Effective Interventions for Youth with SED

Susan McCammon, PhD
East Carolina University
SED prevalence

At least 1 in 10 children/youth has a serious emotional disturbance.

“No other illnesses damage so many children so seriously.”

Early assessment and treatment are critical.
Early Intervention with Adolescents and Young Adults with Psychosis

Bruce S. Neben, PsyD
EAST Program
Mid-Valley Behavioral Care Network

August 14, 2010
Rationale: The research says

- Shorter DUP ➔ Better Outcome
- Strong Psychotic Symptoms at age 11 ➔ 25% chance of Schizophrenia at age 26
- Strong Symptoms at age 11 ➔ 90% chance if social and occupational impairment at age 26
The Research Says

Early Intervention

- Reduces the likelihood of relapse
- Reduces hospital admissions
- Increases chance of full or partial recovery
- 35% reduction in costs
The EAST Program
Qualifications

Ages 12 to 25
Symptoms for less than one year
   Hallucinations
   Delusions
   Thought disorder
   Deterioration in functioning
The EAST Program
Qualifications

General Symptoms

Changes in eating and sleeping
Social withdrawal
Changes in hygiene
EAST Program
Services Offered

Psychotherapy
Case Management
Family Therapy
  Single
  Multifamily
EAST Program
Services Offered

Supported Education
Supported Employment
OT Evaluation
Psychiatry
Assessment
Management
EAST Program
Services Offered
Consultation
Community Education
Case Finding
EAST Program
Services Offered

Services are flexible

Home
School
Community
EAST Program

Outcomes

Hospitalization dropped from 50% to 10%
Arrest rates dropped from 20% to 2%
Increased high school and college attendance
Increased social networks and improved social functioning
Improved Independent living
EAST Program

Outcomes

Since Program Inception in 2001:

- 441 Clients Served
- In 5 Urban, Suburban & Rural Oregon Counties

Since 2009:

- Programs modeled on EAST begun in 9 other Oregon counties with encouragement of State of Oregon
EAST Program
Research Involvement

One site in a national study of Early Intervention
Conclusions

Early intervention with young people with psychosis

• Improves quality of life
• Reduces likelihood of careers in mental illness
• Moderates the course of psychiatric illness
• Reduces costs
Thank You

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Mid Valley Behavioral Care Unit

Eastcommunity.org

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Psychoeducational Psychotherapy for Youth with Depression or Bipolar Disorder

Mary A. Fristad, PhD, ABPP
Professor, Psychiatry, Psychology & Human Nutrition
The Ohio State University
Division of Child & Adolescent Psychiatry
The OSU Psychoeducation 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

- **Three formats**
  - Multi-family psychoeducational psychotherapy (MF-PEP)
  - Individual family psychoeducational psychotherapy (PEP)
  - workshops
Multi-Family Psychoeducational Psychotherapy (MF-PEP)  
Fristad, Verducci, Walters & Young (2009) Arch Gen Psych, 66(9): 1013-1021

- Children aged 8-11 (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!
## Study Sample - Family Characteristic

<table>
<thead>
<tr>
<th>Variable</th>
<th>MF-PEP+TAU (n=78)</th>
<th>WLC+TAU (n=87)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MF-PEP</td>
<td></td>
</tr>
<tr>
<td>Family Structure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married bio par</td>
<td>46%</td>
<td>40%</td>
</tr>
<tr>
<td>Step-family</td>
<td>17%</td>
<td>23%</td>
</tr>
<tr>
<td>Married adop par</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>Single bio par</td>
<td>21%</td>
<td>17%</td>
</tr>
<tr>
<td>Single adop par</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>10%</td>
<td>12%</td>
</tr>
<tr>
<td>Income</td>
<td>&lt;20K to &gt;100K</td>
<td>&lt;20K to &gt;100K</td>
</tr>
<tr>
<td></td>
<td>M=40-59K</td>
<td>M=40-59K</td>
</tr>
</tbody>
</table>
## Demographics: MF-PEP Total Sample & BPD Sub-Sample

<table>
<thead>
<tr>
<th>Variable</th>
<th>TOTAL N=165</th>
<th>BPD N=115</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comorbid D/O</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>67%</td>
<td>70%</td>
</tr>
<tr>
<td>Behavior</td>
<td>97%</td>
<td>95%</td>
</tr>
<tr>
<td>ADHD</td>
<td>87%</td>
<td>80%</td>
</tr>
<tr>
<td>Two-parent families</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(includes step-families)</td>
<td>74%</td>
<td>65%</td>
</tr>
<tr>
<td>Average round trip</td>
<td>56 mi (range: 2-344)</td>
<td>70 mi (range: 14-344)</td>
</tr>
</tbody>
</table>
## Demographics—Various Samples

<table>
<thead>
<tr>
<th>Variable</th>
<th>BPD-ITT n=115</th>
<th>Treated BPD n=89</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>9.8</td>
<td>9.7</td>
</tr>
<tr>
<td>% Male</td>
<td>72</td>
<td>69</td>
</tr>
<tr>
<td>% White</td>
<td>91</td>
<td>94</td>
</tr>
<tr>
<td>% Fam Hx-Mania</td>
<td>53</td>
<td>55</td>
</tr>
<tr>
<td>% Fam Hx-Depression</td>
<td>73</td>
<td>72</td>
</tr>
<tr>
<td>% Fam Hx-Either</td>
<td>84</td>
<td>83</td>
</tr>
</tbody>
</table>
NIMH Study Design, N=165

<table>
<thead>
<tr>
<th>Group(^a)</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>
</tr>
</thead>
<tbody>
<tr>
<td>MF-PEP + TAU(^b)</td>
<td>Baseline: Pre-treatment</td>
<td>Follow-up</td>
<td>Follow-up</td>
<td>Follow-up</td>
</tr>
<tr>
<td>WLC + TAU(^c)</td>
<td>Baseline</td>
<td>Follow-up</td>
<td>Pre-treatment</td>
<td>Follow-up</td>
</tr>
</tbody>
</table>

\(^a\) Families were enrolled in 11 sets of 15 (7-MFPG/8-WLC) = 165 families

\(^b\) Multi-Family Psychoeducational Psychotherapy + Treatment As Usual

\(^c\) Wait-List Control + Treatment As Usual
Outcome Measure

• 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)  
MF-PEP Sample  

- N=165  
  - n=78 Immediate  
  - n=87 Wait List  
- Linear Mixed Effects Modeling  
  - $X^2=4.55, p=.03$  
  - Slope difference= -6.48/12 mos  
- Pre-Post Imm=WLC
Mood Severity Index (Parent, Current)  
MF-PEP  Treated Sample

• N=129
  – n=77 Immediate
  – n=52 Wait List
• Linear Mixed Effects Modeling
  – $X^2=5.99$, $p=.03$
  – Slope difference= -8.17/12 mos
• Pre-Post Imm=WLC
Impact of MFPG on Service Utilization & Mood Severity
Mendenhall, Fristad & Early, 2009, J Cons Clin Psychol

- Parental attitudes toward treatment changes with MF-PEP; impacts quality of services sought

- Improved quality of services leads to better mental health outcomes

- MF-PEP appears to improve quality of services utilized & child’s mood severity over time as designed to do. It helps parents become better consumers.
Individual-Family
Psychoeducation (IF-PEP)  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
IF-PEP 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-T2</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>

The table above shows the number of participants (N) per condition and the effect size for the primary outcome measure (MSI-Parent-Cur) at two different time points (T1-T2 and T1-T3). The graph on the right visualizes the data, with different conditions indicated by lines and markers.
IF-PEP: 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
IF-PEP: 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
IF-PEP 24: Two Case Studies
Leffler, Fristad & Klaus, in press

• Expanded from 16 to 24 sessions
  – 1 sibling session
  – 1 additional systems-of-care (school, mental health) session
  – 1 school professionals session (face-to-face or conference call attendance)
  – 2 Healthy Habits sessions
  – 3 additional “in-the-bank” sessions
IF-PEP 24: Case Studies
Leffler, Fristad & Klaus, in press

• 11 yr old girl “Jane”
• Long treatment history
  – sertraline, 3 mos: akathesia, elevated mood, dangerous behaviors
  – divalproex sodium, clonidine, quetiapine, ages 9-11: no significant improvement
  – fluvoxamine and clonazapam: for compulsive behavior and agitation
  – School and private therapeutic support
IF-PEP 24: Case Studies
Leffler, Fristad & Klaus, in press

- 10 yr old boy “John”
- Extensive treatment history
  - 2 yrs, divalproex sodium (trial of methylphenidate)
  - 4 yrs, risperidone
  - 6 yrs, atomoxetine
  - 8 yrs, trials of methylphenidate, amphetamine/dextroamphetamine, clonidine, lithium, and aripiprazole
  - 9 yrs, trials of quetiapine and escitalopram
  - 10 yrs, oxcarbazepine
  - very significant weight gain
Jane’s Diagnoses
Leffler, Fristad & Klaus, in press

• BP-1: Most Recent Episode Mixed: current moderate to severe symptoms: dysphoric mood, irritability, psychomotor agitation, increased appetite, strong craving for sweets, weight gain, rejection sensitivity, irritability, motor hyperactivity, derailment, mood lability
• ADHD-Combined
• ODD
• GAD
• OCD
John’s Diagnoses
Leffler, Fristad & Klaus, in press

- BP-1 Most Recent Episode Hypompanic:
  - current mild symptoms: irritability, negative self-image, elevated mood, uninhibited people seeking, hypersexuality
- ADHD-combined
- ODD
- Specific Phobia-dark & heights
- SAD
## Jane’s Treatment Response

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pre</th>
<th>Post</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>C-GAS: Current</td>
<td>36</td>
<td>48</td>
<td>Improved</td>
</tr>
<tr>
<td>C-GAS: Worst</td>
<td>31</td>
<td>41</td>
<td>Improved</td>
</tr>
<tr>
<td>KMRS</td>
<td>45</td>
<td>28</td>
<td>Improved</td>
</tr>
<tr>
<td>KDRS</td>
<td>67</td>
<td>55</td>
<td>Improved</td>
</tr>
<tr>
<td>TBQ-P</td>
<td>3.9</td>
<td>4.2</td>
<td>Improved</td>
</tr>
</tbody>
</table>
John’s Treatment Response

<table>
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<tr>
<th>Measure</th>
<th>Pre</th>
<th>Post</th>
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</tr>
</thead>
<tbody>
<tr>
<td>C-GAS: Current</td>
<td>35</td>
<td>40</td>
<td>Improved</td>
</tr>
<tr>
<td>C-GAS: Worst</td>
<td>15</td>
<td>38</td>
<td>Improved</td>
</tr>
<tr>
<td>KMRS</td>
<td>48</td>
<td>28</td>
<td>Improved</td>
</tr>
<tr>
<td>KDRS</td>
<td>43</td>
<td>55</td>
<td>Worsened</td>
</tr>
<tr>
<td>TBQ-P</td>
<td>3.3</td>
<td>4.2</td>
<td>Improved</td>
</tr>
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PEP & MF-PEP Resources

Books & DVD for parents or therapists—order from www.amazon.com

Books & DVD for parents or therapists—order from www.amazon.com

Treatment Manual—2010, Guilford Press

*************

Home Study Course—*for professionals*
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$65 for test scoring/reporting
www.jkseminars.com

www.moodychildtherapy.com

Child, Parent & Child Therapist MF-PEP Workbooks
Thank You, The End

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