006) reported caregivers require a needs assessment instrument to reduce burden. Caregivers globally face similar problems with FB, Jagannathan et al., (2011) studied caregiver needs in India, and Perlick et al. (2006) examined caregivers in the US.

FB is an outcome of schizophrenia. In the 1980’s and 90’s schizophrenia and mental illness, caused Georgia to budget over $1 billion (Miller & Martin, 2004). In 2019, Governor Nathan Deal budgeted $255,944,645 for mental health disorders (Governor’s Office of Planning and Budget, State of Georgia, 2019). These numbers show how much schizophrenia influences budget challenges in Georgia.

Families who find themselves in crisis have few alternatives other than calling law enforcement. These crises may include hallucinations, delusions, or threats to harm self or others. If this encounter leads to arrest and jail, this may not be safe for patients. Harki (2019) investigated jails in the US and found 41% of persons who died were in solitary confinement, and solitary confinement is detrimental to a person who is paranoid. Harki also noted 11% of the families told the jail staff about the family member needing medication but no one listened to them. Medication non-compliance for persons with schizophrenia may lead to decompensating symptoms.

Chapter 2 involves understanding the full nature of the study. I will discuss the literature search strategy, followed by theoretical foundation, conceptual framework, variables and concepts, strengths and weaknesses of theories, and a summary, and conclusion.

Literature Search Strategy

All journal articles obtained for this study and most electronic books came from the Walden University Library via the following electronic databases: ABI/Form Global, Academic Search Premier, CINAHL, ERIC, EBSCOHost, InfoTrac, Psych ARTICLES, PsychINFO, ProQuest, ProQuest Dissertations & Thesis Global, Sage Journals Premier, Science Direct, and SocINDEX. I used these keywords: *costs*, *schizophrenia*, *first episode ,expressed emotion*, *Georgia*, *budget*, *Georgia Department of Medical Assistance*, *Georgia client tracking database*, *National Association of State Mental Health Program Directors Research Institution*, *counselor educator theory*, *counselor theory application*, *integral theory*, *FB*, *caregivers*, *incorporating practice*, *chronic mental illness*, *focus groups, mind maps*, *communities*, *social justice*, *family systems*, *teaching*, *grounded theory*, *counselors*, *family relationships*, trauma, *systems theory, mental health, financial costs, state of Georgia, expenditure*, *Medicaid*, *Medicare, reimbursement*, *inpatient hospitalization*, *treatment*, *deinstitutionalization, community services*, *benchmarking, taxes, comorbid processes*, *fiscal costs, jails, mental health barriers*, *recovery*, *stigma*, *mental illness*, and *homelessness*.

I determined schizophrenia and FB worthy of research due to implications and costs on Georgia's mental health system. I also understand families and patients have problems accessing local mental health system for services. I noted when MHPs assisted families and patients dealing with FB and schizophrenia, they were ill equipped to provide meaningful interventions and deal with symptoms. I determined MHPs' knowledge of FB and coursework needed refinement to help MHPs treat FB.

Theoretical Foundation

GT

I used GT in this study because no theory existed for this problem, theory comes from data, and data collection and analysis are interrelated. It allows researchers to access the innermost experiences of participants, create meaning from data, discover, and to test variables, and investigate complex relationships (Corbin & Strauss, 2015).

The qualitative approach is a frequent method in many research studies. Subjects similar to this study exist in literature, but none directly related to how best to train MHPs about FB. Literature shows studies about FB and families, FB and recovery, FB and patients with traumas, spouses and children and FB, and some training families and frontline staff need to address FB.

Ae-Ngibise et al. (2015) said burden occurs in 14% of medical disorders globally. Burden in families showed psychosocial, emotional, economic, and physical challenges. Burden produced stress, made families feel unsupported, created financial problems due to caregiver inability to work, and stigma. Stigma comes from family and society viewing families negatively because of schizophrenia. Suryani (2019) showed

31% of families had good knowledge on burden, 42% had sufficient knowledge, and 27% insufficient knowledge on burden. Family's education level correlated directly to how they provided care. Families lacked knowledge on what to do during a relapse, families who worked experienced more burden and FB increased overtime. When families experienced more relapses, burden was greater. Suryani (2019) said stigma stemmed from interpersonal interactions, structural discrimination, developing images of mental illnesses, and problems in social access. Årestedt et al. (2014) found Swedish families have a "naïve" understanding of schizophrenia and lacked a comprehensive understanding of it.

Friedemann and Buckwalter (2014) used caregiver identity theory to determine how male and female spouses and male and female adult children differed on their views of caregiver burden. Caregiver identity theory comprises interactions between caregivers and care recipients. It addresses caregiver's self-appraisal and understanding of self. Caregivers have two choices to either change their role norms or change the situation. In the study, families adjusted by asking for help, or exhausted themselves by not asking for help. Families further learned how to readjust by dropping cultural stereotypes that impeded change. Families needed help reducing depression, and finding resources to help. Caregiver identity was also used in understanding how parenting roles change with raising a child with schizophrenia as in Milliken and Northcott (2003).

Milliken and Northcott (2003) found, parents think they have a right to care, protect, and make decisions for adult children when society feels the adult child has that right. These rights collide when the child has schizophrenia and needs help from parents to function. Parents then then they have more of a take more fights from the child. Parents progress through several stages of identity development to include anticipating liberty, marginalization, disenfranchisement, embracing the collective, redefining their identity, re-enfranchisement, evaluating their life, and emancipation. Poonnotok et al. (2016) addressed the parental caregiver process too. Their study categorized parents' experience in dealing with children diagnosed with schizophrenia with a core category of a struggle to remain normal. This struggle contained six categories of learning about the diagnosis, facing shattered dreams, caregiving as an unavoidable role, struggling to control psychotic symptoms, struggling to deal with the illness impact, and accepting the new normal.

Literature on GT has asked what families and patients need to navigate FB. Gavois et al. (2006) used GT to interview 12 families dealing with severe mental illness about what they needed from MHPs. Findings showed contact with MHPs decreased during crises. Contact decreased when MHPs excluded families from care and increased stress. When families remained in contact, four themes the families wanted to see in MHPs were being present, listening, sharing, and empowerment. Gunnmo and Bergman (2011) did a similar study focusing on schizophrenia patients. They found core categories identified were striving for a normal life. Five categories found by patients related to providers taking part in a professional relationship, receiving information on the illness, receiving help during a relapse, having meaningful employment, and taking part in social contacts.

Patients are a frequent subject of many studies. Jacques et al. (2019) used GT to explore coping processes of patients living with schizophrenia. Their model listed four filters or barriers to coping. These included filters of their previous experiences, involuntary filters or perceptions, imposed limiting filters, and conscious filter to disclosure. Further ways to assist in coping included, asking for help, transforming behaviors, putting salutary conditions in place, preparing for the future, and maintaining fragile gains.

Rossenschoon et al. (2019) studied clinicians, patients, and the relationship between functional, personal, and clinical recovery. Recovery is an outcome and reflects a cross-section of functional status. Functional recovery is objective and covers vocational and social functioning and age appropriate roles, housing, and independence. Personal recovery is subjective and covers spirituality, empowerment, and acceptance of illness, hope, and positive identity. Clinical recovery involves reduction or absence of clinical symptomology. Results revealed a strong relationship between functional and personal recovery. What clinicians noted at recovery moderately correlates to patient perception of functional recovery. Similarly, although quantitative in nature, Mathew et al. (2019) assessed eight patients recovering from schizophrenia and found increased severity of symptoms negatively correlates with subjective recovery. Patient's perceptions of functional and subjective well-being positively correlated with overall subjective recovery.

Provider of services is a subject of studies. Rhoades (2000) conducted research on what counselors should know when treating schizophrenia in families. Rhoades recommended counselor be aware of risks of patient homelessness, suicide, permanent disability, and challenges in family life. Rhoades further listed other areas of awareness around development, education, skill building, support, therapeutic issues, and family systems. Morris and Stuart (2002) addressed training needs of families and front-line staff. They investigated if front-line workers who worked with families and patients rarely received the right training. The investigators also questioned if healthcare systems allocated money to address needs.

Investigations with FB have involved other illnesses, trauma, and nurses. Gräβel et al. (2010) studied how caregivers of dementia patients perceived quality of care. They learned caregivers do not reach out for help even if offered help via telephone. Trauma may become a comorbid issue with FB. Newcomb and Hymes (2017) found trauma nurses could assist in terms of reducing FB by encouraging self-care, giving families' privacy, and educating families about the hospital system. Lehan et al. (2012) studied caregiver burden and traumatic brain injuries. Results showed assistance with locating resources, and higher functioning patients decreased burden. Noiseux and Ricard (2008) wanted to understand how nurses, patients in recovery, and families perceived schizophrenia. Results formed a mid-range theory starting with an inner process of a "descent into hell". Their theory proceeded to show themes in families of igniting a spark of hope, developing insight, activating insight to fight back, discovering keys to well-being, maintaining equilibrium between internal and external forces, and perceiving light at the end of the tunnel.

Researchers have studied professionals, schizophrenia, families and used GT as a method. They have also used FGs and surveys to understand how best providers can assist with treating the family. What the literature does not show is what MHPs say they need to assist in reducing FB in families. These providers are many times the only community-based MHPs who work with families. This study determined needs to better train MHPs on FB. The theory created in this study imbedded IT in research questions. Prior to this study, studies rarely used FB and IT to improve MHPs understanding. Schools should add IT into coursework for MHPs. This study is just a baseline step in adding it. Again, I used GT in this study. GT imbedded questions from IT and FB to create new theory.

Conceptual Framework

IT

Ken Wilber created integral-transpersonal psychology (Fall et al., 2004; Fisher & Davis, 2012). Wilber described transpersonal counseling as going beyond the person. Wilber believed Western psychology focused on personal development of the ego and self and Eastern psychology on the transpersonal.

When Ken Wilber created his theory, he drew from theorists like Hegel, Bergson, Whitehead, deChardin, Gebser, Habermas (Fisher & Davis, 2012), and Indian philosopher Sri Aurobindo (Starnino, 2009) to create a quadrant model. Integral philosophy is a new way of seeing phenomena (Fisher & Davis, 2012; Starnino, 2009). Ken Wilber’s integral approach contains five elements: types, states, lines, levels, and quadrants. IT allows viewing self and the world. Marquis (2007) described Wilber’s IT as "a way of knowing that helps one strive for the most comprehensive understanding of any phenomenon" (p.162). IT according to Marquis, gives all aspects of reality equal importance it also is metatheoretical and honors many epistemological outlooks, and limits misconceptions of different perspectives. Esbjörn-Hargens (2006) said IT might hold promise as a better way of educating students. Esbjörn-Hargens said, "In other words, integral theory is interested in the participatory relationship between the multiple ways of knowing the myriad of dimensions of reality as it reveals itself through various methods of inquiry" (p. 22).

Wilber (2006) said states of consciousness are all permanent states, never leaving a person but existing only temporarily as waking, dreaming, and deep sleep. If one gets to meditative states or altered states of consciousness, Wilber believes this encompasses peak experiences. Zampella (2018) noted conscious states of awareness are fluid with stages showing stability. Wilber explained IT's stages of development are permanent and consist of eight to 10 stages. These stages are F1 to F10. Stages of development form in three realms prepersonal, personal, and transpersonal (see Table 1).

Table 1

Wilber's IT as Applied to Human Development

Realm	Holon	Psychological functioning	Developmental fulcrum /level	Age in years	Identity
Prepersonal	Matter/life	Prerational	F-1 Sensoriphysical	0-1.5	Physical self
			F-2 Phantasmic/emotional	1.5-3	Emotional self
			F-3 Representational mind	3-7	Mental self

Personal	Mind	Rational	F-4 Rule/role mind	7-12	Role self
			F-5 Formal-reflexive	12-21	Conscientious self
			F-6 Vision-logic	21 (potential)	Centaur
Transpersonal	Soul	Transrational	F-7 Psychic	(potential)	Universal self (nature mysticism)
			F-8 Subtle	(potential)	Includes union with deity
			F-9 Causal	(potential)	Witness consciousness/unmanifest source
			F-10 Nondual	(potential)	Unity consciousness

Adapted from *Theoretical Models of Counseling and Psychotherapy* (pp.399-400), by K.A. Fall, J.M. Holden, & A. Marquis, 2004, Brunner-Routledge.

The prepersonal realm is the matter/life sphere, lasts from ages 0 to 7, and contains levels F1 or sensoriphysical, F2 phantasmic/emotional, and F3 representational mind level. The personal realm or mind sphere lasts from ages 7 to 21 and contains developmental levels F4, F5, and F6. Developmental level F4 is the rule-role model level. Level F5 is the formal-reflexive level. Level F6 is the vision-logic level. All levels in the personal realm are dichotomous. The transpersonal realm is the soul/spirit sphere and lasts from age 21 until the end of life. The transpersonal realm consists of levels F7, F8, F9, and F10. Level F7 is the psychic level or the universal self. Level F8 is the subtle level identifying the soul in union with the deity. Level F9 is the causal level and realizes all other levels are the source that supports this level. Level F10 level explains the existence at the same time of all the levels.

Regarding lines or streams of development there are over two dozen (Fall et al., 2004). Some of these lines include cognitive, affective, moral, empathic, creative, worldview, and spiritual. Duffy (2020) noted each line of development is a product of life’s challenges. All people or collectives have their own strengths and weaknesses. Some have more strength on certain lines compared to others. States represent only two levels of consciousness people exist, which are natural and altered.

Integral psychology is not a subset of psychology but a junction or intersection of many fields (Fall et al., 2004). Duffy (2020) stated this psychology “recognizes the evolutionary impulses that incorporates, rather than devalues or destroys, previous perspectives” (p.1). The Holon is a sequence of spheres consisting of a whole level and it exists simultaneously. To understand a phenomenon, therapists need all quadrants to include the intentional, behavioral, cultural, and social perspectives (see Figure 1).

Figure 1

Ken Wilber's Holon System

Adapted from *Theoretical Models of Counseling and Psychotherapy* (p.387), by K.A. Fall, J.M. Holden, & A. Marquis, 2004, Brunner-Routledge.

IT is a quadrant model usually known called AQAL meaning all quadrants, all levels, all lines, all states, and all types (Marquis, 2007; Wilber 2006). Wilber (2006) said the quadrants of IT views many components of man (see Figure 2). The upper left is the inside of the individual and has “I” language. This quadrant is also for the self and the beauty within. It also represents the arts. The upper right quadrant is outside the individual and addresses “It” language. This quadrant is the objective truth and represents science. The lower left quadrant is inside the collective and uses “We” language and is for culture, morality, and addresses the good in people and our treatment of others. The lower right quadrant uses “Its” language is outside the collective.

Wilber (2006) has interpreted his quadrants’ as the upper right quadrant: organic states, the limbic system, and neocortex. The upper left as integral, holistic, egocentric, power, archaic, and instinctual. The lower left is also integral and holistic but is scientific and rational. The lower right quadrant addresses ethnic clans, survival clans, value communities, and holistic commons. Fall, Holden, & Marquis (2004) said the upper right quadrant is the exterior-individual and is behavioral. The upper left is interior-individual and is intentional. The lower left is interior-collective and addresses culture. The lower right is exterior-collective and is social.

Wilber (2006) said the upper right quadrant is the causal, subtle, and gross body. In this quadrant, the gross body is the physical material or sensorimotor body. The subtle body is light energy, emotions, feelings, fluid, and flowing images. The upper left quadrant is all spirit, mind, and body. The lower left quadrant comprises issues, me, us, and all of us. The lower right quadrant comprises issues of the whole group, nation, and globe. Duffy (2020) noted these four quadrants serve as a filter for all of life’s experiences. For a person to understand any phenomena all quadrates needed to have a complete understanding. All quadrants work in tandem without excluding the others.

Figure 2

Wilber's Quadrant Model with Psychotherapy

Upper Left [a] Interior-Individual (Intentional/Subjective) Experience "from the inside" I • Client's self-experience, self-image, self-concept[b,c] • Self-esteem-self-concept • Instability-stability • Depression, sadness, emptiness, Anxiety • Political, religious, spiritual beliefs • Consciousness of mind • Interpretation of loss	Upper Right [a] Exterior-individual (Behavioral/Objective) Individual Behavior "from the outside" IT • What behaviors brought the client to therapy? [b,c] • Medical disorder/ medication • Diet/Alcohol and/or drug use • Aerobic/ strength training • Sleep/rest • Consciousness (neurotransmission/brain functioning) • Observable changes in behavior
• Client's experience of ethnicity[b,c] • Client's experience of family dynamics • Client's meaning-making system(s) • Client's relationships • Intersubjectivity of client/therapist relationship • Cultural meaning applied to life issues WE Lower Left[a] Interior-Collective (Cultural/Intersubjective) Collective Culture-group's experience "from the inside"	• Client's SES [b,c] • Client's neighborhood condition • Environmental stressors • Analyses of interpersonal dynamics • Treatment context • Social systems that contribute to life issues ITS Lower Right[a] Exterior-Collective (Social/Interobjective) Collective Systems-Group's behavior "from the outside"

[a] Adapted from "Theoretical Models of Counseling and Psychotherapy" (p. 388), by K.A. Fall, J.M. Holden, & A. Marquis, 2004, Brunner-Routledge. [b] Adapted from "What is Integral Theory? by A. Marquis 2007, *Counseling & Values*, 51(3), p. 166,

(https://doi.org/10.1002/j.2161-007X.2007.tb00076.x.). [c]Adapted from “An Integral Approach to Mental Health Recovery: Implications for Social Work” by V.R. Starnino, 2009, *Journal of Human Behavior in the Social Environment, 19*(7), (p. 831), (https://doi.org/10.1080/10911350902988019).

The upper right quadrant is the behavioral or objective aspect of the individual viewed from the exterior. The upper left quadrant represents the intentional/experiential or subjective aspect of the phenomenon. The lower left quadrant is the cultural or intersubjective aspect, which is the collective, viewed from the interior. The lower right quadrant is the social or interobjective or the collective aspect viewed from the exterior.

The behavioral exterior-individual (objective) quadrant houses the “It” language of the person. This quadrant encompasses a positivistic perspective with individual structures, behaviors, events, and processes. The upper left or interior-individual subjective quadrant contains issues related to individual consciousness, sensations, perceptions, feelings, insight, thoughts, and “I” language. The lower left or cultural, interior collective quadrant addresses shared worldviews, customs, linguistic semantics, ethics, communal values, relationships, and “You/we” language. The lower right exterior, collective quadrant addresses questions of economic structures, civic resources like education, employment, and transportation, governmental systems, city planning, the interaction of parts of a system, and “Its” language (Marquis, 2007).

Starnino (2009) summarized the quadrants in simpler terms (see Figure 3). Starnino explained the right side of the quadrant correlating to the exterior physical world and the right side correlates to the interior conscious subjective world. The upper right is the scientific empiricism or behaviorism quadrant. The lower right quadrant is for ecological sciences, systems theory, and structural-functionalism. The upper left is for introspection phenomenology. The lower left quadrant is for hermeneutic and collaborative inquiry. Esbjörn-Hargens (2006) said the upper right is brain/organism, upper left as self-consciousness, lower left as culture and worldview, and lower right as social system and environment (see Figure 4). This view looks at the right side of the quadrants as life in a societal system and the left side as consciousness navigating cultural and the world.

Figure 3

Starnino's View of Ken Wilber's Quadrant Model

Upper Left Introspection-Phenomenological	Upper Right Scientific-Empiricism Behavioral
Lower Left Hermeneutic Collaborative/inquiry	Lower Right Ecological Science Systems Theory Structional-functionalism

Figure 4

Esbjörn-Hargens' View of Ken Wilber's Quadrant Model

Upper Left Self-consciousness	Upper Right Brain/organism
Lower Left Cultural/Worldview	Lower Right Social System Environment

Wilber (2006) stated the Integral Operating System (IOS) allows other disciplines to interact with each other. Marquis (2007) remarked an IOS touches all bases of a phenomenon. An IOS reminds users to consider all theories and information to answer a phenomenon and to look at the subject matter at all levels.

Ingersoll (2007) viewed IT and discussed its importance in psychotherapy (see Figure 5). The theory allows four quadrants to represent four views of human development. The first quadrant views human development in childhood. The second quadrant is the person who feels what others feel. In the third quadrant, the person is a fully developed individual and looks at the world from a self and others perspective. The fourth person perspective allows multiple perspective comparison without favoring one perspective over another. Duffy (2020) recommended an Integral psychiatry model (IPM) to improve the delivery of services. An IPM approach would: expand practice beyond neurobiology, support an interdisciplinary team approach, looks at patterns and not just details, promotes self-assessment, humility, and self-cultivation, recognizes community engagement, it supports human flourishing and not pathology, promotes cultural diversity, appreciates first-person experiences, and promotes self-cultivation.

Figure 5

Ingersoll's View of Ken Wilber's Quadrant Model

Upper Left Feels what other's feel (empathy)	Upper Right Human Development in Childhood Piaget, Erickson, and human development scales
Lower Left Fully developed person Views world from self-others view Objectification Allows client/therapist to interact but stay separate	Lower Right Multiple perspective view

If these new perspectives become part of psychotherapy training programs, Ingersoll (2007) stated this would inform therapists how to view client's lives, improve structural sensitivity to psychoeducational interventions, and assist therapists in self-reflection. Similarly, to Ingersoll, the IPM clinician in Duffy's research would incorporate first-hand, second-hand, and third-hand perspectives into assessments, and clinical practices.

Again, IT is a way of seeing any topic from different perspectives. IT does not have a methodology to test concepts. IT is a possible teaching technique to help MHPs know about FB. FB is a complex phenomenon involving interactions of several viewpoints. One viewpoint or perspective is clients suffering from schizophrenia and family or MHPs not understanding sensorimotor and physical body sensations this disease produces.

FB

The central concept/phenomenon of this study is FB, also called caregiver burden. FB conveys costs physically, emotionally, socially, and economically families endure when taking care of a loved one with schizophrenia. One early theorist and proponent of its consequences on families was Harriet P. Lefley. She has raised awareness of its harm on families. FB is in literature but much of literature does not ask MHPs ways to reduce it.

In 1985, Lefley discussed issues families face when dealing with mental illness. When seeing how schizophrenia affects families, Lefley (1985) noted the original conceptual theories about schizophrenia created by Eugen Bleuler in the 1800s and used a family causation model to explain schizophrenia’s origin. This family causation model now disproven by science replaced with a diathesis model with biological and genetic components as causes of disease and not families. Despite this shift, the original mistake about the origins of schizophrenia still exists in the provider community.

The newer view sees mental illness with an external locus of control defined by the disease model. The individual is not sick by an agent of disability. To lessen burden society must give families and patients realistic expectations on functioning. Families also have a benign relationship to the illness. After deinstitutionalization, society blamed families less because families began to provide more care to the mentally ill. Families are not independent but interdependent in to the health and well-being of the patient. Prior to the shift, mental illness was a challenge the patient had to master. Now from the disease model prospective, it is an issue to cope with not eliminate.

FB has two components. These are objective and subjective burden (Lefley, 1989). Objective burden addresses problems mental illness causes in families. Its consequences are financial, negative on family functioning, reduced social activities, alterations in relationships, and time limitations. Subjective components include consequences of psychological illness on families, diminished hope in the future of loved one, limitations on personal family plans, loss of the premorbid personality of loved one, and guilt. FB does change over a family’s lifespan (Cook et al., 1994). Objective burden comes from efforts families show dealing with mental illness and subjective burden is distress caused by mental illness. Marsh et al. (1996) defined subjective burden as personal suffering and a grieving process, and objective burden deals with daily problems and challenges accompanying mental illness, patterns of coping with symptoms, stigma, and barriers in the mental health system.

The dichotomy of subjectivity and objectivity in burden leads to stigmatization. As stigmatization occurs, friends and other family start to distance themselves from family. Family also feels betrayed by the system as they seek services to help but they cannot find help. Further, mental health systems have high staff turnover so once families build rapport with one therapist they leave and must re-start the process with new people.

Attempts to address improper training of psychologist is a strategy to reduce FB. Lefley (1990a) saw the problem in how schools train professionals to work with the mentally ill. In working with the mentally ill, psychiatry addresses the medicine; and the milieu and group therapy lies with clinical social workers and psychiatric nurses. The profession according to Lefley needs to include psychoeducation intervention training, and training on admission criteria, mental health services research, and collaborative roles with families. Psychologists abdicated themselves from working with the seriously mentally ill for a number of reasons (Lefley, 1990b). First, psychologists had no interest because training programs did not include this knowledge. Next, training programs did not research what the needs were for graduates.

To fix the problem, Lefley (1990b), suggested faculty development incentives to include faculty role models who work in the field and curriculum development changes. The changes included knowledge and awareness about the attitudes psychologists have about the severely mentally ill, trainings on biopsychological assessments, treatment plans, and trainings on the mentally ills’ experience in the mental health system. Last, organizations need more continuing education training on treating the seriously mentally ill. The system has not provided the right interventions needed to address issues of the mentally ill (Lefley, 1994). For families dealing with severe mental illness, they have had to deal with oppression, stigmatization, and low quality of life, and they need contemporary interventions.

These contemporary interventions must correct inappropriate educational deficits given to families, teach illness management, and problem-solving skills. Some of the incorrect thinking involves high emotional expression not causing schizophrenia. New models must incorporate a stress-coping model to help families deal with the stress of mental illness. Family therapy must change to address alliances and interactions with family. Families should learn skills to decrease relapse and skills to cope with relapses. Providers should remember deinstitutionalization did improve freedoms of patients in poor treatment facilities but released patients to families now subjecting families to burden.

Lefley and Hatfield (1999) emphasized as caregivers age, there are unique concerns, but there is no national data on the severity of problems. Cook et al., (1994) found young parents endure more burden and stress, as families get older. Stress in older parents is from emotions and family conflicts. The study found burden increases in less educated families. Families with higher levels of education have fewer burdens and less problems with connectedness, negative cognitive thinking about child, and less problems with role responsibilities. Minority parents tend to have greater cognitive preoccupation and not feel responsible for their child. White parents have more distress over their child’s behavior. To address subjective and objective components of FB, Marsh et al. (1996) proposed an evidence-based approach to decrease FB and increase resilience. The competency-based models provide theories to base this work provide research and practice working with the population. This model should increase family’s quality of life by working collaboratively with family and provide mutual respect to families. Additionally, the model proposes involving family in clinical decisions, meeting family needs with information, and creating a system to address the whole family. When working with whole families, address the needs of each family member, and encourages family resilience.

Lefley (1997b) extended many of the ideas of Marsh et al. (1996) and asserted the creation of the architecture of healing. The vision addressed family and patients served by MHPs and agencies. These primary parts of the system must reduce barriers by working with legislative funding bodies, legal advocates, create consumer movements, and involve social planners, policy makers, and medical providers.

Barriers causing FB have three sources (Lefley, 1997b; March & Lefley, 2003). These are situational, societal, and iatrogenic stating the family caused the illness. Societal ones lead to stigma, lessen recovery, result in little research on the subject, produce fewer hospitalizations and but more premature discharges, cause legal constraints on family involvement, cause inadequate community support, and increase time in jails. MHPs must not support iatrogenic factors because these lead to stigma. Iatrogenic causes result in inadequate clinical education on mental illness, spread the inaccurate family pathogenesis model, causes clinical deficits, results in failures to prioritize information, provide a lack of support, encourage using principles of confidentiality to block flow of information to families causing providers to refuse to communicate, make families feel rejected, and lead to inappropriate therapies. The situational ones make adverse consequences producing to FB.

Interventions work to improve functioning of families dealing with schizophrenia are family consultations, family education, family psychoeducation, and if needed psychotherapy (Marsh & Lefley, 2003). Family psychoeducation is an evidenced-based model (Dixon et al., 2001). The Schizophrenia Patient Outcomes Research Team (PORT) noted the preferred treatment modality is psychoeducation. Interventions remove barriers, reduce stigma, and create a recovery framework leading to meaningful patient lives, purpose, and hope from mental illness (Marsh & Lefley, 2003).

FB is a social policy problem (Lefley, 1997a). This social problem has clinical, fiscal, legal, and humanistic components. The majority of caregivers are women. This is an issue because after deinstitutionalization women left the home and entered the workforce. Now they had to learn how to balance work and caretaking responsibilities. Lefley created the caregiver experience model. This model incorporates elements of stress and coping. The model embeds an adaptive hypothesis implying the more a caregiver takes care of someone the better caretaker they become. The caregiver experience model relates to the marginalization for parents in Milliken and Northcutt’s (2003) caregiver model.

In Lefley’s caregiver experience model, caregiving has four rules. These are, burden increases with age; burden is hardest early and decreases later in life. Last, burden increases over time but plateaus in middle years then rises as families’ age. Regarding the family life cycle, burden is less early in life due to hope, acute in middle years, and less in late life. Smaller families and less educated families have worst burden. Centripetal forces act on families early on to rally the family to raise young children to maturation. Later when children grow up centrifugal forces naturally help families, encourage independence in children. However, in families with mental illness centrifugal forces stop when families understand independence may not occur due to mental illness. Lefley’s model showed parents must make choices in life. This choice and changes of roles is what Friedemann and Buckwalter (2014) found in their caregiver identity theory.

The subject of siblings should get more study about their potential to serve as caregivers once parents die (Hatfield & Lefley, 2005). Stålberg et al. (2004) also noted the need for more research on siblings and FB. Lefley and Hatfield (1999) emphasized as caregiver's age, there are unique concerns, but there is no national data on the severity of the problems.

Lefley (1998a) addressed culture's impacts on expressed emotion (EE) in families. Different cultural groups display EE differently. Different cultures also have different views of social networks and kinship roles influencing the severity of FB. Facilities treating families must educate families on FB, provide support groups, and refer families to advocacy groups. Expressed emotion is the way families show their emotion. Zanetti et al. (2018) studied first episode psychosis, expressed emotion (EE), and FB in Brazil. FB is a psychological state summarized by physical work, emotional pressure, and social and financial consequences. EE is the feeling expressed by families in relationship to the patient. EE is comprised of critical comments (CC), emotional over involvement (EOI), and hostility. The study revealed EE and EOI are highly related in FB. FB, EE, CC, and EOI correlate strongly. EE and burden are related. Nuralita et al. (2019) used non-probalistic sampling in 100 patients in the Indonesian province of Sumatra to measure the level of burden. In the families, 27 % of them had low EE and 73% had high EE. The level of burden in the families was none at 18%, mild at 34%, moderate 36%, and severe 12%.

Because of how FB influences the emotions and relationships in families, MHPs need more training in recovery-based programs specializing in the severely ill and they must work on rehabilitation teams (Lefley, 1998b). The general core of training should include respect for the client/patient, medication knowledge, mental health system education, learning about the economics of healthcare, discussions about the quality of life for those with mental illness, comprehensive psychosocial/functional assessment, treatment planning, and specific discipline knowledge. Agency in-service trainings to keep MHPs informed of new treatments contain four stages. These include Stage 1 administrative support and needs assessments and appointment of a multidiscipline program committee with a champion. Stage 2 involves staff in program development, Stage 3 program implementation with a pilot study and evaluation, and last, Stage 4 with maintenance. Studies show how effective family psychoeducation and group psychoeducation is (Duckworth et al., 2013; Lefley 2009; Lefley, 2010; Lefley & Shapiro, 2013).

FB is often the topic of research in many areas important to families. Stanley et al. (2017) investigated caregiving in India. India has few resources to improve the quality of life for caregiving. In their quantitative study, patients who had high positive schizophrenia symptoms produced lower quality of life in families and increased burden. Panes et al. (2018) used meta-analysis to explore family member’s experiences with FB. Research found themes related to family empowerment. These were perspectives on empowerment, process of coping, perceived effects and elimination of burden loss. FB affects other illnesses in equally harmful ways.

Torane et al. (2019) compared 100 caregivers with a family member with schizophrenia and 100 caregivers with a family member with bipolar disorder. The level of burden in the families was equal. Relapses result in re-hospitalizations and increased FB.

This current study investigated what MHPs know about FB. The previous section on FB showed FB's importance. It showed Harriett Lefley's research on FB. The review showed how FB has subjective and objective components. These components have situational, societal, and iatrogenic parts. Families show EE, EOI, and CC all related strongly to FB. Lefley also proved an evidence-based approach to lessen FB might be family psychoeducation. When Lefley discussed family psychoeducation, she described using it in clinical settings and with psychologists and psychiatric nurses implementing it. FB because of the objective components has financial impact on caregivers.

Cost of Caregivers

Sruamsiri et al. (2018) conducted a cross-sectional study of caregivers from in Japan. They surveyed 171 caregivers about their activity impairment, absenteeism, and presenteeism at work. They revealed 19% of caregivers had to quit work. Five percent had missed work in the last 7 days and 25% had a drop in productivity. The loss in productivity cost ¥ 2.42 million per capita and in presenteeism ¥ 2.36 million per capita. The study did provide one positive outcome. When patients used long-acting injectable medications more, there was a drop in productivity losses. Likewise, Diaz-Castro et al. (2017) noted the lack of therapeutic compliance increased costs on health care systems and caused more rehospitalizations. Society also absorbs direct care costs in the treatment of schizophrenia.

In Georgia, the treatment of severely mentally ill does not always occur in hospitals but instead in outpatient community facilities or i subcontracted to agencies. Agencies assign the cases to independently licensed MHPs who perform services in client's homes, personal care homes, or in community. MHPs must understand issues noted by Lefley and others to understand FB. MHPs must also understand economic costs on family and caregivers. This study has relevance because few research studies asked MHPs what they think about FB, or their training to reduce it.

Literature Review Related to Key Variables and Concepts

IT

IT involves moving counseling beyond the person (Fall et al., 2004; Fisher & Davis, 2012). Integral philosophy is a model designed to see concepts in a new light (Fisher & Davis, 2012; Starnino, 2009). A unique feature of IT is the quadrants (Marquis, 2007; Starnino, 2009; Wilber, 2006). This study asked MHPs' view of FB, what they did and did not know about it. The language of IT is in the FG questions and developed new theory. Schizophrenia is co-morbid disease with FB. This review will look to the disease next.

Schizophrenia

Schizophrenia is a well-studied concept. To understand schizophrenia's complexity, I will review its impact on society, epidemiology, the disease, its symptomology, its course, financial costs, budget challenges, impact on Georgia, treatment, and criminal justice issues. This broad review will show why MHPs who treat

FB need additional training on schizophrenia to reduce FB seen in families and negative impact on clients.

Societal Concerns

Society has several myths about the mentally ill influencing society's view of patients and family dealing with FB. There are several myths according to the U.S. Department of Health and Human Services (n.d.) which causes societal concerns when treating FB and schizophrenia. One myth is mental health problems don't affect me, when in fact 2020 data shows one in 5 adults experience mental health issues; one in six young people experience major depression; and one in 20, Americans live with schizophrenia, bipolar disorder, or major depression. A second myth is that children do not experience mental health problems when in fact, half of all mental health disorders show before age 14 and ¾ by age 24. A third myth is people with mental disorders are violent and unpredictable when in fact, only 3%-5% of mentally ill people engage in violent acts. A fourth myth is people with mental illness cannot hold a job, however they can and when they do it improves treatment outcomes, decreases disability costs, lowers absenteeism, and lowers medication costs. A fifth myth is there is no hope with those with mental health problems however, with recovery hope is possible. A sixth myth is treatment and medications are not helpful when actually; treatment and medication can improve recovery. A seventy myth is that families cannot do anything with someone with mental illness however, engaging patients, helping with resources, knowing facts about mental illness, showing respect, and not defining them by the illness will help. A last myth is prevention does not work, however prevention can improve outcomes. Mayville and Penn (1998) said society could prevent many of the myths by educating about misconceptions, increased contact with mentally ill, and changing negative attitudes.

Deinstitutionalizations led to a decrease in hospital admissions for behavioral health issues and diagnoses. Deinstitutionalization and treatment in various communities in Georgia and the US led to many myths. Society needs new training methods for MHPs because deinstitutionalization made family and community primary arenas for treatment.

Epidemiology of Schizophrenia

Messias et al. (2007) noted prevalence of schizophrenia is 5/1000 and incidence is 0.20/1000/year. Marcellusi et al. (2018) found prevalence in Italy at 0.5 % of the population. Zaprutko et al. (2016) reported 1% lifetime prevalence. Zhang et al. (2018) found a worldwide prevalence of 0.54%. Fasseeh et al. (2018) found in the European Union (EU) prevalence of psychotic disorders was 1.2% with an incidence of 15.2 per 100,000. Schizophrenia affects 24 million people worldwide (Christenson et al., 2014; Oloniniyi et al., 2019; World Health Organization [WHO], 2022). The WHO (2022) said worldwide, one in 300 (0.32%) or one in 222 (0.45%) for adults. Pyne et al. (2006) said schizophrenia affects 1% of the general population yet those suffering with the illness make up 40 % of all patients in in-patient psychiatric units. This disparity in the numbers of those affected with the disease and the number of resources consumed is reasons why schizophrenia and FB need new treatments to reduce inpatient treatment.

Schizophrenia is the lifetime cause of 0.4% illnesses according to Sado et al. (2013) and 0.6% according to Christenson et al. (2014). These prevalence rates have an economic cost on society and world governments. These numbers help to show the importance of studying this illness in FGs with MHPs to find better treatment approaches.

Policies inherent in improving this disease in the US come from the state level not nationally like other countries (Wolff, 2002). Therefore, each state has its own standards and it is difficult for states like Georgia have uniform sets of criteria. MHPs seeking to change policies must understand Bardach's (1982) implementation process and understand intergovernmental and interagency relationships.

Disease

Crespo (2003) noted schizophrenia is a disease of thought effecting both content and form. Hart and Lewine (2017) said thought disorder is multidimensional with peculiarities in thinking, language, and communication. Thoughts involve primary processing of unconscious and nonverbal material and involve paralogical cognition. Primary processing converts thoughts into words, meaning, concrete concepts, and abstract thoughts. Problems in primary processing occur when a person is unable to differentiate external from internal processes.

The patient with schizophrenia is further unable either to modify or differentiate connotation and denotation of words or objects. If schizophrenia causes problems in separating external from internal thought processes and connotation and denotation of words, then this could lead to a common symptom in schizophrenia known as poverty of speech.

One characteristic symptom of schizophrenia is hallucinations. Arieti (1976) said, "…the hallucinatory and delusional experiences of the schizophrenic are generally accompanied by a more or less apparent disintegration of the whole person" (pp. 251-252). Schizophrenia further causes patients to have a fusion of emotional and thought disturbances (Crespo, 2003). The two become one with patient becoming unable to distinguish the two. Ego regression and disorganization are also common since ego becomes paralyzed and unable to tell inner from outer self.

Symptomology

Patients receive a diagnosis of a mental illness only when certain conditions exist. Epidemiologists use three different constructs to make this determination (Frank & Glied, 2006). The first is signs and symptoms of the mental illness, the second, impairment from the illness, and the third past treatment. Davis (2009) noted a patient could get a psychiatric diagnosis by assessing the Four D's of deviance, dysfunction, distress, and danger. Frank and Glied noted over the past 50 years, science has done nothing to cure mental disease. It has provided relief from symptoms and medicines have reduced symptoms but providers have not eradicated this disease.

The early phases of the disease produce a variety of symptoms related to a fusion of inner and outer self (Crespo, 2003). This fusion creates symptoms like disturbances of low self-esteem, feelings of failure, depersonalization, short attention span, problems with relatedness to others, restlessness, depression, anxiety, trouble with thinking and concentration, lack of energy, poor work performance, social withdrawal, and distrust (Crespo, 2003; Häfner et al.; 2003; McGorry, 1995; McGorry et al., 2005; Yung & McGorry, 1996).

Edwards and McGorry (2002) break these into four symptoms categories and these are changes in affect; changes in cognition; changes in perception of self, others, and work; and physical and perceptual changes that include problems with sleep, appetite, and somatic complaints. Insel (2010) contrasts this and noted stage I has features of genetic vulnerability, environmental exposure; diagnosis of genetic sequence, and family history; no to mild disability; and unknown interventions.

Tsuang et al. (1999) said positive features or symptoms are manifestations producing behaviors outside or extra to usual behavioral presentation. Positive symptoms occur during the active phase of illness when the person is most disturbed. Khamker (2015) listed positive symptoms as delusions, hallucinations, disorganized speech, and disorganized behavior. As a positive symptom, delusions are beliefs causing alterations in reality. Hallucinations are altered perceptions of a person’s taste, touch, hearing, or smell. Disorganized speech in a patient makes them speak incoherently and illogically. Disorganized behavior is behavior inconsistent with what a patient should do according to situation, or place. Khamker (2015) defined some negative behaviors as a blunt affect, alogia, anhedonia, avolition, and social withdrawal. Negative features or symptoms eliminate or take away normal behavioral manifestations. Negative symptoms occur during the prodromal and residual phases. A negative symptom of a blunted affect takes away emotion from a person. Alogia as a negative symptom takes away a person’s ability to speak. Social withdrawal as a symptom makes a patient not want to engage in social contact.

Positive and negative symptoms of schizophrenia described by Tsuang et al. (1999) and Khamker (2015) by some clinicians are called Type I and II. Kay et al. (1987) noted schizophrenia comes in two categories these are positive (Type I) and negative (Type II). Type I symptoms as their name implies add things to the personality not normally there. These are delusions, hallucinations, and disorganized thinking. Type II symptoms are negative and take things away from the patient.

Nasrallah et al. (2005) said in episodes of schizophrenia cognitive deficits precede episodes of positive symptoms. The cognitive deficits of the disease may cause social and vocational impairments. For patients with first episode schizophrenia about 22 % -75% of them have mood or anxiety issues. Khamker (2015) listed cognitive symptoms as attention deficits, memory deficits, and executive functioning deficit.

In the clinical research of diseases, one important piece of data is the Duration of Untreated Illness (DUI). Cameron (as cited in Häfner and Maurer, 2005) mentioned in their work the majority of schizophrenic patients went six months before receiving a first treatment and almost half went up to two years without any treatment. The time factor when symptoms occur for those with schizophrenia is an important clue as to the severity of the illness for first episode schizophrenic patients. Häfner & Maurer (2005) found first-illness episode patients had early positive symptoms and delusions, occur 14.3 months on average before the first admission, the first auditory hallucinations occurred 8.7 months from the first admission, and the first thought disorder occurred 8.2 months before the first admission. Khamker (2015) noted the time of symptoms before treatment might last 9 months to 2 years before treatment. Schizophrenia’s origin is further complicated because patients suffer in silence for years before seeking treatment. Cameron (as cited in Häfner and Maurer, 2005), noted 32.4 % of patients suffer for up to six months with symptoms prior to their first treatment. A second group of 17.5 % went six months to two years without treatment and a last group of 48.1 % went more than two years without treatment. This disease is hard to define when it starts because of the nature of the symptoms.

Häfner & Maurer (2005) reported prevalence of these symptoms in the early stages of schizophrenia was 96 % for delusions, 69 % for hallucinations, and 62 % for thought disorders. This is an important fact to remember when dealing with potentially first episode patients who complaint when their first delusions arise. Khamker (2015) reported these early episodes contain patients engaging in social isolation, psychotic symptoms, impaired functioning, and patient violence and aggression. These findings show the need for measures to treat these first episode symptoms to reduce the effects of schizophrenia. These complaints need consideration and steps to address.

In these early episodes, periods of depression present between 60 months and 36 months prior to the first hospital admission (Häfner & Maurer, 2005). Between 4 and 2 years before the first admission, the patient has negative symptoms. Social disability might appear approximately 51 to 24 months before the first admission and, 57 % of those studied had work impairment issues 2 years before the first admission. The peak incidence for this illness peaks at 15 to 24 years old for males and 15 to 29 years of age for women. Women experience a second peak after menopause at ages 45 to 50 years old. Khamker (2015) noted this duration of untreated psychosis (DUP) makes patients only come to treatment when a crisis occurs when the disease has gone untreated for months or years.

The DUP in schizophrenia influences co-morbidity with other diseases. One co-morbidity and risk factor with schizophrenia is violence. The propensity of a person with schizophrenia to become violent is not unlike other diseases. Those with schizophrenia, major depressive disorder, or bipolar disorder share a similar prevalence rate of between 11 and 13% (Monahan, 2004). However, of these disorders' schizophrenia shows the strongest link to violence (Pinard & Pagani, 2004).

Pacchiarotti et al. (2011) found patients with bipolar disorder had a length of first treatment of 19.7 years (Standard Deviation (SD) 10.8). The length of time to receive a diagnosis is 7.2 years (SD 8.3). Yatham et al. (2009) noted patients averaged 2.9 years with the illness before entering their study with a mood disorder. In a study on Obsessive Compulsive Disorder, Dell`Osso et al. (2010) noted some patients had duration of untreated illness (DUI) of 93.1 (SD 110.99) months. Altamura et al. (2008) studied depression and found a DUI of 47.83 months (SD 119.63).

Delays in treatment have severe consequences Edwards and McGorry (2002) listed several risks of delayed treatment. These risks include slower and less complete recovery with a poorer prognosis. This prognosis increases risk of depression and suicide interfering with psychological and social development. Social development issues strain relationships leading to a loss of family, social supports, disruption of patient parenting skills, distress and increased psychological problems within the patient's family. Poorer prognosis and relationship problems lead to disruptions of schoolwork and unemployment, substance misuse, violence/criminal activity, unnecessary hospitalizations, loss of self-esteem and self-confidence, and increased costs of management. Lieberman and Fenton (2000) noted untreated schizophrenia could lead to neurotoxicity and irreversible brain damage.

Origins

Like all diseases, schizophrenia occurs if risk factors exist. Risk factors of any disease are necessary to know to decrease the likelihood of its presentation. For patients, family, and MHPs, they must know schizophrenia's risks to increase awareness of them. The origins for schizophrenia are hard to discern. Knowles (2000) noted one involves a trigger or a series of events or processes. Unfortunately, the trigger is different for each individual. There are four commonly held views of schizophrenia. The most prevalent is as a disease, the second is it creates a loss of the authentic self; the third is it is the result of spiritual suffering and punishment, and fourth is it is some form of a conspiracy. Tsuang et al. (1999) listed biological relatives with schizophrenia, premature or low-birth rates at birth, and autoimmune disease triggered by infection as risk factors.

First episode patients have unique traits separating them from others (McGorry et al., 2005). One of these traits is they are younger and less informed about mental illness. Khamker (2015) reported average age of first presentation for males in this group is 20 and 25 for females. This group also has increased rates of social isolation, agitation, and distress because of unfamiliarity with symptoms they become frightened and bewildered. This first episode group also tends to be unaware of the mental health services available to them and more likely to deny they have an illness.

They further exhibit normal adolescent behavior masking symptoms, experience a hard to diagnose evolving illness, are uncertain and afraid about treatment, and are very sensitive to the effects of psychotropic medications since they have never had them. These behaviors might appear as normal adolescent behavior, and not overt clinical signs and symptoms causing them not to come under the attention of a MHP.

Two early theorists who studied the initial course young people may face with schizophrenia were Wilhelm Griesinger and Emil Kraeplin (Häfner & Maurer, 2005). Griesinger described a melancholic prodromal period preceding psychosis whereas Kraeplin saw changes in mood weeks or a month before the on-set of the disease. The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.) listed the following diagnostic criteria for schizophrenia. The first is two or more of the following for 1-month: negative symptoms, hallucinations, grossly disorganized or catatonic behavior, disorganized speech, and delusions. Two of these symptoms must cause social or occupational dysfunction. Third, the symptoms must exist for a 6-month period with at least 1 month of symptoms. Fourth, clinicians must rule-out other causes of disturbance like schizoaffective and mood disorders. Fifth, the cause of illness is not the result of substance abuse or a general medical condition. Sixth, if a pervasive developmental disorder is present the diagnosis of schizophrenia occurs if delusions or hallucinations exist for one month.

Current classification of schizophrenia further derives from the models of other theorists. Two reviewed are the Conrad and Docherty et al. models (Häfner et al. 2003; Häfner & Maurer, 2005). Conrad’s first stage is trema. It lasts years and characterized by several years of uncertainty, depression, anxiety, suspiciousness, delusions, and social withdrawal. Stage 2 is apophany. In this stage, the patient experiences hallucinations, delusions, and thought disorders. The third stage is anastrophae. Stage 3 begins the formal thought disorder of the disease. The patient may also experience something known as delusional-projective attribution of inexplicable experiences to external causes. Stage 4 is apokalypse. In this stage, the patient now has severe psychosis associated with disorganization in behavior. The patient may also experience anxiety, restlessness, and catatonic symptoms. The fifth stage is catastrophe. In this stage is an increase in severe symptoms, agitation, disorganization, and concomitant physical phenomena. The final and most ominous stage is terminale. It leads to death if the disease is untreated. This death occurs more so from the patient being unable to care for themselves.

The Docherty et al. model has four stages. The first three occur in the prepsychotic prodromal phase. The first stage is overextension. This stage finds the patient in a state exhibiting passivity, overstimulation, irritability, persistent anxiety, and cognitive impairment. Stage 2 is restricted consciousness. This stage displays apathy, social withdrawal, hopelessness, somatization, and a decrease in personal appearance. The next stage is the disinhibition stage. During this period, the patient loses inhibitory abilities, and experiences hypomania, elevation of mood, and ideas of reference. The last stage is psychotic disorganization. This leads to the onset of the disease disorganized cognitions and perceptions, hallucinations, ideas of reference, disorders of the self and catatonic symptoms. These models are very helpful in understanding the possible course of the disease. What they fail to do is tell how long it takes to progress through all the stages.

The previous theorists showed as schizophrenia progressed, symptoms get worse. Therefore, it is intuitive for MHPs to intervene with families sooner to diminish the effects of the disease. McGorry et al. (2005) proposed some advantages of interventions in the prepsychotic phases. These include better strategies to tackle social withdrawal, impaired functioning, and subjective distress, increased trust of providers, a decreased period of untreated psychosis, and better treatment of comorbid disorders like depression and substance abuse, and decreased cognitive and emotional impairment. Khamker (2015) proposed these recommendations for first-episode treatment. Clinicians during first-episode assessment should evaluate the cause of psychotic episode and interview family. Clinicians should verify the diagnosis with a complete psychiatric and medical history while identifying comorbid, psychiatric, and medical conditions. Clinicians must further evaluate patient’s medical health, suicide risk, and dangerous behavior. Last, the clinician should identify strengths and limitations, assess baseline lab values, and engage in a therapeutic alliance.

This study found how MHPs view FB related to schizophrenia. These interventions based from this new theory may develop better ways to deal with problems of social withdrawal, impaired functioning, trust, and co-morbid disorders. However, as there are advantages to early intervention, there are some obstacles to providing these services. McGorry et al. (2005) noted the incidence of first episode psychosis is so low and it is hard for primary care physicians to detect it. Second, patients are overly concerned about the stigma of a referral for services. Third, clinicians and doctors themselves are unsure as to when to intervene. This causes doctors to enlist therapeutic nihilism where they believe any intervention they suggest will not help. Last, the health care system is reactive and not proactive to the seriousness of mental illness. Khamker (2015) additionally stated early episode treatment barriers included, stigma, medication side effects, and limitations on treatment access.

McGorry et al. (2005) said interventions in this early phase should first look and address warning signs in young people like extreme social withdrawal, poor performance in school and work, and increased agitation. If these signs present, the author noted the best course of action is assessment and monitoring. They also noted family and providers must look for suicidal behavior during the early phases. Young people during this phase need information about the risk of psychosis and mental disorders. The authors did caution on using medications unless the criteria for schizophrenia occur for one week or if there is imminent threat of self-harm. Recommendations in McGorry et al. (2005) compare with those previously mentioned by Khamker (2015) regarding assessment, and assessment of risks, and engaging family in the assessment.

Despite the classification of schizophrenia, in the early stages of the disease, families play a major role in the treatment process. Most families experience negative effects during the early stages (Addington & Burnett, 2004). As the symptoms get worse in the early stages, the family takes on an increased role as caregiver. Burden on families is immense with 60-70 % of those patients with a first presentation living at home. Families also begin to have feelings of anger, despair, and anxiety. They feel as though there is no support from the mental health community. They experience depression and social isolation. Caqueo-Urizar et al. (2015) found families during this period also experience guilt and blame. Family guilt comes from not knowing what to do and blame from soceity telling them they caused schizophrenia.

Thus in this section, it was learned the course of schizophrenia is improved with early interventions. Schizophrenia’s course is necessary information to educate families. This study is a first step in understanding what MHPs know about the illness and ways to lessen the influence of FB. The course of schizophrenia produces financial strain on governments and systems.

Financial Costs of Schizophrenia

World governments spend a large part of their budgets combating schizophrenia. These expenditures strain budgets and take away from other vital services. In addition to these budget issues, in the U.S., it spends more than expected with less positive outcomes. Blomqvist et al. (2006) found Canada spends $1,122 million per capita and the U.S. spends $2,306 million per capita. The rate of increase is almost double while the U.S.’s outcome is half as good. This finding suggests the U.S. needs to find effective ways to treat schizophrenia and save tax revenue. Estimates further show the economic cost on the U.S. healthcare system ranges from $33-65 billion. Rice (1999) revealed the cost at the low end of the previous range with $7.3 billion attributed to direct medical costs. Rupp and Keith (1993) said 2.5% of the annual healthcare expenditure is on schizophrenia. Rupp and Keith further found 10% of people in the U.S. who are totally and permanently disabled have schizophrenia and comprise 14% of the homeless population.

Lombardi et al. (2020) did a study on schizophrenia’s prevalence in homeless patients who visit Emergency Departments (ED). Homeless patients with schizophrenia and psychosis visit at greater rates. Ayano et al. (2019) found in homeless populations, on average 2.48% of them had schizophreniform disorder, 3.53% had schizoaffective disorder, 9% had psychosis not otherwise specified, and 21% had a psychotic disorder.

Direct Care Costs

Schizophrenia influences the economy of the U.S. and other countries (Fitch et al., 2014; Jin & Mosweu, 2017; Marcellusi et al., 2018; Willerman and Cohen, 1990). In Europe, Kovács et al. (2018) found schizophrenia’s costs in 2010 in Europe at € 29 billion. The average per patient cost of direct care was € 5,800. In Sweden, lower Global Assessment of Functioning increased costs 236% per year. Negative symptoms also consumed 23% more healthcare costs over a 12-month period. When patients discontinued medications, this increased re-hospitalization costs. In Brazil, Barbosa et al. (2018) determined psychiatric hospitalization for schizophrenia was the largest cost category per patient and antipsychotic medication was 80% of direct healthcare costs. Chi et al. (2016) learned in Taiwan, 80% of the patients relapsed within five years of the first episode with 20% relapsing in the first year of treatment, and 60-70% relapsed in the first year if they had no treatment.

Budget Challenges

Miller and Martin (2004) determined during an 8-year period in the late 80s and 90s, Georgia spent over $1 billion on schizophrenia. Most of this funding paid for medications. They suggested using Assertive Community Treatment (ACT) teams, psychosocial rehab, vocational rehabilitation, case management, and patient/family education, symptom monitoring, and cognitive and social skills training to combat the costs. Despite the age of research, no one according to Dr. Martin has updated the research since he left the University of Georgia in the early 2000's and relocated to the University of Arkansas (J. Jenkins, personal communication email, February, 10, 2020). Harker (2022) noted Georgia invested $256 million since 2011 in supportive housing and crisis service, but cut $91 million in 2021 from behavioral health because of COVID revenue declines. Therefore, the budget for mental health services in FY 2022 was $494,232,886.

The last closest comparison to the 2022 budget is the 2019 budget. In the 2019 state budget, former Governor Nathan Deal, proposed spending $255,944,645 on Medicaid and $3,000,000 for one new behavior crisis center in the state (Governor's Office of Planning and Budget, the State of Georgia, 2019). For the years, 2016, 2017, and 2018 the following line items received funds: ACT teams $17,160,000 for all three years, and Mobile crisis units received $13,765,916, $13,621,587, and $13,000,000 respectively. The Georgia Crisis and Access line received $3,894,306 for all three years. Community mental health centers received $35,995,028, $30,839,483, and $40,000,000, respectively. Services to crisis stabilization received $54,783,917, $50,986,973, and

$56,573,604, respectively. Community support teams received $2,634,552, $2,304,728, and $2,300,000, respectively. Lastly, intensive case management received $7,589,060, $7,201,341, and $9,000,000, respectively. Balancing the needs of the state's budget is delicate as the state tries to balance all of its priorities.

Kanso (2019) noted in the 2019 budget, Georgia had to juggle a $530 million teacher raise with all other state priorities. The state settled on raising Medicaid spending to $89 million for a total of $337 million. Kanso (2019) further reported the budget had $7.6 million for behavioral health crisis beds. It also included $5,000,000 for the Morehouse School of Medicine. An additional $500,000 for the Center of Excellence on Maternal Care, $250,000 for rural hospital upgrades, $250,000 for Mercy Health Care to serve the uninsured, and $2.7 million to increase funding to the Department of Family and Children's Services (DFCS) which added $1.00 more to the per diem for families caring for kids in foster care. SAMSHA conducted a survey of services Georgia citizens received from this budget. The survey asked about adult and children services regarding access to services, quality/appropriateness of services, outcome of services, participation in treatment planning, and general satisfaction with care. From the survey, adult services ranked 52nd for all states in the categories mentioned (SAMSHA, 2019). For children's services, the survey showed Georgia ranked 46th for access, 47th for quality, and 46th for outcomes, 47th treatment planning, and 45th for general satisfaction among states.

Despite seeing some increase in funding for services, Georgia still has issues with access to mental health services. Mental Health America (n.d.), stated overall, Georgia in 2020-ranked 36th in the nation for mental health services, 4th in the nation with prevalence for mental illness, and 40th for adult mental health services. States in the range of Georgia in 40th place have adults with great levels of mental illness and less access to care. Regarding access to care, Georgia is 50th with 49th being Texas. Yes, budget short falls have dire implications for those with mental illness. SAMSHA (2019) as previously shown gave Georgia a worst rating than Mental Health America. If the state cannot provide additional funding one solution may involve better-trained MHPs to reduce the harmful effects of FB.

There is a critical need for evidence-based trained outpatient MHPs because many of Georgia's state hospitals are unsafe. The Justice Department in 2010 filed suit alleging many of Georgia's state hospitals discriminate against people by keeping them segregated in facilities (Trenkner, 2011). Dr. Shelp, the former Commissioner of the Georgia Department of Behavioral Health and Developmental Disabilities, agreed the system does need repair and wanted more services in the community but he felt the court's ruling asked the state to act too quickly (Miller, 2012). Commins (2010) agreed with the need for fast action and interviewed Thomas Perez, assistant attorney general who asserted Georgia's state hospitals do harm patients. Green (2011) spoke with Tom Wilson, a representative with Georgia, who denied the claims. However, Andy Penn, an attorney for Bazelon Center Mental Health Law, wishes the federal government's actions would make Georgia act faster to protect patients.

Government's concern appears to have changed over the years. Torrey and Sinclair (2018) wrote the federal government revised how it reported the number of people with schizophrenia. Researchers did the last prevalence studies in the 1980's. In the 1980s, the standard was 1.1 % for adults (Torrey & Sinclair, 2018). Now as government officials change the number of people impacted by schizophrenia, budgets can provide the same funding but claim to help more people.

There are many factors contributing to this problem of treating those with mental illness and schizophrenia, among these as already noted, budget issues, inadequate community resources for crises, and a lack of patient, family, and provider awareness regarding decomposition signs. When patients decompensate families and caregivers suffer.

Impact on Georgia

The federal government sued Georgia demanding it provide more services in the community. Despite the lawsuit, according to Williams (n.d.), Georgia only spends $59 per capita on the mentally ill in 2013. Estimates show there are 1.4 million Georgians with mental illness. Georgia spent from 2011 to 2015 between $214,277,645 and $345,102,519 on mental health annually. Miller (2020) reported 10 years after the settlement Georgia, still has not made many changes to improve the system.

Members of the state legislature are beginning to understand the need for change. Georgia is 48th out of 50 states for access to care and two out of five children have problems accessing care (Georgians for a Healthy Future, 2022a). Many of those with problems accessing care have schizophrenia.

One significant piece of state legislation introduced addressing Georgia's mental health system is Georgia State House Speaker Ralston's HB 1013, The Mental Health Parity Act. Amy (2022) reported HB 1013 provided parity in health coverage. This means in Georgia, mental illness and physical ailments coverage is the same in insurance plans. HB 1013 also provided easier access to treatment in the community, and initiated a pilot program to assist with outpatient treatment, gave grants for mental health transports and crisis teams, and listed psychiatric medications in Medicaid and Peach Care formularies. This legislation passed during the 2022 legislative cycle and will become state law.

Other legislation in is H.B. 972, The Professional Counselors, Social Workers, and Marriage and Family Therapists Licensing Act. The act cleaned up and modernized the law overseeing the Professional Counselor practice in Georgia. On May 02, 2022, Governor Brian Kemp signed H.B. 972 after it passed both chambers. This law will help ensure Georgia continues to have a qualified group of professional counselors to work as MHPs.

Another newly passed law in 2021 was The Professional Counselor Compact Act. This law allows professional counselors with a license in Georgia to carry a license to another state. Ten other states must pass the same law then these 10 must ask Congress for a national law. According to the Counseling Compact (n.d.) as of 09/11/2022, 14 states passed the legislation. Lastly, SB 403 passed and was signed into law mandating community service boards establish teams comprised of police officers and MHPs to go to a mental health crisis and assess a situation (Georgians for a Health Future, 2022b). Georgia is trying to improve its mental health system. The state needs research like this study to find better ways to improve treatment outcomes for families dealing with FB.

Martin and Miller (1998) found from 1991 to 1993, the prevalence rate for schizophrenia in Georgia was 6.02%. In 1991, 1992, and 1993 the medical cost for schizophrenia related Medicaid claims at all places in Georgia other than state hospitals was $12,094,478, $13,553,651, and $12,824,017, respectively. No one has updated this exact data since the early 2000s (J. Jenkins, personal communication email, February 10, 2020). However data from SAMSHA (2019) reported in 2019, Georgia's mental health block grant for Medicaid was $24,287, 010 and spending for all Medicaid was $17,163,578.

Martin and Miller (1998) stated nine service categories in mental health cost $8,433,828, $8,979,738, and $9,113,863 for the same years respectively. This evidence shows despite these numbers from the 1990s, mental health services for schizophrenia costs the state. SAMSHA (2019), reported in 2019, Georgia spent $266,639,716 for in-patient state hospital treatment and $2,236,108 for early serious mental illness. Georgia must find better ways to address mental diseases. Improving MHPs, training to treat FB is one way. Some of the new training methods may result in early intervention strategies.

Treatment Options and Early Intervention Strategies

One useful intervention is cognitive behavioral therapy (CBT). Van der Gaag et al. (2011) studied the therapeutic effect of CBT on schizophrenia. Van der Gaag et al. (2011) compared CBT and treatment as usual (TAU). They studied patients with schizophrenia and schizoaffective disorder in the Netherlands between the ages of 18-64 at treatment months 0, 3, 6, 9, 12, 15, and 18. CBT improved functioning and decreased suffering more than TAU. Patients given CBT as an intervention had 183 days of normal functioning compared to 106 days of those with TAU. At 18-months, the mean cost for CBT was € 33,130 and for TAU € 29,578. Therefore, CBT was no more expensive than TAU but patience had better functioning. This type of research shows the value of these treatments. However, SAMSHA (2019) reported in 2019, Georgia mental health block grant was $2,105,690 for evidenced-based practices for first-episode psychosis. With the new treatment strategies gained in this study, this funding may increase.

Treatment Issues

Wancata et al. (2006) studied treatment issues of those with schizophrenia and mental illness. The needs mostly are along the lines of explaining problems experienced by patients, finding interventions to alleviate problems of patients, and finding providers to provide interventions. Correll et al. (2019) engaged psychiatrists in a 45-min online survey to ask if they understood how to treat treatment resistant schizophrenia (TRS). The results showed a lack of clarity on a uniform way to treat TRS.

Tristiana et al. (2018), researched community mental health barriers in Indonesia, where universal health coverage does exist but, found families still face barriers in transporting a loved one for services, getting enough services, and stigma. Norman et al. (2017) investigated the Canadian psychosocial treatment outcomes of schizophrenia. The study revealed optimal management required medical and psychosocial interventions, interventions to address empathy and rapport, and all interventions must contain recovery-based language. Staff needs the right training to deliver skills, patients need comorbid and self-management skills, and the patient/family should remain the center of treatment.

Treatment Needs

When schizophrenia is the diagnosis, the question of what treatment approach is a major decision between the patient, family, and provider. Treatment is best determined based on the evidence, context, and values (Bollini et al., 2008). Evidence comes from the clinical picture emerging from symptomology presented by patients. Context is how this disease despite similar symptoms looks completely different from the patient's viewpoint. This means many may voice problems with a symptom but this symptom can affect patients in different ways. This context question is one not receiving a lot of investigation. Those suffering from schizophrenia seem lumped in one broad category without any reference to the nuances of the disease making it unique for this patient. Khamker (2015) provided a model to look at Bollini et al.'s (2008) approach with eleven recommendations for first episode treatment to include evaluation, determining the reason for the psychosis, asking family member for history, determining strengths, and assess dangerousness.

This study involved looking at the context of the disease from the vantage of the MHPs and compared, and contrasted their differences and created a new model to improve their training and thus the treatment of patients. The last important treatment consideration is the values of the patient. The patient's values have a unique way of influencing how this disease looks for this patient.

One reason why medication compliance is an issue may lie in the recovery phase. Nasrallah et al. (2005) noted recovery includes symptom remission, improved vocational functioning, desire for independent living, and better peer relationships. Although medication is mostly responsible for reducing symptoms and increasing the likelihood of independent living, the side effects of medication may impair a patient’s ability to function at work, and may damage peer relationships. These negatively influence the chance of a positive recovery. McCombs et al. (1999) provided more data on medication non-compliance. McCombs et al. found 11.6 % of Medicaid patients continued with medication consistently for one year and 20% of Medicaid patients in four other states. It appears the medication non-compliance is a key factor in seeing how different stakeholders see this disease. Those who suffer with schizophrenia in many cases do not fully understand why this disease is affecting them. One need is to educate the patients on the exact reasons for the disease to reduce misperceptions and to reduce stigma.

Frank and Glied (2006) took data from the 1999 GSS survey and reported 32.8% of the respondents in the survey stated schizophrenia originated from their own bad character. In this same survey, 84.6 % thought the cause of the disease was by a chemical imbalance in the brain. Another 45.1% thought the disease’s cause was upbringing. The overwhelming majority thought it was due to stressful circumstances in life at 90.7 %. Some 67.0% thought they had the disease for genetic or inherited reasons. The last group at 17.4% thought God caused the disease. Frank and Glied noted MHPs’ need to educate family and patient on schizophrenia’s origin and FB. Zafar et al. (2008) did a survey of 404 people in Karachi Pakistan. Their survey asked if schizophrenia was caused by mental illness, heredity, or weak mental constitution. The categories to choose for each was main cause, possible cause, not likely a cause, and definitely not a cause. The respondents who answered mainly for the cause were 30% mental illness, 8.9%

hereditary, and 22.5 % weak mental constitution. The respondents who answered a possible cause were 30.2 % for mental illness, 30.3 % heredity, and 35.4% for weak mental constitution. For those respondents who listed not likely a cause of mental illness were 16.6%, heredity 23.1%, and a weak constitution 15.8 %. Respondents who listed these reasons definitely not were 23.3 % for mental illness, 37.7 % for heredity, and 26.2% for a weak mental constitution. Both of these surveys suggest more education on causes of schizophrenia.

Recovery Implications

Addington et al. (2017) stated recovery was subjective, objective, and based on five key recovery processes. These recovery processes are connectedness, hope, identity, meaning, and empowerment. Addington et al. (2005) also recommended a recovery-based mental health system. The system should include comprehensive care across all treatment phases. The interventions across the system must address psychological aspects, pharmacology, social and occupational issues. All providers in this system are competent, engaged, manage risks, use least restrictive treatments, and practice from a diversity model. Community treatment teams can improve service utilization with interventions to include ACT Teams, case management, culturally diverse focused treatment, first-onset psychosis models, crisis management, early assessment/interventions, crisis housing, and decrease use of hospitals, supported employment, housing, peer support, and relapse prevention.

The intervention with the most improved strategy is the first-onset psychosis model. This model has key components of engagement /assertive outreach, family involvement and family interventions, access to psychological informed interventions, vocational/educational support, and access to medications. This first-onset model could serve as a starting point for MHPs when addressing patients with first episode issues to improve recovery.

Robinson et al. (2015) found risperidone is the most common oral medication and olanzapine is the second. For those patients having a first episode, the treatment protocol includes antipsychotic medications and side effect reduction. Psychiatrists frequently use olanzapine for first episodes despite its lack of clinical efficacy and used it in higher doses than recommended. One-third of the patients received antidepressants even when there were no depressed symptoms. Women got lower dosages than men did and they got more long acting injectable medications. African American patients got more 1st generation medications. Hispanic patients received more risperidone. Patients with private insurance generally received better treatment outcomes. These findings suggest even psychiatrists do not select the right medication. Medication non-compliance can lead to family relying on police for services. Abolmagd et al. (2020) surveyed 124 psychiatrists on their prescribing habits. Their survey found 77.4% prescribed atypical medications as a first-line, 42.7 % added anticholinergic, 50% would continue the anticholinergic as long as antipsychotic is given, 93.5% combined shots and oral medication, 88.7% use antipsychotics for sedation, and 55.6% would add a mood stabilizer. These findings showed the Egyptian psychiatrists did not use evidence-based practices. This finding supports the findings of Robinson et al. (2015).

Criminal Justice Issues

When families feel overwhelmed and frightened by a loved one in their home they ultimately rely on the police and jail for assistance. Jails are a problematic place for the mentally ill because there is no conviction, the length of stay is indefinite, and the mentally ill do not have the rights they would if convicted. Harki (2019) noted there were 404 deaths of the mentally ill in 5000 jails in America. Of these deaths, 41% occurred while someone was in solitary confinement, 44% by suicide, 70 deaths by Taser, stung gun, pepper spray, or restraint, and in 11%, families told officers the need for medication. This jail problem is costly with 53% of these deaths resulting in lawsuits totaling $145 million. Watson (n.d) reported about 1 in 7 prison inmates and 1 in 4 people in jail have serious mental illness. Watson further stated about 4 percent of people in jail and prison has schizophrenia. The rates of mental illness in the criminal justice system are three to four times more than general population. Deinstitutionalization might be a factor in increasing the number of people with mental illness or schizophrenia in prisons and jails because of a lack of treatment resources.

In 1955, America, according to Harki (2019), had 337 mental health beds per 100,000 people; in 2019, the number is 12 beds per 100,000. In 1950, American jails held 86,500 people. By 1983, the number rose to 223,500, and by 2016 it had risen to 740,700. The 2016 population is actually a decrease from a peak in 2008 of 785,500. Harki (2019) determined in jail now there are about 186,000 people with a mental health diagnosis. Watson (n.d.) stated prisons like Los Angeles County Jail and New York’s Rikers Island house more inmates with mental illness than US psychiatric hospitals. Patients with schizophrenia serving time in prisons or jails cause legal and mental health barriers. MHPs need better skills to prevent incarceration of those with schizophrenia.

Literature Approach to Schizophrenia

The previous review of schizophrenia has shown its epidemiological impact. Schizophrenia comprises over 1.0% of the population and accounts for 40% of in-patient admissions (Pyne et al., 2006; Zaprutko et al., 2016). The Global Burden of Disease is 0.4% of all disease for the lifespan of people (Sado et al., 2013). Most countries around the world incur significant consequences due to schizophrenia (Jin & Mosweu, 2017).

Schizophrenia takes a toll on many countries like Italy (Marcellusi et al., 2018), Brazil (Barbosa et al., 2018), and Taiwan (Chi et al., 2016). This toll is both economic and personal with the loss of the hopes and dreams of people who cannot get treatment due to lack of providers. CBT is a useful treatment for schizophrenia (Van der Gaag et al., 2011).

This survey makes it clear modern science has educated society on the biological reasons causing schizophrenia. However, too many people still believe in antidotal or character traits as the basis of acquiring schizophrenia. These myths are reasons for lingering stigma and shame about this disease. The stigma of the disease may reduce if schools develop better training to improve treatment outcomes by MHPs. If this training does not occur, it will lead to more instances of FB.

Literature Approach to FB

Harriett P. Lefley first recognized FB. FB comprises subjective (distress) and objective components (symptom/behavior) (Chan, 2011; Lefley, 1989; Marsh et al., 1996). FB leads to oppression, stigmatization, and low quality of life (Lefley, 1989). To address it, families need new interventions to deal with schizophrenia. FB includes situational, societal, and iatrogenic sources (Lefley, 1997b; Marsh & Lefley, 2003).

Lefley (1997a) developed the concept of FB into the caregiver experience model. As families begin, there are centrifugal forces focused to help raise a child through the normal stages of development. At some point, these forces change to centripetal ones to help launch a child to independence and self-sufficiency. When a family is raising a child with schizophrenia or serious mental illness, these centripetal forces do not occur. The family and family member realize full independence may not occur due to disease. Despite the difficulty this disease places on families, there are some techniques to lessen its effects (Dixon et al., 2001; Duckworth et al. 2013; Lefley, 2009; Lefley, 2010; Lefley & Shapiro, 2013; Marsh & Lefley, 2003). Family psychoeducation is an evidence-based approach.

FB is a well-studied concept. However, for many researchers, there is inconsistency in how properly to describe the disorder. Tamizi et al. (2019) said the research field was not consistent in describing the concept. FB does have a direct impact on the lives of families. Das et al. (2019) found the level of burden occurred in over half the families. Velligan et al. (2019) saw TRS patient families spent 61 hours per week and $490.00 per week caring for loved on with schizophrenia compared to 40 hours per week and $373 for non-TRS patients.

FB does impose a burden on families over time. Zhang et al. (2014) investigated the relationship between symptoms, disability, and FB at an in-patient treatment center.

They found the longer a patient stayed in the facility the greater burden on the family. In addition, a longer stay increased rates of disability. FB decreased with early interventions. These findings somewhat compare with Lefley's (1997a) caregiver experience model.

One aim of all forms of interventions is to improve the quality of life for those dealing with an illness. Poor quality of life is a primary consequence of FB. Nuttal et al. (2019) measured the level of FB and found less FB families experienced the greater the quality of life. Sruamsiri et al. (2018) revealed FB influenced caregivers 'daily activities and at work their presenteeism and absenteeism. DeTore et al. (2018) found during first order schizophrenia episodes, FB is worst if the caregiver had a job. Villalobos et al. (2017) found if the families cared about the symptoms of the family member, the family member perceived the family to be less critical. If the family had less concern about the feelings of the patient, the patient perceived this unsupportive. If the family was more concerned with the patient's affect, the patient perceived this as supportive.

Literature Approach to System Change

Von Bertalanffy (1972) said science needed to new shift in thinking when investigating scientific principles. These principles were the creation of general systems theory. A key factor to solve the mental health problem is ensuring providers receive FB training in universities. Universities are systems. Systems have unique components making them difficult to change (Gilley et al., 2009; Rago, 1996; Rieley, 1997). These difficulties may answer why training programs are resistant to change.

Holder and Dixon (1971) noted systems that changed cycle through four phases. The first phase has the system in order. This ordered system may not function well for all constituents but it is in order. Then the second phase has the system undergo tensions and pressure on its boundaries. As pressure increases on the boundaries, extreme internal and external pressures characterize a system transitioning to a third phase of disorder. The system next after expending energy in the third phase, transitions to a re-ordering phase. Once re-ordered the system returns to a system of order. Policy makers make numerous mistakes when attempting to help complex systems deal with the pressures in phase three of the Holder and Dixon model of a system. Forrester (as cited in Holder & Dixon, 1971) stated, "…we apply the same intuition to complex systems and are led into error, as a result, we treat symptoms, not causes" (p.895). Holder and Dixon argued for a corrected system of mental health care interventions both individually and in society. Holder and Dixon believed individual interventions are good but societal interventions better. Managers of systems often run the system without a proper command structure. "Application without adequate theory is like a body without a brain, as theory without application is like a brain without a body to make it operational and relevant" (p.903). The irrelevance of the system has continued unchanged since deinstitutionalization. McBain et al. (2021) of the RAND Corporation recommended change through promoting a pathway to care, improving access to care, and establishing an evidenced-based continuum of care.

To promote care they suggested, improving mental health education, integrating mental health care into general practice, linking homeless to supportive housing, and strengthen community behavioral health. The report recommended: improvements to access of care by strengthening mental health parity, regulation, and enforcement; reimburse mental health services at their true cost; establish an evidenced-based crisis system; create a national evidence-based system for early intervention of serious mental illness; establish loan-forgiveness programs to increase the workforce; improve peer support services; expand access to digital and telehealth services; and include patient-centered outcomes on evaluations and treatment plans. The evidence continuum of care is achieved by establishing a continuum of care; launching a national care-coordination initiative; and form a learning collaboration for Medicaid behavioral finance.

If systems and organizations change, these can influence MHPs. The organization with these changes can therefore have a profound impact on the actions of a MHP. This study studied how to improve the graduate coursework of MHPs who work in the mental health system of Georgia.

Laureate Education Inc. (2010) explained there is a scientific process a researcher can follow to change organizational behavior. The first step involves the observation of organizational behavior. After step, A insight occurs leading to step B. At step B, general explanations occur about the organization’s behavior. After step B, deduction leads to step C. At step C, the organization makes specific predictions. Step C completes with verification. These changes listed by Laureate are processes organizations can use to change organizational climate. Gibson et al. (1979) reported on changes International Harvester made from 1967-71 after a new president ran the organization and wanted to change the organizational environment. After a study of senior management, the organization uncovered a lack of a sense of direction, insufficient delegation for authority and discouragement of individual initiative, an emphasis on short-term decision making, and, highly strained communications. These recommendations for International Harvester seem comparable to issues in mental health systems with problems in direction, no authority in decision-making, clients helped with short-term goals while in facilities and communication issues with providers in the system.

In this study, the general observation is MHPs do not receive adequate training to treat FB. The general explanation for this is Georgia does not train providers to improve the treatment of the population. By deduction, with better training in the system, this may predict efficiency. The verification of this is to use MHP FGs to find training improvement needs. The system never adjusted to provide MHPs with the skills to deal with the severity of patients now in the community.

Rieley (1997) stated system organizations change for one of five reasons. These reasons are increases in competition, a decrease in environmental resources, more demands for agency accountability, the need for more technology, and stakeholder demands for a better return on investment. When change is needed Rago (1996) listed barriers to implement total quality management (TQM) to improve the Texas Department of Mental Health and Mental Retardation (TDMHMR). Rago (1996) noted barriers as field forces or driving forces. These barriers were identifying the purpose for change, coordinating change, communicating change, and empowerment. Empowerment of the organization leads to employee empowerment and ultimately consumer, client, or patient empowerment. When a system needs changing, Gilley et al. (2009) suggested a way of not alarming the system of pending changes to improve effectiveness. They suggested concealing system changes with gradual implementation and use of non-threatening language. Modifying behaviors start with creating a culture of change, define the culture, explain why change is important, define the culture assessment process, identify alternatives applications to culture change, implement an action plan, manage change, monitor change, and integrate change.

Strengths and Weaknesses of Theories

The major areas of focus in the study are IT, the disease of Schizophrenia, FB, and system change. The research done in the past on these concepts has had inherent strengths and weaknesses.

IT provided a new prospective on how to view a concept or construct from multiple perspectives. It provided a view of the world of families and clients from the inside, outside, up and down, left, and right. Universities have not used Wilber’s theory to teach MHPs about FB from the perspective of clients and families. Wilber’s theory does provide a way of educating MHPs on FB after an assessment of their knowledge. However, its use as a methodology is limited because IT does not come with a method to use to test a theory. It only views issues with no testable method. The research needed the structure of GT to provide a method to understand what MHPs know about FB. What MHPs know about FB may improve with this knowledge and the insights of IT.

Theorists in schizophrenia show clear and convincing research on the disease, its course, and effective treatments. Researchers are consistent on the incidence, prevalence, and economic costs of schizophrenia to global economies. Even though many psychiatrists know evidence-based medication to give, some still do not follow clinical guidelines. One weakness for schizophrenia research is despite its ability to explain the disease, literature does not provide pointers on treatment techniques for MHPs who treat and counsel this population.

FB is a concept worthy of research. Harriett P. Lefley has developed a theory adequately explaining the stress, strain, and coping experienced by families taking care of a loved one with schizophrenia. The caregiver experience model shows consistency with many studies. The greatest strength of FB research is proving psychoeducation improves the quality of life and lessens FB. One weakness of research on FB using interventions geared toward in-patient or hospital-based outpatient programs. These settings are not where MHPs work. Their work is in outpatient settings in homes and communities of Georgia. Research needs to incorporate community-counseling interventions in the literature. Additionally, none of the studies used MHPs' opinions about FB.

Summary and Conclusion

This literature review involved surveying several topics including IT, schizophrenia, FB, and system change. Science developed medications and treat symptoms once the disease manifests. There is a lack of research involving how MHPs treat FB associated with the illness. There was literature about how FB affects families, but not what to do about it. This study used the strengths of GT and applied it to address weaknesses in current literature about how best to train MHPs to treat FB.

I discussed schizophrenia and the negative impact it caused families in terms of FB. FB is a worthy topic for this study. The literature review showed those who assist in reducing FB might not have the skills to reduce its impact. To determine what MHPs know about FB, I used GT to develop a new theory.

I used IT to address views MHPs have about FB. MHPs assembled in FGs to discuss questions related to FB. Themes derived from interview transcripts became recommendations to improve training of MHPs.

I hoped to improve quality of life for those with schizophrenia as well as their freedom within society, which will lead to positive social change. My goal was to understand what MHPs know about FB. I discussed the methodology I used to interview MHPs in FGs in Chapter 3.

Chapter 3: Research Method

The purpose of this GT study was to determine MHPs' understanding of FB. I used FGs with MHPs to determine their knowledge of training involving FB. Knowledge derived from FGs created a model and recommendations to improve training. If training improves FB, then MHPs will have new training tools to make an impact to decrease the incidence of FB. MHPs in these FGs explained barriers they saw when treating FB. By addressing multiple viewpoints and perspectives involving FB, this study created new coursework needs for MHPs.

Chapter 3 includes the research questions, research design, and rationale, role of researcher, methodology, and trustworthiness in research, ethical procedures, and a summary.

Research Design and Rationale

The research questions are:

RQ1: How do mental health professionals define FB?

RQ2: What do mental health professionals think are barriers for families dealing with FB?

RQ3: How can multiple viewpoints and perspectives assist in defining FB and influence formal education of mental health professionals to reduce FB?

Central Concepts and Phenomenon

The study used IT to obtain data to create a new theory involving MHPs' views of FB. IT was a new way of teaching MHPs about FB. IT involves using integral philosophy and a quadrant model to see concepts and processes in a new way. IT allows

MHPs to use their normal signs and symptoms perspective in the right upper quadrant but allows new information like their perspective from inside and outside clients, and analysis of how clients' issues look in society and in Georgia. MHPs have not previously seen these views. This study used Harriet P. Lefley's FB as the central concept. Lefley (1989) noted FB is comprised of subjective (etc., psychological problems on family, diminished hope, limits on family plans, loss of premorbid personality of patient, and guilt) and objective (etc., financial, family functioning barriers, reduced family activities, problems in family relationships, and time limits) components. These components come from situational, societal, and iatrogenic sources causing stress on family caregivers who take care of a loved one with schizophrenia. Situational sources come from stressors in how patients and family interact in their relationships. Societal sources come from stigma and negative attitudes society has about schizophrenia. Iatrogenic sources come from therapists and providers imposing negative views about clients and family during treatment. Chan (2011) noted objective burden is a result of patient symptoms and behavior and subjective burden is the family's distress from the symptoms. These concepts showed in FG data. In order to gather this data I used GT.

GT

This study's purpose was to address graduate coursework needs of MHPs treating FB from schizophrenia. This issue needed addressing to improve quality of life for families and patients with schizophrenia. This study's use of FGs increased the likelihood of generalizability.

Qualitative research is preferred for studying social and human problems (Creswell, 1998). McNabb (2008) described qualitative research as nonstatistical inquires of a social phenomenon where data involves words, symbols, pictures, and artifacts. According to Creswell and Poth (2018), GT is a type of qualitative research generating a theory using inputs from a large number of participants.

Research questions guided this study via FGs to ascertain data from transcripts in order to create a new theory involving what MHPs know about FB. Creswell (2007) said GT involves interviews or FGs. During the analysis of the transcripts, I used line-by-line coding of transcripts, and axial coding. Axial coding is a step of the coding process after open coding. This involves looking at categories of open coding, identifying the central phenomenon, strategies, and context of the phenomenon leading to selective coding. Selective coding involved creating a story around the interaction of the central phenomenon, and categories. Axial coding and selective coding created a substantive level theory and conditional matrix. The conditional matrix is a diagram used to present conditions and consequences related to the study. This helped me show the relationships of data in FGs.

GT is a process with many steps. These steps include conducting interviews, transcribing data, and looking for themes (Creswell & Poth, 2018). Memos are personal notes I wrote about the process. These memos helped to track how I thought about the process from its beginning to conclusion. Grbich (2013) noted memos help in showing the path from indicator to concept, help develop properties of categories, identify hypotheses, and link categories and generate theory. Categories in GT are events and explain what happens in the data. Axial coding in GT looks at the causes, strategies, context, and consequences of FB. As more FGs occurred, the constant comparative method compared incidents, events, and activities discussed in each FG to new categories or confirmed the strength of existing categories from previous FGs. Then I returned to the data to start the process again.

Causal conditions are factors causing the central phenomenon. Strategies and intervening conditions increase, decrease, assist, or impede the core phenomenon. Selective coding occurs when, “the researcher takes the model and develops propositions (or hypotheses) that relate the categories in the model or assembles a story that describes the interrelationships of categories in the model” (Creswell & Poth, 2018, p. 85).

Maykut and Morehouse (1994) stated the constant comparative method of GT data analysis involves four steps: creation of category coding and comparing meaning across categories, refining of categories, explore relationships and patterns across categories, and integration of new data. Miles and Huberman (1994) noted 12 ways of creating categories include noting patterns and themes, seeing plausibility, clustering, making metaphors, counting, making contrasts/comparisons, partitioning variables, subsuming particulars into the general, factoring, noting relationships between variables, finding intervening variables, building a logical chains of evidence, and making conceptual/theoretical coherence.

When analyzing patterns and themes the purpose is to look at transcripts and see if data falls in predictable patterns. Plausibility in FG decisions in this study determined if a FG answer is plausible or likely from the question asked. Clustering is taking viewpoints of participants in FGs and putting their answers together because these address specific similar issues. Clustering helped to simplify data and reduce it to smaller piles. Partitioning of a variable is analyzing the magnitude of a variable and using this as a way of distinguishing results. Metaphor making is using the literary devise of metaphors to compare data for similarities. Counting in category creation is noting the number of times or frequency some data is mentioned in FGs. When making contrasts and comparisons of data, the researcher compares and contrasts answer questions differences in FGs. Subsuming the particulars into the general, involves looking at data in FGs and going back and forth between, first-level data and the general until no more categories exist. Factoring involves looking at large second-level variables that on the surface appear unrelated but have slight communalities and overlap. Noting relationships between variables is using arrows or connectors to show relationship and connection. Finding intervening variables is looking for variables in data that influence behavior of other variables. The logical chain of evidence part of data analysis, lays all data from FGs out to build a case around what this means or how data fit. When making conceptual/theoretical coherence in GT, the story of what data means in FGs moves from metaphors and interrelationships to constructs and theory.

McNabb (2008) and Grbich (2013) stated the purposes of GT is to evaluate earlier evidence accuracy, make generalizations based on experience, identify a unit of measurement for a one-case study, verify an existing theory, or generate a theory. In this study, I wanted to generalize experiences treating FB related to schizophrenia from the perspective of MHPs. The identified unit of measurement is training of each MHP in each FG. GT produced themes derived from FGs of MHPs to determine their understanding, knowledge, and training related to FB.

Several assumptions exist in GT's methodology. These include symbols relate to other symbols in systems, interactions imbed actions of participants and actions are time-limited. Other assumptions are the basis of actions in human development are interactions and these occur in many levels, interactions may not always look rational, and; previous member interactions are complex, overlapping, contrasting, conflicting, and not always apparent to other people, and actions contain emotions.

This study's theory emerged by deductive processes. In GT, interviews, FGs and multiple points of view explained a phenomenon. These interviews led to open coding, themes, and categories became the new theory. It is for these reasons GT was the methodology for this study.

Role of the Researcher

Corbin and Strauss (2015) stated qualities of a researcher are humanism, curiosity, creativity, logical thinking, and ambiguity tolerance, accepting self as a research instrument, and trusting self. Creswell and Poth (2018) noted researchers ground a theory in views of participants. Acknowledgement of the self as a research instrument in GT made me an observer-participant. I observed processes in FGs and interjected questions to broaden a concept. In memos, my thoughts or ideas about research helped develop themes. I was aware of whom and why participants were in the study. I controlled for any biases I or participants brought to the study. I did use a $10.00

incentive but understood it was not to influence participants. I also understood research phases.

MHPs are participants. Since all were licensed MHPs, there was no power differential between participants and me. One scenario of possible note is a participant might have been a colleague working at a similar agency, but I was not responsible for paying participant’s wages. I may have served as a note/documentation signer for a participant’s clinical documentation but not the boss of participant. Another scenario is a participant might have been a former supervisee while they completed a master’s degree but now is not in school and graduated. If the latter occurred, again no power differential existed because the participant and I are equal in licensure. However, the participants and I might have come to the study with biases.

Biases and assumptions occur naturally in research. These skew answers in a certain directions. I came to this study with over 20 years’ experience in the mental health field. My choice of this topic meant some biases in seeing a problem exists. Inherently the problem made me want to find answers. My need to seek answers to questions may have biased this study. These biases can surface in meanings applied to data, concepts applied to data, questions asked, and comparisons of data.

Two simple strategies to deal with bias are to keep a journal and follow the method. Journaling allowed me to track my thoughts and perceptions and gain a vantage point to see their origin. Following the method, kept this study on track, and kept me from traveling down unethical paths. Another strategy I used was analyzing differing opinions. These included examining positions of mine, examining my personal responses, empowering participants to offer different ideas, evaluating the process, and encouraging public scrutiny of my work.

Regarding incentives, in this study I provided each participant with a $10.00 gift cards for participation. These were to thank participants for their time. Another incentive was a small pack of candy to eat prior to the FGs beginning. This was to allow participants to focus on the study and not physiological needs. These incentives were small in price and they do not seem to coerce participants to participate.

Creswell and Poth (2018) listed five phases of research as elements of this study. The first phase shows me as a multicultural subject. I brought my own perspective and experience to the research. My experience was feeling poorly trained from graduate school to help many families.

Research’s second phase explains my philosophical assumptions and interpretive frameworks. These assumptions guide my ontology, epistemology, axiology, methodology, and theoretical worldview. My theoretical orientation as a counselor is cognitive behavioral. This theory states a person’s faulty thoughts cause poor behavior. In this study, I believed MHPs might have inappropriate thoughts about their client’s and families. It is an assumption of mine these faulty thoughts hampered their ability to create positive interventions to help families. If they received better training maybe, their thoughts could change.

The third phase addresses research strategies and approaches. GT research fits this study because its sole purpose is to create theory where one does not exist. Also, if a problem is MHPs' faulty thoughts about families, then one way to assess thoughts is through FGs.

The fourth phase looks at methods of research. This study follows the tenets of GT by using FGs to create categories and axial coding to become the theory to explain how to help MHPs become more effective at understanding and treating FB. The fifth phase is evaluating outcomes to become public policy to change current training practices. This fifth phase involves developing recommendations as seen in Chapter 5.

Methodology

Participant Selection Logic

MHPs in Georgia were the population for this study. Their experience working with families dealing with FB from schizophrenia was the phenomena of investigation. Participants were a combination of licensed professional counselors, licensed marriage and family therapists, and licensed clinical social workers licensed for at least three years and who had worked with patients with schizophrenia for at least 2 years. Selection of participants occurred because they would provide data on their experience needed in this study.

Those excluded from this study had less than a master's degree, were non-licensed, worked in the field less than three years and had not worked with patients with schizophrenia for two years. This level of experience allowed for a deep level of professional knowledge to bring rich meaning to the themes in the study.

I could have accomplished verification of experience by cross checking the names of participants in a state database to verify a license for inclusion. This approach might produce more information about participants needed for this study. This might have additionally exposed confidential data about participants. During the consent process, when participants reviewed inclusion criteria, and agreed, I assumed they fit criteria.

Creswell and Poth (2018) and Creswell (2007) stated participants in GT should number between 20 and 30 individuals. This number allows for a saturated theory. For this study, the number of participants was 22. I conducted seven focus groups comprised of 3-4 participants each. This study’s FGs occurred via Zoom due to the pandemic.

This study recruited participants in a number of ways. Recruitment of the last FG occurred at a state level mental health conference. I sent out social media posts on Facebook, LinkedIn, and I called or emailed some asking about participation. I further sent out an email blast through a state counselor association to recruit members and contacted professionals via Psychology Today. Total contacts used to obtain participants were 28 phone calls, 123 emails, 5 faxes, 2 mental health list serves, and 15 contacts via Psychology Today.

Once interested participants were located, an email went out asking about their participation. I used the phone call protocol (see Appendix C) during each call. I modified the phone call protocol to specify the date and time of the next FG. After participant screening and acceptance, and after an initial review of inclusion criteria, then consent documents, demographics form (see Appendix D), and mind map drawing surface (see Appendix E) went out. I used U.S. priority mail for all participant materials. Only the last three participants recruited at a state level mental health conference had their material handed to them at the conference. A last email or phone call the day before went out and served as a reminder.

During FGs, I followed the focus group protocol (see Appendix E). The focus group protocol was self-produced, and the main document to question participants in FGs. Participants during virtual FGs completed the Informed Consent Form and the Demographic sheet (see Appendix D). I asked participants to follow instructions on how to return demographic sheets in a separate self-addressed envelope to me to protect their confidentiality. Next, I asked participants after the study, to return the mind map and signed consent document in a second self-addressed envelope. After signing informed consent documents, all participants used pseudonyms to protect confidentiality. I asked participants to use these names when referring to each other in each FG. During the FGs, participants viewed the same power point presentation to ensure uniformity of information given to all participants.

I recorded FGs via Zoom and secondarily via an external MP3 recorder to ensure capture of information. FGs again followed the focus group protocol (see Appendix E) developed by me to ensure each MHP answered identical questions. Zoom simultaneously transcribed conversations and these appeared on the screen in real time. I also took notes during FGs. Since this study was via Zoom, it did follow the virtual protocol (see Appendix M).

After the FGs, I began to tabulate the data from the demographic sheets. Documentation of raw data from the demographic sheets was on the demographic raw data sheet (see Appendices F and G). I took information observed while in FGs and made written notes of subjective experiences and other thoughts from experiences and recorded them on the contact session summary form (see Appendix H).

For accuracy, FG information transcribed from Zoom reviewed for accuracy by comparing typed transcripts to recorded sessions twice. I took mind maps created by participants and overlaid them with a piece of clear plastic divided into four quadrants. I viewed all quadrants of each participant's mind maps and recorded the images, colors, words, and impressions seen in each quadrant on the mind map raw data collection form (see Appendix I). Raw data from each participant's demographic raw data sheet included race, grade level, income, marital status, employment level, and number of hours worked per week. This data tabulated to determine averages, ranges, and rank orders. I did this to describe the demographics of participants.

I used ATLAS.ti 9 to input data from FGs including my memos, raw data mind map raw data collection forms, contact summary forms, and transcriptions of FGs to analyze data. For this study, instruments used to collect data were mind maps and FG transcripts. I will explain instrumentation I used next.

Instrumentation

Mind Mapping Exercise

All members of FGs completed a mind mapping exercise. This exercise asked all to create a drawing showing what they believed families dealt with when caring for a loved one with schizophrenia. Creativity Web (n.d.) and University of Adelaide (2014) explained concepts behind mind maps. These include using colors, shapes, lines, and figures to represent a concept or idea. FGs were the vehicle used to derive the theory to improve the training of MHPs.

FGs

MHPs were participants in this study. Participant recruitment occurred at a state level mental health conference, via social media posts on Facebook and LinkedIn, and an email blast over a counselor association website to its members. Participant recruitment additionally occurred from personal contacts, calls, or emails from my contact list. All FGs occurred via Zoom. The IRB of Walden University approved this study before any FGs occurred.

A FG is "a small temporary community formed for the purpose of the collaborative enterprise of discovery. The assembly is based on some interest shared by the panel members, and the effort is reinforced because panelists are paid for the work" (Templeton, 1994, p. 4). FGs emerged after World War II (Stewart et al., 2007). Their use is found in two primary sources and these are clinical psychology and in sociology or social psychology to study group dynamics.

The purpose of a FG is to use a humanistic interview to conduct focused research studying group interactions and gathering in-depth data. Stewart et al. (2007) noted FGs serve to research group behavior, and not individual behavior and the observation of group and members of the group accept or reject information. FGs can serve as adjuncts to other methods, a vehicle to conduct phenomenological research, and participation action research (Wilkinson, 1998).

FGs typically consist of 6 to 15 people who discuss one single topic for 1.5 to 2.5 hours (Babbie, 2007; Cronin, 2005; Stewart et al., 2007). Some advantages of FGs include, capturing real life data in a social environment, flexibility, high face validity, speedy results, low costs, direct interaction with participants, data gathered in respondents own words, the process built on itself, and it is user friendly (Krueger & Casey, 2009; Stewart et al., 2007). The FG was where I collected, confirmed, and expanded data from interviews. Therapy was not involved in FGs. This study's FGs only extracted data.

Some disadvantages of FGs are less control over interviewees by the interviewer. This loss of control can cause difficulty in analyzing data. FGs also need the researcher or moderator to have special skills. A moderator also has challenges in FGs because each group may give different answers and sometimes FGs are difficult to assemble. Moderators must make environments inclusive for success. In FGs a biased group member may influence discussion of others, and the live nature of FGs may put more emphasis on results rather than warranted (Krueger & Casey, 2009; Stewart et al., 2007).

Stewart et al. (2007) noted some criticisms of FGs are they do not yield hard quantitative data and members do not represent the larger population. Stewart further noted these are not true fatal flaws. In this study, I used MHPs to discuss FB and allowed them to discuss it with few limitations. Their shared experiences brought opinions into question about FB. Krueger and Casey (2009) listed other criticisms of FGs as participants tend to intellectualize too much, participants do not tap into emotions, participants make up answers, FGs produce trivial results, some participants may dominate results, and FGs results may not be believable if participants voiced an opinion on a product they did not use.

Despite the limitations of FG research, this modality worked to determine how MHPs view FB. An important element of FGs is a moderator. Langer (1978) provided nine key components of a good moderator. These components include moderator genuinely having an interest in thoughts and feelings of others and expressing his or her own feelings. Moderators are animated and spontaneous with a sense a humor. Moderators are also empathetic, admit biases, are insightful, express clear thoughts, and are flexible. Templeton (1994) stated moderators must also become a member of FG, and instigator and cohesive force in discussions. These qualities guided me in this study to ensure a successful outcome.

Cronin (2005) noted FGs are successful when four criteria materialize. These criteria are FGs have a range of topics, participants are encouraged to be specific in discussing their experiences, FGs must have depth, and members must share a personal context with regard to social role or social category pertaining to the FG. Krueger and Casey (2009) stated FGs are correct to use when: a range of ideas or feelings is needed, when different perspectives needed in a study, when research wants to uncover factors on a topic, and when there is a need for ideas to emerge from a group.

The questions derived in FGs followed a set format indicated. McNabb (2008) stated this format should include, establish what information is gathered, specify the appropriate data gathering method of FG, specify procedures for analyzing data, select questions and question types, select the best wording, organize questions in a logical manner, and pretest questionnaire. Krueger and Casey (2009) noted questions in FGs should also be clearly understood by participants, be presented in an environment for conducive honest answering, be questions participants can answer, have questions participants can articulate an answer, and produce understandable answers.

This FG's study questionnaire had structured questions but allowed participants to answer freely. McNabb (2008) stated, "Subjects' responses will not emerge from a vacuum; rather, the words chosen for the sentence completion will reflect the subject's subconscious attitudes" (p. 145). Krueger and Casey (2009) listed questions should evoke conversation, use words participants would use, are easy to say, are clear, are short, are open-ended, are one dimensional, clear, and well thought out. These approaches allow for theory development since participants have free range to answer questions. In this study, collection of research data came from demographic forms, mind mapping exercise, and FG questions.

Babbie (2007) noted when conducting field research, the researcher must prepare for field research by conducting a literature search of literature. Next researchers should conduct field interviews. Creswell and Poth (2018) listed common procedures to conduct these FGs. These include determine questions, identify interviews, distinguishing the type of interview, collect data using appropriate recording procedure, design and use an interview protocol, define questions with pilot testing, locate a distraction free place for interviews, obtain consent, follow good interview procedures, and decide on a transcription logic.

I asked FG participants the same questions from the focus group protocol (see Appendix E). For each question's relationship to research questions, refer to the cross check (see Appendix L). There were 22 FG participants in this study. Recording and transcribing of all groups occurred. These seven groups contained between 3-4 members each. In this study, 22 participants were sufficient for saturation. All participants completed demographic sheets and answered questions according to this study's focus group protocol.

Researcher-Developed Instruments

Questions in the FG protocol derived their origin from IT, FB, and GT. Since questions came from GT, IT, and FB, the data helped, create new theory. Content validity for questions was field tested to ensure questions were clear and conveyed implied meanings.

FGs can serve many useful purposes. Krueger and Casey (2009) listed these as helping with decision-making, and helping to guide program change. In this study, I wanted to know how to help MHPs make better decisions about FB by learning what new training they needed. I also wanted to know how to change training programs. Stewart et al. (2007) noted from FG research four elements exist for FGs' use, to engage in focused research, analyze group interactions, produce in-depth data, and conduct humanistic interviews. These four elements existed in this study as well. Before FGs of this study occurred, the IRB had to approve the study and I field-tested questions.

Field Test Procedures

On August 13, 2020 the IRB of Walden University approved this study and gave approval number 08-13-20-0114018 expiring on 08/12/2021. After approval, a field test occurred with five experts. This field test served as a means to correct possible errors in FG protocol prior to beginning this study. These five experts reviewed the mind map exercise along with FG protocol. Any ambiguity of wording or procedures they detected along with recommendations for changes they suggested prompted changes to FG protocol. These changes are in chapter 4.

Procedures for Recruitment, Participation, and Data Collection

All participants in this study had pseudonyms. These pseudonyms protected confidentiality. Data was stored in a locked file cabinet. All data collection occurred in FGs in this study. Early in the methodology section, I explained recruitment of participants. Data obtained from participants in FGs was anonymous and came from demographic sheets, mind-mapping exercises, verbatim transcripts from FGs, and my memos. I collected all data. I collected data collection in seven one-time FGs, lasting 1-2 hours in length.

Due to COVID-19, this study occurred virtually and followed protocols in Appendix M. Participants in this study totaled 22. Each FG answered the same FG questions in Zoom sessions. Open and axial coding of data came from virtual FG sessions. After the study, de-briefing occurred the same day. Follow-up interviews did not occur in this study because of logistical reasons.

Data Analysis Plan

Since this study is qualitative and based on GT, data obtained had certain features. Miles and Huberman (1994) noted these features as; prolonged contact in the field; from this the researcher's role is a holistic overview of context with logic, arrangements, and explicit/implicit rules; the researcher gathered data from participants "from the inside"; the researcher bracketed themes and expressions of participants; explicated participants responses, and accounted for events; made interpretations on this material when possible; the researcher is the main instrument; and analysis is done with words. Creswell (2007) noted the plan for GT research as previously noted analyzes data through open coding, axial coding, and selective coding.

FB and schizophrenia need this approach of investigation because the study used stakeholders close to the illness, MHPs. This study had local grounding. The richness and holism of the study revealed itself in the conditional matrix in results of the findings. Although Miles and Huberman noted a sustained period for collecting data, this study only collected data on a one-time basis in seven FGs. This study had high flexibility because answers derived from FGs and changed from group to group. This study connected to the social world because one of the outcomes is to improve the lives of those with schizophrenia and lessen effects of FB.

Data in this study came from demographic sheets, FG question responses, and mind mapping exercises. Demographic sheets (see Appendix D) contained data about which group participants were in, location of the group, participant's name (pseudonym), age, race, education level, occupation, marital status, annual income, and employment status. Data from Appendix D summarized who participants were in the study. I did not engage in quantitative analysis but only provided a table to describe participants.

In addition to demographic information, FGs produced data such as MHPs' thoughts and beliefs about FB. I learned information about their training. Furthermore, I gained insight into how MHPs think FB and schizophrenia feels; what treatments work for this population and, any barriers to treatment. I obtained this information in open FG discussions to maximize the richness of data. I processed all data from FGs through ATLAS.ti 9 to produce themes.

Creswell and Poth (2018) noted data analysis should take on a strategy to include preparing to organize data, reducing data into themes, and representing data into figures, tables, and discussion. Corbin and Strauss (2015) noted data analysis in GT is via constant comparisons. Constant comparison obtained the themes in this study. Creswell and Poth (2018) stated themes develop through the data analysis spiral. This spiral has seven steps: data collection, managing and organizing data, reading, and memoing emerging ideas, describing and classifying codes into themes, developing and accessing interpretations, representing and visualizing data, and accounting for findings.

Steps 1 and 2 involved me storing and filing data or using software. Step 3 involved diligent and accurate note taking. Step 4 began the initial codes and the codebook. Step 5 looked at theory and themes. Steps 6 and 7 involved creating a diagram and model explaining this new theory about FB from the MHPs' view.

I kept memos and they are a part of this process. A memo can be of three types: segment, document, or project. A segment memo only describes one piece of data. A document memo is a review of multiple files. Project memos are memos over the entire project. Creswell and Poth (2018) discussed memos importance by noting memos capture important themes, noteworthy quotes, and patterns. Grbich (2013) listed purposes of memos. Memos follow a pathway from indicator to process, develop properties of categories, identify a hypothesis of a category, and link categories to generate theory. These memos can help in theme creation. The themes help create diagrams, links, and concepts. ATLAS.ti 9 software helped create themes in this study.

The center of GT research is the code or categories. These codes or categories build detailed descriptions, help apply codes, develop themes, and provide interpretation. When I produced the codebook, I provided names and descriptions for codes. Thus, in GT research codes show processes, actions, and interactions of central phenomena under investigation.

In this study during the open coding phase, I examined demographic sheets, transcripts, and mind mapping exercises for categories. This examination labeled text (data) based on codes derived from this study. These initial codes increased as new codes emerged. Axial coding looked for connectedness or levels of disconnection between MHPs’ perspectives. The central phenomenon of this study looked at strategies. Strategies explored context, intervening conditions, and consequences of my research questions. The coding paradigm as stated by Creswell (1998) became a model to show how all categories relate. Once I described the theoretical model, created the conditional matrix then I was able to create a diagram visualizing the central phenomenon.

Issues of Trustworthiness

Trustworthiness in results is a goal of all research. If outcomes do not seem believable then, I wasted time in to obtain outcomes. Creswell (2007) listed researchers achieve trustworthiness by long engagement in the field, triangulation, debriefing, negative case analysis, clarifying researcher biases, member check-ins, rich thick descriptions, and external audits. Stahl and King (2020) listed credibility in research arising from triangulation of data, theories, informants, and trustworthiness from transferability of findings, and dependability of findings via per review.

This study achieved some of these points by taking an extended search of the literature to understand the issues of schizophrenia, FB, and ITs importance. The participants and I both worked in mental health and understood problems and we both had knowledge allowing for comparison and triangulation of data.

Triangulation adds depth to research Carter et al. (2014) noted data sourced triangulation from multiple sources in FGs aids in data analysis. Cope (2014) described ways to show trustworthiness of qualitative data from credibility, dependability, conformability, transferability, and authenticity. Credibility allows a researcher to describe the experiences of participants to verify results. Dependability is a factor that allows for consistency of data. Confirmability allows data to represent its true meaning for the participants. Transferability allows findings in this study to have meaning for others reading it. Authenticity is from participant voices in quotes and recommendations. Lincoln and Guba (1985) stated triangulation occurs through internal validation, external validation, reliability, and objectivity. The qualitative counterparts to these are credibility, authenticity, transferability, dependability, and confirmability as described by the Cope (2014). Confirmability occurs by prolonged engagement and triangulation. Triangulation of the data is corroborating evidence from multiple data sources. My lens viewed data from the 22 FG members and mind map to aid in credibility.

Credibility is again a degree to which research is believable. Transferability means results travel between researcher and those being researched (Creswell and Poth, 2018). Dependability allows adjustments to the context of research changing as findings adjust to these changes (Creswell and Poth, 2018). Credibility in this study occurred when I described in detail categories obtained from themes. I took data from transcripts to prove categories existed from open and axial coding. Views of many participants formed consensus on themes. FGs captured data to prove all themes and conclusions. I was responsive to participants and the changing nature of data. I followed the methodology. I used participants who added data to create theory. I continued used all data until no new themes formed.

Glaser and Straus (1967) stated credibility occurs when studies provide sufficient detail, and description of data, evidence on how data develops, and researcher gives multiple comparison groups, and specifies where data proves conclusions. Silverman (2005) listed these strategies to achieve validity refute assumptions about data and research proceedings, engage in the constant comparison method, use all cases in the study, and discussed data falling outside the norm. Morse et al. (2002) saw qualitative studies achieving reliability and validity when, the investigator is responsive, follows the methodology, uses theoretical sampling, samples adequately, and allows data to reach saturation. This study followed the above information by providing evidence of data sources, providing details in transcripts, used multiple subjects, explained data if it refuted assumptions, used all data, followed the method, and engaged in constant comparison.

Triangulation occurred by comparing transcripts or data to themes created and then back to theory. Triangulation occurs as themes in the text compare to IT and FB. Debriefing occurred at the end of each interview session as I processed what happened. In this study when cases did not match theory, an explanation as to why occurred. Therefore, in this study, triangulation used data from mind maps, FG interviews, memos, and field notes from me, observation of participant interactions, thick description, and narration back to participants.

The processing of my biases occurred in the memo process. Member check-ins occurred throughout FGs. Members were allowed to discuss what emotions came up. All themes had thick descriptions attached from coding in this study. External auditing is a part of this study process with committee review.

I increased internal and external validity, by not allowing assumptions in FG transcripts to impair judgment. I valued all FGs equally knowing all data helped form the new theory. I explained why some data fell far from the norm and what implications it had on the study.

Chiovitti and Piran (2003) stated rigor in studies occur when participants guide the process. Rigor occurs by checking all constructs with participant meaning and phenomenon, using participants’ quotes, acknowledging my biases and views about phenomenon, discussing why participants got into the study, staying within scope of study, and comparing categories with theory. Cypress (2017) reported rigor in research as a quality of being exact, precise, thorough, and accurate.

Regarding rigor, I am a licensed professional counselor who allows clients to lead the way in therapy. It is an easy step to allow MHPs to lead FG questions. Allowing MHPs to lead, added to preciseness and accuracy of findings. MHPs participated in this study because of their experience in mental health and their closeness to the process under investigation. This study only wanted to understand MHPs' view of FB and ways to lessen its effects. Therefore, limits of the study were set. Last, I cross-referenced research questions in FGs to create the new theory.

Regarding reflexivity and confirmability, I used my background to frame my justification for doing the study. As previously stated, from my 20+ years' experience as a counselor, I found problems in my training. Reflexivity explains my role in the research process. Research with credibility, transferability, dependability, and conformability is useless if ethics is not guiding it.

Ethical Procedures

Before the study took place, it received approval from the IRB of Walden University. This study's recruitment material did not use coercive language. Material allowed MHPs who were qualified and who wanted to participate, to do so without favoritism. All participants signed consent documents and had an opportunity to ask questions. I reminded all participants their participation was voluntary and all information was confidential. All recruitment material and consent documents went to participants prior to the study.

Those in the study knew they could withdraw at any time. They also knew this research contained no treatment component. I gave participants a choice to receive copies of the study findings or results. Participants also received my contact information and information for Walden's IRB who approved this study.

All data collected were anonymous and confidential. I used pseudonyms for all participants. Confidentiality was granted because many participants' statements may be criticisms they had about work place or a former client. This information if shared might damage participants. In addition, for this reason, no participant got copies of transcripts. A participant could leave this study at any point in time. If a participant came to a FG and decided they did not want to participate, they were free to leave and if so any demographic information then destroyed. If a participant took part in a FG discussion but later choose not to participate their verbatim words from typed transcripts would be deleted and would not be used to create themes.

During the transcription process, I used Zoom to transcribe FGs. Only I had access to those final products. I will destroy this study's tapes and transcripts 5 years from the time Walden approves this study.

Procedures during the study had little risk of harm to those in it. I did monitor for signs of psychological damage and provided participants with the Georgia Crisis and Access Line (1-800-715-4225) if a crisis state followed their participation.

I posed as the moderator and followed ethical guidelines of all associations I held membership. Amdur (2003) listed the Belmont Report's principles of respect of persons, beneficence, and justice as cornerstone principles for research. Vanderpool (1999) stated respect of persons is in the informed consent process with the information in it, participant comprehension, and participant voluntariness. Beneficence occurs in studies by assessing risk and benefits. Justice occurs in how a study selects subjects.

The first principle is respect of persons. All participants received respect in this study for them as individuals and professionals. All persons in this study were autonomous. To aid in autonomy, all participants voluntarily consented to participate. Autonomy's proof occurred during the informed consent process. These FGs took place via Zoom with protection of confidentiality. I told participants to wear headphones or be in a private setting during FGs. In this study regarding autonomy, only participants who were stable and compliant were included.

The second principle beneficence means treating people how you want to be treated. This study had few risks. Some of these might be topics causing pain and hurt in MHPs and the MHPs questioning their effectiveness. However, this risk was minimal and balanced by benefits society could gain from this study. There were no conflicts of interest since no participants had financial gain.

The last principle, justice involves an adequate distribution of risk equally amongst those who benefit. All FG subjects used the same procedures. Participants enrolled after they responded to a flyer, email, or internet posting.

Summary

I used FGs to derive new ideas about graduate coursework needs of MHPs to treat FB. I used FG groups to answer questions and mind maps to analyze MHPs' views of FB. I used the GT method to analyze data obtained from FGs. I used ATLAS.ti version 9 to create themes.

This chapter included an explanation of my role as an observer participant. It included the method of study and participant selection procedures. The chapter included a review of data collection and analysis procedures. I also addressed credibility, validity, reliability, trustworthiness, and ethical procedures in this chapter. In Chapter 4, I will discuss results.

Chapter 4: Results

The purpose of this GT qualitative study was to address MHPs' knowledge of FB. Due to the COVID-19 pandemic, I used Zoom-based FGs to investigate MHPs' knowledge of FB. FB is burden families endure taking care of loved ones with schizophrenia.

The research questions were:

RQ1: How do mental health professionals define FB?

RQ2: What do mental health professionals think are barriers for families dealing with FB?

RQ3: How can multiple viewpoints and perspectives assist in defining FB and influence formal education of mental health professionals to reduce FB?

Chapter 4 contains information about the pilot study, study setting, demographics of participants, data collection, data analysis, trustworthiness evidence, results, and a summary.

Pilot Study

After the committee approved this study, they suggested a field test. The committee suggested emailing at least five experts in the field for advice on procedures and study questions. Emails went to six experts and five responded. I emailed field testers the FG protocol, and a study orientation Microsoft PowerPoint.

Field tester 1 only requested minor grammatical changes to the Microsoft PowerPoint presentation and FG protocol, as well as minor changes to the order of slides. Field tester 2 only suggested grammatical corrections in questions 1, 2, and 3. Field

Tester 3 asked a process question related to questions 1 and 2 and requested a combination of questions 5 and 6 since they appeared to be redundant. Field tester 4 had the same concern about combining questions 5 and 6. Field tester 5 suggested I replace the term family burden with family challenges. I did not adopt this suggestion. The field-testing process lasted from August 29 to September 29, 2020. Results of field-testing led to the following revised FG protocol questions:

1) What coursework did you receive in graduate school that discussed FB or specialized skills to treat families dealing with loved ones with schizophrenia?
2) As you now think about FB, what training in graduate school would help to treat or mitigate this condition?
3) What do you think are some of the factors that cause FB?
4) If FB is not addressed what may be some of the effects on patients and families?
5) What emotional impact do you think FB has on families and patients?
6) How do you think society views FB?
7) In your opinion, what strategies, and practices can you suggest to reduce FB?
8) In what way to do you think local, state, and federal levels of government can improve resources or psychoeducational programs, reduce stigma, and increase family involvement for these strategies? Please address each level one at a time.

After the first FG, I felt the order of slides needed changing (see Appendix O). The Microsoft PowerPoint did not have a natural flow and rhythm at that time. As a result, the order is slightly different than the one proposed originally.

Setting

This study changed from face-to-face to virtual interviews via Zoom. My use of virtual platforms for FG research does come with considerations. Hensen et al. (2021) listed some of the strengths of online platform as these allow a researcher the ability to facilitate interactions with participants to understand socially normal behavior and online formats provide peer support. These online options must consider participant ability to their own access to online resources, participants should use private places to participate in studies, and online research saves participant travel time. Varma et al. (2021) said some benefits of online research is to decrease the burden for participates in studies, greater geographic coverage, providing more access to rural participants, and a clearer flow of information.

To reduce some of these challenges, I mailed consent forms, demographic sheet, study Microsoft PowerPoint, and FG protocol to all but three participants. I contacted three participants at a state conference, and they received their information at the conference. Their participation in the study still occurred via Zoom. All received the same materials to control for variables. Regarding privacy concerns, I asked all participants to use earphones and participate in a private setting. Participants received a Microsoft PowerPoint of study to aid in understanding since we were not face-to-face.

Despite not meeting face-to-face, FGs produced relevant data. Virtual sessions made transcription easier because Zoom transcribed dialogue in real time. Additionally, I was able to replay videos to improve transcription accuracy. Participants in this study all had various experiences, adding to the richness of findings.

Demographics

Twenty-two licensed MHPs agreed to participate. Participant recruitment occurred in a number of ways. One of these was at a state level mental health conference. I additionally sent out social media posts on Facebook and LinkedIn, emailed contacts via *Psychology Today*, and I sent out an email blast through a state-level counselor association to recruit members. Last, I used personal contacts to call or email potential participants. I made 28 phone calls, 123 emails, sent five faxes, used two mental health list serves, and contacted 15 participants via *Psychology Today* until 22 participants enrolled. My committee told me to recruit a minimum of 20 participants to have enough data for analysis.

I mailed 19 participants demographic sheets and asked them to mail back the anonymous form, with three potential participants receiving it in-person. Each got a stamped envelope with my return address. No information on the return envelopes contained participant addresses in order to protect confidentiality. I chose this method to give participants confidentiality by separating demographic information from their identity. I asked participants to put the mind map and consent document in one envelope. I requested them to put the demographic sheet by itself in a separate envelope addressed to me.

As a result, participants only returned 14 of 22 demographic information sheets. It is possible some forms were lost in the mail. I did not follow up on unreturned demographic sheets because some participants might have chosen not to provide requested information. If I asked participants to fax information, a fax number would potentially lead to a breach of confidentiality because I would be able to match demographic information to a fax number. Participants returned every mind map and consent document. I obtained basic information about race and gender during FG sessions.

Based on visual observations of participants, 16 were female and six were males (see Table 2). Average age of participants was 53.9, with an age range of 39-80 (for those returning a demographic sheet), and racial breakdown of 73% African-American and 27% Caucasian.

Table 2

Participant Demographics

Demographic	Count	Percentages
Race	16 African-American	73
	6 Caucasians	27
Education/License Status (Some checked more than one)	2 Masters	14
	1 MEd	7
	1 LMFT	7
	4 LCSW	29
	2 LPC/MA/LMFT	14
	1 MEd/LPC	7
	3 MA/LPC	21
Occupations (Some checked more than one)	2 Counseling	14
	1 Psychotherapy	7
	1 Social Work	7
	1 Therapist	7
	1 School Counselor/ Private	7

	LPC practice	
	1 Clinical Social worker	7
	1 University Counselor	7
	1 Behavioral Health Specialist	7
	2 Clinical Director	14
	1 Writer	7
	1 Mental Health counselor	7
	1 Retired	7
Marital Status	3 Never married	21
	10 Married	48
	1 Divorced	7
Salary ranges	1 $21, 000-$50,000	7
	3 $51,000-$75,000	21
	4 $76,000-$100,000	29
	5 Above $100,000	36
	1 Did not answer	7
Employment status	9 Employed full-time	64
	2 Employed Part-time	14
	1 Unemployed	7
	2 Self-employed	14
Clients seen per week	3 0-10	21
	6 10-20	43
	1 20-30	7
	3 30-40	21
	1 50-60	7
Hours worked per week	1 0-15	7
	5 15-30	36
	3 30-40	21
	4 40-50	29
	1 50+	7

Data Collection

During this study, I collected the same data from all subjects. All participants completed a demographic sheet, a mind map, and participated in a FG. This study comprised seven FGs done in 2021 on March 14, March 21, April 1, April 6, April 11, May 1, and May 10. All groups lasted 1-2 hours. All groups had three participates except FG #5 which had four, thus average participants per group was 3.14. I used Zoom for all

FGs. Participants viewed identical Microsoft PowerPoint presentations to explain the study and the research questions. During FGs, participants completed their mind map drawing. I asked participants to mail back the mind map, consent documents, and demographic documents in envelopes provided. After participants drew mind maps, I asked if they needed a break, then formal FGs began. I asked participants to draw a mind map with colored pencils and markers provided. Once mind maps were completed, FG questions began and Zoom recorded and transcribed these FGs.

The most relevant change in data collection began when it was obvious during the pandemic, face-to-face FGs could not occur and this study had to occur virtually via Zoom. Since I did not use sites, no local facility personnel recruited any participants.

Once participants agreed, I reviewed possible dates of availability. After scheduling, participants received the previously stated study documents. To help participants understand a mind map, they received examples, and a Microsoft PowerPoint explaining this study. If participants were hungry, I included candy. Participants received a pack of 20 markers, 10 colored pencils, a pencil sharpener, 2 erasers, and 1 pencil to facilitate drawing a mind map. To thank the participants for their time they received a $10.00 gift card.

Because of scheduling, it was difficult to get many to choose the same day. Thus, it was difficult to get the initially suggested 6-15 participants in one group. This virtual format also made it harder to have five participants in four groups. No group had less than three. In addition, it was not possible to have two groups in a metro area and two in a rural area because FGs were virtual.

Some unusual circumstances in data collection were from some participants not being ready or talking from a parked car. These circumstances do not appear to alter outcomes. I asked all to wear headphones to protect confidentiality. Also during the start of FGs, all told, if they recognized a participant not to use actual names but instead use pseudonyms. I asked all to change the screen name on Zoom to the pseudonym.

Data Analysis

This study used FGs of MHPs in Georgia. However, the FGs only contained raw data. In this study, the data analysis process is how raw data became usable to create theory. Babbie (2007) stated inductive reasoning takes data from the particular to the general. Trochim (2001) believes inductive reasoning starts with an observation of a process then looks for patterns. Creswell and Poth (2018) noted GT uses interviews, and transcriptions, to search for themes. Corbin and Strauss (2015) stated GT starts with categories or units of information. Categories derive from raw data obtained in interviews. The data analysis process is next.

First all seven FGs were conducted via Zoom and all groups were recorded and transcribed via Zoom. Second, after each group, I wrote a process memo for what occurred in FGs. Third, after Zoom produced a raw transcript with multiple grammatical errors, I copied and pasted transcripts to a Microsoft Word document, and printed it. I reviewed printed transcripts while viewing each recording. I wrote corrections on transcripts. Once I noted all corrections, I re-typed each transcript with corrections. After a second transcript was printed, the new transcript or third, was reviewed for accuracy while viewing recordings again. I did this to make transcripts as accurate as possible. I took a third revised transcript from all seven FGs and uploaded into Atlas.ti 9 to start data analysis.

My first round of open coding of transcripts and mind maps produced too many small buckets of data. During data analysis with Atlas.ti 9, it was difficult to determine, meaning from results. Therefore, all seven transcripts and mind maps where re-coded into broader buckets. After reviewing ATLAS.ti's User Manual, it noted this error in coding. The manual mentioned benefits of a well-structured code list with order, conceptual clarity, prompts for more codes, and greater pattern development. Friese (2019) further noted characteristics of such code lists are distinct code meanings and code meaning given in a comment. These categories should show clear distinction from other categories. Any sub codes should have a similar meaning, codes appear only once, the code system is theoretical, codes describe data, and code system is logical. The code system created contains 10-25 top-level categories, and the code system has no more than two or three levels. I used these guidelines in my second open coding process. My first and second data coding system for each question and the mind maps had the following categories and colors to note their origin of data (see Table 3). These colors helped to match answers to participant's responses.

Table 3

Color Used for FG Category Coding

Question	Category	Color
Mind map	Mind Map	Orange
Q1	Coursework	Brown
Q2	Training Needs	Green
Q3	Factors Causing	Pink
Q4	Effects on Families	Black

Q5	Emotional Impact	Gray
Q6	Societal View	Turquoise
Q7	Strategies to Reduce	Red
Q8	Policy Changes	Purple

These categories had the following initial code (see Table 4) to use in the open coding process. As data showed in transcripts, they had these codes with more entering in the codebook as needed.

Table 4

Category Initial Coding

Question number	Category	Initial Code
Mind map	Mind Map	MM
Q1	Coursework	Classes
Q2	Training Needs	Training needs
Q3	Factors Causing	Factors
Q4	Effects on Families	Effects
Q5	Emotional Impact	Emotional
Q6	Societal View	View
Q7	Strategies to Reduce	Reduce
Q8	Policy Changes	Policy

Now I put data into categories, next is how these become a code system. For example, the category Mind map had six different codes, Classes contained eight different codes and the category Training needs had 10, and Factors category contained 24 (only ten listed). Table 5 shows an example of codes derived from the mind map question.

Table 5

Mind Map Code Meanings

Code	Code meaning
Mind map: feelings (emotions)	A problem treating FB is feelings (emotions).
Mind map: mental health problems	A problem treating FB is mental health problems.

Mind map: stressors	A problem treating FB is stressors.
Mind map: resources	A problem treating FB is a lack of resources.
Mind map: family problems	A problem treating FB is family problems.
Mind map: cultural	A problem treating FB is cultural implications.

These codes and those following form other data sets. My code sets used key points of Charmaz (2014). These points were remain open, stay close to data, keep your codes simple and precise, construct short codes, preserve actions, compare data with data, and move quickly through data.

To obtain data, I followed the FG protocol to ensure consistency of questions and data collected. I asked these MHPs FG protocol questions for reasons mentioned by Charmaz. These points were selection of research participants who have first-hand experience fitting for this research topic, in-depth exploration of participant experience and situations, reliance on open-ended questions, obtaining detailed responses, and emphasis on understanding participants' perspective, meaning, and experience; practice of following up on unanticipated areas of inquiry, hints, and implicit view and accounts of actions.

Participants had first-hand knowledge by working in the field with FB patients and families dealing with schizophrenia. During FGs, I discussed with participants' their career experiences, and what they knew about the topic. All questions were open-ended to provide flexibility for participants answering questions. GT is rooted in participant perspectives and understanding how they understand a phenomena. Throughout FGs when needed, I followed-up on inquiries, hints, and opinions. Table 6 is a listing of codes for question one on what classes participants had in graduate school.

Table 6

Classes Code Meanings

Code	Code meaning
Classes: symptoms	Classes only on symptoms
Classes: abnormal	Classes in abnormal psychology about schizophrenia
Classes: diagnosis	Classes only on diagnosis
Classes: case studies	Classes on case studies
Classes: patient only	Classes about the patient only
Classes: none	No classes on subject
Classes: internship better	Classes in internship explained burden better
Classes: case management	Classes in case management only

Table 7 lists codes for question two.

Table 7

Training Needs Code Meaning

Code	Code meaning
Training needs: more counseling skills	Subject needed more help with subject of FB in counseling skills class
Training needs: diagnosis	Subject needed more helping learning how to diagnosis
Training needs: case studies	Subject needed more help with case studies about FB
Training needs: professional real world	Subject learned more in the real world about FB than in school
Training needs: more exposure	Subject needed more exposure to FB while in school
Training needs: after school	Subject learned more about FB after leaving school
Training needs: about families	Subject needed more training about subjects
Training needs: about patients	Subject needed more training on what patient experience
Training needs: SPMI	Subject needs more training on the severely persistent mentally ill
Training needs: co-morbidity	Subject need more training on the co-morbidity of mental illness

Table 8 lists the codes for question three on what factors cause FB.

Table 8

Factor Code Meaning

Code	Code meaning
Factors: financial	FB impacted by family finances
Factors: resources	FB impacted by lack of resources in community
Factors: time-constraints	FB impacted by time-constraints on families
Factors: scheduling	FB impacted by scheduling issues in the family
Factors: age of client	FB impacted by the age of the client
Factors: family violence	FB impacted by a history of family violence
Factors: untrained staff	FB impacted by untrained staff in treatment facilities
Factors: stigma	FB impacted by stigma
Factors: families refusing to help	FB impacted by families refusing to help a loved one
Factors: isolation	FB impacted by patient/family isolation

Table 9 lists of the number of codes created for other FG questions.

Table 9

Summary of Total Number of Codes for Other Questions

Other categories	Number of codes
Effects	8
Emotional	13
Societal view	9
Reduce	11
Policy	7

Code sets show how data coded from transcripts put data into buckets to begin analysis. This analysis process does not create patterns to create theory. Charmaz (2014) noted GT seeks to make patterns visible and understandable. Data analysis hedges on theory creation from four concepts of theoretical plausibility, direction, centrality, and adequacy. Theoretical plausibility's basis is on questions asked in research during data collection.

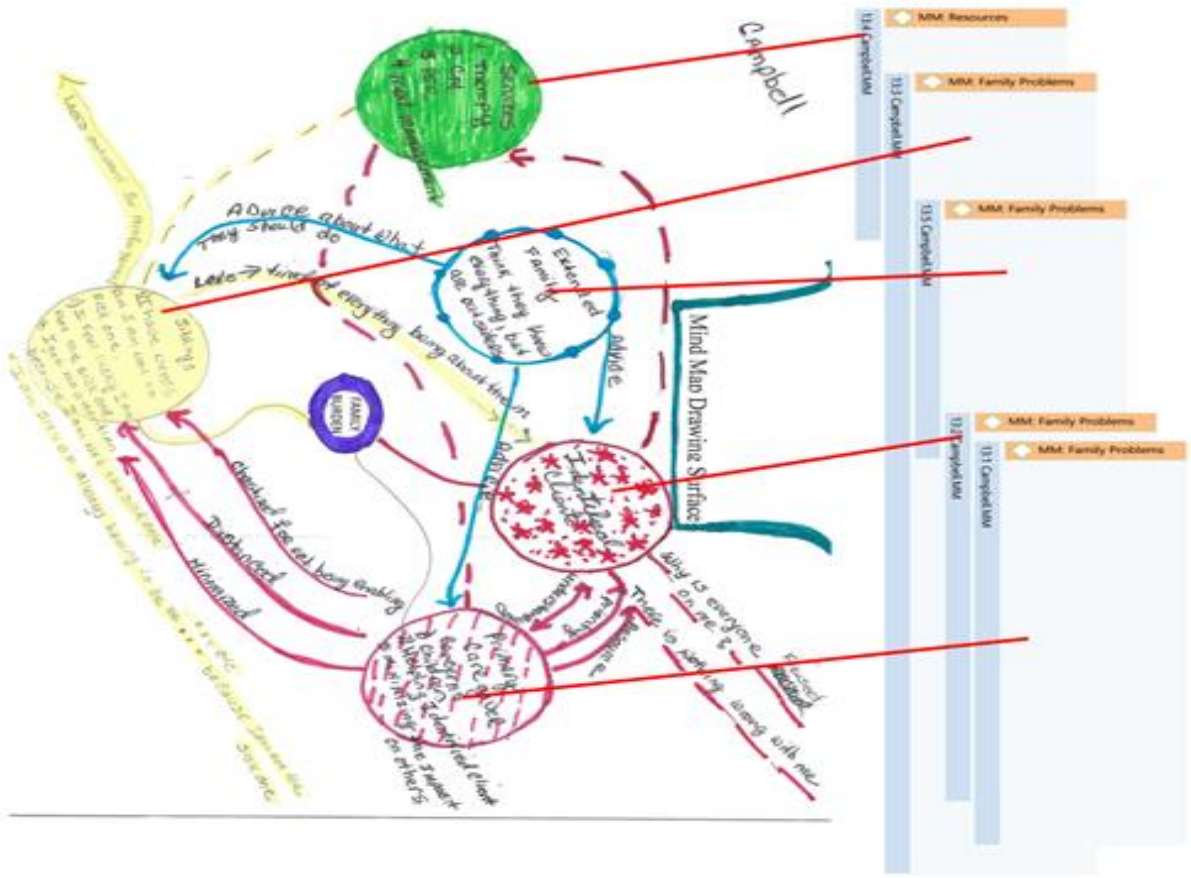
Data collected in this study, 22 mind maps, in seven FGs, totaled 298 pages of double-spaced one-sided data (average 43 pages per focus group), lead to substantial data offsetting the chances of misleading account and data. Data in this study drove study direction. Centrality came from data answering research questions. Data revealed the story of participants leading to a new theory.

Charmaz (2014) noted the purpose of data analysis is to ask what is happening here, what are basic social processes, what are basic social psychological processes, who exerts control over these processes, and under what conditions? These questions direct the line-by-line coding of transcripts and mind maps. Charmaz (2014) said:

> Coding means categorizing segments of data with a short name that simultaneously summarizes and accounts for each piece of data. Your codes show how you select, separate, and sort data and begin an analytic account of them. (Charmaz, 2014, p. 111)

Figure 6

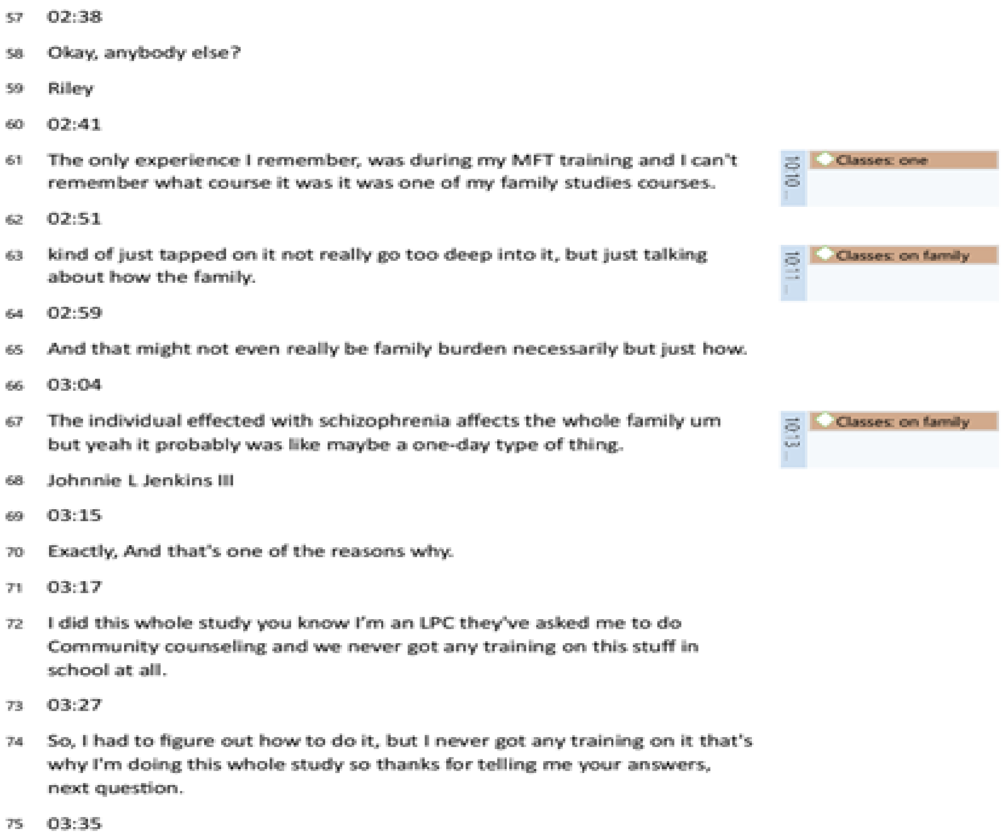
Open Coding of Campbell's Mind Map



In Figure 6, for Campbell (all names given in the results are pseudonyms to protect confidentiality) the green area was coded MM: Resources because it illustrated issues in getting services related to therapy, CM (case management), PSR (psychosocial rehabilitation), and medication management. The MM: Family Problems code used for issues regarding extended family, siblings, client, and primary caregiver. I coded the other mind maps in a similar way.

Figure 7

Transcript Open Coding Focus Group 1



02:38

Okay, anybody else?

Riley

02:41

The only experience I remember, was during my MFT training and I can't remember what course it was it was one of my family studies courses.

02:51

kind of just tapped on it not really go too deep into it, but just talking about how the family.

02:59

And that might not even really be family burden necessarily but just how.

03:04

The individual effected with schizophrenia affects the whole family um but yeah it probably was like maybe a one-day type of thing.

Johnnie L Jenkins III

03:15

Exactly, And that's one of the reasons why.

03:17

I did this whole study you know I'm an LPC they've asked me to do Community counseling and we never got any training on this stuff in school at all.

03:27

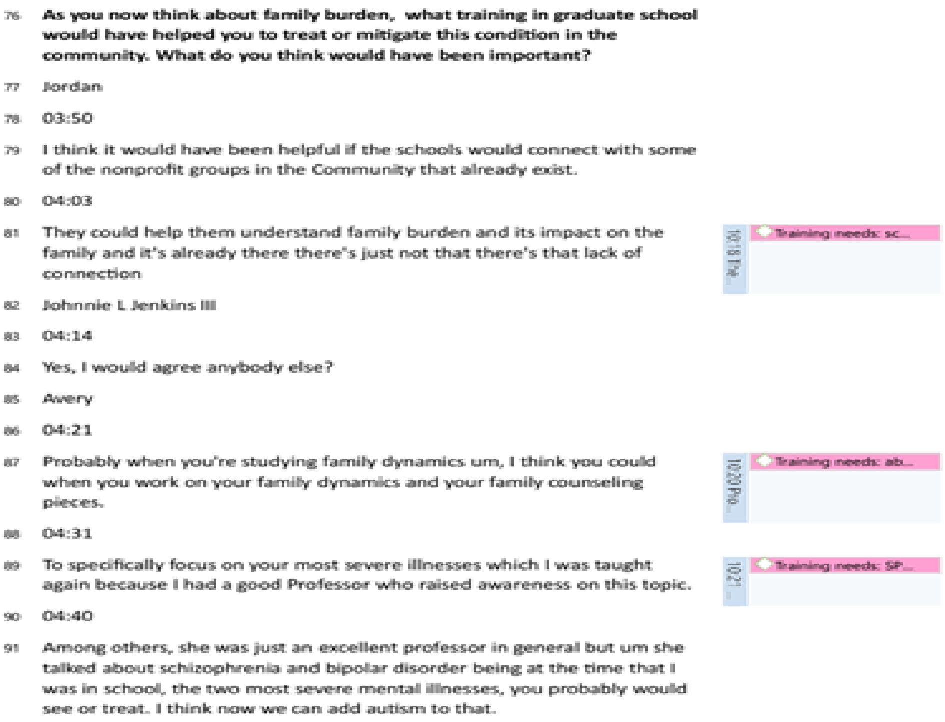
So, I had to figure out how to do it, but I never got any training on it that's why I'm doing this whole study so thanks for telling me your answers, next question.

03:35

Figure 7 shows lines of text from the first FG. This section of transcript asks participants what coursework they took in graduate school to prepare them to work with families dealing with a loved one with schizophrenia. Riley stated, “The only experience I remember, was during my MFT training and I can’t remember what course it was, it was one of my family studies courses.” Since Riley stated one, class and Classes: one code used for this text. Riley said, “kind of just tapped on it not really go too deep into it, but just talking about how the family....” Since it mentioned what this class was about, the code Classes: on family used. Then in line 65 and 67, Riley discussed, “And that might not even really be family burden necessarily but just how… The individual affected with schizophrenia affects the whole family um but yeah it probably was like maybe a one-day type of thing.” Again, in this sequence, the short length of training, and emphasis of it being about family thus the code Classes: on family used again. Figure 8 is a continuation of an example of how transcript coding occurred for all FGs.

Figure 8

Transcript Open Coding Focus Group 1 Continued



76 **As you now think about family burden, what training in graduate school would have helped you to treat or mitigate this condition in the community. What do you think would have been important?**

77 Jordan

78 03:50

79 I think it would have been helpful if the schools would connect with some of the nonprofit groups in the Community that already exist.

80 04:03

81 They could help them understand family burden and its impact on the family and it's already there there's just not that there's that lack of connection

82 Johnnie L Jenkins III

83 04:14

84 Yes, I would agree anybody else?

85 Avery

86 04:21

87 Probably when you're studying family dynamics um, I think you could when you work on your family dynamics and your family counseling pieces.

88 04:31

89 To specifically focus on your most severe illnesses which I was taught again because I had a good Professor who raised awareness on this topic.

90 04:40

91 Among others, she was just an excellent professor in general but um she talked about schizophrenia and bipolar disorder being at the time that I was in school, the two most severe mental illnesses, you probably would see or treat. I think now we can add autism to that.

In Figure 8, the transcript in FG 1 has now gone to question two about what training in graduate school would have helped MHPs understand FB better. Jordan stated, “They could help them understand family burden and its impact on the family and it’s… already there there’s just not that there’s that lack of connection.” This data given code Training needs: school connection. Avery stated, “Probably when you’re studying family dynamics um, I think you could when you work on your family dynamics and your family counseling pieces.” I coded this Training needs: about families since the desire was to have more classes about families. Avery stated, “To specifically focus on your most severe illnesses which I was taught again because, I had a good professor who raised awareness on this topic.” This information coded Training needs: SPMI (meaning Severe Persistent Mental Illness). These examples show how I analyzed data. A similar line-by-line coding style occurred for all FG 1’s transcript and transcripts for groups 2-7.

In this study, no data are unimportant or discrepant. Charmaz (2014) noted data appearing in small instances and not repeated is not discrepant but instead not ever captured much in research. Therefore, all results have meaning.

Evidence of Trustworthiness

As stated by Creswell (2007), trustworthiness occurs in research by long engagement in the field, triangulation, debriefing, negative case analysis, clarifying my biases, member check-ins, rich thick descriptions, and external audits. This study’s research demonstrated long engagement in the field by an extensive review of literature to determine this study’s need. Literature review determined IT could help MHPs understand FB. Both participants and I worked in mental health and had real world experience related to this study. All debriefing of participants occurred during FGs. This study did not produce any negative case results. These FGs did not reveal any biases of me. Transcripts produced rich thick descriptions of data. My study committee served as an external auditor for this study.

Lincoln and Guba (1985) stated qualitative research achieves trustworthiness with credibility, authenticity, transferability, dependability, and conformability. Transferability according to Lincoln and Guba is by thick descriptions of participant responses. In this study, thick description comes from 7 FG transcripts and 22 mind maps. Long engagement listed previously along with triangulation produces confirmability.

Again, in this study data came from FG transcripts and mind maps creating multiple data sources. Triangulation looked at transcripts or data for themes and then related this back to theory.

LeCompte and Goetz (1982) saw internal validity, external validity, reliability, and objectivity as keys to make qualitative research valid. Making results believable is a basis of credibility. Transferability allows data to transfer from me to participants (Creswell & Poth, 2018). Dependability allows findings to adjust as research changes (Creswell & Poth, 2018).

This study was credible because I used categories based on mind maps, and FG questions as categories to create themes. I also used open coding of transcripts and mind maps. Participant views and mine created new theory. Regarding dependability, as different participants answered FG protocol questions, new information added to an existing category by using an existing code or creating a new one.

In this study, controls for internal and external validity occurred by not allowing transcripts to impair my judgment. I remained open to learning new information during each FG. All participants were valued as experts in what they provided. According to Chiovitti and Piran (2003), rigor occurred because participants answered questions in ways they needed without interference from me. Rigor also occurred by asking participants' their meaning of the phenomenon. Rigor ensured with direct quotes of participants, an explanation for my biases as needed, and me allowing participants to elaborate on why this study is meaningful to them, me following research protocol, and my comparing categories to theory. These guidelines did not create any changes in credibility, transferability, dependability, and conformability as mentioned in Chapter 3.

Results

Mind Map Analysis

The mind map portion of FGs asked participants to create a mind map illustrating the problems dealing with FB.

Figure 9

Campbell's Mind Map In-Depth Analysis

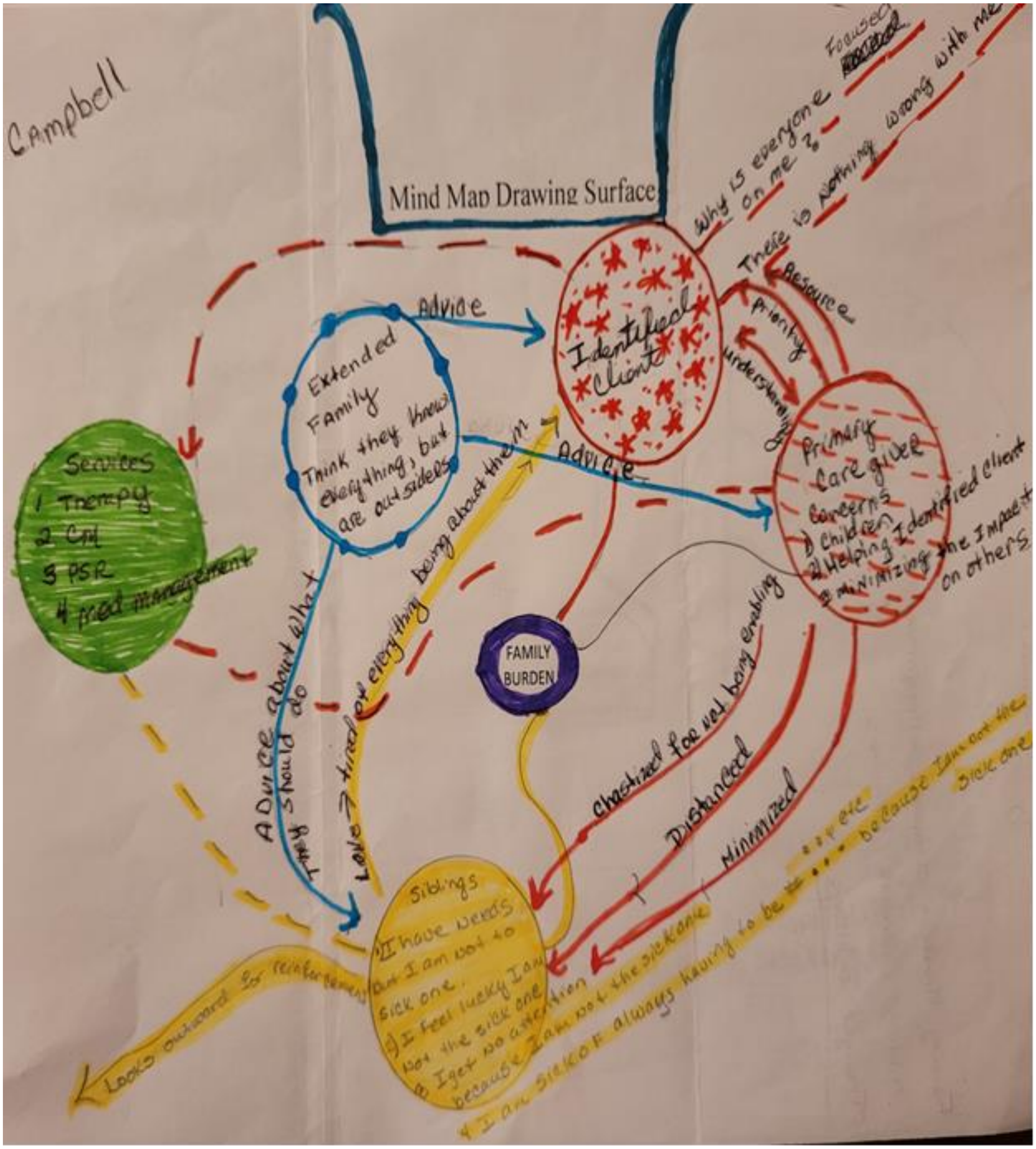

Campbell
Mind Map Drawing Surface
Why is everyone Focused on me ?
There is nothing wrong with me
Identified client
Resource
Priority
understanding
Primary Care giver
Concerns
1) children
2) Helping Identified client
3) minimizing the Impact on others
Extended Family
Think they know everything, but are outsiders
Advice
Advice
Services
1 Therapy
2 CM
3 PSR
4 med management
Advice about what they should do
Love → tired of everything being about them
FAMILY BURDEN
Chastized for not being enabling
Distanced
Minimized
Siblings
1) I have needs but I am not the sick one.
2) I feel lucky I am not the sick one
3) I get no attention because I am not the sick one
4 I am sick of always having to be … etc … because I am not the sick one
Looks outward for reinforcement

Figure 10

Lennon's Mind Map In-Depth Analysis

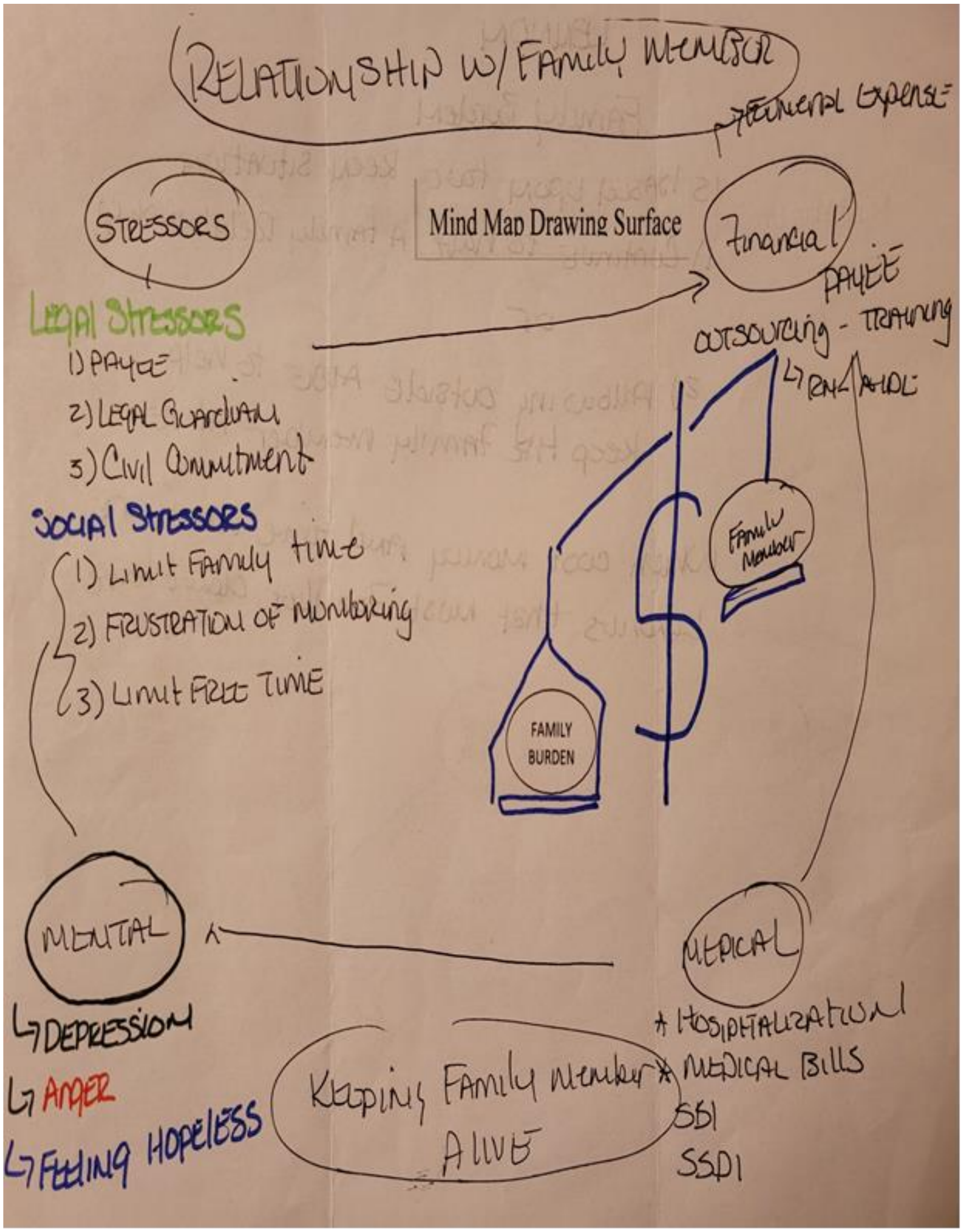
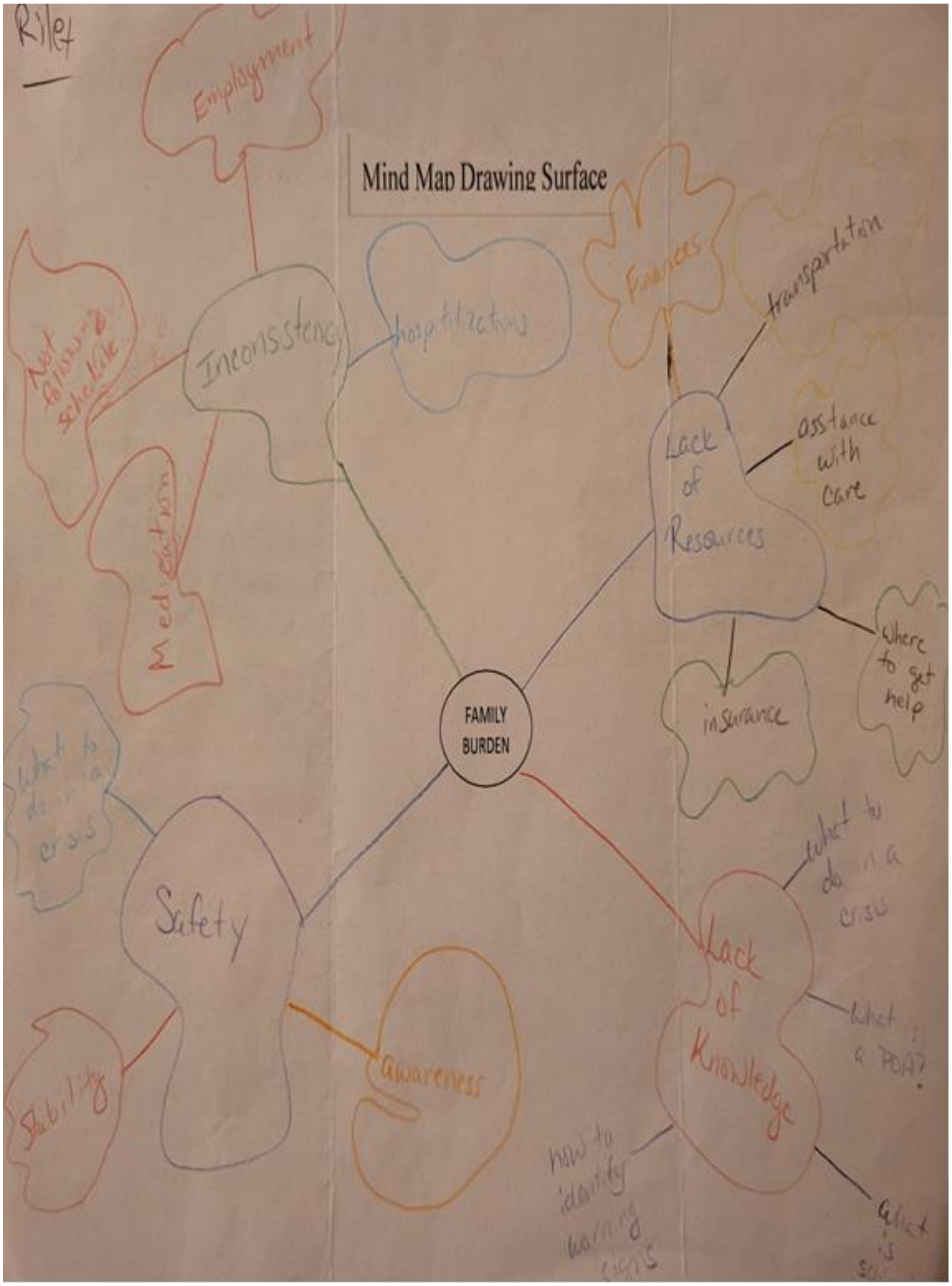


Figure 11

Riley’s Mind Map In-Depth Analysis



Figures 9, 10, and 11 are examples of concepts participants created when considering problems encountered when dealing with FB on the mind map. In general, some issues presented where cultural concerns, family problems, difficult feelings, mental health problems, resources, and stress.

Figure 9 described FB as a problem for identified patient, extended family, and siblings. Identified patient is concerned with the family focusing on them and believes nothing is wrong with them. Caregivers try to minimize problems, but pressures arise from a lack of resources to help clients who do not understand what families go through. Siblings feel a lack of attention in family since all attention goes to identified client. Siblings may also feel lucky not being sick. This feeling lucky leads to guilt. Other influences on siblings in these families are minimization, distancing, and chastising for not helping more. Therefore, siblings may look outside family for support.

Extended families stay trapped in giving too much advice to family about what they should do about problems when they do not have similar lived experience as those inside family. Services received at all elements of this system influences what happens with the patient. Services can help to ameliorate some problems in the system.

Figure 10 described FB influencing families with stressors, mental issues, medical problems, and financial strain. Stressors come in two types legal and social. Legal stressors may arise from being a payee of a loved one, legal guardian, or seeking civil commitment proceedings. Social stressors derive from limited family time, frustration from monitoring family members, and limits on free time. Mental issues may come from depression, anger, and feeling hopeless. In addition, family members fight just to keep loved ones alive. Medical problems arise from repeated hospitalizations, medical bills, SSI, and disability filings. These problems lead to financial strains on family. If families must hire nurses and home health aides and ultimately pay for final funeral expenses these are additional financial strains.

Figure 11 described four main concepts surrounding inconsistency, safety, lack of knowledge, and a lack of resources. Inconsistencies in family member's lives may lead to employment issues, member's inability to follow a schedule, medication regime changes, and repeated hospitalizations. Safety concerns develop when family does not know what to do in a crisis, family member instability, and a family's lack of awareness about mental illness. Family's lack of knowledge comes from them not identifying warning signs, not knowing what schizophrenia is, what or how to obtain a Power of Attorney, and again what to do in a crisis. A lack of resources in Georgia affects family finances, transportation to appointments, and lack of help with caretaking, locating available help, and not having insurance to cover treatment.

Figures 9, 10, and 11, provided a representative sample of mind maps created by MHPs. Issues raised on mind maps were resource issues, family problems, stress, and mental health problems. Other issues included resource deficits from family not getting help with meals, medications, or activities of daily living. Resource deficits may exist when it comes to a lack of services to address other family health problems. Stress could be from a lack of coping skills in family, fear of judgment, being overwhelmed, and loss of family member potential, stigma, fear, and family member's bosses not understanding time-off requests. Family problems result in detachment and isolation, relationship strain, concerns about who will care for patients after family members die, differences in care depending on the age of family members, and marital status of caretaker. Mental health problems come from fear from isolation, depression, panic, and anxiety. Families may also have a fear of judgment. Families are in crisis with family members leading to stressors. Loved ones may experience a poor academic performance leading to problems getting a job. These may then lead to negative thoughts of future and past with accompanying depression, anger, and hopelessness. Next are results from data obtained from each FG question.

Classes in Graduate School Analysis

During FGs when participants were asked about which classes, they took in graduate school to prepare them to help family dealing with a loved one with schizophrenia. Classes varied from none to classes about psychopathology, and some gained more understanding in practicum and internship. Phoenix in FG 2 had a similar response like many, “I had more generalized studies, I did not dive into the burden part in our coursework we…I had an abnormal psychology course”. Most participants like Phoenix had an abnormal psychology class but nothing specific on FB. In FG 5, Hollis remarked, “I don't remember having any specific training, no.” Again, this statement shows consistency with most participants not having any training in FB. Rowan in the same FG 5 stated, “No not specific in FB no.” None of the 22 participants had any specific training in FB. Karter did have a course in family dynamics in graduate school while working on a doctorate degree, “yeah because it was it looked at the dynamics of a lot of families, and this was particularly one of them as well.” Avery said:

> They [We] would wear headphones to understand the auditory hallucinations and then before they learn their way around campus, they were told to follow a series of instructions and communicate with people while wearing headphones with all the different voices going on.

Hartley in FG 2, as others had an abnormal class in graduate school but received nothing specific on FB, “Patients, and then the abnormal psychology course kind of focused on… The symptoms… the symptoms of schizophrenia or any severe mental health issues, along with common interventions.” In FG 1, Riley had minimal training on how schizophrenia affects the whole family and said, “The individual affected with schizophrenia affects the whole family um, but yeah it probably was like maybe a one-day type of thing.”

Training Needs Analysis

Hartley said:

> Um, the impact on the family until you are directly in the home yourself as a provider then you see like well dang let me see if there's some respite or let me see that you know so it's not….. I think our education kind of, lets us know how to provide individually to the patient, but it doesn't really address the system, the family system.

Hartley’s comments show the best teacher of knowing what families and patients experience dealing with FB is more exposure to families with FB.

Taylor in FG 3, revealed many new therapists are fearful of clients and this impairs their thoughts about this population, “And I want to add that, although I was fearful once I started working with that population um it was actually a population, I wanted to work with …I'm glad I got over that fear.” Fear clouded their perception they had about people with schizophrenia.

Karter said:

> …That would definitely assist with eliminating and reducing some of the family’s burden if you had that multiple exposure and understanding how to be an effective parent, how to raise your children effectively to help them in a global society.

Although, all participants completed a mind map to conceptualize what FB looked like, later in FGs they discussed the concept to allow further processing.

Causes of FB

Mind map exercises mentioned in previous analysis, helped to answer what causes FB. The FG asked this again as a question. In mind maps, factors causing FB in transcripts, coded as factors code. A lack of resources was one predominate response in transcripts, Hartley in FG 2 stated, “I mean it feels like often that probably all of us have experienced that mental health is just not getting a light shined on it and um…and still doesn't have enough resources poured into the service area.” Phoenix said:

> Yeah I’ll talk about mine, I put lost productivity at work and financial you know, with all the medical expenses and the medications and sometimes insurance doesn't cover those things. And then transportation costs, having to go back and forth to medical appointments a lot and finding resources and…

Jordan and others in FG 1, listed stigma affecting FB, Jordan stated, “I think stigma is a huge one, depending on what the mental health diagnosis is there's a little bit more stigma on families, considering what the diagnosis is.” Thomas in FG 5 noted along with others, issues of family discord created by FB. Jordan pointed out, “treatment amongst family members, creates a lot of conflict, you might have some local family members they're getting overwhelmed.” The feeling of being overwhelmed puts barriers between families creating distance in families.

Campbell said:

> The uh the uh other one, the siblings feel left out, they don't have the diagnosis, the siblings are either admonished because they don't understand, they may feel left out, or they may feel minimized with their problems, because their problems aren't as intense as the identified clients’.

MHPs further explained if FB is not addressed what are its negative effects in the next question.

FB Effects

Karter in FG 4 said:

> We know typically pain can be felt emotionally and physically those are the typical ways that pain is felt it is going to continue to be more emotional pain it contributes to some physical pain if it is not addressed. And that's going to impact not just that family but it's going to impact those neighboring families that are close to them these neighboring cities and those neighboring counties around it when things are left unaddressed there's a spill over into other areas as well. And

> we got to make sure we're addressing those if we're not it's going to be more pain for everyone who's involved directly and indirectly and we got to make sure we address those…

Stress is also an effect of FB. Phoenix in FG 2, noted, “I think, burnout, burnout for the caregivers.” As family care for loved ones, burn out occurs. Hollis in FG 5 reminded us FB also influences providers of care with, “I don't think we talked enough about compassion fatigue and vicarious trauma….” This reminds us of many dangers providers need training on in becoming better clinicians.

FB also causes family fragmentation, Avery in FG 1 stated,

> To me the fragmentation that can occur, over time, or the isolation, you see a lot of isolation of the clients, as well as anybody that's involved in their care, they isolate other people that they don't want to know about these problems.

FB can then go on to have ripple effects on family as noted in the next question.

Emotional Impact of FB

Jordan in FG 1 said, “Well you should know what to do, because it's it's your child right, you know how to navigate everything else, why don't you know how to navigate this.” Laramie in FG 2 said, “[one] strategy as opposed to going to get labeled because those labels, as we know, stick with us.” FB produces a mix of emotions for family. All these pressure points lead to a feeling of being overwhelmed. Rowan in FG 5 stated,

> …the family might decompensate you know, there may be one locally on the ground taking care of the day-to-day needs becoming very overwhelmed

> resentful with the others that are not helping out more than just financial, so the whole family could just kind of decompensate.

Other emotional impacts are stigma, stressors, and fears from mind map examples. Fear also showed in FG. Fear came in multiple types of fear from patient, family, and medications. Hartley in FG 2 said, “So in that fear… you know the family is scared of the medication, family is scared of their family member….” Karter again in FG 4 stated,

> Fear of rejection, that the family is going to experience the uncertainty that if families experience this has been going on for a period-of- time and they are not getting the support that they believe they should receive and not sure how to support.

FB has many internal influences on family and patient but externally society views FB in ways which influences how to treat it. These aspects reside in the next question.

Societal View of FB

Many participants noted society has not thought much about FB. River in FG 3, stated, “They haven't given it a thought.” This statement reflects society’s lack of concern of issues not directly in its face. Remington in FG 6, said, “[It’s] Not my [society’s] problem.” Phoenix in FG 2 noted society’s view this way, “I don't think they get it, I think they can at times maybe even unfortunately blame the family.” It is evidence FB has many negative impacts. Despite these negatives, let us turn now to ways to reduce FB.

Factors to Reduce FB

In FGs, one issue noted to reduce FB is better training of staff. Baylor in FG 7 noted changing ineffective treatment approaches as a way to reduce burden:

> A unified kind of model for really tackling this… we can't just continue to treat people and not have the resources and not have the policies …to support it and not have the advocacy piece (phone rings) ….that has to have all of those working. And it has to be working… you have sets of policies that get in the way you have agencies that are drained, the families that are a burden and drained …just trying to deal with the direct and indirect kinds of services, we have not enough education. All kinds of pieces and I can't…I can't think of one kind of strategy and practice, it all comes back to how we unify practices, procedures, advocacy, policy where they start to work for the benefit….

In FG 6, Ryan mentioned improving resources as one strategy to reduce FB, "I feel increasing community programs, and I think that will definitely help." A lack of resources has been a repeated issue in this research. Georgia has not done enough to provide families, clients, and MHPs with tools to deal with FB.

Reducing FB could start to normalize mental illness. Rowan in FG 5, discussed how the military culture in the past did not do well in allowing military members to receive help to address mental health concerns. These concerns can apply to Georgia too. Rowan said:

> To admit that he [soldier in military] suffered with chronic illness…mental illness for it to begin to start being normalized because for a long time, you know just

> relating to having PTSD, having depression, anxiety, ADHD, schizophrenia those chronic illnesses,…to have those type of things, was a bad thing, you know that you're on your way out [of the military] ….it took that sergeant major of the army to be bold enough to change the climate and so now veterans are more apt to come in and say hey this is what's going on with me versus so long ago, it was taboo to say. You know I suffer from this I don't know what's wrong with me they just kept it to themselves, again on that island.

Education became another idea to reduce FB. Education can come in two forms, educating families and educating professionals. In FG 3 Peyton stated,

> And then maybe the family can you know kind of be educated, because the whole community needs to know I mean because, just like you all were just saying…It starts within the family, the family, needs to be educated um… and you don't want to have to wear a red letter but still I think just education just period in the in this whole community, because we have, we have no, no, no place to even house people with severe mental health issues, you know what I'm saying so it's it's it's like ... it's like the low, the low end of the totem pole you know what I'm saying when in actuality it should be at the top, because everything in our society now [all] people have mental health. Mental health, they have mental health issues they have killings and shootings and mental health issues, you know what I'm saying so, I think, within the family system there needs, there needs to be tons of education, education, on how to deal with them… education on how to help with finances.

Jordan in FG 1 highlighted another aspect of education needed to reduce FB, and this is education of professionals:

> I think one of the things is how we educate practitioners like how we educate you know other people in the same practice we are in how they interact with families um there is I think there's …I think as practitioners I think therapists and other people put a lot of stigma on the families themselves and how they interact with them.

Thomas in FG 5, proposed a unique way to combat FB and it involves increasing the number of providers who provide services to the family. Thomas said:

> I think in some way, shape or form, I don't know that it can be produced, but on a minimal level, I think there should be a therapist that focuses on family burden with the family…from day one, and then a therapist that focuses on the client and maybe have those two therapists collaborate to be on the same page for the overall treatment plan at a minimum, I think this is a strategy and practice, I believe, would be most effective.

Ryan in FG 6 felt ACT teams need more funding to change FB’s outcome. Ryan stated,

> Assertive Community Treatment teams, I think those would really, really be helpful, but again great teams, are not just something you put together in your backyard, but really great teams, with people who are educated and trained and things of that nature.

Next is a review of policy changes.

Policy Strategies to Address FB

Advocacy was a popular answer in FGs. Participants noted needs for advocacy at local, state, and federal levels. Increased awareness was a theme for a policy change to improve FB. Taylor in FG 3 stated:

> Maybe, even at school levels because we don't actually, I can't remember the guidance counselors providing guidance they don't provide mental health education so even putting it in the school because I don’t, I'm not familiar with the school system now but this has been quite some time we didn't have any type of way of addressing mental health in school.

Coding for awareness and education occurred in this question but it showed up in other questions. Education again was a policy change for educating family, public, and professionals. Peyton in the same group with Taylor felt public awareness with marketing campaigns could help and said:

> I mean I really don’t know but we market everything else, and it just seems like there should be some type of way that we can just give it more exposure, you know with without and I'm just saying mental illness...in general, I just don't know because we market, we market everything else everything else, and even if you don't have Internet access, I mean…there's gotta be a way and I don't know what it is, I don't know, but if there's gotta be a way that we can just kind of just put it out there a little different um just like Taylor was saying, you know, maybe the guidance counselor can get more educated, because they are only focused mostly on career and can get more education to teachers so that they can make

> parents more aware, or vice versa, parents make teachers more aware, I don't I don't know, but the resources are so limited…

Arden in FG 5 supported more ACT teams to improve outcomes from FB. However, Arden reminds us a lack of funding in Georgia is detrimental do deal with FB. Arden said:

> I agree 100% with what Rowan just said, and also, I believe that we need 50,000 million trillion ACT teams (group giggles) with that it will cost federal funding and that's the that's the issue, so it goes right back to money you know they put money where they want to, and not where it's you know needed not a priority.

With all the individual questions in FGs answered now let us turn the focus on reviewing how the FG responses answered the three RQs.

Cross Check Analysis

The three research questions of this study were:

RQ1: How do mental health professionals define FB?

RQ2: What do mental health professionals think are barriers for families dealing with FB?

RQ3: How can multiple viewpoints and perspectives assist in defining FB and influence formal education of mental health professionals to reduce FB?

RQ1’s answers came from analyzing, mind maps, FG Question 3, FG Question 4, and FG Question 5. RQ2’s answers came from analyzing FG Question 7, and FG Question, and 8. RQ3’s answers came from analyzing FG Question 1, FG Question 2, FG Question 7, FG Question 6, and FG Question 8.

RQ1

Again, as previously stated, MHPs' mind maps noted most problems in addressing FB were a lack of resources. Resources divide into those affecting families inside home and those outside. Inside home concerns included families needing help with meals, Activities of Daily Living (ADLs), and medications. MHPs further stated families stressed by financial obligations. Pressures inside home also caused families to disconnect. MHPs noted families are unable to take vacations or breaks from caregiving. This may also lead to safety concerns. Safety may be an issue for family taking care of a loved one who may be violent. Outside concerns also addressed, issues with transportation to appointments, a lack of services to assist, problems obtaining benefits, questions about how to hospitalize family members, questions about where is affordable housing if a family member wants independence, and is there insurance to pay for treatment.

MHPs' views of family problems from mind maps were also from inside and outside families. Inside family problems can lead to social-detachment of members with strained relationships. Families may stress about what will happen to their family member once they die. A caregiver's age is a factor to remember because as families age caretaking responsibilities become strained. Other related concerns are if a family member is divorced or widowed then, the amount of family help is less and this causes more strain on one caregiver. In families, they overlook the role of siblings. Siblings may feel neglected because all focus in family is a member with schizophrenia. All these problems result in poor attention to basic family activities like preparation of well-balanced meals.

Mind maps showed outside issues for families who work, are if they needed time off work to care for a loved one or take family to treatments, will a job understand, and give time-off and keep them employed. Families also receive poor treatment from those outside nuclear family, as schizophrenia progresses and they become similarly stigmatized and isolated.

Mind maps showed stress as a defining issue with FB. Stress is cognitive, physical, and occurs in other ways. Cognitive manifestations of stress in FB is from a lack of coping skills, limited time, isolation, loneliness, depression, unaddressed mental illness, seclusion, being overwhelmed, hopelessness, grief/loss, self-blame, and a fear of the unknown. Physically stress makes families develop co-morbid medical problems. Other factors may include legal issues and social stress. Next, I will look at FG question 3.

Factors influencing FB were, availability of resources, who/what is in support system, awareness of illness, stress levels, family size, and treatment compliance/non-compliance. Arden in FG 5 pointed out an often-stated fact about resources, “You know, they were unsure where to turn for help, you know how to connect with others and lack of support group or awareness around that.” Avery in FG 1 remarked stigma causes stress because of a diagnosis of schizophrenia. Avery stated:

> I think the stigma especially for families that I was just reflecting Johnnie, when you were going over the introduction to the study and when you first contacted

> me and I reflected on the cases I've seen and when if and when I did deal with family or not, If you start off with uh….A child or young person or a young adult that had a lot of promise you know, maybe they made good grades, set high goals, and had more social economic opportunities. They seem to suffer more with stigma… they dealt with that grief and loss of the high hopes…

Thomas in FG 5 said, “Distance amongst treatment [approaches] amongst family members creates a lot of conflict, you might have some local family members they're getting overwhelmed.” Campbell has already noted from FG 6 how FB influences siblings. Phoenix in FG 2 mentioned financial factors influencing families.

With factors causing FB addressed, how does it change families is discussed in FG question 4. Most noted effects of FB on families, were family’s own development of mental illness, family fragmentation, treatment compliance, and negative impacts. Taylor in FG 3 stated, “Um the cycle continues; because usually people who have been diagnosed with this condition are not an isolated issue it’s usually something that may have been going on in the family.” FB may push a family to self-destruction. Hollis stated in FG 5, “I mean most extreme would be like the parent or caregiver [committed] suicide, you know because they couldn't handle it.” Hartley in FG 2 saw the cycle of this disease having grave influences on families. Hartley said:

> I think the caregivers themselves start to experience mental health concerns just from trauma and depression, anxiety and then I think the person who is also ill um their condition worsens also, and it seems like it's a trickle-down effect on the whole family.

Family fragmentation may also be an effect of FB. Avery in FG 1 spoke about fragmentation. Riley similarly in FG 1, understood how cyclical this illness is because of this, this may fragment families over time. Riley said: “If that cycle continues, then the family is like you know you can't stay here, we have to find somewhere else for you to go or someone else to help you and it that's where the separation occurs.”

Treatment non-compliance is always an issue when treating a person with a mental illness who stops taking medication because they begin to feel better. However, Campbell in FG 6 spoke of a different way treatment non-compliance is an issue and this is by family trying to assure a family member everything is fine. Campbell said:

> I want to stop you…sometimes we give the client a false sense of security that they're okay…that they don't need help that yeah I'm good there's nothing wrong with me and they think they can function normally but they actually don't because no one is helping them to see that you know or know that your behaviors and mannerisms are not quote normal.

Now I will look at the last component of research question one and this is FG question 5 about emotional impact of FB. Some concerns about effects of FB on families repeated from others questions were medical issues, stigma, and being overwhelmed. New concepts on this question were normalization of illness, guilt, labeling, fear, anger, and blame. Campbell in FG 6 again had a different take on normalization of schizophrenia. Normalization according to Campbell is detrimental to the process. Campbell said:

> And then, when things happen there you know it's almost like because I'm treating you as if you're normal I'm expecting more from you, yet I kind of reoffend you because I am not taking in consideration that you have this disorder.

Guilt is an emotional impact of FB. However, it may present as a dichotomous issue. Jordan in FG 1 noted in an earlier quote how families should know what to do. Then Harley in FG 2 presented the other end of guilt, “There was just a lot of guilt, I did something wrong he didn't used to be like this.” Now the guilt is not from not knowing what to do but blame for the illness. Ryan in FG 6 pointed out labeling as an emotional impact, “…schizophrenia somebody was like no, you know why we give these people a label, you know why can't we just say this is a disorder that they had… this is not who they are.” Labeling does seem at times to strip the person away leading to dehumanization. Rowan in FG 5 had previously commented on the overwhelming nature of labeling as a mental health impact.

Hartley also addressed emotional impact of fear. Fear not from bodily harm but from concerns about who will provide care once a parent has dead. Hayden said fear may come in other forms and said: “Fear… so there's just as you know the family is scared of the medication the family is scared of their family member….” I in FG 7 combined many ideas raised from emotional impact of anger and said: “this gets you angry at number one at yourself, for not knowing and number two for your family member putting this stress on you.”

RQ2

RQ2 addressed what MHPs think are barriers when addressing FB. FG questions 7 and 8 addressed barriers. FG question 7, looked at ways to reduce FB and FG question 8, asked what policies needed to deal with FB. Regarding ways to reduce FB, issues raised were educate patients and family, educate professionals, train staff, improve ineffective treatments, use multiple providers on a case, normalize mental health, and improve resources.

Many participants like Hartley in FG 2, felt stigma needed more education. Hartley said: “Education around the stigma piece, I think that is why we don't use the village early on, because we feel some shame about what's going on in our family.” Thomas in FG 5 felt the young need to know about mental illness early to warn them of future dangers. Thomas said, “No, absolutely but I'm saying as a whole, my energies would be more toward the young and upcoming because they're more impressionable they're more open they're more in if we look at you know, stages of change.” Educational improvements were not limited to families and Georgia. Jordan in FG 1 repeated a sentiment of other groups in an already noted quote about stigma staff puts on families.

One solution suggested to reduce FB was to have multiple providers’ assigned different roles to assist families. Thomas in FG 5 already stated in an earlier quote needs for multiple therapists. This is a unique and novel approach to this problem. It would call for these therapists to have additional training in FB.

Society has not made it easy for those with mental illness to exist. Mental illness needs more discussion. Hayden in FG 4 said, “I mean just as you talked about the society and ripping of the family and all of those things…there's like not a safe place for people that are mentally ill.”

As stated in previous sections a lack of resources poses a continued barrier. Remington in FG 6 spoke previously to another barrier as poor staff training leads to burnout if not addressed. Remington made another point about organizations or agencies providing services. These are not blameless in problems and must do more to train staff. Remington stated:

> Yeah, but you know…the auditors coming in and auditing of files and the people who own companies, they have to get to a point where it's not about just making all the dollars, you can make you have to invest in your workers...not investing in their workers regardless of what company it is you know if they're not investing in their workers enough well, you don't have the workers that you need to get the top quality of work you would normally get.

Justice in FG 7 made a keen statement about addressing ineffective treatment, “Because we have to look at strategies that do not work just, as well as, we look at strategies that work.” This statement suggested mental health has not analyzed all solutions both bad and good.

There are also barriers in dealing with FB from policies needing change to address the issue. Major themes in this area were awareness, and education, as stated earlier, funding, and system change. Awareness is an issue and just having discussions with MHPs similarly to this study may be one effective policy change. Peyton in FG 3 wanted issues discussed more in school and increased public awareness about mental illness.

Many professionals know funding is always a concern. Cuts to mental health budgets occur because constituents do not ask elected officials and policy makers to increase funding. This lack of engagement leads some to use law enforcement for help. Rowan in FG 5 stated helping mentally ill people avoid jail would reduce burden. Rowan said:

> Well, I'll mention a couple of things. I don't know if I could go over each level, but I know for sure that locally obviously as I spoke to before we can begin to…um free up money and really put money towards the mental health court...

Campbell in FG 6 suggested a different way to address funding, with maybe including illness severity as a factor in changing funding policies. Campbell said:

> And when you say one, at a time, I would say just convince them to allocate more funds in regard to mental health and mental health services and maybe earmark a certain amount for each particular disorder, especially…we're talking about the prevalence if this is the one that is most prevalent then, it should get the most funds.

Participants discussed some topics and themes more than others did. The decreased frequency of noting an issue does not lessen the issues’ importance. If data or answers in a FG only show up once or a few times this does not make this data less important. Instead this may point out this question has not been raised previously in ways for data to count. Taylor in FG 3 does such a thing by suggesting an entirely new federal agency to correct the broken mental health system. Taylor said, “Do we have we have anything on a federal level that does address mental health like we have the Department HUD and emergency disasters.” This is a new way of addressing this issue needing serious consideration if Georgia wants to address FB and other mental illnesses correctly.

Thomas in FG 5 made a suggestion about a need to intervene in systems and said, ‘integrate systems you know the court systems, working with the faith-based systems, working with the schools working together, so you have some collaboration, so when the state comes up with a philosophy and you get federal funding.” Another system change was how criminal justice handles minor crimes mentally ill people commit. Hayden in FG 4 stated:

> As opposed to let me just criminalize this and take them through the you know…the ringer and then cost family member more, I think the local and state can put together programs to address this issue, and how to actually support the police department with mental health staff with more education…

RQ3

RQ3 involved multiple perspectives defining FB. This question was in FG questions on the coursework received in graduate school, trainings needed to become effective dealing with FB, ways to reduce FB, FB’s societal view, and policies needed to address FB. Coursework revealed most had no training on FB and some had very limited exposure to it. Training needs question revealed professionals need more classes on families, need more exposure to severe and persistent mental illness, MHPs could benefit from parenting education, MHPs need case studies with more real world exposure, and MHPs need more knowledge on how to help families advocate.

Ways to reduce FB centered on education of patients/family/professionals, training professionals better, improving ineffective treatments, using multiple professionals on a case, normalizing mental health, and improving resources. Results previously presented examples on what course work professionals took in graduate school. Now I can address what classes they need. Rowan in FG 5 stated, “For me for family burden, I think, maybe the role of the family, because a lot of them don't know what schizophrenia is and what it looks like.” Thomas in this same group said, “Teaching families, knowledge, and understanding of working with the treatment providers that they have and boundaries and understanding the overall illness, so they don't continue to enable the ill, the person that's dealing with the illness”. Hartley in FG 2 stated, “I think our education kind of lets us know how to provide individually to the patient, but it doesn't really address the system, the family system.” Lennon in FG 7 said, “I would, I would agree with that, but also say that we also need to develop a program in the school that provides the type of advocacy training for us to deal with families.”

Case study is an important tool to teach how to deal with FB. River in FG 2 stated, “Like Taylor said, in the case studies, you were really focused on diagnosing you know what's in front of you, I think it would have helped me to go a step further.” Hayden in FG 4 felt like many new professionals when entering the field, while addressing needs for more exposure. Hayden said, “Uh I think yes, it would have helped just so you didn't sort of go in blind and feeling your way, and then …when dealing with the families." Karter in FG 4 saw professionals learning about parenting as an unmet need. Thomas in FG 5 said: "I think in schools they don't really use or teach about severe and persistent mental illness."

Society's views FB in these FGs ranged from blaming families for its existence, a complex view, society does nothing about it, society has no view at all, society not caring about it, and society's view depends on social economic status of client. Campbell in FG 6 said, "It's the family's problem." Phoenix in FG2 was quoted earlier stating society blames families. Hartley in FG 2 felt American society helped in blaming families, and said:

> I think our families got victimized by that concept of pull yourself up by your own bootstraps kind of thing too is like okay that's your family that's what y'all got to deal with is not seen as Oh, maybe our system is lacking some resources.

Society can at times almost ignore FB because it does not affect everyone. River in FG 3 stated, "it's almost as if, as if it hasn't happened in your family or within your social group, or whatever, then it's now almost like non-existent." Karter in FG 4 said, "society is just dismissive they really don't care they are the ones who [society] that are contributing to the burdens that a lot of families are experiencing." Thomas in FG 5 said:

> I think that's a complex concept, because…What society are you talking about, so I think when you look at society, you can look at the overall like maybe American society…maybe in looking at maybe your religious affiliation or your cultural affiliation so there's that burden and of itself, the overall view the popular view which is ever evolving.

Thomas’ remarks showed society’s view is ever evolving due to cultural implications. These shifts must go into any solution. Thomas also related social economic status in this discussion and said: “Those who are more affluent with power in society [get] changes and then some of those are dealing with social economic issues and do not have the power they're the forgotten.” The last question on policy, I previously summarized in a review of RQ2.

I reviewed major findings for RQ1, RQ2, and RQ3. During review of results, there were no discrepant or nonconforming data.

Figure 12

MHPs' View of FB in Georgia

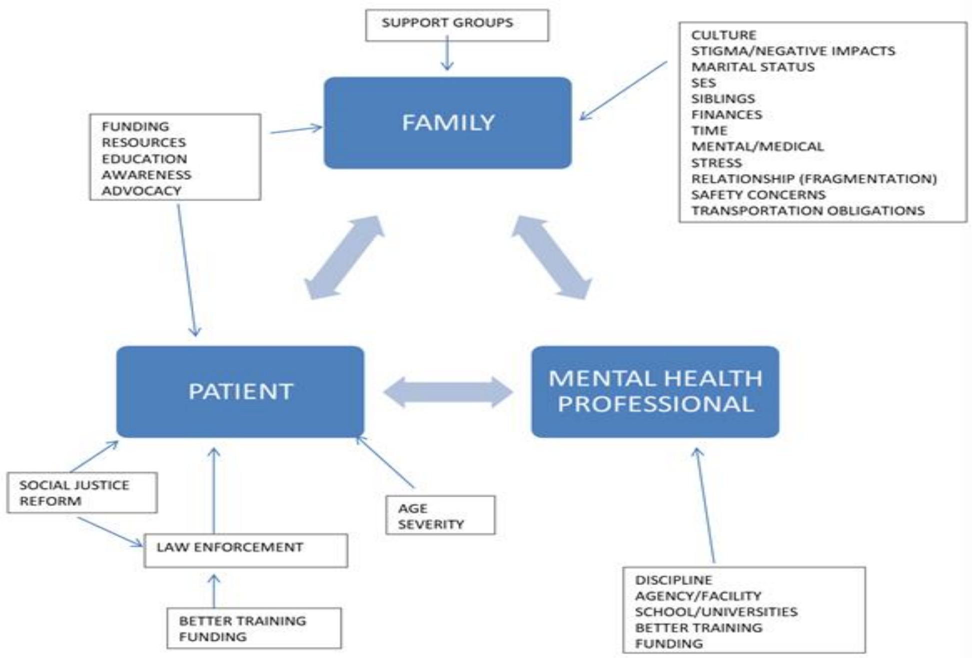


Figure 12 shows factors in Georgia influencing FB as highlighted by participants. FB is a construct composing three main constituents, patient, or client dealing with schizophrenia, family caring for them, and MHP treating both. The first influence on MHPs is what they know about FB from a school or university granting a degree. Another important factor is what degree or discipline MHPs studied to shape how they learned about clients or patients. Another influencer is agency/facility employing them and its rules for treating patients. One point made is MHPs need more training about FB in school. In addition, treatment facilities should work to improve ineffective treatment approaches.

Family in Figure 12 is a separate entity from client/patient but in reality, both are fused. For this discussion however, I separated them to show their unique factors. Many factors influence families. First, social economic status of family influences FB. Families more affluent have more access to resources than less affluent ones. A family's culture also matters as an influencer. Minority families have less access to resources. A family's marital status also is important. Single parents have greater burden as opposed to married parents. For siblings, if they assist with caretaking, or withdraw from this role it influences FB. Extended families have an influence on families too. If extended families are supportive, FB is less. Schizophrenia in families produces stigma and negatively influences families. Because families treat a loved one, this takes finances and time away from families. These deductions produce stress, and relationship strains/fragmentation. All these could develop into mental/medical problems for families. FB lessens in families with more funding, more community resources, more education, awareness, and advocacy.

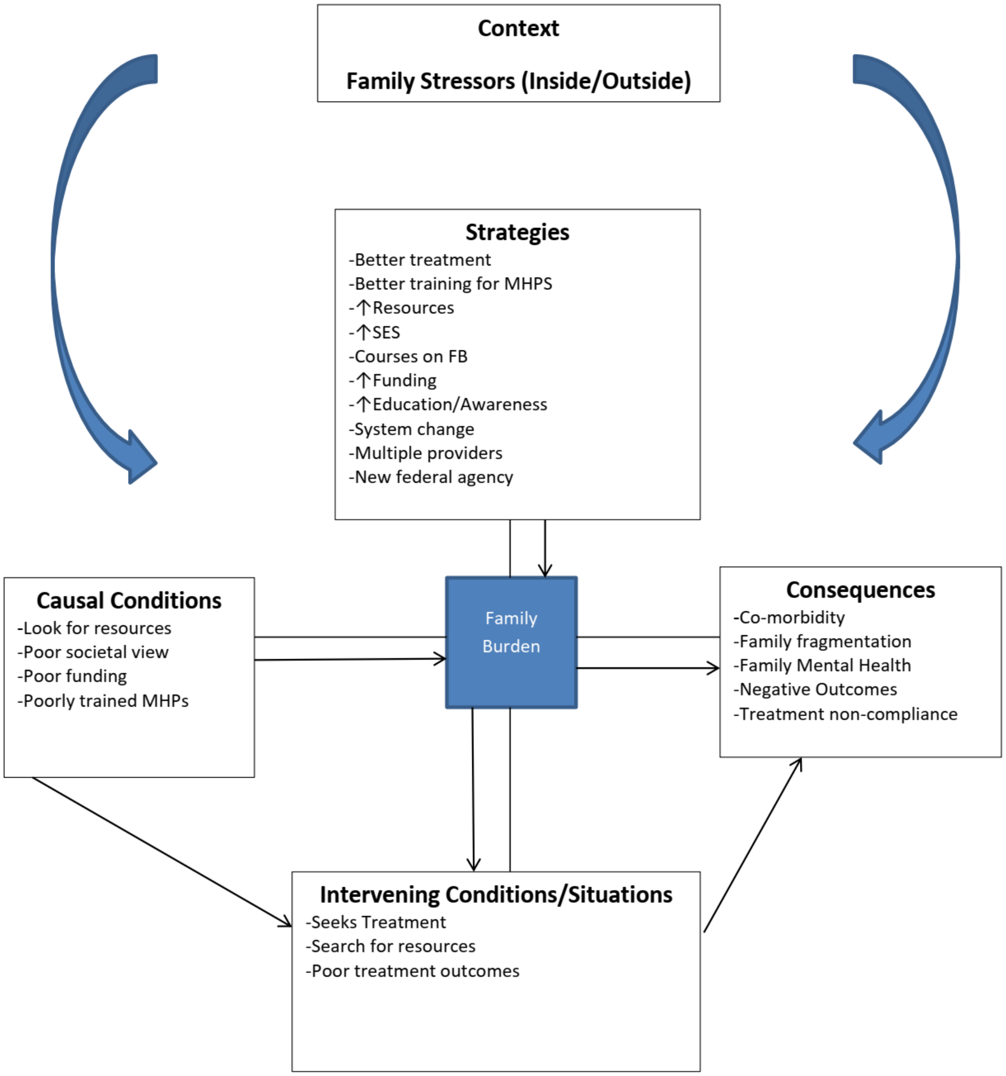
Client/patient in Figure 12 is not immune to any of influences of family. Separately for client/patient, illness severity, and age, influences levels of FB. A client's age influence services, funding, and treatment providers. Because of erratic behaviors, clients/patients may receive a referral to the police/criminal justice system. These erratic behaviors and poor decision-making is a by-product of disease symptoms. Social justice reform and better training of law enforcement can improve this interaction. Additionally, just like families, clients/patients may show a reduction in influences of FB if there was more funding, resources, educational awareness, and advocacy. Further interpretations on results appear in next section.

Diagrammatic Representations of Results

Charmaz (2014) referenced to early stated, GT should answer the following: what is happening here, what are the basic social processes, what are the basic social psychological processes, who exerts control over the process, and under what conditions? Figure 13 is a coding paradigm to explain Charmaz's points. Figure 13 depicts the context, strategies, casual conditions, intervening conditions/situation, and consequences of FB.

Figure 13

Coding Paradigm



This knowledge created a new theory about MHPs' knowledge of FB, which needs teaching in school to improve treatment for FB and schizophrenia. Causal conditions produce FB. These conditions are a lack of resources in Georgia, funding issues, a poor societal view of FB, and poor training of MHPs. Despite these conditions, patients/clients, and families seek out treatment and look for resources in Georgia. Since resources are limited, this may lead to poor treatment outcomes. Conditions and situations in patients and family lead to consequences. These consequences may be co-morbidity with other mental health or medical conditions, family fragmentation, family mental health issues, and treatment non-compliance. Improving FB involves, better treatment of families and patients, improved training of MHPs, increasing social economic status of families, university courses on FB or mental health's impact on families, greater awareness and education, systemic change, using multiple providers on a case, and creation of a new federal agency to deal with mental health problems.

A lack of resources in Georgia causes FB. This forces families to seek treatment. Poor resources cause comorbidity and fragmentation. Families need better treatment, education, system changes, and funding. These changes occur in a context of on-gaining family stressors.

This study produced this substantive level theory. When MHPs learn better treatment approaches and obtain better training, families will show a decrease in co-morbidity, less fragmentation, fewer mental health issues, lowered negative outcomes, and better treatment compliance. Now let me summarize this chapter's findings.

Summary

Research questions revealed MHPs defined FB in terms of forces both in and outside family homes. Inside factors may be daily life tasks, financial strain, and family pressures; outside factors include safety concerns, transportation issues, and lack of resources. Effects of FB may lead to family mental health issues, negative impacts, family fragmentation, and treatment noncompliance. FB may lead to medical problems for families, stigmatization, and overwhelmed feelings.

Ways to reduce barriers in FB include education of patients, families, and professionals, improved training, addressing ineffective treatments, using multiple providers on FB cases, normalizing mental illness, and improving allocation of resources. Policies for implementation to reduce barriers are improved awareness, more funding, criminal justice reform, and creation of a new federal department to address mental illness.

Therefore, multiple viewpoints can address this issue. MHPs receive no classes in graduate school to address FB. Society according participants too often blames families for FB and then makes burden worst by not assisting families to get help.

With this summary complete, Chapter 5 includes an introduction and restatement of the purpose, interpretation of findings, a review of study limitations, recommendations, implications, and a conclusion.

Chapter 5: Discussion, Conclusions, and Recommendations

I examined MHPs' perspectives of FB related to issues families endure when taking care of loved ones with schizophrenia. Data for this qualitative GT study came from 22 MHPs in seven FGs. In these FGs, they produced mind maps of problems families face when dealing with FB. Participants were asked questions related to classes they had in graduate school to treat FB, training they need to treat FB, factors causing FB, effects of FB, emotional impact of FB, Georgia's societal view of FB, ways to reduce FB, and policy changes to address it.

MHPs defined FB as a problem with a lack of resources. Lack of resources causes strain inside and outside of families, causing pressure, stress, and a lack of awareness. These issues worsen due to family size, lack of family support, family discord, treatment failures, family fragmentation, and guilt. Ways of easing FB included educating families, schools, patients, providers, and communities in Georgia. Other remedies include better training of professionals, using multiple providers on cases, more funding, reforms to the criminal justice system, and a new federal agency to address mental health. It is clear MHPs need more training in school. Agencies need better-trained staff. Georgia and the US need to normalize mental illness. Georgia needs to recognize FB exists in order to provide families the right support.

Interpretation of the Findings

The literature review in Chapter 2 covered many topics involving the theoretical background of this study. I addressed the severity of FB, implications for IT to look at complex problems like FB, Lefley's work on FB, and schizophrenia. The last topic addressed in literature was system change.

Wancata et al. (2006) said caregivers need a needs assessment to understand what families need to survive FB. This is consistent with more education of families about FB. Stälberg et al. (2001) noted the loss siblings experience in FB families. Campbell during the mind map exercise noted siblings conflicted roles in families dealing with FB.

Many participants listed stigma as a factor and barrier for families. Jordan mentioned it as a barrier in FG 1. Another barrier is the criminal justice system as not safe for people dealing with mental illness. Rowen in FG5 noted reducing jail stays might reduce this burden. Participants noted better treatment for those with schizophrenia as a remedy.

MHPs are ill equipped to handle issues with clients and families dealing with schizophrenia or severe mental illness (Morris & Stuart, 2002; Rhoades, 2000). MHPs in this study validated this with their acknowledgment of their lack of training in graduate school.

Ae-Ngibise et al. (2015) found in Ghana 14% of families dealt with FB when treating loved ones with schizophrenia. When FB was present, it produced stress, feelings there was a lack of support, and stigma. Many participants noted family's lack of knowledge about schizophrenia is an outcome of FB. The education of families could improve if schools use IT to train MHPs about FB.

Marquis (2007) described IT as "a way of knowing that helps one strive for the most comprehensive understanding of any phenomenon" (p. 162). This does appear to be a better way to educate MHPs about FB. The four-quadrant system is a comprehensive way to address all issues of FB in a new way. The upper right quadrant involves ways MHPs look at clients or patients.

The upper left quadrant involves issues inside individuals. The lower left is “We” language to address the impact of culture and morality. The lower right is the “Its” language looking outside the collective. The quadrant system addresses how to educate families and clients on FB and schizophrenia. The quadrant system helps with cultural implications of FB and its influence on communities and society in Georgia and the US. The results of the study show the complex nature of FB and the need us IT to have a better conceptualization of clients and families.

Despite participants having little knowledge of FB, many of them used similar terms Harriet P. Lefley used to describe FB. Lefley (1989) said objective components of FB caused mental illness in families, financial problems, family functioning issues, reduced social activity, family strain, and time limitations. Subjective components were loss of hope, reduced family plans, and guilt. According to Lefley, stigma for families occurs when families feel betrayed by the mental health system due to staff turnover and staff distancing them from family. Again, these themes showed up in FGs and mind maps. These FGs showed MHPs of today do not receive proper training.

Barriers have situational, societal, and iatrogenic components (Lefley, 1997b; Marsh & Lefley, 2003). Situational barriers have adverse consequences. Societal barriers lead to stigma, decreases recovery, produces less research on FB, causes more hospitalizations, premature discharges, legal issues, inadequate community supports, and jail. Iatrogenic barriers stem from staff blaming families for illness, poor clinical training, lack of community support, and lack of providers. Participants noted these same issues.

Crespo (2003) said poverty of speech is an outcome when patients cannot differentiate or modify connotation or denotation of words. This may make conversations with families difficult, leading to family fragmentation. Arieti (1976) said hallucinations are a way of making concrete and real, unusual perceptions due to schizophrenia. If patients hallucinate, they may appear paranoid while interacting with family members or providers, thus leading to misinterpretations of their behavior.

Findings in this study confirm research in the literature review. In graduate school, MHPs received little to no training on FB. MHPs also mirrored what effects, barriers, and causes of FB found in literature.

Limitations of the Study

Some limits in this study were participants bringing biases to FGs. There is no apparent evidence of this occurring. All participants discussed freely what they learned in school and what would make training better. Participant views did not seem restrictive or refusing to change. All listened to each other and at times agreed with statements or added comments.

Another potential limitation was I presenting my biases, which could sway FGs. I controlled this by following the FG protocol and I allowed data in FGs to lead to further discussion. By following GT principles, this also protected against my biases. I kept a journal to monitor my feedback and thoughts.

In this study, research questions drove data collection. I asked research questions in FGs. Questions were open ended to allow flexibility to answer all questions freely. The original assumptions for this study did become reality. All participants were professionals. All were voluntary. All appeared to be honest and had a sincere desire to address this study's topic FB. This study allowed them to contribute in creating a new theory. Because I was a trained therapist, rapport was easy to build with participants. With rapport established, trust developed. Trust allowed participants to give honest, evidence for this study.

Recommendations

A major recommendation is teaching MHPs about FB. When teaching FB to MHPs, I recommend incorporating IT into curriculum. This curriculum should include teaching MHPs about parenting skills, and teaching families about advocacy.

Other recommendations to consider are a similar study like this with patients and family. FGs should view perspectives of patients and families and use IT to ask FG questions. Many questions of this study I would use again to see if similar mind maps and a theory on FB occur from these groups. I recommend dividing these FGs into patients and family. It probably is best to build theory separately for family and participants to ensure unbiased answers. After analyzing and comparing findings, of this study along with two separate patient and family FGs, then I suggest a final FG with patients, family, and MHPs come together to discuss FG questions to create a final combination of all three in one theory.

Implications

Positive Social Change

The reason for this study was to produce positive social change. After working in mental health field for a number of years, I noticed problems in how those living with schizophrenia and their families were treated. One way to help this population is to devise better ways to improve treatment they receive.

I hope this study will improve how patients receive services to improve their dignity and liberty in society. In addition, if better-trained MHPs are a result then they will feel more confident and competent in their work. An outcome of study recommendations could be families feeling less stress, less fragmentation, less alienation, families receiving integrated services, and better relationships in families.

Organizationally, universities could graduate better students and mental health treatment facilities may have better potential employees to hire. These better-trained staff may become more efficient in their work and save expenditures on staff salary, thus increasing company and state budget profits. Society will have less people in jail and hospitals for mental health reasons. All these could lead to tax dollars going to other projects.

Policy wise, better-trained, and informed MHPs could advocate in state and federal legislatures for more money for mental health research and treatment. These implications remain within the scope of this work and do not exceed it.

IT needs inclusion in MHP training programs. The field of mental health has relied on the same model of client symptoms and clinician signs to define diseases for too long. Because of old training methods, this current system does not seem to meet the needs of families and patients. IT is a new approach combined with Lefley's research on FB could create innovations. This new way could provide theoretical and empirical changes to how the mental health system and field looks at mental illness. Before, these theories can apply, Georgia needs this research to understand MHP understanding of FB and form this new theory.

Regarding implications for practice, just having this knowledge changed how I see clients. Now I look beyond signs, symptoms, and look more systemically to find solutions. This knowledge has improved my practice and I am certain it will do the same for others.

Counseling and mental health students in graduate casework present case conceptualization during practicum and internship. The current way has students presenting demographic information, why clients presented, signs, symptoms, and treatment history. Nowhere in presentations do students view how mental illness either influences clients or how being mentally ill in society produces barriers for clients and families. Figure 14 shows how IT needs combination with present theoretical orientation and ethics MHPs learn in school. IT, the theoretical orientation of MHPs, and ethics of MHP's all share and interweave topics to provide a new teaching model, which solves the current void in MHP's education. MHPs in graduate school will have IT infused in coursework in graduate school to help them understand the complex issues in addressing FB.

Additionally, Figure 15 extends this model to include FB’s void. Now when asked to conduct a case presentation, students will bring this new knowledge they gained in school as a result of this study along with their ethics, and theoretical orientation to present cases in a new and more relevant ways to address a complete clinical picture. This new clinical picture will help MHPs derive efficient interventions to treat mental health problems and reduce FB.

Figure 14

Proposed New Model of Case Conceptualization

Figure 15

Proposed New Model of Case Conceptualization for FB

Conclusion

This study has added relevant new data to the literature. First, MHPs are knowledgeable of problems in their profession if added to research studies to provide their knowledge. Second, FB is a complex problem with no one solution. Reducing its effects will take MHPs with the training to improve it. Third, GT though lengthy and time consuming is an appropriate tool to use to address social concerns.

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Appendix A: Partnership Letter

To: Potential Research Partner
From: ________________
Re: Site use for research
Date: July 1, 2020

I am pursuing a PhD in Public Policy from ________. I am currently in the study phase of my journey the title of my study is “Mental Health Professionals and Family Burden: Ways to Improve Training and Treatment”. I am asking you if I could use your location and facility to host focus groups to conduct the research. Attached to this document you will find my prospectus on this unique topic. I am hopeful that we can form a strong partnership to improve treatment outcomes of this population.

If you have any questions please reach me at____________.

Thank you in advance for your time and consideration.

Appendix B: Study Announcement

WHO: PROVIDERS THAT TREAT PATIENTS WITH SCHIZOPHRENIA?

WHAT: A UNIQUE FOCUS GROUP RESEARCH OPPORTUNITY IN YOUR AREA TO UNDERSTAND AND INVESTIGATE BETTER TRAINING METHOD FOR PROVIDERS WHO TREAT SCHIZOPHRENIA

WHERE: xxxxxxxxxxxxxxxxxxxxxxxxxxx

WHEN: xxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
ALL INTERESTED PLEASE COMPLETE THE
ENCLOSED POSTCARD OR CALL:__________
JOHNNIE L. JENKINS, III,
DOCTORAL STUDENT AT __________

THANKS.

Appendix C: Phone Protocol

Hello! Is _____________________in?

Hello! My name is ___________, a doctoral student at ____________who is conducting research on using focus groups comprised of mental health providers to investigate better training methods to help them assist families in dealing with the family burden of schizophrenia.

I received your postcard stating your interest in the study.

I want to speak with you briefly to make sure you meet the criteria.

First, are you a licensed mental health professional who treats patients with schizophrenia?

Second, do you have a masters or higher degree?

Third, did you obtain licensure at least 3 years ago?

Fourth, have you treated people with schizophrenia for at least 2 years?

Fifth, do you understand that participation is voluntary?

Sixth, are you willing after the study to review the findings for accuracy?

Are you available on XXXXXXXX at 6:30 PM?

[If no to the above, I would thank the person for their time but state that they do not fit the criteria. “Goodbye”.]

[If yes to all the questions, I will say, “Great, you are eligible”].

Our session will be on XXXXX at 6:30 PM at________________. Are you familiar with the location? I will send you a map of the exact location.

You do understand that you will come to __________ on ___________ to discuss your training related to schizophrenia in a focus group session. You will only be in the focus group all providers.

I will be the one leading the discussions.

You are aware that the sessions are audio taped. Are you okay with that? In a few days, you will receive a confirmation letter, directions, and informed consent document for you to bring to the session to participate.

You are able to terminate your participation at any time.

I will also provide snacks and refreshments.

Your statements in any reports will remain confidential.

If you want a summary of the results please email, call, or write me.

Do you have any questions?

Do you still want to participate?

If you cannot participate please let me know as soon as possible.

Thanks for your help and have a nice day.

Appendix D: Demographics Form

Name (pseudonym)____________________________

What is the location of the group? __________________________

Age____

Race (check one)
__African American
__Hispanic American
__Caucasian
__Asian American
__Other____________________

Highest Grade Completed
__MA
__MS
__MEd
___LMFT
___LCSW
__Nursing
__Other

Occupation ____________________________

Marital Status: (check one)
__Never married
__Married
__Divorced
__Widowed

Approximate Household Income Level (All sources): (Check one)
__$0-5,000
__$5,100-10,000
__$11,000-$20,000
__$21,000-$50,000
__$51,000-$75,000
__$76,000-$100,000
__Above $100,000
__Don’t want to answer

Employment Status: (Check one)
__Employed Full-time
__Employed Part-time
__Unemployed
__Disabled (unable to work)

How many clients do you approximately see per week?
___0-10
___10-20
___30-40
___50-60
___60-70
___Other

How many hours per week do you approximately work?
___0-15

___15-30
___30-40
___40-50
___50 or more

Appendix E: Focus Group Protocol

PROJECT:

TIME OF THE FOCUS GROUP:

DATE:

PLACE:

POSITION OF INTERVIEWER: (DESCRIBE THE PROJECT):

CONFIDENTIALITY:

CONSENT FORMS:

GROUND RULES:

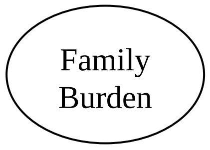
OPENING CIRCLE:

INTRODUCTORY QUESTIONS:

EXPLANATION OF FB: refers to the caregiving, psychosocial, and financial burden associated with a family member’s medical condition. Many physical and mental conditions make significant demands on caregivers’ resources, and these requirements can result in care providers becoming depressed, socially isolated, and physically ill (Schulz & Beach, 1999).

MINDMAPPING ACTIVITY:
Mind map- a brain storming memory process using diagrams to build, arrange, and discuss activities or concepts radially around a central concept or idea. Connectors, arrows, lines, with different colors used to show relationships (Creativity Web, n.d.; Mind-Map, n.d.; Ungvarsky, 2019; Smith, 2019; Dunn, 2020).

Mind Map Drawing Surface



Create a Mind Map that illustrates the problems with treating family burden. Please address this question in your drawing:

1) What are the problems in dealing with family burden?

After completing this write, a brief sentence or paragraph about what you created.

FOCUS GROUP KEY QUESTIONS:

The questions asked in the individual interviews and focus groups are:

1) What coursework did you receive in graduate school that discussed family burden or specialized skills to treat families dealing with a loved one with schizophrenia?
2) As you now think about family burden, what training in graduate school would help to treat or mitigate this condition in the community?
3) What do you think are some of the factors that cause family burden?
4) If family burden is not addressed what may be some of the effects on patients and families?
5) What emotional impact do you think family burden has on families and patients?
6) How do you think society views family burden?
7) In your opinion, what strategies/practices can you suggest to reduce family burden?
8) In what way to do you think local, state, and federal levels of government can improve resources or psychoeducational programs, reduce stigma, and increase family involvement for the strategies described above? Please take each level one at a time.

ENDING QUESTIONS:

THANK THE PARTICIPANTS FOR PARTICIPATING

Appendix F: Demographics Raw Data Sheet

Total number of participants in this focus group: ________

What is the location of the group? _________________________

Age: What was the average age? ____What was the range of ages. ______________

Race: How many participants were?

____African American ____Percentage
____Hispanic American ____Percentage
____Caucasian ____Percentage
____Asian American ____Percentage
____Other ____Percentage

Highest Grade Completed: How many were.

____MA ____Percentage
____MS ____Percentage
____MEd ____Percentage
____LMFT ____Percentage
____LCSW ____Percentage
____Nursing ____Percentage
____Other ____Percentage

What were the Occupations of these mental health professional?:

____
____
____
____
____
_________ ______________________________

What were the totals for this group?

____Never married ____Percentage
____Married ____Percentage
____Divorced ____Percentage
____Widowed ____Percentage

How many mental health professionals had income in the following ranges?

____$0-5,000 ___Percentage
____$5,100-10,000 ___Percentage
____$11,000-$20,000 ___Percentage
____$21,000-$50,000 ___Percentage
____$51,000-$75,000 ___Percentage
____$76,000-$100,000 ___Percentage
____Above $100,000 ___Percentage
____Didn’t want to answer ___Percentage

How many mental health professionals were?
____Employed Full-time ___Percentage
____Employed Part-time ___Percentage
____Unemployed ___Percentage
____Disabled ___Percentage

How many clients do you approximately see per week?
___0-10 ___Percentage
___10-20 ___Percentage
___30-40 ___Percentage
___50-60 ___Percentage
___60-70 ___Percentage
___Other ___Percentage

How many hours per week do you approximately work?
___0-15 ___Percentage
___15-30 ___Percentage
___30-40 ___Percentage
___40-50 ___Percentage
___50 or more ___Percentage

Appendix G: Demographics Totals for Each Group

Total number of participants in all Provider Groups: ________

Age: What was the average age? ____What was the range of ages. ______________

Race: How many participants were?

____African American	____Percentage
____Hispanic American	____Percentage
____Caucasian	____Percentage
____Asian American	____Percentage
____Other	____Percentage

Highest Grade Completed: How many were?

____MA	____Percentage
____MS	____Percentage
____MEd	____Percentage
____LMFT	____Percentage
____LCSW	____Percentage
____Nursing	____Percentage
____Other	____Percentage

What were the Occupations of these mental health professionals?
:____
____
____
____
____
________ ___________________________

What were the totals for all groups?

____Never married	____Percentage
____Married	____Percentage
____Divorced	____Percentage
____Widowed	____Percentage

How many mental health professionals had income in the following ranges?

____$0-5,000	___Percentage
____$5,100-10,000	___Percentage
____$11,000-$20,000	___Percentage

_____$21,000-$50,000 ___Percentage
_____$51,000-$75,000 ___Percentage
_____$76,000-$100,000 ___Percentage
_____Above $100,000 ___Percentage
_____Did not want to answer ___Percentage

How many mental health professionals were?
_____Employed Full-time ___Percentage
_____Employed Part-time ___Percentage
_____Unemployed ___Percentage
_____Disabled ___Percentage

How many clients did the mental health professionals see per week?

___0-10 ___Percentage
___10-20 ___Percentage
___30-40 ___Percentage
___50-60 ___Percentage
___60-70 ___Percentage
___Other ___Percentage

How many hours per week did the mental health professionals work per week?
___0-15 ___Percentage
___15-30 ___Percentage
___30-40 ___Percentage
___40-50 ___Percentage
___50 or more ___Percentage

Appendix H: Contact Summary Form

Focus Group Location ______________________________

Focus Group Time start_______ end_____

What were the salient concepts, themes, issues, reflections, and emotions during this session?
What information did I get or failed to get for each of the targeted questions?

What was the participants' level of rapport?

What are some issues to address for the next group?

What new hypothesis or speculations come from this group?

Appendix I: Mind Mapping Raw Data Collection Form

Focus Group Location ________________________________

Focus Group Time start_______ end_____

Focus Group Composition: __Provider

Participant: _______________

Quadrant 1:
Images:

Colors:

Words:

Impressions:

Quadrant 2:
Images:

Colors:

Words:

Impressions:

Quadrant 3:
Images:

Colors:

Words:

Impressions:

Quadrant 4:
Images:

Colors:

Words:

Appendix J: Study Research Questions

The research questions are:

RQ1: How do mental health professionals define FB?

RQ2: What do mental health professionals think are barriers for families dealing with FB?

RQ3: How can multiple viewpoints and perspectives assist in defining FB and influence formal education of mental health professionals to reduce FB?

Appendix K: Mind Mapping/Focus Group Questions

MINDMAPPING ACTIVITY: Create a Mind map that illustrates the problems with treating family burden. Please address this question in your drawing:

1. What are of the problems in dealing with family burden?

After completing this write, a brief sentence or paragraph about what you created.

FOCUS GROUP KEY QUESTIONS:

The questions asked in the individual interviews and focus groups are:

1) What coursework did you receive in graduate school that discussed family burden or specialized skills to treat families dealing with a loved one with schizophrenia?
2) As you now think about family burden, what training in graduate school would help to treat or mitigate this condition in the community?
3) What do you think are some of the factors that cause family burden?
4) If family burden is not addressed what may be some of the effects on patients and families?
5) What emotional impact do you think family burden has on families and patients?
6) How do you think society views family burden
7) In your opinion, what strategies/practices can you suggest to reduce family burden?
8) In what way to do you think local, state, and federal levels of government can improve resources or psychoeducational programs, reduce stigma, and increase family involvement for the strategies described above? Please take each level at a time.

Appendix L: Cross Check Research Questions

Research Questions	Mind Mapping/Focus Group Questions
1. How do mental health professionals define FB?	1. Mind Mapping Activity 2. What do you think are some of the factors that cause of FB? 3. If FB is not addressed what maybe some of the effects on patients and families? 4. What emotional impact do you think burden has on families and patients?
2. What do mental health professionals think are barriers for families dealing with FB?	1. In your opinion, what strategies/practices can you suggest to reduce FB? 2. In what way do you think the local, state, and federal levels of government can improve resources or psychoeducational programs, reduce stigma, and increase family involvement for the strategies described above? Please take each level at a time.
3. How can multiple viewpoints and perspectives assist in defining FB and influence formal education of mental health professionals to reduce FB?	1. What coursework did you receive in graduate school that discussed FB or specialized skills to treat families dealing with a loved one with schizophrenia? 2. As you now think about FB, what training in graduate school would help to treat or mitigate this

	condition in the community? 3. In your opinion, what strategies/practices can you suggest to reduce FB? 4. How do you think society views FB? 5. In what way to do you think local, state, and federal levels of government can improve resources or psychoeducational programs, reduce stigma, and increase family involvement for the strategies described above? Please take each level at a time.

Appendix M: Format Change to Virtual Study

(NOTE THIS IS ONLY FOR AN ENGERGENCY SITUATION. THE INTENT IS TO CONDUCT IN-PERSON GROUPS)

Participants: Due to social distancing concerns, the study titled "Mental Health Professionals and Family Burden: Ways to Improve Training and Treatment" has made the following change in the protocol.

Change: The original intent was to hold in-person focus groups. However, due to health concerns, the format has changed to a virtual or group chat study. The interviews may be individual or in a group of up to five. This change may also require you to type some responses prior to the group to ensure accuracy of the information. In the future, you will receive a link or telephone number to call.

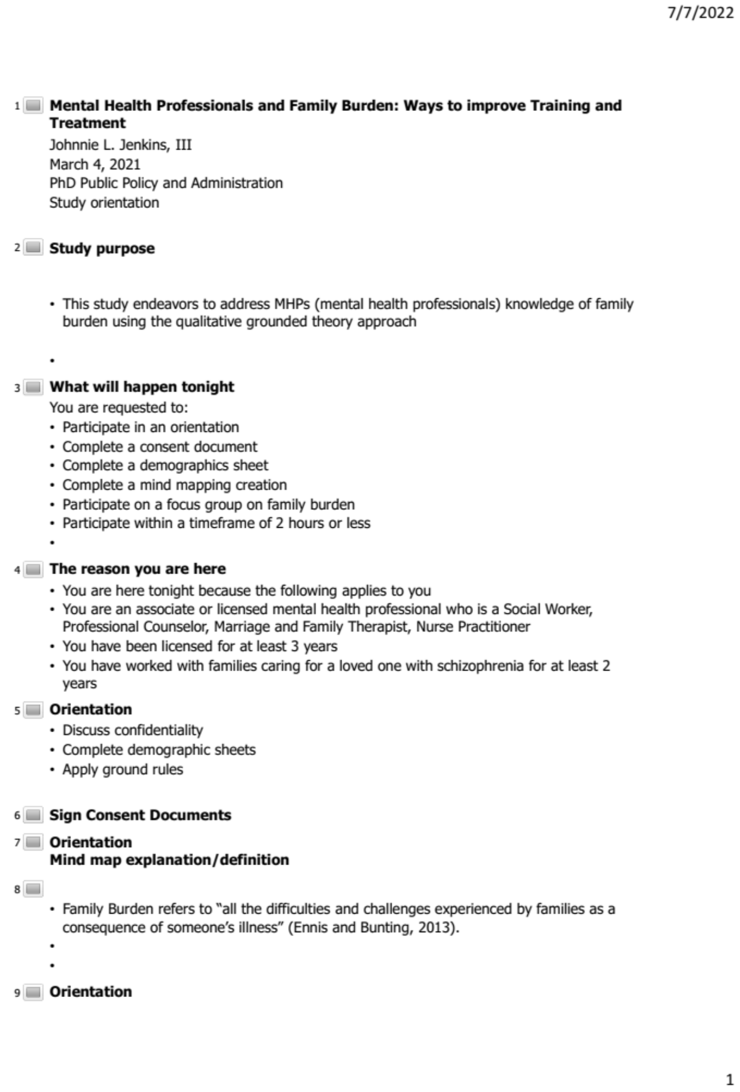
Appendix N: Format Change Due to Social Distancing

(NOTE THIS IS ONLY FOR AN ENGERGENCY SITUATION)

Participants: Due to social distancing concerns, the study titled "Mental Health Professionals and Family Burden: Ways to Improve Training and Treatment" has made the following change in the protocol.

Change: The current community situation is safe enough to provide in-person focus groups. However due to health advice, the format has changed to include the use of facemasks and gloves. It is the intent of me to provide those items but if not possible, I may ask you to bring your own items.

Appendix O: Study PowerPoint Presentations



7/7/2022

1 **Mental Health Professionals and Family Burden: Ways to improve Training and Treatment**
Johnnie L. Jenkins, III
March 4, 2021
PhD Public Policy and Administration
Study orientation

2 **Study purpose**

- This study endeavors to address MHPs (mental health professionals) knowledge of family burden using the qualitative grounded theory approach
-

3 **What will happen tonight**
You are requested to:
- Participate in an orientation
- Complete a consent document
- Complete a demographics sheet
- Complete a mind mapping creation
- Participate on a focus group on family burden
- Participate within a timeframe of 2 hours or less
-

4 **The reason you are here**
- You are here tonight because the following applies to you
- You are an associate or licensed mental health professional who is a Social Worker, Professional Counselor, Marriage and Family Therapist, Nurse Practitioner
- You have been licensed for at least 3 years
- You have worked with families caring for a loved one with schizophrenia for at least 2 years

5 **Orientation**
- Discuss confidentiality
- Complete demographic sheets
- Apply ground rules

6 **Sign Consent Documents**

7 **Orientation**
Mind map explanation/definition

8
- Family Burden refers to "all the difficulties and challenges experienced by families as a consequence of someone's illness" (Ennis and Bunting, 2013).
-
-

9 **Orientation**

1

- MINDMAPPING ACTIVITY:
- Mind map- a brain storming memory process using diagrams to build, arrange, and discuss activities or concepts radially around a central concept or idea. Connectors, arrows, lines, with different colors may be used to show relationships (Mind-Map, n.d.; Ungavarsky, 2019; Smith, 2019; Dunn, 2019; Buzan, 2007).
-
-
-
-
-
-

10 **Orientation**

- Mind map examples
-

11 **Creative Map Illustrations**
Exhibit A

-

12 **Exhibit B**

-
-

13 **Exhibit C**

-
-

14 **Questions?**

15 **Tonight's research**

- If there are no questions let's start the study.
- Please begin by completing the mind map creation exercise.
- Create a Mind map that illustrates the problems with treating family burden. Please address the following question in your drawing:
-
-

16 **Tonight's research**

- What are the problems in dealing with family burden?
- After completing this, write a brief sentence or paragraph about what you created. You will have about 15-30 minutes to complete.
- Once you are done we will start the focus group discussions

17 **Focus Group Questions**

- What coursework did you receive in graduate school that discussed family burden or specialized skills to treat families dealing with a loved one with schizophrenia.?

18

- As you now think about family burden, what training in graduate school would help to treat or mitigate this condition in the community?

19

- What do you think are some of the factors that cause family burden?

20

- If family burden is not addressed what may be some of the effects on patients and families?

21

- What emotional impact do you think family burden has on families and patients?

22

- How do you think society views family burden?

23

- In your opinion, what strategies/practices can you suggest to reduce family burden?

24

- In what way do you think local, state, and federal; levels of government can improve resources or psychoeducational programs, reduce stigma, and increase family involvement for the strategies described above? Please take each level at a time.
-
-