Family Psychoeducation Groups
Overview

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Presented by:
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Rural Services Director
The experience of working with young people and their families

What do families want and need?

What do individuals want and need from their families?
...an opportunity for mental health providers, individuals, families, and primary supports to better understand and manage the symptoms of a new mental health diagnosis, while maintaining hope.

....a social intervention that empowers individuals and their families, who face new diagnoses, to successfully navigate associated experiences and combat stigma.
Why Implement Evidence-Based Practices?

According to the New Freedom Commission on Mental Health:

If effective treatments were more efficiently delivered through our mental health services system ... millions of Americans would be more successful in school, at work, and in their communities

—Michael Hogan, Chairman
What would you want and need if you or a family member one developed a first episode of psychosis, schizophrenia, or bipolar with psychosis for the first time?
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.
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.
• 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?
Principles of Multi-Family and Single Family Psychoeducation

- Offers long-term perspective to treatment and recovery.
- Reduces risk for relapse of symptoms via low stress communication strategies, and learning what to pay attention to in order to catch early warning signs and avoid relapse.
- No blame—directly and indirectly addresses stigma and grief.

- Each step in the process counts!
- Allows for conflict between family members.
- Not required that family or young person attend but incredibly helpful if this is an option.
Evidence-based benefits for participants

- Understanding of symptoms
- Skills
- Alleviates family sense of burden
- Reduces social isolation
- Reduces relapse and hospitalization
- Encourages community participation in school, work, and daily life activities
- Promotes socialization and friendships
Why focus on MFG/SFE?

- People want information to help them better understand the symptoms.
- Individuals generally benefit from 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 benefit from independent life and relationship skills to get back into the mainstream of life.
- Protect familial relationships often compromised with first episodes, repeated hospitalizations and chronicity of symptoms.
- 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.
Research is in: 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

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

<table>
<thead>
<tr>
<th>Treatment Type</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>No medication</td>
<td>65</td>
</tr>
<tr>
<td>Individual therapy &amp; medication</td>
<td>41</td>
</tr>
<tr>
<td>FPE &amp; medication</td>
<td>15</td>
</tr>
<tr>
<td>MFG &amp; Meds</td>
<td>9</td>
</tr>
</tbody>
</table>

Copyright West Institute William R. McFarlane, MD
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
Influences of multi-family and single family group 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
- Social skill development
Intervention deliberately treats common vulnerabilities associated with risk for relapse:

- Sensory stimulation
- Prolonged stress, strenuous demands
- Rapid change
- Complexity
- Social disruption
- Illicit drugs and alcohol
- Negative emotional experiences (expressed emotion, “EE”)
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
- Unwilling to give consent
- Insurmountable logistical problem
- Parties in domestic violence
Shared decision: MFG or SFE?

- Provide psychoeducation on purpose of group
- Explain benefits of the intervention (multi- or single family format)
- Allow family and young person time to discuss hopes and concerns about group vs. single family format.
- Assess barriers to MFG and problem-solve for possible solutions
- Support MFG or SFE choice
- Look for opportunities to encourage MFG participation that fit family and young person’s needs, hopes, goals

*Individuals and families will likely need the facilitator’s guidance to decide which is the best fit.*
Model’s assumptions about what generates successful outcomes

- Encouragement and modeling of cooperative, collegial, non-judgmental interactions among all participants
- Ongoing education combined with support, guidance, and practice
- Learning and applying problem solving skills.
  - These skills help break problems into their components and solve them in a step-by-step manner
- Support from a network of well-informed people united around similar goals and experiences
- Will reduce internalized stigma linked to low self-esteem which fuels increased risk for relapse and post-psychotic depression.
MFG and SFE buffer common stressors associated with increased risk for worsening and relapse of symptoms

Take a deep breath.
Risks for increased vulnerability to worsening symptoms/relapse

- Continuous critical or overly protective comments
- Excessive pressure to perform
- Conflict
- Multiple and disruptive sources of input
- Social and emotional experiences associated with stigma
- Excessive life events per unit of time
- Disruption of social supports
- Challenges picking up and having typical interpretations of social cues
- Entry into a new environment
Growth enhancing effects of stress

The positive effects of stress include:

- growth
- reprioritization of goals
- increased self-esteem
- expanded or strengthened networks
Limiting effects of stress

The negative consequences of chronic stress might look like:

- heightened arousal, anxiety and psychosis, then
- withdrawal, apathy, depression and
- Probably influences sense of self-worth and self-efficacy

However:

The absence of meaningful stimulation can be stressful as well; too little stress can lead to boredom and lack of energy.

Take away message:

We need stress! Just not too much 😊
What helps us buffer stress?

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

UNFORTUNATELY... for our population of young people

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
- This includes young people who enter program in the attenuated risk group category
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
- Identify and meet culturally specific needs.

*For families and young people involved in SFE the team will need to assess how to provide access to these resources
Family Emotional Responses and Psychoeducation
Emotional experiences of family members: shame, guilt, and self-blame

- Expressed emotion describes criticism and/or too much emotional involvement from a primary support person (in research this is often identified as a family member).

- 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. Efforts are often made to alleviate that sense of guilt.

- Not necessarily associated as having the same intensity for family members facing bipolar disorder as those facing schizophrenia.

Wasserman, Weisman de Mamani, & Suro, 2012
Effects of critical and overly protective comments, or “expressed emotion”, and medication on relapse in schizophrenia

Bebbington and Kuipers, 1994
Brené Brown on Empathy

https://www.youtube.com/watch?v=1Evwqu369Jw
Review:
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 (in family network and across group members).

• Supports differences in family explanations.

• Is realistic, honest, and hopeful. Reassures!
- 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.
● 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 the Problem-Solving Intervention

- Joining
- Education
- HOPE

**Same in multi- or single family format**
Joining Sessions

- Initially, early intervention for psychosis clinicians meet with individuals and their respective family members in introductory meetings called *joining sessions*.
  - Facilitators of the intervention will complete 3 joining sessions with individuals who are going to participate in the intervention.

- Opportunity to start work on relapse prevention plans, strengths assessments, crisis plans, provide important psychoeducation, prepare for workshop and strengthen 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
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
Successful Attendance /Retention

- Early intervention team understands the value and purpose.
- Entire team promotes the intervention
  - Refer to family guidelines
  - Makes links between presenting challenges and concerns to usefulness of the intervention
    
    for example: family disagreements about medication or house rules—there are many many more!

- Preparation—as facilitators and with group participants
- Relationship—too you and eventually and hopefully the group
- Consistency (time, place, facilitators) —DON’T CANCEL
- Outcomes and experience
- Hope
Introduction to the Problem-Solving Method
Components of Groups

● Two co-facilitators for multi-family

● One facilitator for single family format (can be done at participant/family home or in community location).

● 3-6 families

● Meetings every other week for the duration of treatment program... maybe access after graduation from EASA

● Families, individuals, and clinicians become partners

● On-going education about symptoms, medication, community life, work, etc.

● Problem-solving format
Your tasks as Facilitator

- Facilitate joining sessions with individuals who will participate with you in intervention.
- Welcome everyone each time you meet.
- Assume the role of educator, family partner, and trainer-coach.
- Teach families and individuals to use the problem-solving method and family guidelines to deal with life stressors and symptom-related challenges.
- Keep asking, “what’s next?”
- Advocate
- Bring information from group back to the EASA team in weekly team meeting.
- Might need to remind people about group or single family meeting.
The 1st and 2nd 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
Disclosure in the 1st and 2nd groups

- There are different kinds of disclosure, ex.: encouraging, similarities and differences, humanizing, in-the-moment

- No agreement on exactly what to disclose/not disclose — evasiveness is not helpful
  - Disclosures that 1) humanize therapists 2) convey similarities associated with fewer clinical symptoms after the session than disclosures that expressed appreciation and encouragement.
  - Disclosures that convey similarities associated with fewer interpersonal problems that disclosures that conveyed neither similarities or dissimilarities.

Gibson (2010); Levitt, Minami, Greenspan, Puckett, Henretty, Reich, & Berman (2016)
Disclosure Take Away:

- Attend to affect on individuals and group as a whole
- Might address power differentials and move alliance toward increased equity and collaboration
- Prepare for wide range of responses
- Disclosure happens: BE DELIBERATE!
- Preparation helps!

Gibson (2010); Levitt, Minami, Greenspan, Puckett, Henretty, Reich, & Berman (2016)
## Structure of Sessions:
Multifamily groups (MFGs) & single-family treatment (SFT)

<table>
<thead>
<tr>
<th>Session</th>
<th>MFG</th>
<th>SFT</th>
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<tbody>
<tr>
<td>1. Socializing with families and consumers</td>
<td>15 m.</td>
<td>10 m.</td>
</tr>
<tr>
<td>2. A Go-around, reviewing—</td>
<td>20 m.</td>
<td>15 m.</td>
</tr>
<tr>
<td>a) The week’s events</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Relevant biosocial information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Applicable guidelines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Selection of a single problem</td>
<td>5 m.</td>
<td>5m.</td>
</tr>
<tr>
<td>4. Formal Problem-solving</td>
<td>45 m.</td>
<td>25 m.</td>
</tr>
<tr>
<td>a) Problem definition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Generation of possible solutions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Weighing pros and cons of each</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) Selection of preferred solution</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) Delineation of tasks and implementation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Socializing with families and consumers</td>
<td>5 m.</td>
<td>5m.</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>90 m.</strong></td>
<td><strong>60 m.</strong></td>
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</tbody>
</table>
What is the hierarchy for problem-solving? Why?

- Medication concerns (can’t obtain, side effects, not working, reducing, stopping)
- Street drug and alcohol use
- Life events
- Problems generated by other agencies
- Conflicts between family members
- Conflicts with family guidelines
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
Types of problems

- Based on clinical experience and family guidelines (Greatest risk of relapse!)
- Direct action and intervention by clinicians
- Problem is agreed upon by all family members
- Problem that is not agreed upon by all family members.
Negotiating Conflict

- Acknowledge conflict or concern
- Validate all positions
- Provide any relevant psychoeducation related to concern
- Negotiate with family or individual to see if there is a version or a portion of challenge that would be okay to problem-solve.
- Define the problem as symptom-based, to the degree that is reasonable and if you pick participant’s challenge
- Look at consequences of each position in the conflict itself -- what are the advantages and disadvantages?
- Support limit-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 - 3 suggestions to try
- Group receives a copy of action plan
Pros and Cons of Suggestions

- Key to choosing solutions—*don’t skip this step!*
- Shows different perspectives
- Not all “cons” are disadvantages!
- Choose language that will work for you:
  - Pros and cons; advantages and disadvantages
- Don’t count them up!
Characteristics of Problem-solving

- Multiple new perspectives
- Makes complex problems manageable
- Builds agreement
- Limits strong affect & arousal
- Compensates for information-processing difficulties through structure, predictability, simplicity
- Organized and systematic
- Facilitates small successes
The Psychoeducation Workshop

An educational and social engagement opportunity for individuals, their families, and their early intervention treatment teams, held after the joining sessions and prior to starting the single or multi-family group problem-solving format.
The first time families & individuals “come together”

- Multifamily: 4-6 hours of early intervention
  - Developmentally informed education about the things they most need to know

- Single family: Same content as workshop but delivered to single family, likely less time needed or done over multiple meetings

- Relaxed, friendly atmosphere
- All early intervention direct service 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 or other normative setting

- Promotes comfort
- Families can interact without pressure
- Encourages learning
- Honors different learning styles
- Entire team attends and takes on role of 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
Information is **tailored** to meet educational needs of families of adolescents/young adults after initial episodes of psychosis

- Management of symptoms
- Management of stress
- Needs of the family, including siblings
- Developmental issues for adolescents (relationships, body image, autonomy...)
- School / work
- Parenting in the new context
- Communication
- Treatments
- What to expect from services and the treatment team
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.
Sample of Family Guidelines

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!
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
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)
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