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
- Service Delivery
- 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

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

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- Concordance
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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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Relevant Issues

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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
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
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- Concordance
- Father Involvement
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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)

- 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, PhD
  - Catherine Malkin, PhD
  - Kitty W. Soldano, PhD, LISW
  - Barb Mackinaw, PhD
  - Nicholas Lofthouse, PhD
  - Colleen Quinn, MS
  - Jarrod Leffler, PhD

- Child Group Therapists
  - Barb Mackinaw, PhD
  - Nicholas Lofthouse, PhD
  - Colleen Quinn, MS
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  - Ben Fields, MEd
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  - Radha Nadkarni, DeAngelis, BA

NIMH Study Design, N=165

<table>
<thead>
<tr>
<th>Group</th>
<th>Time 1 (Month 0)</th>
<th>Time 2 (Month 6)</th>
<th>Time 3 (Month 12)</th>
<th>Time 4 (Month 18)</th>
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<tbody>
<tr>
<td>MFPG + TAD+</td>
<td>Baseline</td>
<td>Follow-up</td>
<td>Follow-up</td>
<td>Follow-up</td>
</tr>
<tr>
<td>WLC + TAD+</td>
<td>Baseline</td>
<td>Follow-up</td>
<td>Pre-treatment</td>
<td>Follow-up</td>
</tr>
</tbody>
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*Families were enrolled in 11 sets of 15 (7-MFPG/8-WLC) = 165 families
*Multifamily Psychoeducation Group + Treatment As Usual
*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

<table>
<thead>
<tr>
<th>Variable</th>
<th>MF/PEP+TAU (n=78)</th>
<th>WLC+TAU (n=87)</th>
</tr>
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<tbody>
<tr>
<td>Family Structure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married bio par</td>
<td>46%</td>
<td>48%</td>
</tr>
<tr>
<td>Step family</td>
<td>17%</td>
<td>23%</td>
</tr>
<tr>
<td>Married adopt par</td>
<td>37%</td>
<td>7%</td>
</tr>
<tr>
<td>Single bio par</td>
<td>21%</td>
<td>17%</td>
</tr>
<tr>
<td>Single adopt per</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>10%</td>
<td>12%</td>
</tr>
<tr>
<td>Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;20K to &gt;100K</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD=40-59K</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;100K</td>
<td></td>
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</tbody>
</table>

Baseline Characteristics - ITT Group

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

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, X²=4.55 (df=1), p=.03)
  - Pre-post Imm=WLC

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], X²=5.99 (df=1), p=.01
  - Pre-post Imm=WLC
Impact of Parental Psychopathology on Outcome
Fristad, Verducci, Walters & Young, in press, Arch Gen Psychiat
- 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
- 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

<table>
<thead>
<tr>
<th>Variable</th>
<th>N per Condition</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSI-Parent CUR T1-T3</td>
<td>64</td>
<td>.45</td>
</tr>
<tr>
<td>MSI-Parent CUR T1-T3</td>
<td>36</td>
<td>.60</td>
</tr>
</tbody>
</table>
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
- 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
- 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
- Training DVDs— in development
- Interested in workshops? Contact: mary.fristad@osumc.edu