EASA Center for Excellence

OHSU Portland State University | SCHOOL OF PUBLIC HEALTH

Family Psychoeducation Training

Early Assessment and Support Alliance Center for Excellence

OHSU-PSU School of Public Health

Learning Objectives

a) Be able to describe the typical impact of early psychosis symptoms on individuals and families

b) Understand the four core goals of family psychoeducation

c) Become familiar with the research supporting effectiveness of psychoeducation

d) Become familiar with and practice the core fidelity practices of family psychoeducation

e) Practice the use of self-disclosure and effective problem solving in family psychoeducation

Four Goals of Family Psychoeducation

- **Increase knowledge and understanding** within the family
- Preserve and build **family support and social network**
  - Reduce conflict, facilitate coping, stabilize relationships
  - Introduce new supporters
- **Develop skills and confidence** for communication and problem solving
  - Routine involvement is key!
  - MFG: Encourage participation 2x/month and support if 1x a month is only feasible option. SFE: Might be adapted to existing meetings or alternate to trained team members rather than group facilitators.
- **Facilitate decision making and steady progress** through structured incremental problem solving

Stages of family psychoeducation

I. Entry into program and introduction of family guidelines
II. Joining (2-3 sessions, then as needed)
    I. Presenting the intervention as useful for the range of concerns and diagnoses/symptoms/experiences that are commonly raised during time in EASA.
III. Education workshop and ongoing individual family education
IV. Group process introduction/single-family
    - Group 1: Getting to know each other: strengths & hobbies
    - Group 2: How has mental health/mental illness/situations impacted our lives?
V. Ongoing structured family education
    - Socialize
    - Check-in
    - Problem selection and definition
    - Brainstorming
    - Action planning
    - Socialize

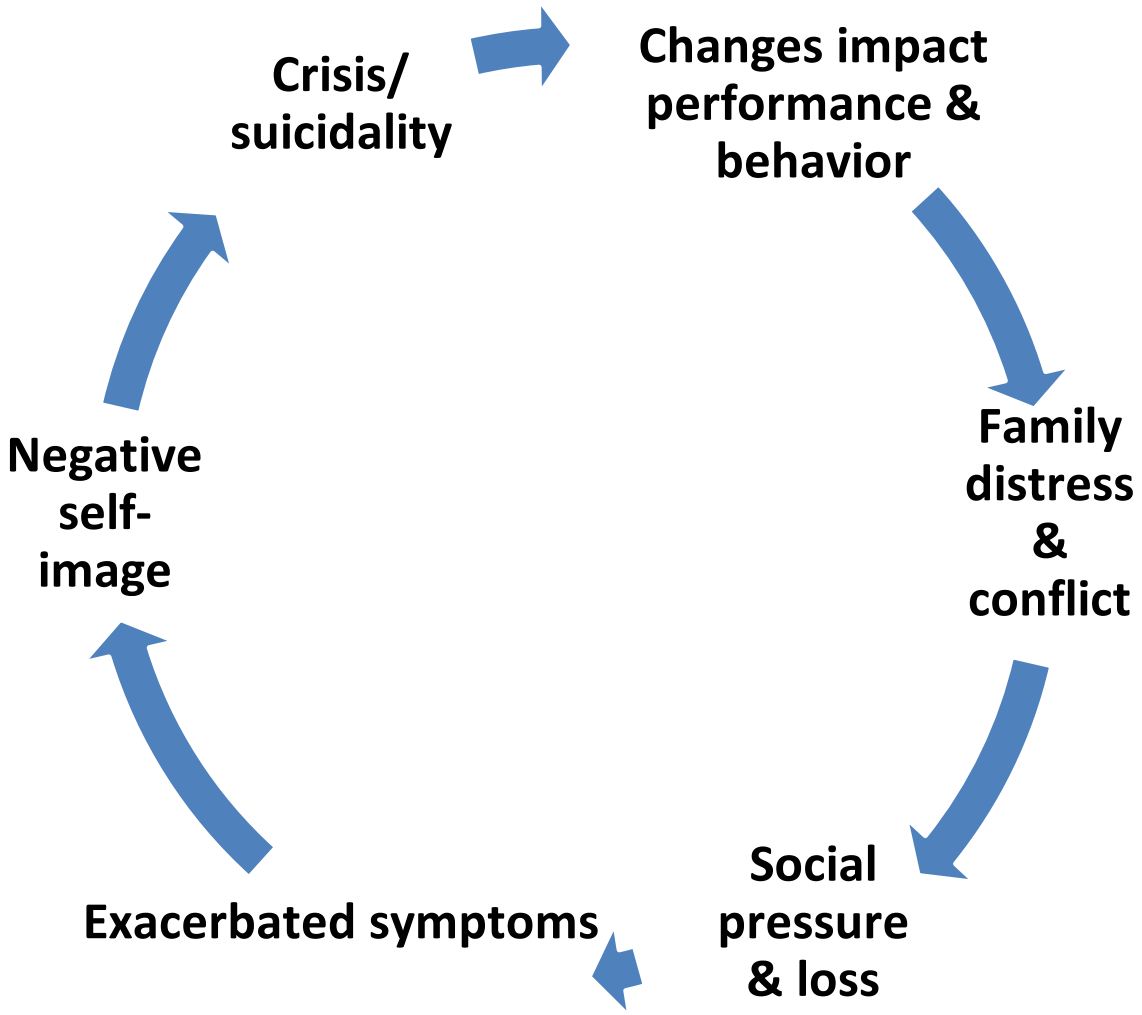
What do we mean by family?

- Family of choice
- People the individual relies on for support
- May include parents, siblings, partners, extended family, close friends
- Family includes the individual
- The individual may choose not to include all family members
- Family members and/or young person welcome to participate on their own.
  - In these instances, continue to look for opportunities where those individuals would be interested and able to join (make it a "fit").

What do individuals in the early stage of psychosis need from their families?

What do their family members and supports need?

Gradual onset



Effects of Psychosis on Families

- Earthquake to reality- fear, loss of what take for granted
- Sense of isolation, lack of ability to cope
- Situations feel impossible to manage, no sense of control
- Trauma
- May blame selves and get blaming messages from others

Developmental framework

- It is important to keep in mind that for many young people this life stage includes increased drive for autonomy.
- Relational changes and increased tension is common during adolescence and young adulthood as young people, their family members and supporters negotiate the developmental changes.
- This is all happening while our participants, families, and supporters are also negotiating the stress and changes that come with the onset of symptoms.
- Please provide educational information to your participants and their family members and supports to help them better understand the developmental context of the symptoms occurring.
  - This can help facilitate the grief process, reduce stress, and improve problem-solving skills.

History of the Family Psychoeducation Model

- Developed by Carol Anderson based on problem solving research in the private sector and clinical practice
- Adapted with William R. McFarlane MD. to focus on schizophrenia
- 30 years in research and development worldwide with diverse populations in mental health
- SAMHSA Evidence-Based Toolkit included Family Psychoeducation in 2006
- Integrated into Early Psychosis Programs as an Evidence-Based Practice

Clinical High Risk for Psychosis and Family Psychoeducation

- Promising but inconclusive evidence of benefits related to uptake of communication, problem solving skills, and adoption of different strategies over time for caregivers of individuals with CHRp (Ma et al. 2018)

- RTC family focused intervention (stress management and prevention of psychosis symptoms, communication training, problem-solving skills training)

After 6 months improvements in:

- family relationships,
- active listening skills (reduce communication barriers and decrease criticisms)
- reduced positive symptoms
- Individuals =<20 years old greater improvements in psychosocial functioning; 16-19 years old showed greater functional improvements
- Better outcomes than focusing on symptoms prevention and showed similar gains to some CBTp studies addressing similar issues.
- Findings were overall better than group who received 3 sessions of family psychoeducation focusing on symptoms management. (Miklowitz et al. 2014)

CHRp common concerns

- Interpersonal relationships
- Anticipated discrimination (when a person limits involvement in important aspects of everyday life out of fear of experiencing discrimination):
- Problems keeping or making friends and establishing intimate relationships; compared to older individuals with schizophrenia where more problems in job domain associated with higher levels of discrimination.
- Significantly higher reports of discrimination in social life domain associated with poorer self-perceived social functioning, than older individuals with schizophrenia.
- Higher levels of discrimination associated with higher levels of need in functioning domain (self-care, childcare, money, education)
- Higher levels of insight into illness symptoms
- Participants awareness of the negative consequences of symptoms and disabilities led them to pick up on discrimination more easily.
- Implications for possible challenges participants and family members and supporters might face and bring to the problem-solving groups as concerns
- Implications for skillfulness around selecting and fine tuning the content and delivery of psychoeducation different from individuals with schizophrenia.

(Lasalvia et al. 2014)

What does the research say?

Family Interventions-Caregiver related outcomes

- Family's expressed emotion (historically referred to as “EE”)
- Psychological condition and/or distress
- Emotional climate
- Care burden or strain
- Everyday function
- Caregiving experience, coping skills, and problem-solving ability

Secondary outcomes included:

- Supportive service utilization and/or satisfaction
- Perceived social support
- General health condition

Ma et al 2018

"Expressed Emotion" Common emotional responses to stressful complex experiences

- Family psychoeducation moderates expressed emotion by teaching and providing the opportunity to practice new skills
- Non-coercive
- Welcoming setting
- Offers validation for real time challenges and experiences while recognizing successes
- Provides and structured methods to resolve conflicts and challenges of individual and family members/supporters in the meeting and to apply at home and across life settings
- Deliberately celebrates successes
- Deliberately shares stress/burden across group members

What are some examples?

Research: Several decades of research

- Higher expressed emotion associated with higher relapse...lower expressed emotion influences vulnerability for relapse and worsening symptoms, consistent involvement with intervention as effective as medicine

Butzlaff & Hooley, 1998

A closer look at expressed emotion

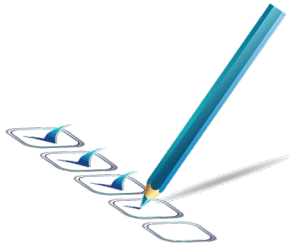
- Expressed emotion describes criticism and/or “too much” emotional involvement from a primary support person (in research this is often identified as a family member)
- Higher levels of shame and guilt about having a relative with schizophrenia predicted higher levels of expressed emotion “EE”
- Guilt 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

Butzlaff & Hooley, 1998

International Research
Structured Family Interventions

Family interventions primarily included:

-teaching psychosis knowledge
-practicing coping skills
-sharing with peers in groups



Benefits:

- Evidence for reducing care burden over time for caregivers of those with recent-onset psychosis
- In CHRp families there is some evidence that there is a fit to learn new skills to reduce stress and prevent worsening of symptoms and secondary losses

Ma et al 2018

Another international study on First Episode Schizophrenia found:

- A decrease in common familial interactions that increase stress and if left unsupported may impact the independence and functioning of the consumer

- Improvement in problem-solving abilities, reduced stress in communication of emotions, conflict and disagreement, and more effective communication skills of family members

Öksüz et al 2017

Psychoeducation specifically addresses common vulnerabilities associated with risk for relapse of symptoms

- Sensory stimulation
- Prolonged stress, strenuous demands
- Rapid change
- Complexity
- Social disruption
- Use of substances and alcohol
- Negative emotional experiences

Let’s Take A Break!

Social Networks and Stress

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

UNFORTUNATELY…for our population of young people

- **Family network size**
  - is already smaller at the time of first admission
  - diminishes with length of illness
  - decreases in the period immediately following a first episode
  - includes young people who enter program in the clinical high risk group category

Considerations Influenced by Culture

- Beliefs about what is typical, why this is happening
- What support the person /family finds helpful
- Who is the primary focus: Individual vs. family
  Family may feel shame/"saving face"
- Differences between youth, immediate family, and extended family perspectives
- Who in the family is involved (children, siblings, etc.)
- Impact of historical trauma, historical and ongoing oppression
- Participants may know each other already in different contexts (rural/frontier, interpreters)
- Willingness to speak publicly may have many layers

Cultural Humility

Moving from concept of “cultural competence” to cultural humility:

- Health care is a cultural construct based on beliefs about disease
- Cultural issues are central for useful service delivery and treatment
- Cultural humility is an openness, not a precise process, something that takes place between two people

Credit: CC0 Public Domain

Cultural Humility

- Individuals receiving services are experts in their own lives—what is seen as distressing to one person may not be to someone else

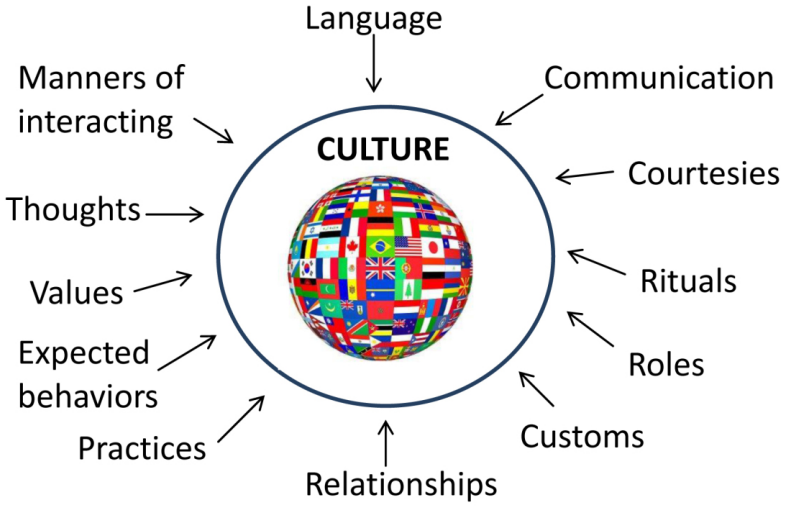
- Incorporates a commitment to lifelong learning and reflection, and an understanding of power dynamics in provider-consumer relationships and in one's own role in society

Tervalon & Murray-Garcia, 1998

Consider the composition of your team, community, family members, participants and supporters…

What cultural adaptations do you need to make?

- For the Educational Workshop content? Handouts?
- Joining sessions?
- Group meetings?



Psychoeducation

Not the same as community education

- Has been found to be incredibly useful in empowering everyone involved to be helpful in addressing concerns, reducing symptoms and reaching life goals.

- Psychoeducation refers to a systemic method, used in a purposeful manner in treatment, to offer educational information to individuals experiencing and supporting the healing and recovery from mental health symptoms.

- Psychoeducational material should be offered in a culturally humble manner, at a pace that fits the presenting concerns, needs, and hopes of the young person, their family members and supporters, and is a planful intervention supported by the entire CSC team for the duration of the young person's time in the program.

Bäuml, J., Froböse, T., Kraemer, S., Rentrop, M., & Pitschel-Walz, G. (2006). Psychoeducation: a basic psychotherapeutic intervention for patients with schizophrenia and their families. *Schizophrenia bulletin*, *32 Suppl 1*(Suppl 1), S1–S9. https://doi.org/10.1093/schbul/sbl017

Who Receives Structured Psychoeducation?

- Offered to ALL participants and their primary supports/family members
- 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 use
  - Feeling stuck
  - Desire to support others in similar situations
  - Loss of hope

Additional Considerations

- Invite person to define family
- Offer in single-family format if participants/families are unable to attend groups or if this is a better fit

- Consider group coherence: i.e. age and diagnosis
- Unwilling to give consent
- Insurmountable logistical problems that have been problem-solved without a viable solution
- Evaluate cognitive impairments for adaptations and fit

*Do not use for problem solving life threatening/high risk situations

*Do not include individuals who are perpetrators of abuse, neglect, or domestic violence

Adaptations for Individuals with Intellectual or Developmental Disabilities & Psychosis

- Group is not about organizing individuals by diagnosis …consider from a skills-based approach of what needs for the participant and family/supports are identified:
- Consider the floor plan setup when in person

- consider mobility, vision, hearing, sensory needs, accessibility to leaving as needed

- Consider reviewing the problem-solving plan with increased frequency after MFG to support carry over
- Utilize different media within the plan:

-incorporate colors, pictures to clarify action steps

- Have a plan for rest breaks for the participant as needed
- Provide psycho-education to all participants as needed to support fluid and thoughtful communication.

-Group members may benefit from psychoeducation to help with understanding challenges and how to maximize strengths with receptive and expressive language difficulties

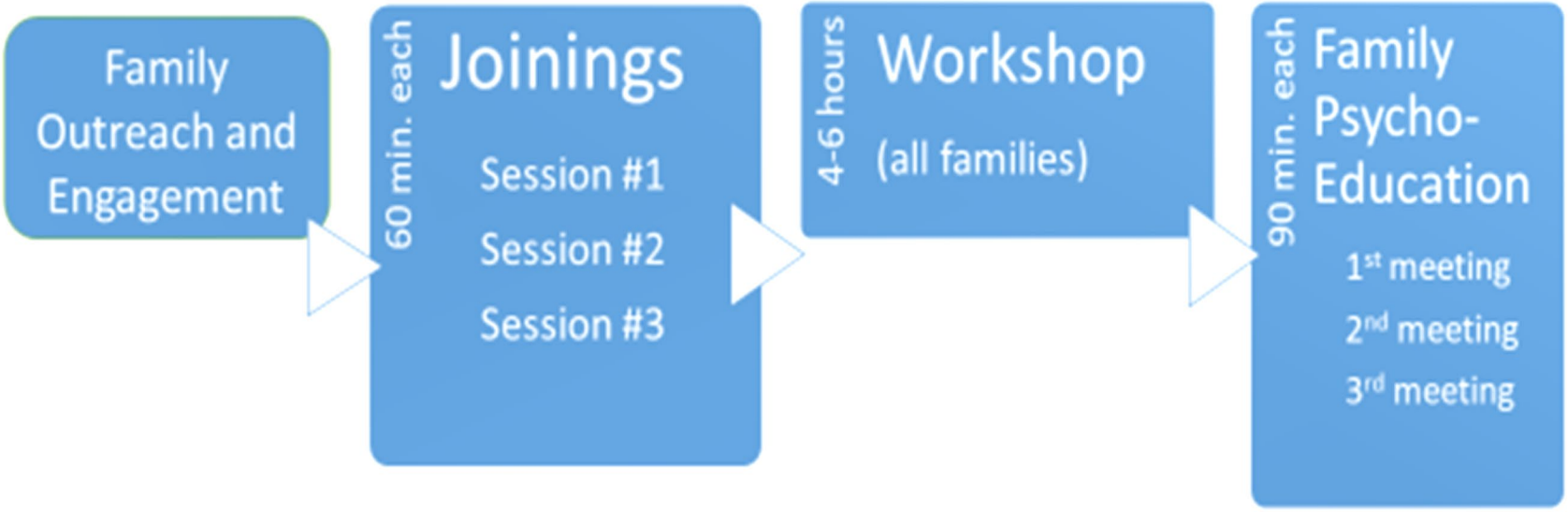
Benefits of psychoeducation

- Reduced family burden
- Reduced relapse
- Reduced judgment and pressure
- Focus on short-term problems
- Reduced conflict and negative attitudes
- Encourages each individual to own their own problem
- Builds social network
- Supports steady progress
- Evidence-based
- Simple
- Encourages creativity, humor, normalization
- Teaches useful and developmentally beneficial skills

Stages of Structured Psychoeducation

- Joining
- Education
- Introduce ongoing process
- Ongoing problem solving groups
- Each step in the process matters!!

Stages of Family Psychoeducation Group Intervention




Stages of Family Psychoeducation Group Intervention
Family Outreach and Engagement
60 min. each
Joinings
Session #1
Session #2
Session #3

Joining Sessions

- Early intervention for psychosis team members 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 and family members who are going to participate in the intervention.

- Use session checklists to organize sessions and pace yourself and participant and family: https://easacommunity.org/PDF/MFG_Handouts/2_Joining_session_structure.pdf

Joining Sessions

Joining session example: https://easacommunity.org/easa-mfg-handouts.php

Why Joining Matters

Opportunity to start central interventions: documents:

- Relapse prevention/wellness/stress reduction plans
- Identifying strengths and values
- Comprehensive crisis planning
- Offering psychoeducation specific to their concerns, needs, and hopes
- Preparing for the workshop
- Buidling trust and facilitating engagement!

Engagement

- Builds trust & comfort: people will come to the group because of their relationship with you
- Gives others time to get to know you
- Gives you time to understand their unique strengths, challenges, symptom presentation, vulnerabilities
- Provides potential opportunity to address conflicted communication and model skills.
- Reinforces resilience and coping
- Gain understanding of experiences with systems of care and concerns about treatment

Elements of Joining

- Listen & get to know each other
- Understand 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 or Strengths Exploration
- Describe multi-family group/single-family & why it is important
- Answer questions & gain commitment to participate

Stages of Family Psychoeducation Group Intervention

60 min. each

Joinings

4-6 hours

Workshop

(all families to attend or receive)

-Should be given individually to a family if they are unable to attend the workshop.

Examples: unresolved transportation barrier, work conflict, or family enters the program right after a workshop is completed

-Entire team takes on the role of educators of the program

Educational Agenda (workshop, individual sessions)

- Socializing at beginning and end of all sessions
- History and epidemiology (prevalence of the diagnoses)
- Symptoms and biology, psychology, cultural aspects of the condition
  - Address the conditions of people in the room (Bipolar, Clinical High Risk need different information)
- Typical adolescent and young adult development and how it looks different than the symptoms
- Treatment: what is it; effects, side effects

Educational Agenda
(clear structure)

- Common family reactions
  -Grief cycle, conflict during onset; trauma
- Family Guidelines (in detail!)
- Specific communication & coping skills
- What to expect in the 1st, 2nd, and ongoing psychoeducation sessions
- Include those with lived experience perspective as people state this is often most helpful
- Questions and Answers
- Socializing

Structure of Sessions
Multifamily groups (MFGs) and single-family treatment (SFT)

	MFG	SFT
1. Socializing with families and consumers	15 m.	10 m.
2. A Go-around, reviewing— a) The week's events b) Relevant biosocial information c) Applicable guidelines	20 m.	15 m.
3. Selection of a single problem	5 m.	5m.
4. Formal Problem-solving 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 implementation	45 m.	25 m.
Socializing with families and consumers	5 m.	5m.
Total:	**90 m.**	**60 m.**

The first time that families and individuals "come together"

- Multi-family: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
- Questions and interactions encouraged

All early intervention direct service team members attend and take on role of educators

The first time that families and individuals "come together"

- Food provided
- Honor different learning styles
- Families can interact in ways that are comfortable for them
- Additional transportation/employment/ childcare barriers identified and problem-solved
- Schedule when team and families can attend
- ADA, cultural, and language needs are met
- Reminders about first group meeting

Family Guidelines

- A set of 20 guidelines based in biological social and emotional stressors and needs.

- Use:
  - 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.

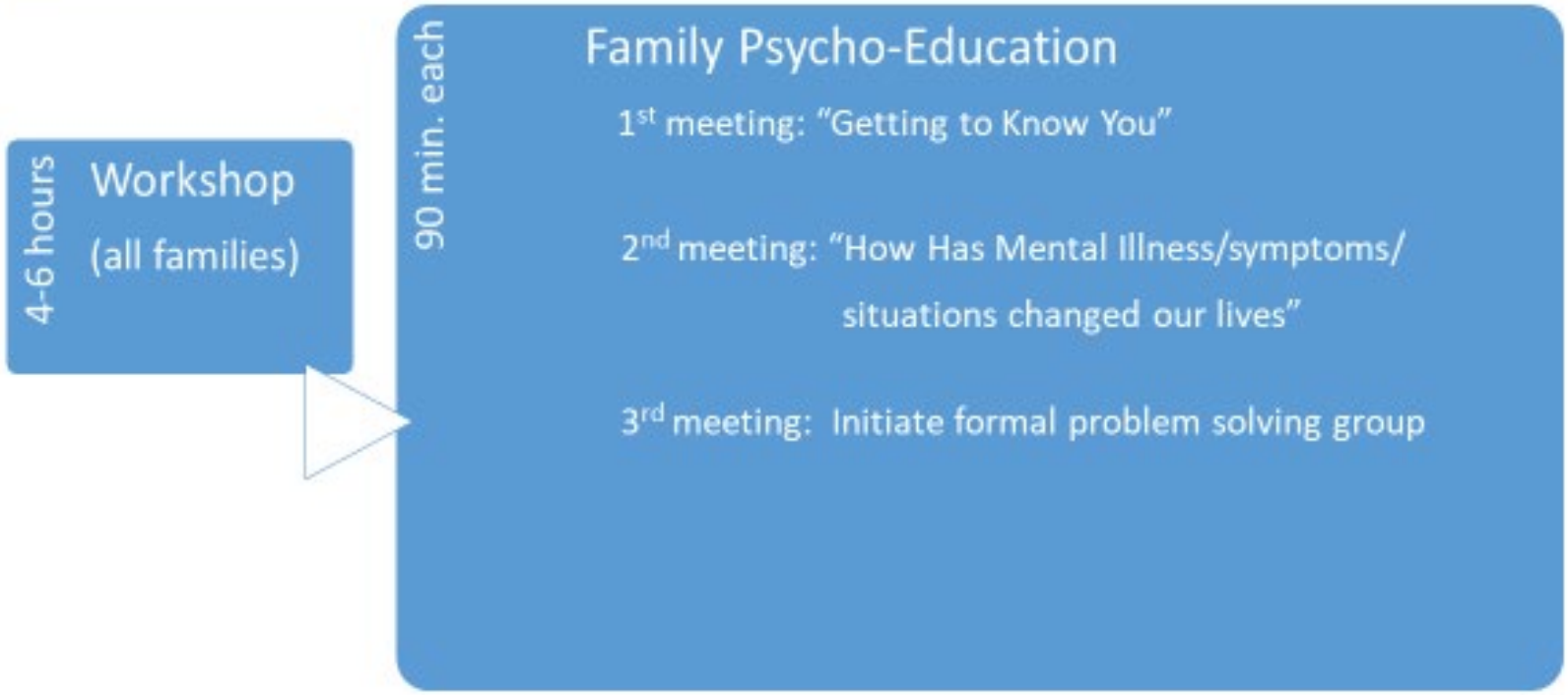
Family Guidelines

Family Guideline Exercise

- Take turns explaining first two guidelines
- Switch partners

Introduction to the problem-solving method

Stages of Family Psychoeducation Group Intervention



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 is ideal for multi-family groups
  - Not a drop-in group
- Families, individuals, and treatment team facilitators become partners
- Meetings every other week for the duration of treatment program.
  - Attending 1x/month rather than none is better than not participating.
  - Ideal to offer option to access after graduation from EASA
- 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, trainer-coach, and group member
- Teach families and individuals to use the problem-solving method and family guidelines to deal with life stressors and symptom-related challenges

Your tasks as facilitator

- Keep asking, “What’s next?”
- Advocate
- Bring information from group back to the EAS/ weekly team meeting
  - This should be a specific action plan or need for team members to follow-up on.
- Remind people about group or single- family meeting
- Don't cancel MFG/Single-family group or replace the problem-solving group with a different type of group (like skills training or a socialization group)!

Multi-Family or Single Family?

- 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

Multi-Family or Single-Family?

- Support MFG or Single family
- 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.

Successful attendance/retention

- Early intervention team understands the value and purpose
- Entire team promotes the intervention routinely across sessions/meetings *(team members look for a "fit" with expressed concerns, emergent needs, changing goals, hopes, etc.!)*
  - 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—to you and (eventually and hopefully) the group
- Consistency (time, place, facilitators)—DON'T CANCEL
- Outcomes and experience
- Hope

The 1st and 2nd Groups

"Getting to know you"

- Co-facilitators model disclosure and behavior
- Share personal information (clarify)
- 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 and no agreement on exactly what to disclose or not disclose—however, evasiveness is not helpful

Examples: encouraging, similarities and differences, humanizing, being in-the-moment

Strategic self-disclosure can instill hope, reduce shame, and reduce feelings of isolation in consumers and their family members

Self-disclosures that humanize and convey similarities are most helpful

Howe (2011)

Disclosure Take Away

- –Attend to impact 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 people decide in advance what choices they want to make about how to share and what to share about their lived experiences.

*Co-facilitators should do this with each other or with support prior to meeting with the group for the sharing session.

Gibson (2012);
Levitt, Minami, Greenspan, Puckett, Henretty, Reich, & Berman (2016)

What is the hierarchy for problem-solving? Why?

- Medication concerns (can't obtain, side effects, not working, reducing, stopping)
- Substance use and/or 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!
- -Avoid problem solving crisis issues too complex or risky for the group setting---instead, create an **immediate** plan for addressing crisis or complex issues **outside** of group setting
- -Simplify
- -Narrow
- -Concentrate on behavior
- -Focus on relapse risk

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

Brainstorming solutions

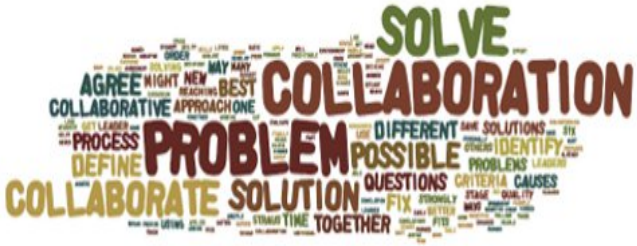
- All members can and are encouraged to contribute
- All suggestions are welcome
- No suggestion is analyzed or critiqued during brainstorming
- Suggestions are limited to 10 - 12 ideas (number them!)
- The person with the identified problem chooses 1 - 3 suggestions to try
- Group receives a copy of specific action plan that has clear, written steps

Advantages and Disadvantages of Possible Solutions

- 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 challenges through structure, predictability, simplicity
- Organized and systematic
- Facilitates small successes



Preparation for Structured Family Psychoeducation Sessions

- Remind people the date, time, and place of meeting the week before and again the day before the sessions
- Explore and problem solve barriers to attendance
- Have food budget ready if in person!
- Distribute list of meetings
- Review format of first 2 meetings

Importance of "Chat"
before and after each group

- People with psychosis often forget how to initiate and join in conversation
- Reduces tension and anxiety
- Participants learn about one another and connect
- Great way to learn what's going on in the community

Virtual SFE/MFG Considerations

- Plan enough time to ask about needs and offer technology support for all participants (and facilitators).

- Invite choice to have camera off/on and/or join by phone.
- Help young person define family---consider folks living far away as an option (virtual platforms accommodate participation from anywhere!)

- SFE: Offered to all participants and family members/supports who are not engaged in MFG

- MFG: Limit group size to 9-11 (2 facilitators).
  - Consider age, diagnosis, rapport with facilitators

- Text or call to remind day before and day of meeting.

- If budget allows, consider sending food by delivery to participants locations.

Virtual Considerations continued

- MFG/SFE: Discuss benefits and drawbacks of virtual participation
  - (+) really useful intervention, time to gather with others on a routine basis, supports reaching treatment goals, saves time and gas money, reduced exposure to illness, won't have to change plan due to weather or new Covid19 restrictions.
  - (-) tired of the screen, symptoms make participating remotely stressful, feel controlled by Covid19 mandates/restrictions
- MFG/SFE: Seek feedback routinely about how it's going and what might be changed to improve attendance.
- If someone misses a meeting without letting you know, be sure to follow up and check out what happened and if there is anything facilitators can do differently next time.
- Avoid deciding (pre-cancelling) based on assumptions no one will attend.
- Allow plenty of time for adjustment.
- Be consistent and predictable with offering the MFG/SFE group. For many folks now--more than ever, predictability is of great value to reduce stress and the group offers an opportunity for social connection.
- Welcome and accommodate change and communication so that there is a plan to support the transitions: for example--going from MFG to SFE or SFE to MFG, frequency, preferred format, etc.

Common facilitator questions—these (or any other questions) are great questions to bring to consult calls!

- When do we start a group vs. implement single family? (how many group 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 share situations that we can work with in group?
- How do we accommodate language barriers?
- How do we support each other as leaders if we are burned out, fatigued or need to miss a group?
- How do you manage a group member who has difficulty following the group structure?
- 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 SFE 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!

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