Family Psychoeducation (Multi-Family and Single Family Groups)
Overview

Presented by: Katie Hayden-Lewis PhD LPC
Rural Services Director
A social intervention that is:

an opportunity for mental health providers, individuals, families, and primary supports to better understand and manage the symptoms of a new mental health diagnosis, reduce risks associated with relapse, and maintain hope.
History of Multifamily Groups

- William R. McFarlane MD. Clinical researcher, doctor, and practitioner developed and studied model to address common and often complex concerns family members faced when addressing serious mental illness.
- Authored leading text on Multi Family Group intervention.
- Adopted in USA and internationally.
- More than 30 years in research and development.
- Based in organizational problem-solving and clinical practice.
- Extensive evidence suggesting strong efficacy for most mental health diagnosis.
Structure of Sessions
Multifamily groups (MFGs) and single-family treatment (SFT)

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**Total:** 90 m. 60 m.
Components of groups

- Two co-facilitators
- 3-6 families with similar diagnoses
- Meetings every other week for the duration of EASA...maybe longer.
- Families, individuals, and clinicians become partners
- On-going education about symptoms, medication, community life, work, etc.
- Problem-solving format
Imagine you or a family member one developed psychosis, schizophrenia, or bipolar for the first time? What would you want and need for yourself? For your family?
What is Multi-Family and Single Family Psychoeducation?

A structured approach that brings one or multiple families together to:

- Learn about mental health symptoms in order to better work together towards recovery/healing, mental well-being and reduce risks associated with relapses.
- Establish and activate family’s important role in this process.
- Improve social skills, reduce stressors, improve outcomes.
Psychoeducation (continued)

- Structured approach for partnering with individuals and families to support recovery and well-being.

- Individuals and families learn:
  - Information about mental health symptoms
  - Problem-solving, communication, and coping skills.
  - How to separate those symptoms from their family member’s and their own sense of personhood.

- How might this help young people and families involved with early intervention for psychosis treatment efforts?
Central assumptions of the Multi and Single Family Group model

Successful changes in behavior and attitude come from:

- Non-judgmental encouragement and modeling of interactions
- Ongoing education with support, guidance, and practice
- Learning and applying a step-by-step approach to problem solving.
- Support from a network of well-informed people united around similar goals and experiences
Principles of Multi-Family Psychoeducation

- Can achieve clinical goals with or without young person in attendance
- Long-term perspective to treatment and recovery.
- No blame—directly and indirectly addresses stigma and grief
- Each step in the process counts!
Why Focus on MFG/SFG?

- People want information to help them better understand the symptoms.
- Individuals generally want and need the support of their families and/or extended support network.
- Families/primary supports often want to be a part of the consumer’s recovery.
- People want to develop skills to get back into the mainstream of life.
- Work to reduce risks associated with stigma. Research indicates family members are aware of stigma and concerned about how it might impact their young person.
Some initial *Positive Outcomes*

- The individual *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
Evidence-based benefits for participants

- Understanding of symptoms
- Skills
- Alleviates family sense of burden
- Reduces relapse and hospitalization
- Encourages community participation in school, work, and daily life activities
- Promotes socialization and friendships in group
Research with Family Psychoeducation

- Functioning in the community improves steadily, especially for employment.
- Family members report less stress, improved coping skills, and greater satisfaction in their care giving roles and responsibilities.
Relapse outcomes in clinical trials

- No medication: 65%
- Individual therapy & medication: 15%
- FPE & medication: 9%
- MFG & Meds: 9%
Influences of multi-family groups on education and work

- Reduces family tension and stress
- Tuning and modifications of goals
- Coordination of effort by family, team, individual and employer
- Developing informal job leads and contacts
- Cheerleading and guidance in all developmentally typical phases-- schooling to career development
- Ongoing problem-solving
Other effects in clinical trials

- Improved family-member well-being
- Increased individual participation in rehabilitation
- Substantially increased employment rates
- Decreased psychiatric symptoms, including negative symptoms
- Improved social functioning
- Decreased substance abuse
- Reduced costs of care
Group Referrals

- Offered to ALL EASA participants and their primary supports/families
- Group coherence: age, diagnosis
- Appropriate for families experiencing:
  - Conflict or high anxiety
  - Instability/high acuity in the patient or family distress
  - Disengagement and lack of participation in treatment
  - Substance abuse
  - Feeling stuck
  - Desire to support others in similar situations
  - Loss of hope
Not Appropriate for MFG

- Predatory behavior
- Severe cognitive impairment: consider SFG
- Unwilling to give consent
- Insurmountable logistical problem: consider SFG
- Parties in domestic violence: consider SFG
Who can benefit from MFG?

- Individuals with psychosis who are newly diagnosed, at risk of developing psychosis, bipolar disorder or longstanding schizophrenia
- Adolescents, young adults, and their primary support people who are facing early symptoms of psychosis

Who can benefit from SFG?

- Individuals and their families/primary supports who are have insurmountable barriers to participate in MFG (non-negotiable childcare issues, work conflicts, legal constraints).
Fit: MultiFamily Group/Single-Family Group?

- Some families prefer meeting with one practitioner for the entire time.

- Some families want to hear what other families have done and benefit from accessing that kind of unique support.

- Individuals and families may need the clinician’s guidance to decide which is the best fit.

- Cultural adaptations and considerations likely important for individuals and families with ethnic minority status.
MFG buffers common stressors associated with increased risk for worsening and relapse of symptoms.
Symptoms of psychosis are vulnerable to worsening due to sensitivities:

- Sensory stimulation
- Prolonged stress, strenuous demands
- Rapid change
- Complexity
- Social disruption
- Illicit drugs and alcohol
- Negative emotional experience (EE)
Expressed emotion and symptom vulnerability

- Expressed emotion: Is a term that describes common interactions in families. Those interactions involve critical comments and/or overprotective comments between a primary support person and their family members.
Research has shown that while expressed emotion is common in families with a family member who develops schizophrenia it is also a communication exchange that can cause symptoms to worsen.

Higher levels of shame and guilt about having a relative with schizophrenia predicted higher levels of expressed emotion “EE”.

Guilt is a common emotional response by family members who face mental illness in another family member. MFG treats these kinds of emotionally common interactions in our families.

Wasserman, Weisman de Mamani, Suro (2012)
Effects of Social Networks

- Networks
  - buffer stress and adverse events
  - determine treatment compliance
  - predict relapse rate
  - correlate with coping skills and burden

UNFORTUNATELY...

- Family network size
  - diminishes with length of illness
  - decreases in the period immediately following a first episode
  - is already smaller at the time of first admission
Social Benefits of Multifamily Groups

- Creates a larger network
- Enhances continuity of treatment & long-term support
- Varying kinds of social ties play an important role in a young person’s life
- Learning from each other what’s worked and what has not worked
- Sharing employment, school, community resources
Purpose of Family Psychoeducation in early phases

- Build on the person’s and family’s experience to educate and teach skills: step-by-step solving problem, discusses risks, relapse plans and crisis plans purpose.

- Defines psychosis as set of treatable symptoms, like diabetes, that with early intervention often does not necessarily lead to long-term complex losses associated without early intervention.

- Promotes commonalities across family members and young people. Allows for welcoming of differences.

- Supports differences in family explanations.

- Is realistic, honest, and hopeful. Reassures!
Family Psychoeducation in early phases

- Emphasizes no blame or fault: no one caused the sensitivity
- Shares current understanding of biological, social, spiritual, cultural, research about psychosis and schizophrenia. Presents as ongoing learning happens all over the world to find best treatment approaches.
- Begins to treat stigma through education and a network of support.
Family psychoeducation in early phases

- Important not to ignore psychosis and the underlying condition.

- Learning about early warning signs is crucial to intervene early when symptoms progress. Reassure it is a warning, with all the good and bad aspects of any warning.
  - Relapse prevention plans
  - Crisis plans

- The sensitivity needs to be respected and accommodated but not take over the family forever.

- There will be a fair amount of uncertainty about causes and outcome, but providing treatment quickly and early intervention has been shown definitively to greatly improve prospects and outcome.
Core Elements of MFG/SFG Treatment

- Joining
- Education
- HOPE
- Deliberate and ongoing for either format
Joining Sessions

- Initially, EASA clinicians meet with individuals and their respective family members in introductory meetings called *joining sessions*.

- The purpose of these sessions is to learn about their experiences with symptoms (explanatory models), their strengths and resources, and their recovery goals.

- Opportunity to start work on relapse prevention plans, strengths assessments, crisis plans, and engagement!
Why Joining Matters

- Builds trust & comfort: people will come to the group because of their relationship with you
- Gives you a chance to understand their strengths, challenges, relapse profile
- Reduces conflict
- Reinforces resilience and coping
- Helps educate them using their unique story
- Reframes issues in terms of what groups offer
Elements of Joining

- Listen & get to know each other
- Understand their story from each person’s perspective
- Explore precipitants & warning signs (Complete relapse prevention and/or crisis plan)
- Explore family reactions (grief, fear, conflict, resilience)
- Review & encourage coping strategies
- Review & encourage social supports (Complete Strengths Assessment)
- Describe multi-family group & why it is important
- Answer questions & gain commitment to participate
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Preparation for MFGs

- Remind people about date, time, and place of first meeting
- Explore and problem solve barriers to attendance
- Have food budget ready!
- Distribute list of meetings
- Review format of first 2 meetings
Successful attendance/retention

- EASA team understands the value and purpose of MFG/SFG.
- Entire team promotes the intervention
- Preparation
- Relationship
- Consistency (time, place, facilitators)
- Outcomes and experience
- Hope
Throughout Process

- If they stop attending, do another joining session.
- View this as a *rupture* (tension or breakdown in collaborative relationship) in the alliance and seek feedback.
  - Is the rupture due to the model?
  - Is the rupture due to the relationship? (they are not being honest about attendance).
  - Ruptures present opportunities to repair and strengthen trust.
The role of MFG clinician

- Collaborate with families and individuals to separate symptoms from personhood
- Assume the role of educator, family partner, and trainer-coach
- Teach families and individuals to use the problem-solving method to deal with symptom-related behaviors
- Keep asking, “what’s next?”
- Advocate
- Bring information from group back to the EASA team (FACT).
The 1\textsuperscript{st} and 2\textsuperscript{nd} Groups

“Getting to know you”

• Co-facilitators model disclosure and behavior
• Share personal information
• Culturally normative introductions
• Begin to develop trust, rapport, and understanding

“Impact Group”

• Co-facilitators model disclosure and behavior
• Personal stories of impact of mental illness or “what brought me to EASA” are shared
• Continue to build trust and rapport
The Psychoeducation Workshop

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

- 4-6 hours of EASA education about the things they most need to know
- Relaxed, friendly atmosphere
- All EASA team members attend
- Questions and interactions encouraged
- Food provided
- Additional transportation/employment/childcare barriers identified and problem-solved
- Reminders about first group meeting
- Schedule when team and families can attend
- ADA and language needs are met
Classroom Format

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

- Socializing
- History and epidemiology (prevalence of the diagnoses)
- Symptoms and biology, psychology, cultural aspects of the condition
- Treatment: effects, side effects
- Common family emotions, thoughts, feelings, and behaviors
- Family Guidelines
- Specific communication & coping skills
- What to expect in the 1st, 2nd, and ongoing Multi-Family Groups
- Questions and Answers
- Socializing
Family Guidelines

- A set of 20 guidelines based in biological social and emotional stressors and needs.
- Used to:
  - Teach family members and individual participants skills they can use to problem-solve
  - Recognize and reduce vulnerability and risks associated with relapse of symptoms
  - Promote shared understanding of what helps
  - Empower individuals and their families to take steps with support and on their own to keep recovery moving forward.
1. Believe in your power to affect the outcome: you can!
2. One step at a time.
3. Consider using medication to protect your future, if the doctor recommends it.
4. Reduce stresses and responsibilities for a while.
5. Use the symptoms as indicators.
6. Anticipate life stresses.
7. Keep it calm.
8. Give each other space.
9. Set a few simple limits.
10. Ignore what you can’t change.
11. Keep it simple.
12. Carry on business as usual.
14. Keep a balanced life and balanced perspective.
15. Avoid alcohol and street drugs.
16. Explain your circumstances to your closest friends and relatives and ask them for help and to stand by you.
17. Don’t move abruptly or far away until stability returns.
18. Attend the multi-family groups.
19. Follow the recovery plan.
20. KEEP HOPE ALIVE!
Family Guideline
One Step at a Time

● Helps give context to recovery/healing process
  ● Will support skills to identify early warning signs and identify stalled progress.
● Long term experience of feeling well and staying well involves small careful steps--that you can repeat after EASA!
● Use positive and negative symptoms as indicators
Family guideline
Keep a balanced life and perspective

- Reframe your expectations of what is ideal, what you have to be doing
- Build energy to heal
- Big picture perspective can provide emotional and psychological relief—reducing impact of acute or chronic stress.
The 1\textsuperscript{st} and 2\textsuperscript{nd} Groups

“Getting to know you”
- Co-facilitators model behavior
- Share personal information
- Culturally normative introductions
- Begin to develop trust and understanding

“Impact Group”
- Co-facilitators model behavior
- Personal stories of impact of symptoms are shared
- Continue to build relationships
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**Total:** 90 m. 60 m.
Group logistics

- Provide snacks/dinner or pot luck
- Consider a time of day and day of week that is least disruptive of typical life activities and sustainable by co-facilitators
- Maintain the same time and location
- Offer telephone reminders, transportation and meeting schedules to reduce “no shows”
- Provide a take-home action plan following problem-solving
- Maintain schedule
Hierarchy for problem-solving
Why do we have one? How do we use the hierarchy in group?

- Medication concerns (can’t obtain, side effects, not working, stopping)
- Street drug and alcohol use
- Life events
- Problems generated by other agencies
- Conflicts between family members
- Conflicts with family guidelines
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 - 3 suggestions to try
- Group receives a copy of action plan
Develop an action plan with the participant

- 2 week timeframe.
- Share action plan with group members.
- At beginning of next group touch base to see if the plan was effective.
- Celebrate successes with group.
- Take responsibility for anything that did not work out in the plan.
Importance of “Chat” before and after the group

People with psychosis 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?
Some common workable challenges

- Protecting time and keeping up motivation to engage families and individuals so that they participate.
- Deciding on MFG or SFG as best fit.
- Honoring individual’s sense of voice and choice for participation while encouraging attendance and participation.
- Selecting group members.
- Following the structure while allowing for flexibility.
- Creating and maintaining a learning atmosphere.
- Choosing the most appropriate problem to solve.

Know that these challenges are common—and often resolve with strategies to address and overcome them as barriers!

Nilsen, Norheim, Frich, Friis, Rossberg (2015)
Stay Connected!

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● **Website**

Reference:
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