George Furstenburg

Adjunctive Family/Whanau Focused Intervention in the Treatment of Severe Mental Disorder
Adjunctive Family Focused Intervention in the Treatment of Severe Psychiatric Disorders

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Motivation

- I am interested in the use of systemic intervention in the treatment of severe mental health difficulties.

- Increasing emphasis on community based care.
  - Periods during which the family/community becomes the primary treatment context are increasing for all phases of psychiatric illness (i.e. prodromal, acute, recovery)

- I am increasingly questioning the wisdom of the MH system’s over reliance on the creation of new, complicated, and potentially harmful relationships in treatment. Prioritizing this over attempts at optimizing existing relationships.
Aims

- To briefly discuss the history of Family Focused Interventions (FFI) for severe psychiatric disorders.

- To explore the development of FFI models through discussing:
  - Two foundational theoretical models,
  - the characteristics shared by current FFI models, and
  - a specific FFI for Bipolar Disorder.

- To present the evidence base for FFI, and the impact it has had on best practice.

- To discuss the practicalities of providing FFI in real world settings.
Family

- The term family, for the purpose of this presentation, includes those who undertake the care and support of the person with a severe mental illness, regardless of whether they are related or live in the same household.
Family Focused Intervention (FFI)

- a **method for working with families** of persons with mental illness.

- Based on a **family-consumer-professional partnership**, it combines clear, accurate information about mental illness with training in problem solving, communication skills, coping skills and developing social supports.

- The goals are to **markedly improve consumer outcomes and quality of life**, as well as to **reduce family stress and strain**.

- It builds on and **combines the complementary expertise and experience of family members, consumers and professionals** to develop coping skills that lay the foundation for mastery and recovery.
Severe Mental Illness

- Schizophrenia
- Bipolar Disorder
Evidence Based Practice

- Evidence-based practices are services for people with severe mental illness (consumers) that have demonstrated positive outcomes in multiple research studies.

- Randomized controlled trials (RCTs)
History of Family Intervention for Severe Psychiatric Disorder
Deinstitutionalization:

The nature of professional-family relationships has varied over time according to the assumed causes of mental illness.

- When consumers went home to their unprepared families and supporters (and inadequate community resources), many consumers suffered relapses.

- In keeping with the prevailing assumptions about families at that time, these relapses were taken as evidence that the home environment was counter-therapeutic.

- Families and supporters found themselves in painful situations in that they not only had to experience their loved one’s suffering from mental illness, they were also blamed for its occurrence.
Blaming the family

- Contributons:
  - RD Laing (Disturbed communication patterns)
  - Jackson & Bateson's (Double Bind Communication)

- Research base inadequate
- Cause and effect confusion
- Family dynamics not measured before onset of illness

- The guilt and confusion of being blamed by professionals, relatives or neighbours induced conflict within the family.

- Families are frequently victims of a double bind, rather than the source of the problem.
Decade of the Brain – 1990’s

Attention turned away from the family pathology models of mental illness toward the neurodevelopmental models of mental illness. Families who had long been viewed as “part of the problem” were now considered as “part of the solution.” Collaborative treatment planning with family and other supportive caregivers has since been incorporated under many professionals’ standards.
The limitations of Pharmacotherapy alone

- When treated with pharmacotherapy alone:
  - adult and pediatric patients still have slow time to recovery and high rates of recurrence;
  - poor school, work, and social functioning;
  - high rates of suicide risk; high rates of service utilization; difficult environmental circumstances that provoke recurrences;
  - significant family disruption.

- Recent study by managed care organization showed that:
  - Average time on lithium 76 days;
  - 31% of bipolar children and adolescents failed to comply with any mood stabilizer over 6-wk period.

- Bipolar episodes are precipitated by psychosocial stressors
Models of Family Focused Intervention

1. Expressed Emotion
2. A Resilience Framework
3. Shared Characteristics of Different FFI Models
4. A FFI for Bipolar Disorder
Expressed Emotion Research

- A term referring to unsupportive, critical interactions.
- Developed by Julian Leff and others in the U.K.
- Based on research observations that when patients were forced into close proximity with their families (deinstitutionalization) some of them experienced significant deterioration.
- Subsequent experiments, during which a time budget approach was used, led to significant improvements for these clients.
- Resulted in the development of methods to help families with high expressed emotion to reduce their exasperation by learning from other families who have more fully understood and mastered the illness and how to cope with it.
A Resilience Framework

- Family resilience approaches are focused on the strengthening families’ capacity to master adversity.

- A basic premise of this approach is that stressful crises and persistent challenges influence the whole family, and in turn, key family processes mediate the recovery of and resilience of vulnerable members.

- Intervention aims to build family strengths as problems are addressed, thereby reducing risk and vulnerability.

- The stress/diathesis mental health disorder is central to resilience thinking.
Stress/diathesis model

Vulnerability

Stress
Vulnerability

High genetic loading; In utero damage; physiologically damage; non-supportive or negative family/whanau, school, and peer environment

Low genetic loading; safe in utero environment; physiologically protected; supportive and positive family/whanau, school, and peer environment

Stress
Stress

Vulnerability

Challenges (risks) – Stress – Resources/ strengths
Stress/diathesis model

Adaptive functioning • Effectively deals with challenges • Protects and buffers individual members

Vulnerability

Non-adaptive
• Unable to cope with challenges
• Individual members at increased risk

Adaptive functioning
• Effectively deals with challenges
• Protects and buffers individual members

Stress
The Development of FFI models

- A variety of Family Psychoeducation models were developed over the past two decades.

- These models have a deep enough research and dissemination base to be considered evidenced based practices.
Treatment Focus:

- Are usually diagnosis-specific.
- Offered as part of an overall clinical treatment plan for the consumer.
- This is a *treatment for a disorder*, much as is medication, not a method of treating the family (Not to be confused with family support).
- Variable emphasis on didactic, emotional, cognitive-behavioral and systemic techniques.
- The descriptor “psychoeducation” can be misleading; family psychoeducation includes many therapeutic elements, often utilizes a consultative framework, and shares characteristics with other types of family interventions.
Treatment setting:

- Models differ in their format (multiple-family vs. single-family sessions vs. mixed), duration of treatment, type of participation by the consumer, location (hospital- and/or clinic-based, home, family practice or other community settings).

- Practitioners of all mental health disciplines—psychiatrists, psychologists, social workers, nurses and nurse practitioners, counsellors, occupational therapists and licensed counsellors—have proven to be remarkably capable of conducting these model of treatment.

- In some carefully supervised situations, Para-professionals working closely with a professional clinician have effectively conducted family Psychoeducation.

- Last nine months to over five years.
Are FFI approaches for the family or the consumer’s benefit?

- It supports recovery from a major mental illness with assistance of family members – family is the active treatment ingredient.

- Studies found both a dramatic reduction in rehospitalizations and negative symptoms among the consumer participants and a reduction in medical illness among the family participants.
Why is it necessary for FFI to be led by well experienced health professionals?

- The effectiveness of lay counsellor or consumer led support groups in reducing distress and burden and increasing mastery is well documented.
- These benefits does not appear transfer to a reduction in symptoms for consumers when groups are led by lay counsellors or inexperienced clinicians.
- Accurate information about the specific disorder in its many permutations is possibly a critical ingredient for effecting change.
Schizophrenia

- Barrowclough & Tarrier (1992): "Families of Schizophrenic Patients: Cognitive Behavioral Intervention"
- Falloon et al (1984): "Family Care of Schizophrenia: A Problem-Solving Approach to the Treatment of Mental Illness"
- McFarlane (2002): "Multifamily Groups in the Treatment of Severe Psychiatric Disorders"
Bipolar Disorder: David J. Miklowitz
Theoretical Orientation:

- Miklowitz's program is an adaptation and extension of Falloon's behavioral family therapy (originally focused on schizophrenia - see Falloon's 1984 book) to bipolar disorder.

- This program incorporates Family Systems Theory and Communication Theory.
Goals:

- Assist the patient & family to integrate experiences associated with bipolar episodes
- Accept the awareness of vulnerability to future episodes
- Accept dependency on psychotropic medications to control symptoms
- Distinguish between the patient's personality & his/her bipolar symptoms
- Recognize and learn to cope with stressful life events that may trigger recurrences of the disorder
- Help the family to re-establish functional relationships after a manic or depressive episode
Phases of Treatment:

- Initial functional assessment
- Psychoeducation for patient & family (disease symptoms, etiology, treatment, relapse planning, etc.) [~7 sessions]
- Communication skills training [7-10 sessions]
- Problem-solving training [4-5 sessions]
Setting:

- Research has been conducted in clinic-based as well as home-based family sessions. Patients are included.

Frequency / Duration:

- Decreasing frequency of sessions (21 sessions in all) 9-month duration
FFI is Very Effective
FFI for Schizophrenia

- At present, FFI has been shown to be most effective for individuals diagnosed with schizophrenia.

- There have been at least 20 controlled trials, involving nearly 5000 consumers and their families and two are underway in Scandinavia that will involve nearly 1000 consumers and their families.

- Outcome has been remarkably consistent across all but two of these clinical trials.
**FFI for Bipolar Disorder:**

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| Simoneau, Miklowitz et al. (1999):         | - More positive nonverbal (not verbal) interactional behavior than patients in control group.  
- Patients who showed improvements in positive nonverbal interactional behavior showed the greatest reductions in symptoms over a 1-year pre/post-treatment interval. |
| Miklowitz, Simoneau et al. (2000) and Miklowitz, George et al (2003): | - 35% relapsed in FFT vs 54% in control group  
- Longer delays before relapses than control group.  
- Greater improvement in depressive symptoms.  
- Lower mean levels of manic symptoms.  
- Improved medication adherence. |
| Rea et al. (2004):                         | - FFT patients had longer delays prior to re-hospitalization or relapse than patients in individual therapy.  
- Re-hospitalization rates 12% in FFT and 60% in the individual therapy condition. |
Ingredients rather than formula predicts outcomes:

- a **collaborative relationship** between the treatment team and family,
- **basic psychoeducation** about psychiatric illness and its management,
- **social support and empathy**, 
- interventions targeted to **reducing tension and stress in the family** 
- improving **functioning in all family members** (and not just the consumer),
- a program length of **six months or more** (Dixon, McFarlane et al., 2001).
FFI works for most people:

- Specifically, symptomatologies, age, gender, disability status, prior hospitalization, duration of illness and education have been examined and none have proven to be strong or consistent predictors.

- Diagnosis may be the closest to a specific indicator.

- Modifications have therefore been developed and tested for, depression, borderline personality disorder and OCD.
Cultural Competence Focus:

- Flexibility in presentations allows for good cultural competence, in effect, allows for the adaptation of approaches to meet the needs of consumers from different cultures.
- There have been large-scale and very successful applications of these methods in:

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Impact on Practice Guidelines
British Medical Journal: Clinical Evidence

- Multiple sessions family intervention beneficial in reducing relapse rates of Schizophrenia.

- Family focused psychoeducation likely to be beneficial in reducing relapse rates of mania or bipolar depression.
The Substance Abuse and Mental Health Services Administration (USA) Identified six treatment practices which currently demonstrates the strongest evidence base in treating severe mental illness:

- Standardized pharmacological treatment
- Illness management and recovery skills
- Supported employment
- Family psychoeducation
- Assertive community treatment
- Integrated dual disorders treatment (substance use and mental illness)
“Although drugs remain the primary treatment, associated psychological treatments are valuable. The limitations of medication in alleviating symptoms and functional impairment highlight the need for psychosocial interventions which aim to reduce symptoms, prevent relapse and recurrence, restore social and psychological functioning and support patient and family.”

“In summary, family or couple therapy, together with medication, is effective for patients recovering from an acute episode.”
Practical Limitations

- Why is an approach that is included in most best practise guidelines, and one that has consistently demonstrated itself to result in an 20% - 50% reduction in relapse and rehospitalization rates and not used more widely?
Management Concerns and response:

- **It costs too much:**
  - The organization’s leadership will need to ensure that reimbursement covers the slightly greater initial costs, if the program is to be maintained and achieve its potential cost savings.

- **We have to change the procedures already in place:**
  - Yes, a few procedures will need to change, but they are minimal compared to the changes required for assertive community treatment or supported employment. Set up methods for determining which consumers have family available and join with families as soon as possible during an acute episode.

- **Staff has no experience working with families of consumers:**
  - Nearly every practitioner who has adopted this approach and followed the suggested methods has succeeded in achieving the same results as in clinical trials.
Clinician Concerns and response:

- **There will be an increase in workload:**
  - Studies have shown that over the first year the total workload for a given group of consumers will either be the same as or less than for standard individual therapy and/or case management.

- **There is no time to learn a new treatment model, regardless of what the research outcomes indicate:**
  - The first implementation will require extra time and effort, but it will be compensated by fewer crises, improved outcomes, and a much greater sense of accomplishment and gratification in one’s work.

- **It is difficult to find a colleague to co-lead groups:**
  - It is much more important to include families in the ongoing clinical and recovery work, so start on a single-family basis with a small number of cases and allow colleagues to see the results.

- **Agency administration will not reduce or rearrange caseloads of staff:**
  - It will be the job of the program leader to allow for 3–4 months of reduced case load or relief from intake to set up family psychoeducational services, especially in a multi-family group. It will balance out quickly in improved clinical efficiency.
Consumer and Family Concerns and response:

- Consumers do not want their families involved with their treatment:
  - There are suggested methods for involving consumers in making decisions about including family members in treatment. Once they understand what is involved and how they will benefit, it is extremely rare that a consumer will not give consent and participate.
Impact on my Practice

- Increased my CE focus on recovery and family focused models of care.
- Created specific times within my clinic dedicated to family focused work.
Future directions

- Training
- Training
- Training that endeavours to close the gap between the expectations of family involvement and evidence based practice.
- Dedicated family treatment?
Essential Readings


Thank You
References

References (continue)


