Family Psychoeducation Groups (Multi-Family Groups) Training for EASA

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The experience of working with families

What do families want and need?

What do consumers want and need from their families?
What would you want if you or a loved one developed a psychotic illness?
...an opportunity for practitioners, consumers, and families to better understand and overcome the symptoms of mental illness, while maintaining hope.

.....a socially constructed paradigm to combat mental illness.
Why Focus on MFG?

- People want information to help them better understand the illness process.
- Consumers generally want and need the support of their families.
- Families usually want to be a part of the consumer’s recovery.
- People want to develop skills to get back into the mainstream of life.
Positive Outcomes from MFG

• The consumer and family work together towards recovery.

• Can be as beneficial in the recovery of schizophrenia and severe mood disorders as medication.

• Leaders report greater work satisfaction
Research with Family Psychoeducation

• This treatment is an elaboration of models developed by Anderson, Falloon, McFarlane, Goldstein and others.

• Outcome studies report a reduction in annual relapse rates for medicated, community-based people of as much as 50% by using a variety of educational, supportive, and behavioral techniques.
Research with Family Psychoeducation

• Functioning in the community improves steadily, especially for employment.

• Family members have less stress, improved coping skills, and greater satisfaction with caretaking.
Relapse outcomes in clinical trials

- No medication: 65
- Individual therapy & medication: 41
- FPE & medication: 15
- MFG & Meds: 9
Other effects in clinical trials

- Improved family-member well-being
- Increased patient participation in rehabilitation
- Substantially increased employment rates
- Decreased psychiatric symptoms, including deficit syndrome
- Improved social functioning
- Decreased substance abuse
- Reduced costs of care
Negative symptom outcomes: PMFGs vs standard care

SANS score, mean

PMFG vs SC: p<.05, all f/u time points

Dyck, et al., 2000
Family influences on education and work

Modeling
Information
Encouragement
Buffering
Guidance
Adjusting expectations
Ancillary support
Cueing
Personal connections
Influences of multi-family groups on education and work

Reducing family confusion, tension and stress
Tuning and ratification of goals
Coordination of effort by family, team, patient and employer
Developing informal job leads and contacts
Cheerleading and guidance in all phases of working
Ongoing problem-solving
What is Family Psychoeducation?

An approach designed to:

• Help families and consumers better understand mental illness while working together towards recovery.

• Recognize the family’s important role in recovery.

• Help clinicians see markedly better outcomes for consumers and families.
Central assumptions of the psychoeducational model

Success in promoting change in behavior and attitude requires:

• the establishment of a cooperative, collegial, non-judgmental relationship among all parties

• education supplemented with continued support and guidance

• breaking problems into their components and solving them in a step-wise fashion

• support from a network of well-informed and like-thinking people
Principles of Family Psychoeducation

- Has roots in the clinical care system
- Assumes that reduction of symptoms and successful recovery reduces family burden
- Involves key members of care and social support systems, e.g. family, caseworkers
- Provides skills training to improve coping strategies
Principles of Family Psychoeducation

- Capacity to achieve clinical goals in the absence of consumer.

- Long-term perspective to treatment and recovery.

- Higher costs than self-help or education alone, but markedly lower cost/benefit ratio than standard care ($1/$14-34).

- Need to re-train professionals and case managers in non-blaming paradigms.
The History of Multifamily Groups

- Originated 30+ years ago in a NY hospital
- Families were offered education in a group format without consumers
- Consumers wanted to join
- Hospital staff noticed significant improvements, e.g., increased social skills and interest in treatment amongst consumers, improved family involvement and communication
Evidence-based benefits for participants

- Promotes understanding of illness
- Promotes development of skills
- Reduces family burden
- Reduces relapse and rehospitalization
- Encourages community re-integration, especially work and earnings
- Promotes socialization and the formation of friendships in the group setting
Who can benefit from MFG?

• Individuals with schizophrenia who are newly diagnosed or chronically ill
• Adolescents and young adults with early psychotic symptoms
• There is growing evidence that the following people can also benefit:
  - Individuals with mood disorders
  - Consumers with OCD or borderline personality disorder
Multifamily group vs. single-family meetings

- MFGs are more effective for cases with social isolation, high distress and poor response to prior treatment
- Some families prefer meeting with one practitioner for the entire time
- Some families want to hear what other families have done and need support
- Consumers and families may need the practitioner’s guidance to decide
MFG Referrals

• Individuals with similar diagnoses
• Have a supportive “family” member
• Instability in the patient or family distress
• High symptom level, hospitalization
• Disengagement and lack of participation in treatment
• Substance abuse
MFG Referrals

- lack of progress on recovery goals and/or family distress: frequent clinic calls, complaints about the consumer, sadness/depression
- disengagement withdrawal from the consumer, family, or community
- overinvolvement-self-sacrificing behavior
- Consumers and families with high EE. (Warmth Rejection Protectiveness Fusion)
- Isolated patients and families
- Newly diagnosed consumers
Non-appropriate MFG Referrals

- evidence of behavior in group that would be disruptive
- Evidence of current or past predatory behavior
- Axis II diagnosis/ BPD, etc. Incorrect diagnostic compatibility when working with EASA clients.
- Severe Cognitive impairment that prevents the individual from having benefit from group participation
- Consumer unwilling to give consent to family participation—although the patient could participate if willing
- Inability to come to group, transportation or insurmountable logistical problem
- Family unwilling or unable to participate in group or engage in treatment contract and patient unwilling to attend
- Families where abuse has occurred and issue is unresolved with perpetrator—Contact would make the patient worse. Domestic violence
A brief introduction to the psychobiology of schizophrenia
“...the basic defect in schizophrenia consists of a low threshold for (mental) disorganization under increasing stimulus input.”

Epstein and Coleman, 1970
Psychosis results from a biologically-based sensitivity to:

- Sensory stimulation
- Prolonged stress, strenuous demands
- Rapid change
- Complexity
- Social disruption
- Illicit drugs and alcohol
- Negative emotional experience (EE)
Disorganization in Mania and Depression...

- ...may be similar to that for schizophrenia
- threshold may be raised by medication
- more social support and less stimulation + stress = higher threshold
Functions of the Prefrontal Cortex

- Establishing a cognitive set
- Problem-solving
- Planning
- Attention
- Initiative
- Motivation
- Integration of thought and affect
- mental liveliness
Effects of EE and medication on relapse in schizophrenia

Bebbington and Kuipers, 1994
Causal modeling and punctuation
Effects of stress, in general populations

• The positive effects of stress include
  – growth
  – reprioritization of goals
  – increased self-esteem
  – expanded or strengthened networks;
Effects of stress, in general populations

• The negative effects include, initially,
  – heightened arousal, anxiety and psychosis, then
  – withdrawal, apathy, depression and
  – diminished sense of self-worth and self-efficacy

• The absence of meaningful stimulation can be stressful as well; too little stress can lead to boredom and anergia
Effects of social networks

- Family network size diminishes with length of illness.

- Network size for patients appeared to decrease in the period immediately following a first episode.

- Smaller network size at the time of first admission.
Effects of social networks

• Networks buffer stress and adverse events.

• Networks and families determine treatment compliance.

• Social support predicts relapse rate.

• Social support is associated with coping skills and burden.
Risks for symptom exacerbation and relapse

Intensity, negativity and complexity

- Critical comments
- Over-involvement
- Lack of warmth
- Crowding
- Excessive pressure to perform
- Interactions with conflict
- Multiple sources of input
Risks for symptom exacerbation and relapse

High rate of change

- Excessive life events per unit of time
- Disruption of social supports
- Lack or loss of "bridging" cues
- Entry into a new context
- Multiple functional levels involved in compensating
Risks for symptom exacerbation and relapse

**Physical and chemical factors**

- Stimulants
- Hallucinogens
- Dependence on depressants
- Unknown environmental toxins
- Loud noises
- Distracting noises, echoes
- Bright lights
Core Elements of MFG Treatment

- Joining
- Education
- Multi-family contact
Stages of treatment in family psychoeducation

1. **Joining**
   - Family and patient separately
   - 3-6 weeks

2. **Educational workshop**
   - Families and appropriate clients only
   - 1 day

3. **Ongoing sessions**
   - Families and patients
   - 1-4 years
Elements of Joining

- Exploration of precipitants
- Review of warning signs
- Reactions of family to illness
- Coping strategies
- Social supports
- Grieving
- Contract for treatment
- Preparation for multi-family group
What Happens During Joining?

- Discuss personal interests = it’s a good way to facilitate getting to know one another
- Identify early warning signs of illness
- Explore reactions to illness
- Identify coping strategies
- Review family social networks
What Happens During Joining? (cont’d)

• Identify characteristic precipitants for relapse (“triggers”)
• Investigate ways to reduce burden
• Offer opportunities to explore feelings of loss and “what might have been”
• Share “Family Guidelines’ with consumers and family members
The Psychoeducation Workshop

An educational opportunity for families held after the joining sessions and prior to multifamily groups
The first time that families and individuals “come together”

• 6 hours of illness education
• relaxed, friendly atmosphere
• co-leaders act as hosts
• questions and interactions encouraged
Classroom Format

- Promotes comfort
- Families can interact without pressure
- Encourages learning
- Co-facilitators as educators
Educational Workshop Agenda

- History and epidemiology
- Biology of illness
- Treatment: effects and side effects
- Family emotional reactions
- Family behavioral reactions
- Guidelines for coping
- Socializing
Educational needs of families of adolescents/young adults after initial episodes of psychosis

Management of symptoms
Management of stress
Needs of the family
Developmental issues for adolescents
School
Parenting in the new context
Treatments
Educational needs of families of adolescents/young adults after initial episodes of psychosis

Family guidelines
Theories of psychosis
Sibling issues
Differential diagnosis
Prognosis
Medications
Needs of the adolescent
Common problems and solutions
The psychosocial context of early psychosis

Diagnostic ambiguity and instability over time

The dangers of assuming prognosis based on diagnosis

The fragmented and conflicted constructs and behaviors of the mental health system and its professional members
The psychosocial context of early psychosis

The normative state of family interactions and process

The terror of psychosis itself and the dread of the prognosis

Conflicts in the family before and after onset

The explanations given by patients and their families

Social network support or lack thereof
Family psychoeducation in early phases

- Building education and information-sharing on patient and family's unique and evolving experience

- Defining psychosis as a reversible, treatable condition, like diabetes

- Core problem is an unusual sensitivity to:
  - sensory stimulation,
  - prolonged stress and strenuous demands,
  - rapid change,
  - complexity,
  - social disruption,
  - illicit drugs and alcohol
  - negative emotional experience
Family psychoeducation in early phases

- The role of blame and fault: patient and the family did not cause that sensitivity.

- It is part of the person's physical personhood, with both advantages and disadvantages.

- Do not blame yourself: this is a complex biological condition that can have several causes that are now poorly understood and is no one's fault.

- There is active research that is year by year clarifying what the causes are.
Family psychoeducation in early phases

- There is serious danger involved in ignoring the psychosis and the underlying condition.

- It is a warning, with all the good and bad aspects of any warning.

- The sensitivity needs to be respected, but the family need not be overwhelmed by it.

- There will be a fair amount of uncertainty about causes and outcome, but providing treatment quickly and early has been shown definitively to greatly improve prospects and outcome.
Family Guidelines

“Go slow”

• There is a psychobiological recovery process that cannot be accelerated without risking another relapse or stalling functional progress.

• Time is on the side of recovery, rather than an enemy that leads inevitably toward deterioration.
Family Guidelines
“Go slow”

- Stresses and demands are taken seriously and steps toward recovery are paced to keep stress below the threshold for symptom exacerbation.
- Rehabilitation should be carried out in small careful steps, using reductions in negative and positive symptoms as indicators of safety and success.
Family Guidelines
“Keep it cool”

• To compensate for difficulty in regulating arousal, the people closest to the susceptible person can create a relatively quiet, calm and emotionally warm environment.

• They can attempt to protect against sudden intrusions, confrontational conversations, arousing entertainment and simultaneous and multiple kinds of sensory input.
Family Guidelines

“Keep it cool”

Sensory overload can be avoided by these same means, and also by, for example, reducing background noise, keeping light levels moderate, and having only one conversation going at a time.

The optimal emotional tone is in the middle range, not intense and especially not negative, but also not overly distant, cold or rigid, like “Muzak”.

Negative symptoms can moderate with time, but not under conditions of high stress. High negative symptoms are not good.
Family Guidelines
“Give each other space”

• Allow time-outs and a time and place to withdraw, without rejecting
• Try not to nag
• Keep vigilance to a minimum
• Benign indifference is still caring and care-taking
Family Guidelines
“Set Limits”

- A few good rules keep things clear.
- Do not set limits on situations where you cannot follow thru.
- Make rules behaviorally specific and write them down.
- Check lists are helpful.
Family Guidelines

“Ignore what you can't change”

• To compensate for delusions, family and friends can be encouraged to change the subject and not dwell on delusional ideas, but rather focus on less stressful topics.
Family Guidelines
“Keep it simple”

• To help with information processing difficulties, conversations can be shorter, less complex and focused on everyday topics.
• Complexity in the environment and stressful life events will overwhelm cognitive and coping capacities: these need to be protected against and buffered as much as possible.
• Avoid mind-reading and allow everyone to speak for themselves, as positively as possible.
Family Guidelines
“Follow your recovery plan”

• Meeting with your providers allows you to communicate your needs and reach your goals.

• Take medications as prescribed they may be working even if you don’t see it. However don’t ignore side effects.
Family Guidelines

“Carry on business as usual”

• Re-establish family routines as quickly as possible and reconnect with family and friends.
• This helps reduce family and family member stress.
• Social support is important for recovery.
Family Guidelines
“No drugs or alcohol”

• They can make symptoms worse.
• They may mean the need to take medications longer or be in treatment longer.
• They will slow recovery at both the social and biological levels.
Family Guidelines
“Pick up on early signs”

• If you notice changes or you feel things may be getting worse contact the EASA team ASAP. Do not wait. EASA may be able to help prevent a reoccurrence of serious symptoms.

• Like all medical conditions the longer symptoms go the more difficult they may be to treat.

• Work with EASA to know the signs specific to you or your family member.
Family Guidelines
“Solve problems step by step”

- Work on situations one thing at a time.
- Do not try to solve problems too big.
- A slow gradual process moves faster then trying to take on too many things at once.
Family Guidelines
“Lower expectations, temporarily”

- Slow, careful and steady rehabilitation can achieve remarkable degrees of functional improvement without relapse.
Preparation for MFGs

- Remind people about date, time, and place of first meeting
- Distribute list of meetings
- Review format of first 2 meetings
Components of groups

- Two co-facilitators
- 5-6 families with similar diagnoses
- Meetings every other week for the duration of EASA...maybe longer.
- Families, consumers, and practitioners become partners
- On-going education about symptoms, medication, community life, work, etc.
- Problem-solving format
The role of MFG practitioner

- Collaborate with families and consumers to separate illness from personality
- Assume the role of educator, family partner, and trainer-coach
- Teach families and consumers to use the problem-solving method to deal with illness-related behaviors
- Keep asking, “what’s next?”
Group logistics

• Provide snacks/dinner or pot luck
• Consider a time of day and day of week that is not a hardship for participants
• Maintain the same time and location
• Offer telephone reminders and meeting schedules to reduce “no shows”
• Provide a take-home action plan following problem-solving
The 1st and 2nd Groups

“Getting to know you”
- co-facilitators model behavior
- share personal information
- culturally normative introductions
- begin to develop trust and understanding

“Experience with mental illness”
- co-facilitators model behavior
- personal stories of impact of M.I. are shared
- continue to build relationships
Structure of Sessions
Multifamily groups (MFG) and single-family treatment (SFT)

1. Socializing with families and consumers  
   **MFG**: 15 m.  **SFT**: 10 m.

2. A Go-around, reviewing--  
   **MFG**: 20 m.  **SFT**: 15 m.
   a. The week's events
   b. Relevant biosocial information
   c. Applicable guidelines

3. Selection of a single problem  
   **MFG**: 5 m.  **SFT**: 5 m.

4. Formal Problem-solving  
   **MFG**: 45 m.  **SFT**: 25 m.
   a. Problem definition
   b. Generation of possible solutions
   c. Weighing pros and cons of each
   d. Selection of preferred solution
   e. Delineation of tasks and action planning

5. Socializing with families and consumers  
   **MFG**: 5 m.  **SFT**: 5 m.

**Total**: 90 m.  60 m.
Characteristics of Problem-solving

- Borrowed from organizational management
- Offers benefit of multiple, new perspectives
- Complexity of method matches complexity of the situations
- Need to control affect and arousal
- Need to compensate for information-processing difficulties in some consumers and relatives
- Need to be organized and systematic
- Need to succeed and overcome failure
Types of problem solving

- Based on clinical experience and family guidelines
- Direct action and intervention by clinicians
- Problem is agreed upon by all family members
- Problem that is not agreed upon by all family members
Hierarchy for problem-solving

- Medication compliance
- Street drug and alcohol use
- Life events
- Problems generated by other agencies
- Conflicts between family members
- Conflicts with family guidelines
Problem-solving conflict

- Validate all positions

- Define the problem as illness-based, to the degree that is reasonable

- Undertake a step-wise or sequential solution

- Look at consequences of each position in the conflict itself -- what are the advantages and disadvantages?

- Reframe motives of all concerned

- Support limit-setting
Picking the Problem

• Don’t ignore medication, safety or drug issues!
• Simplify
• Narrow
• Concentrate on behavior
• Focus on relapse risk
• Avoid crisis issues too complex or risky for the group setting
Brainstorming solutions

- All members can and are encouraged to contribute
- All suggestions are welcome
- No suggestion is analyzed or critiqued during brainstorming
- Suggestions are limited to 10 - 12 ideas (number them!)
- The person with the identified problem chooses 1 - 2 suggestions to try
Take action!

- An action plan is developed for the chosen suggestion(s)
- Tasks are identified and assigned
- Consensus is achieved prior to leaving the meeting
- The plan is reviewed at the next meeting to determine success or the need for further problem-solving
Importance of “Chat” before and after the group

- People with M.I. often forget how to initiate and join in conversation
- Reduces tension and anxiety
- Participants learn about one another
- Good way to learn what’s going on in the community
Common MFG Questions

- When do we start a group? (how many members do you need?)
- What do we do to help attendance problems? How do we keep missing members present?
- How do we introduce new families?
- How do we formulate questions without blaming the individual?
- How do we keep on structure but still engage in process?
- How do we challenge family members to bring up situations that we can work with in group?
- How do we support each other as leaders if we are burned out, fatigued or miss a group?
- How do you manage the disruptive group member?
- How and what do we disclose as leaders to the group regarding ourselves and other members?
“I would entreat professionals not to be devastated by our illness and transmit this hopeless attitude to us.

I urge them never to lose hope; for we will not strive if we believe the effort is futile.”

--Esso Leete, who has had schizophrenia for 20 years