DOWNLOAD PDF OTHER INPATIENT INTERVENTIONS: MULTIFAMILY PSYCHOEDUCATIONAL GROUPS AND GENOGRAMS

Chapter 1 : MHCP Provider Manual - Mental Health Services - Family Psychoeducation

Other Inpatient Interventions Multifamily Psychoeducational Groups and Genograms chapter seven This chapter rounds out the skill mastery section by introducing two other.

Explore the Benefits of Psychoeducational Group Therapy written by: What is psychoeducational group therapy? Learn about this type of psychological intervention, what issues it can help with, and the layout of the group sessions. Sometimes, you may have a child in your classroom that is dealing with a psychological crisis. He or she may suffer from anxiety, depression or an eating disorder. Different types of therapy may help this child, and one type of intervention that can help is psychoeducational group therapy. The purposes of psychoeducational group therapy include teaching the participants about their particular condition, such as depression, and reducing symptoms from occurring again. By being in a group setting, other patients who are going through the same difficulties can meet and discuss these issues. For example, patients may think they will be forced into sharing their secrets. With psychoeducational group therapy and other types of group therapy, participants control what they share with other people. The group leader will also work to make the setting safe and comforting for the group. Each psychoeducation group therapy meeting is facilitated by a group leader, such as a licensed psychologist or psychiatrist. Each session focuses on a certain topic. During these sessions, participants can have discussions or participate in role-playing activities. Like other types of group therapy, psychoeducational group therapy does have rules that participants should follow. For example, patients in the group should treat each other with respect. By doing so, it keeps the group environment a safe one to open up about tough issues. For example, if the issue is anxiety, patients may learn deep breathing exercises and other relaxation techniques they can use when they start to feel anxious, such as during a test. Psychoeducational group therapy also teaches patients that they are not alone: There are other people going through the same issues. Since these group meetings are keep confidential, patients have a safe space.

Chapter 2 : Family Interventions for Schizophrenia | MHM

Method. This article reviews the evidence-based literature on family psychoeducational interventions for persons with a psychotic disorder, with a specific focus on the gaps, strengths, and limitations of family psychoeducational treatment for children and adolescents.

Multifamily superior for more symptomatic, white, high-EE patients and families. Goldstein and colleagues provided crisis-oriented family therapy in a 2 x 2 design with 96 patients randomized to low or medium drug dose and to family therapy or no family therapy. Six weekly family meetings were conducted at the clinic. Leff and colleagues , randomly assigned 24 patients with schizophrenia who had lived with their relatives for at least 3 months before admission, had at least 35 hours per week of face-to-face contact with family members, and had high EE to a treatment-as-usual control group or a family intervention package. The family intervention included a home-based psychoeducational program, a multifamily support group, and a home-based family therapy. The intervention developed by Falloon and colleagues ; Falloon and Pederson aimed to teach families effective problem-solving and communication skills. In-home sessions, which included the patient, initially provided education, but then focused on problem-solving skills. Multifamily groups were conducted at the hospital after the first 9 months of in-home sessions. The study randomized 36 schizophrenia patients living with high-EE families to family or individual management and provided 9- and month followups. Patients in the family therapy group had significantly lower relapse rates. Kottgen and colleagues studied a family intervention that differed significantly from the others cited. Fourteen patients from high-EE families and 20 patients from low-EE families received conventional treatment. No differences in relapse rates were found across conditions. The family treatment sequentially focused on 1 building an alliance with the family; 2 providing concrete information and management suggestions and building a support network with other families at a 1-day survival skills workshop; and 3 applying workshop skills in individual family therapy with the patient included. Tarrier and colleagues , studied 83 schizophrenia inpatients who had lived with a relative for 3 months before admission and who intended to return to live with that relative. Patients from families with high-EE were randomized to behavioral treatment enactive and symbolic , education only, and routine treatment. Patients from families with low-EE were randomized into education only and routine treatment cells. After 2 years, 33 percent of patients in behavioral treatment groups had relapsed compared with 59 percent from the high-EE control group and 33 percent from the low-EE control group. Followups of patients at 5 and 8 years showed persistently lower relapse rates for patients who received the family intervention. The family therapy intervention provided two educational sessions at the hospital and a series of home-based family therapy sessions. Twenty-four patients with schizophrenia from high-EE households with high family contact were randomly assigned. The study of Glick and colleagues ; Haas et al. Families received 6 to 8 1-hour educational and supportive sessions. Also, patients with poor premorbid functioning did not show any benefit from treatment. Relatives in the treatment condition rated themselves as more open to social support, more positive in their attitude to treatment, and less negative toward the patient, especially families of male and female patients with good premorbid functioning and females with poor premorbid functioning. Significant improvements for both groups in social functioning, symptoms, and days in the community were observed without group differences. Zastowny and colleagues compared behavioral family management BFM , based on the work of Falloon and others, with the supportive family management approach SFM , based on the work of Anderson, Hatfield, and others. Thirty schizophrenia patients hospitalized for an intermediate length of stay months in a State inpatient unit with family available and willing to participate were randomly assigned. All families received an educational program followed by 16 condition-specific weekly sessions with patients and families. Patients improved significantly from their baseline in symptoms, functional status, and behavior and had more days in the community compared with their pretreatment history. Families had reduced burden and family conflict, and

increased knowledge. No group differences emerged. Vaughan and colleagues compared standard outpatient care to a family intervention consisting of a time-limited week program for relatives without the patient. The intervention aimed to build a therapeutic alliance, stabilize home life, and improve problem-solving skills. Thirty-six schizophrenia patients planning to live with both parents, at least 1 of whom was considered to be high-EE, participated in the study. Other analyses of symptoms revealed no significant differences between treatment groups. Forty-one patients with schizophrenia were randomly assigned to clinic-based BFM or to standard services in the Department of Veterans Affairs system. Only patients with at least 4 hours per week of contact with a relative were eligible. Patients in the family intervention cell had significantly fewer symptom exacerbations: There were no differences between groups in the number of days hospitalized. The EE rating at the beginning of the study did not predict response to treatment. This approach explicitly built on the work of Hogarty and Anderson, Goldstein, Leff, and Falloon and colleagues. Both psychoeducational interventions included initial family engagement and educational sessions followed by 2 years of biweekly sessions with clinicians using formal problem-solving techniques. Monthly sessions were conducted for the last 2 years. Patients did not attend engagement and educational sessions but were encouraged to attend the illness-management sessions. In the single-family condition, clinicians met with families alone. In both multifamily group cells, groups of five families met. In the dynamic multifamily group condition, no education was provided and methods emphasized opening intrafamily communication, sharing emotional responses, and attempting to resolve family conflicts. These groups met weekly for the first 2 years and biweekly afterward. Forty-one schizophrenia patients who had 10 hours per week of contact with family participated in the study. Patients were followed for 4 years or until patient relapse. The 2- and 4-year relapse rates for psychoeducational multifamily and single-family groups were 25 and 45 percent, and 45 and 78 percent, respectively, a significant difference when age was entered as a covariate. McFarlane and colleagues attempted to replicate their pilot study comparing psychoeducational multifamily and single-family groups in a six-site randomized trial â€” the New York State Family Psychoeducation in Schizophrenia Project. A total of DSM-III-R American Psychiatric Association schizophrenia patients at six New York State public hospitals with broad geographic representation were randomly assigned to single- or multiple-family psychoeducational treatment. Patients were living with their family of origin or had at least 10 hours per week of family contact. Authors emphasized that the intervention was not conducted in a protected research environment and was offered to a less restricted and more typical sample of schizophrenia patients. Families in both conditions were assigned to a family clinician who was a case coordinator, educator, group leader, and liaison. Eligible subjects also had to attend at least three treatment engagement sessions, the formal educational program, and one subsequent treatment session. As in the earlier pilot study, initial engagement and educational sessions with families were followed by biweekly single-family clinician sessions or multiple-family group sessions aimed at problem solving for the 2 years of the study. The multiple-family group aimed to extend the social network of the patient and the family and to reduce the isolation and stigma caused by mental illness. At 2 years, 28 percent of multifamily group patients had relapsed compared with 42 percent of patients in the single-family condition. When considering those who completed the study, therapy modality and medication compliance were significant predictors of remission. When the total number of relapses were considered, multifamily groups generated 31 percent fewer relapses than did single-family groups with significant treatment modality effects. Note that most of the advantage of the multifamily condition was attributable to its superiority for patients with higher levels of positive symptoms at discharge. Similarly, race and EE status influenced the relative effectiveness of multifamily groups: White families and high-EE families had lower relapse rates in multifamily groups than in the single-family condition. Minority and low-EE families did not show such differences. There were no group differences in hospitalization. When both treatment groups are combined, the hospitalization rate for the first year did not differ from the rate before admission. However, the second-year rate is significantly less than the pretreatment rate, and the hospitalization rate of the final 6 months was lower than that of the previous month period. There were no meaningful differences in symptoms

between the treatment groups. Medication compliance was high in both groups, with no differences between the groups. Employment improved significantly over time in both modalities combined, and there was a trend toward an interaction effect between therapy modality and time that favored multifamily groups. The five-site Treatment Strategies in Schizophrenia study evaluated three medication strategies in relation to two forms of family management in a 3 x 2 factorial design Keith et al. The medication strategies included two forms of dosage reduction: The supportive treatment provided psychoeducation and monthly support groups within a framework of a shared and supportive experience conducted by a family management clinician. A total of patients entered the study with in the applied condition and in the supportive. Patients had a diagnosis of schizophrenia and either lived with their family or had significant family contact. Patients were identified when acutely symptomatic, randomized to one of the two family treatment strategies, and treated with the assigned family treatment and a standard dosage of fluphenazine decanoate for up to 6 months. If successfully stabilized, patients were then randomized into the double-blind dosage study. Assessments of a broad range of outcomes, including psychopathology, hospitalization, medication dose, and side effects as well as social adjustment and family functioning, were conducted several times up to 2 years. Preliminary results revealed few, if any, significant differences in outcome between patients in different family treatments. Approximately two-thirds of patients in both groups attended at least one psychoeducational workshop. There were no differences in attendance at monthly meetings between treatment groups. Nina Schooler, personal communication April Mari and Streiner conducted a meta-analysis of the effect of family interventions on relapse. Their methodology met most of the criteria for an outstanding review as defined by Beaman Primary studies by Goldstein et al. They then evaluated the effect of family interventions on relapse in two analyses. In the first, they included only subjects who completed the interventions. For this analysis, they made conservative assumptions; all patients lost to followup in the experimental condition were assumed to have relapsed, and all patients in the control condition were assumed not to have relapsed. The total number of patients included in the six trials was in the control group and in the experimental group. Consideration of the individual studies and the reviews suggests that there is a consistent and robust effect of family interventions in delaying, if not preventing, relapse. Lam pointed to relapse rates ranging from 6 to 23 percent in the treatment group compared with 40 to 53 percent in the control group at the 9-month to 1-year mark. Studies that compare two family treatments consistently show relapse rates in both cells that are comparable to the family-treatment condition in the studies with nonfamily-treatment control groups. Lam pointed out that this treatment effect seems to disappear by 2 years, suggesting that the intervention serves to delay rather than to prevent relapse. However, the family contact in the second year of treatment in these studies was limited and treatment termination was approaching, as discussed in the Hogarty study. Studying interventions that extend beyond the life of the research evaluation might lead to better 2-year outcomes in terms of relapse. Furthermore, the 5- and 8-year followup study by Tarrier and colleagues suggests the family intervention has some persistent benefits.

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Chapter 3 : Project MUSE - Working with Families of Psychiatric Inpatients

Working with the families of inpatients is one of the most importantâ€”and most challengingâ€”aspects of practicing clinical psychiatry. Clinicians are responsible not only for the well-being of their patients but also for the education and guidance of the patient's family.

Additional Information In lieu of an abstract, here is a brief excerpt of the content: Other Inpatient Interventions Multifamily Psychoeducational Groups and Genograms c h a p t e r s e v e n This chapter rounds out the skill mastery section by introducing two other family-oriented interventionsâ€”multifamily psychoeducational groups and the mapping of family patterns using a genogramâ€”both of which can be easily adapted for the inpatient unit. Co-leading a multifamily psychoeducational group provides the resident another vehicle for learning to understand the concerns of family members and how to communicate empathetically with families. The use of a genogram facilitates talking with an individual patient or family about multigenerational family strengths and weaknesses and is helpful in individual and family assessment and therapy. Genogram groups are a way to work on family issues in a group format. An example of a genogram is provided. Providing psychoeducation to the families of patients has been shown to contribute to sustained clinical improvement for patients at discharge, especially for female patients and patients with chronic schizophrenia or bipolar disorder Glick et al. As the APA Practice Guidelines indicate, families of patients with chronic mental illness should be offered family intervention, and this can begin on the inpatient unit APA Work Groups , , Establishing an inpatient multifamily group is relatively simple. All patients and their family members and friends are invited to the group, which meets at the end of visiting hours. The goals for the meeting are to introduce patients and their families to the multifamily group format, to provide psychoeducation, and to provide information on community resources. These groups are typically co-led by a resident and a clinical social worker or a psychiatric nurse, both of whom are knowledgeable about mental illness and community resources such as the National Alliance of the Mentally Ill NAMI. Pamphlets from these organizations can be available at the meetings. Members of NAMI or other consumer groups can also be invited as guest speakers. The groups usually run from a half-hour to an hour, depending on the interest of those present. The focus is on encouraging families to provide mutual support, especially the sharing of strategies for coping with mental illness. Multifamily groups emphasize the importance of a support network to help family members. Group leaders answer general questions and guide the discussion toward topics such as the role of the family as advocate for the patient, the role of the family in treatment, how to deal with the stigma of mental illness, and how to access community support. Leaders console families by reminding them that not all people need to be informed about the psychiatric hospitalization. Encouraging family members to discuss whom to tell and how to explain the hospitalization may be useful in reducing anxiety for patients as well as family members. The group members can learn a great deal from each other. For example, patients and families who have been living with mental illness for years can be of great comfort to the newly diagnosed patient and family by offering strategies for coping with the illness and for working with the mental health system. A frustrated family member may learn more from a person outside his or her own family. Details of such programs are provided in Chapter Discussion of these differences between patients and family members fosters greater understanding and collaboration as they all live with mental illness. You are not currently authenticated. View freely available titles:

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Chapter 4 : - NLM Catalog Result

Other Inpatient Interventions: Multifamily Psychoeducational Groups and Genograms Challenges in Working with Families The Resident's Perspective: Attitudes and Fears

This varies depending on organizational need. Two days of training is given which is 12 hours of total training. This covers assessment and treatment. An in-service training on assessing bipolar disorder in children can be part of this. Fristad is available for consultation. It is available for free at http: Implementation of Multi-family Psychoeducational Psychotherapy for childhood mood disorders in an outpatient community setting. Journal of Marital and Family Therapy, 40 2 , â€" The program must have at least one rigorous randomized controlled trial with a sustained effect of at least 6 months. Please see the Scientific Rating Scale for more information. Multi-family psychoeducation groups for childhood mood disorders: Contemporary Family Therapy, 20 3 , Ohio State University Summary: To include comparison groups, outcomes, measures, notable limitations The study evaluated the efficacy of Multi-Family Psychoeducational Psychotherapy MF-PEP on treating mood disorders in a sample of children and adolescents. Limitations of the study include the small sample size and the lack of a control group or randomization. Length of postintervention follow-up: Multi-family psychoeducation groups MFPG for families of children with bipolar disorder. Bipolar Disorders, 4, Randomized controlled trial Number of Participants: To include comparison groups, outcomes, measures, notable limitations The study evaluated the efficacy of Multi-Family Psychoeducational Psychotherapy MF-PEP in a sample of families with children with mood disorders. Results indicated that at 4-month follow-up, families described having gained knowledge, skills, support, and positive attitudes during treatment. The major study limitation was the relatively small sample size. Multi-family psychoeducation groups in the treatment of children with mood disorders. Journal of Marital and Family Therapy, 29 4 ,

Chapter 5 : CEBC Â» Multi Family Psychoeducational Psychotherapy â€º Program â€º Detailed

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Chapter 6 : An Overview of Psychoeducational Group Therapy

What it takes to work with patients' families --The biopsychosocial case formulation and treatment plan --Research on families --Family treatments --Abbreviated assessment of the family --Managing a family meeting --Other inpatient interventions: multifamily psychoeducational groups and genograms --The resident's perspective: attitudes and.