Psychoeducational Psychotherapy (PEP): A Collaborative Family-Clinician Model of Care

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Presentation Goals—Attendees should contemplate…

1. ***The focus of psychoeducational psychotherapy***
2. ***The impact of psychoeducational psychotherapy***
3. ***Similarities and differences of consumer vs clinician led interventions***

How to Conceptualize Psychoeducational Psychotherapy (PEP)

- Historically, families
  - Have been blamed
  - Have not gotten useful information/support/skill building
- This can result in families being “skittish” or “defensive” about family-based intervention

Goals of PEP

- Teach parents and children about
  - The child’s illness & its treatment
- Provide support
  - Peers (“I’m not the only one”)
  - Professionals - understand the disorder
- Build skills
  - problem-solving
  - communication
  - symptom management

PEP Philosophy

- *If you give a man a fish, he will eat for a day. If you teach a man to fish, he will eat for a lifetime.*

Why PEP Makes Sense: Relevant Issues

- ***<u>Service Delivery</u>***
- Adherence/Barriers
- Expressed Emotion
- Concordance
- Father Involvement
- Caregiver Stress

Service Delivery Issues

- Financial pressures: managed care/public sector
  - How to perform the miracle of providing adequate services with very limited $$?
- Pragmatic issues
  - How many sessions can/will a family attend?
- What do consumers want?

What Do Families Want?

Hatfield, *'81 J Psychiatric Tx and Evaluation; '83, Family Therapy in Schizophrenia*

- Family members were asked directly what their needs were in caring for the patient
  - 57%: understanding the symptoms
  - 55%: specific suggestions for coping with behavior
  - 44%: relating to people with similar experiences
- There was little congruence between what families wanted and what they received from professionals

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Treatment Adherence

- 1/3 - 2/3 of children in child & adolescent psychiatry outpatient clinics do not keep scheduled appointments *Brasic et al, 2001*
- Meta-analyses suggest treatment adherence is approximately 50% for most children with chronic health conditions *Bryon, 1998*

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What is Expressed Emotion (EE)?

- Refers to a construct initially coined by British researchers
  - Critical—hostile--emotionally overinvolved
- Has been used in studies examining "big" outcomes for "big" disorders
  - eg, relapse in schizophrenia, recurrent mood disorders
- Appears to measure a robust family characteristic
  - ie, findings are often impressive

EE as Predictor of Adult Outcome
Butzlaff & Hooley, '98, *Arch Gen Psychiatr*

- metaanalysis of 27 studies
  - EE is a general predictor of poor outcome
  - EE can be modified
- relapse rates for diagnostic groups:
  - schizophrenia: 65% high EE; 35% low EE--findings strongest for chronic schizophrenia
  - mood d/o's: 70% high EE; 31% low EE
  - eating d/o's: 3 studies, effect size of .51 (medium to large effect)

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Caregiver Concordance

- Disagreement between parents/caregivers on child-rearing linked with
  - higher rates of child problem behaviors *(Jouriles et al, 1991)*
  - poorer marital quality *(Lamb et al, 1989)*
  - lower levels of family problem-solving *(Vuchinich et al, 1993)*
  - decreased parental effectiveness *(Deal et al, 1989)*

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- ***Father Involvement***
- Caregiver Stress

Father Involvement *Schock, Gavazzi, Fristad et al '02, Family Relations*

- Pilot data indicate that fathers
  - at baseline
    - Know less about mood disorders
    - Have less positive and more negative evaluations of their children
  - following intervention—more like mothers
    - Have a similar knowledge base
    - Evaluate their child more positively and less negatively

Why PEP Makes Sense: Relevant Issues

- Service Delivery
- Adherence/Barriers
- Expressed Emotion
- Concordance
- Father Involvement
- ***Caregiver Stress***

Causes of Caregiver Stress

Hellander, Sisson, Fristad, in Geller & DelBello, 2003

- Care of a high-needs child
- Need to advocate in schools
- Worry about the future
- Exhaustion
- Physical illnesses
- Financial strain
- Isolation
- Stigma
- Guilt and blame

Application of Psychoeducational Psychotherapy to Childhood Mood Disorders

The OSU Childhood Mood Disorders Research Program

Future Research Directions—Childhood Mood Disorders ***Burns, Hoagwood, and Mrazek (1999)***

- Paper based on summary prepared for US Surgeon General's Report on Mental Health (2000)
- 5/11 specific recommendations pertain…
  - Study treatment efficacy for comorbid d/o's
  - Involve families in treatment
  - Develop treatments for children ≤ 9
  - Assess functional status to determine real-world benefits; and
  - Use manualized interventions

The OSU PEP Program

- Orientation
  - Nonblaming/growth-oriented
  - Biopsychosocial—uses systems and cognitive-behavioral techniques
- Education + Support + Skill Building ➔ Better Understanding ➔ Better Treatment + Less Family Conflict ➔ Better Outcome
- Two formats
  - groups of families (MF-PEP)
  - single families (IF-PEP)

ODMH Study

Fristad, Goldberg-Arnold & Gavazzi, JMFT, 2003

- 35 children and their parents
  - 54% depressive; 46% bipolar disorders
  - M=3.6 comorbid diagnoses/child (range, 1-7)
  - C-GAS=51 at baseline
  - 29/35 (83%) on meds
  - 8-11 years old (average, 10.1 yrs)
  - 77% boys
- 6 month wait-list design
- 6 sessions, 75 minutes/session, manual-driven treatment

ODMH Findings

Fristad, Goldberg-Arnold & Gavazzi, JMFT, 2003

- Parents
  - *Increased* knowledge of mood disorders
  - *Increased* positive family interactions
  - *Increased* efficacy in seeking treatment
  - *Improved* coping skills
  - *Increased* social support
  - *Improved* attitude toward child/treatment
- Children
  - *Increased* social support from parents
  - *Increased* social support from peers (trend)

MF-PEP Session Format

- Children aged 8-12 (any mood disorder)
- 8 sessions, 90 minutes each
  - Begin/end with parents/children together
  - Middle (largest) portion-separate groups
    - Children receive *in vivo* social skills training (in gym) after formal "lesson" is completed
  - Therapists: 1-parents; 2-children
  - Families receive projects to do between sessions

8 Session Outline--Parents

1. Welcome, symptoms & disorders
2. Medications
3. "Systems": school/treatment team
4. Negative family cycle, WRAP-UP 1st ½
5. Problem solving
6. Communication
7. Symptom management
8. WRAP-UP 2nd ½ of program & graduate

8 Session Outline--Children

1. Welcome, symptoms & disorders
2. Medications
3. "Tool kit" to manage emotions
4. Connection between thoughts, feelings and actions (responsibility/choices)
5. Problem solving
6. Nonverbal communication
7. Verbal communication
8. Review & GRADUATE!

Our Mottos

- The CAUSE of mood disorders is fundamentally *biological*, their COURSE can be greatly affected by *psychosocial events*
- We don't get to pick the genes we get or the genes we pass on
- "It's not your fault but it's your challenge"

Many Contributors…

- ***Parent Group Therapists***
  - Jill S. Goldberg-Arnold, PhD*
  - Catherine Malkin, PhD
  - Kitty W. Soldano, PhD, LISW
- ***Child Group Therapists***
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  - 693 Students
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  - Rita Kahng, MA
  - Becky Hazen, PhD
  - Kari Jibotian, MA
  - Lauren Ayr, MA
- ***165 Families***

*Consensus Conference Reviewer

NIMH Study Design, N=165

Group[a]	Time 1 Month 0	Time 2 Month 6	Time 3 Month 12	Time 4 Month 18
MFPG + TAU[b]	Baseline: Pre-treatment	Follow-up	Follow-up	Follow-up
WLC + TAU[c]	Baseline	Follow-up	Pre-treatment	Follow-up

[a]Families were enrolled in 11 sets of 15 (7-MFPG/8-WLC) = 165 families
[b]Multifamily Psychoeducation Group + Treatment As Usual
[c]Wait-List Control + Treatment As Usual

MFPG Recruitment—N=165

- 225 families screened
- 203 (90%) passed the screen
- 171 (84%) arrived at baseline assessment
- 165 (96%) met study criteria
- Referral sources:
  - 62% health care providers
  - 19% media
  - 19% other
- Rural/geographically remote, 22% (round trip, 56±64 mi; range=2-344 mi)

Study Sample - Family Characteristics

Variable	MF-PEP	
	MF-PEP+TAU (*n*=78)	WLC+TAU (*n*=87)
Family Structure		
Married bio par	46%	40%
Step-family	17%	23%
Married adop par	5%	7%
Single bio par	21%	17%
Single adop par	1%	1%
Other	10%	12%
Income	<20K to >100K M=40-59K	<20K to >100K M=40-59K

Baseline Characteristics-ITT Group

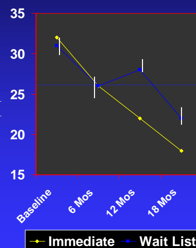
Variable Child/Family	Immediate Treatment (n=78)	Waitlist Control (n=87)
Age (Years, M±SD)	10.0 ±1.3	9.8 ±1.2
Gender (% Male)	76%	71%
Ethnicity (% White)	94%	89%
% w/ + Family Hx Mania/Depression	85%	84%
Mood Severity Index	32.5 ±13.3	31.4±16.1
% Bipolar spectrum	70.5%	69.0%
% Comorbid Anxiety	67%	70%
%Comorbid Behavior	97%	97%
% Comorbid ADHD	86%	93%

Outcome Measures

- MSI=Mood Severity Index
  - CDRS-R + MRS (equal contributions)
  - <10: minimal symptoms
  - 11-20: mild symptoms
  - 21-35: moderate symptoms
  - >35: severe symptoms

Mood Severity Index (Parent, Current) MFPG ITT Sample

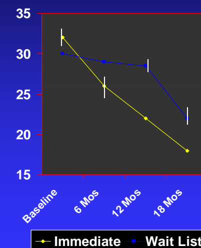
- N=165
  - n=78 Immediate
  - n=87 Wait List
- Difference in slope: 6.48 MSI (SE=3.04; CI [0.48-12.48], ES=0.53, X^2=4.55 (df=1),p=.033
- Pre-post Imm=WLC



R01 MH61512, Fristad, Verducci, Walters & Young, *in press*, Archives General Psychiatry

Mood Severity Index (Parent, Current) MFPG Completer Sample

- N=116
  - n=69 Immediate
  - n=47 Wait List
- Difference in slope: 8.17 MSI (SE=3.35; CI [1.58-14.75], X^2=5.99 (df=1),p=.01
- Pre-post Imm=WLC



R01 MH61512, Fristad, Verducci, Walters & Young, in press, Archives General Psychiatry

Impact of Parental Psychopathology on Outcome

Fristad, Verducci, Walters & Young, in press, Arch Gen Psychiatr

- Related to dropout in the WLC condition
  - participants with less parental psychopathology and lower mood severity were more likely to be study drop-outs
- Each parental diagnosis was associated with ↑ 2 pts on the MSI over time

Mediators of Outcome

Mendenhall, Fristad & Early, in press, J Cons Clin Psychol

- Participation in MF-PEP
  - significantly and directly decreased children's mood symptom severity
    - this relationship was mediated by quality of services utilized
  - significantly and directly improved quality of services utilized
    - This relationship was mediated by beliefs about treatment--improved treatment beliefs were associated with greater improvements in quality of service obtained

Anecdotal Evaluations--Parents

- *No matter how bad the situation is…there is hope and treatment. Don't give up. This program was an eye opener for me. I also was encouraged and relieved to find out that I was not alone.*
- *Listen to what they are saying. They can really help you. Learn what is going on with your child. Stay focused on what is going with your child and do not give up on your child.*

Anecdotal Evaluations--Children

- *You get to meet new people you never knew before. They help you with your symptoms.*
- *They're nice and they're helpful. And you guys support us and give us snacks. You've been nice to us and treated us with respect.*
- *It really helps out if you let it.*

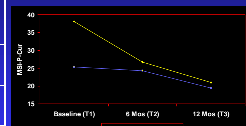
Individual-Family Psychoeducation: IFP

OH Dept Mental Health, 2002-2004
Fristad (2006) Development & Psychopathology

- N=20
- 16 sessions
  - Alternate child and parent with parent
  - Same content + Healthy Habits
    - diet, exercise, sleep
- Comparable design to MFPG

IFP Primary Outcome: MSI-Parent-Cur—Power Analyses

Variable	N per Condition	Effect Size
MSI-Parent-CUR T1-T2	64	.45
MSI-Parent-CUR T1-T3	36	.60



IFP: Parent Evaluations

- Anonymous evaluations completed after treatment
- Parents report (1-5 rating, overall 1.6)
  - ↑ knowledge re: symptoms, medication, accessing treatment
  - ↑ skills re: working with schools and treatment team, managing symptoms at home
  - Feeling supported/not blamed

IFP: Children's Evaluations

- 1-5 Rating Scale
  - Overall rating, 1.7
  - Item Range: 1.3 (therapist) to 2.2 (learned about medications)
- ↑ knowledge re: mood symptoms, medication
- ↑ ability to get along with family, friends and at school
- ↑ skill re: symptom management
- ↑ support/ ↓ isolated, "not the only one"
- parents' behavior toward them better

Hand-to-Hand Evaluation

Davidson & Fristad, 2004, Child & Adolescent Psychopharmacology News, 9(2): 7-9.

- 46 parents
- Assessed twice (n=18)
  - Baseline (Time 1, T1, pre-class)
  - 8 weeks (Time 2, T2, post-class)
- Findings
  - Parents stressed
  - Stress diminishes after H-to-H ($p<.05$), improved ratings for:
    - Less time for marriage/Sig other
    - Dealing w/ personal depression
    - Getting child to do chores/self-care
    - Witness self-harm/suicidal acts
    - Feeling embarrassed by child's public rages

Comparisons of Consumer vs Clinician Led

- Hand-to-Hand *Pro's*
  - Free
  - Community-based
  - In the trenches
  - Modeling
- Hand-to-Hand *Con's*
  - Burn-out
  - How to deal with clinical content?
- PEP *Pro's*
  - Evidence-based
  - Work directly with children & parents
  - Can address clinical content
- PEP *Con's*
  - Availability
  - Cost

What to Do?

- BOTH!
  - H-to-H and MFPG should work well together
    - Models are supportive of each other
    - Information will overlap but reinforce
    - Each will contain some unique content

Efficacy-to-Effectiveness Trial

- NCH Close-to-Home Behavioral Health Clinics, Columbus, OH
- Various outcomes being assessed
  - *Patient-centered*: change in mood severity
  - *Family-centered*: change in knowledge of and attitudes about the child's mood disorder
  - *Therapist-centered*: satisfaction with training in, and delivery of, a new treatment model
  - *Agency-centered*: financial viability of MFPG, pragmatics

Extension Trial

- NCH Close-to-Home Autism Center
- High functioning autism/ Asperger's disorder (HFA/AD)
- Modifications
  - Teach about HFA/AD
  - ↓ medication and ↑ behavioral management
- Various outcomes being assessed—same

Psychoeducational Psychotherapy (PEP) Training Materials

- Treatment Manual– Guilford Press, 2010 (in press 2009)
- Training DVDs– in development
- Interested in workshops? Contact: mary.fristad@osumc.edu