FIRST EPISODE PSYCHOSIS FAMILY TRAINING

COORDINATED SPECIALTY CARE/ EPI-NC

February- April 2023

Sylvia B. Saade, PhD, LCSW

c. S.Saade, 2023

Introduction

- **Training will be divided into 5 to 6 sessions spread out over a period of 3 months: February through April. bi-monthly Wed from 12:00pm to 02:00pm**

- **Training to be interactive**

- **Introduce participants/ background/theoretical approach to family therapy.**

- **Challenges that you have faced or are presently facing.**

In Today's session , we will discuss :

- ❑ **The importance of Family Involvement: WHY Family Involvement ?**
- ❑ **Engaging caregivers in treatment: HOW to engage families?**
- ❑ **Assessment & Orientation : WHAT to look for? WHAT are you assessing? WHAT interventions to use ?**

WHY FAMILY INVOLVEMENT:

- ❑ **Various studies indicated :**

  - ↘ Family burden

  - Better Outcomes / Relapse Prevention/↘ Hospitalization & ↘hospital stay.

- ❑ **Family Burden:** *(“Family Intervention in FEP: A Qualitative Systemic Review” by Anvar Sadath &more; Nov 16,2015)*

  - Family members of individuals experiencing their first psychotic episode have a higher risk of distress compared with family members with a prolonged course of the illness

- **The stress experienced by caregivers during the 1st episode can sometimes tamper recovery and even lead to relapse.**
- **High EE (criticism, hostility or over involvement) significantly predicts relapse in individuals with prolonged psychosis.**

- ❑ **Clients who maintain relationships with their relatives and families that are involved in their care tend to have better outcomes.** (*Brekke & Mathiesen 1995; Clark 2001; Evert,Harvey et al 2003).*

Stowklouly et al,2021 **found in a 1st episode sample that lack of family involvement in the comprehensive care program predicted client disengagement .**

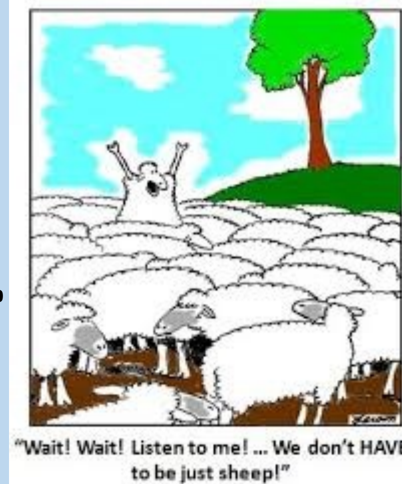
- *Left and Vaugh,1985 and Butzlaff & Hooley ,1998* **indicated "Tense, conflictual family relationships are often associated with worse outcomes."**

- **Significant Clinical and Psychosocial deteriorations in psychosis occurs the 1st 5 years after the onset of the illness. Hence early intervention is critical to achieve better outcome clinical and functional.** *(Reed,S.I , 2008)*

- **Family Interventions need to be provided at least 6 to 9 months to sustain significant clinical outcome benefits.**

A first psychotic episode is more likely to occur :

- **during late adolescence when the teenager still lives at home or**
- **during early adulthood when the young individual is beginning to individuate from his/her family of origin.**


"Wait! Wait! Listen to me! ... We don't HAVE to be just sheep!"

When Psychosis happens:

- **Young adults tend to return to live at home**
- **Family members get re involved in their lives**
- **Parents find themselves back in a caregiver role**

- **<u>The natural course of development</u> towards differentiation and individuation is interrupted**

- **<u>Roles</u> have to be redefined, temporarily in some cases, and more prolonged in others.**

- **<u>The adjustments</u> required from everyone in the household (caregivers and siblings alike) and the experiences of the early stages of psychosis can be devastating, overwhelming and frightening to the family.**

HOW TO ENGAGE CAREGIVERS

- **It begins at the timing of screening:**
  - **- with providers**
  - **- with initial contact with family members/caregivers .**

- **It begins at the time of Intake: doing the assessment with family members and the individual.**

- **Intake (90mn to 120 mn). Intake to be done with parents/caregivers at all times . This sets the expectations of "the culture of family involvement". The only exception is if client is age 28 to 30. At that point , meet with client and partner (if any) or if alone, ask permission to get collateral from parents (to complete assessment ; hx of childhood…) the client chooses to be present or not during the call to their parents.**

- At Intake, explain to client why first intake is done with family:

1- To hear every one's perspective on the events that brought client to treatment. As a clinician, I focus on no one 's perspective is right or wrong . I always give them the example of a vase that is in my office or any other object. .. I show them how one person sees the vase from one angle (a certain color and shape or a crack) , another person sees it from another angle yet who is right who is wrong …no one. They are just different perspectives….. Usually everybody settles in and this strategy will minimize arguments between client and parents/caregivers. (should there be arguments).

2- If client still has concerns or is highly agitated (in particular paranoid towards parents) I explain that we can divide the session. First with everyone as I need to orient everyone to the services provided in the program and then I can meet with client alone and then with parents alone. (or parents at a later date and client will be informed of date and time of the appointment). If client is paranoid, I put the client in charge of the clock…. This allows to develop trust with client and role model to parents consistency in following through with agreements . (In this case agreement to divide the session..)

- **Begin with Orientation to the program :** WHO is WHO on the team. Team includes client and families. Services provided. Reiterate 3 core services . (psychiatry, individual , family) . I explain each service in more details . I clarify frequency of sessions during the Acute Phase and Early recovery when symptoms are still prevalent and then decrease frequency of sessions as the person gets better. I take the opportunity to explain that “when one does not feel good , it is parents’ job to worry and the more they understand what is going on , the more they can step back when client feels better”. Family therapist will be there guiding parents to step back and allow for client to regain their independence in “due time” .

- I explain other services : SEES and PSS and groups (optional for clients) and family groups highly recommended . Crisis Services. How to reach the on call clinician. and Who is Who among staff.
- Open to questions. Ask if client needs a break…
- Begin Intake

- **End of Intake: provide Orientation package:**
- **Crisis pager. Days and Hours . How to use it**
- **Description of the Program with step by step expectations: with time frame…the first 3 months…**

ASSESSMENT: INTAKE

- **A Comprehensive Clinical Assessment with family members and client would guide the family therapist to the nature of interventions that will be most useful with a specific family and related to the needs of each family.**

Assessment ----------------→ Interventions: ↗ Psycho Education Only?

and

↘ Family Therapy ?

FAMILY ASSESSMENT:

- **Perception of the illness by each family member.(** *be sensitive to what what language each person uses : the client may use the "incident". Clinician to avoid using the word psychosis at this time …)*

- **The stress each family member is experiencing (caregivers, siblings)**

- **What is each member doing in response to stress & anxiety (the emotional climate or EE). What coping mechanisms have they used in the past? …**

- **Assess interpersonal relationships in the family system: perception of each other, expectations, needs …how are they being met.**

Basic assumptions in family work:

- **We all face challenges in our life. The level of adaptation and adjustment to change differs from one family to the other.**
- **We all draw from our previous experiences and coping strategies. Families use previous strategies to cope with new situations and life transitions. We all have a treasure box with a variety of tricks we have learnt throughout the years. Sometimes those old coping strategies work, sometimes they don't .**
- **Psychotic illnesses heighten the stress level and anxiety of family *members*(*also known as Family climate or Expressed emotions*)**

Psycho education is a must for all families

- **In this Critical period, individuals and their families are in need for information and support.**
- **International Early Psychosis Programs have included family interventions in their comprehensive treatment. They do differ in the Family Model and its implementation. There is nevertheless consensus that a psycho educational model * has a beneficial effect on patient's relapse rate and on family's subjective burden**
- **In a recent survey of 34 FPP in the US, White et al (2015) found that 96.8% of FEP used Family therapy as an intervention and 61.3% used both single family therapy and MF group .**

** Addington et al: 2013*

*******The OPUS Trial, Denmark: 2005*

- **Brief Individual Family Intervention: (4 to 5 sessions)**
- **Extended Family Intervention: when is this needed?**
- **Encourage attendance to Multifamily group.**

- The way the family handles this heightened anxiety vary greatly and can have significant impact on treatment outcome and on the interventions used in family therapy.

- **A substantial amount of research over the course of 40 years was done on the influence of the family climate on the course of psychiatric illnesses in particular schizophrenia, mood disorders and eating disorders.**

- **The Family Climate has proven to be a reliable and robust predictor of Relapse and Re hospitalization***

Clinical Psychological Review,22(2002):321-341

Family Assessment:

2 Domains are assessed:

- **The Family Climate : assess for level of anxiety.**
- **The Flexibility of the family system to adjust and adapt to change.**

Those domains are being measured by:

1. **Distress level: as reported by family *members***(*SUDS or Subjective Unit* of *Distress Scale)*
2. **Problem solving:** (*Caregivers work together to deal with problem)*
3. **Communication between family members:** (*calm, clear respectful)*
4. **Boundaries:** *(clear and respectful)*
5. **Ability to engage in activities apart from the IP**

- **QUESTIONS ?**