The Frontline Reports column features short descriptions of novel approaches to mental health problems or creative applications of established concepts in different settings. Material may be 350 to 750 words long, with a maximum of three authors (one is preferred) and no references, tables, or figures. Send material to Francine Cournos, M.D., New York State Psychiatric Institute (fc15@columbia.edu), or to Stephen M. Goldfinger, M.D., SUNY Downstate Medical Center (smgoldfingermd@aol.com).

Training Peer Specialists in Cognitive Therapy Strategies for Recovery

Since the President's New Freedom Commission on Mental Health mandated in 2003 a recovery orientation within mental health services, there has been increased demand and proliferation of peer-provided services throughout the United States. Preliminary research suggests that peer-delivered services are feasible and as effective as those delivered by nonpeers in similar roles. However, peer specialists continue to face several challenges, including unclear delineation of roles, infrequent supervision, and limited opportunities for training and ongoing professional development.

As part of an agencywide training effort to establish a recovery-oriented cognitive therapy treatment milieu, we conducted a pilot program with certified peer specialists (CPSs) to provide them skills for working with individuals who have schizophrenia (consumers). Recovery-oriented cognitive therapy emphasizes individualized goal attainment: long-term goals are broken down into intermediate and short-term goals, and specific strategies and techniques are then used to overcome obstacles (such as low energy and positive symptoms) to goal achievement. Accordingly, peers learned to use recovery-oriented cognitive therapy strategies to enhance and support consumers' recovery efforts and use of therapeutic milieu. Training aimed to increase peers' knowledge and application of recovery-oriented cognitive therapy strategies, determine the program's acceptability to CPSs, and obtain feedback to shape future training initiatives.

Six CPSs and two facilitators (doctoral-level clinical psychologists) participated in the program, which took place in a community-based outpatient service. Training consisted of eight two-hour workshops over eight weeks. During the first four weeks, trainees were introduced to several topics, including the cognitive model and its application to schizophrenia, goal setting, empathic communication, and engagement. CPS trainees selected additional topics (such as problem solving and crisis deescalation) from a range of optional modules. The second four weeks involved developing case conceptualizations for peers' consumers, identifying strategies based on the conceptualizations, and practicing recovery-oriented cognitive therapy techniques. Trainees completed a feedback questionnaire after the program to provide their perceptions of the utility and impact of the training.

All of the CPSs stated that the training program had affected the way in which they viewed themselves, their work, or their consumers. They reported as particularly useful the process of conceptualizing consumers in terms of their history, beliefs, and current behaviors. CPSs expressed confidence in their ability to use recovery-oriented cognitive therapy techniques and a willingness to implement them in their ongoing work. Overall, trainees found they were better able to empathize and engage with their consumers after training.

Trainees especially appreciated that the program was specifically designed for CPSs, noting that "[the] best part was interacting with those who had the same job description as myself," and "[getting] a chance to work together as one." One trainee proposed that future training include an opportunity to share how and why trainees became CPSs. Others echoed this desire to see the unique role of peers expanded in future programs. Peers also proposed that future recovery-oriented cognitive therapy training programs be even more interactive, meet more frequently, and have a greater total number of sessions.

The program facilitators also made some important observations. During the second half of the program, one CPS began to use the conceptualization framework to make sense of her own recovery. She identified the relationship between her personal history, beliefs, and associated behaviors and shared this with her fellow peers, who supported her disclosure and formulation. This trainee exhibited a sense of pride at having understood her illness and subsequent recovery, as well as having mastered a new skill. Facilitators also observed peers using recovery-oriented cognitive therapy strategies to manage their own stress. For example, two CPSs reported using imagery and deep breathing to manage a difficult situation at work.

The recovery-oriented cognitive therapy training program for CPSs was very well received. The pilot program suggests that peers are not only able to learn new ways to conceptualize and assist their consumers but are also able to use this information to make sense of and enhance their own continued recovery. In future training sessions, we advise placing more emphasis on self-conceptualization, which appears to be an effective way to help peers grasp the skill of conceptualization and experience a sense of mastery and self-efficacy. These benefits may also result in enhanced efficacy to help their consumers. We also suggest that future programs feature self-care techniques, along with concrete ways for peers to share these skills with others in recovery. Finally, where possible, we recommend implementing a longer training program, with more frequent and practical meetings, to maximize the opportunities for trainees to learn, practice, and apply skills in a supported context.

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Integrating Mental Health Services for Mothers of Children With Autism

Autism is one of the most common childhood mental health conditions, affecting one child per 88 children. Although up to 40% of mothers of children with autism report clinically significant depressive symptoms, there has been little attention to the mental health needs of parents. Because most autism services for young children rely on active parental engagement to deliver recommended therapies, maternal functioning directly affects the intensity and quality of therapy that children with autism receive. Developing feasible and acceptable strategies to support the mental health of mothers who care for children with autism has the potential to optimize both maternal and child functioning.

In 2009, as part of a clinical trial supported by the Combating Autism Act, our group began to offer a brief, manualized cognitive-behavioral intervention—problem-solving education—to mothers of children with new autism diagnoses and who were receiving early-intervention services authorized under Part C of the Individuals With Disabilities Education Act. Problem-solving education is an adaptation of an evidence-based depression treatment known as problem-solving therapy and is tailored to mothers of young children. It aims to strengthen an individual's problem-solving skills as a strategy to prevent depression and improve parental involvement in intensive autism-specific therapy. Experience supports the program's feasibility and provides a model to engage an at-risk group of parents in mental health services in a novel, home-based setting.

Problem-solving education was integrated into the existing service delivery model of early intervention, which has a national infrastructure for replication and dissemination. Early intervention provides a flexible, individualized array of therapeutic services based on a child's needs and a family's goals. Family support is an explicit but not fully realized aim of early intervention. Authorizing legislation allows parents as well as children to receive services. Mothers (N=37) involved in this program received six individual problem-solving education sessions (30–45 minutes) delivered biweekly at home as a supplement to early-intervention services. During each workbook-based session, mothers focused on one problem and worked through a series of problem-solving steps that included defining the problem, identifying a short-term achievable goal, brainstorming multiple solutions, evaluating their pros and cons, choosing the best solution, and developing an action plan. The most common problems that mothers selected to address were related to child rearing, followed by time management.

Time spent providing problem-solving education was billed and reimbursed in the same way as other family support services. This flexibility in the early-intervention service delivery model supports opportunities for integrating parental mental health services into a nonstigmatizing setting.

To support future replication and dissemination, we trained multidisciplinary early-intervention staff, many of whom did not have clinical mental health training, to deliver problem-solving education. Eighteen early-intervention staff completed a standardized training curriculum that included one day of didactics, followed by five practice sessions. All early-intervention staff achieved reliability within eight weeks. Fidelity was assessed in 34 randomly selected problem-solving sessions that were audiotaped and scored with a standardized form and predetermined criteria. All sessions were judged to be of excellent quality.

A major challenge confronted at the outset of the program was the belief that mothers of young children with a new diagnosis of autism would be too busy or overwhelmed to participate. The demographic characteristics of women who received problem-solving education suggested that the program successfully engaged mothers at risk of major depression. Of the 37 mothers who received problem-solving education, 75% had incomes <200% of federal poverty level and were from racial-ethnic minority groups (54%). Almost a quarter (24%) of the mothers were born outside of the United States. Although mothers were not selected on the basis of depression risk, 35% reported they had received a depression diagnosis in their lifetime and 68% had current symptoms. Seventy-five percent of mothers completed the full six sessions, supporting the program's acceptability. Satisfaction with the program and continued use of the skills learned in the program were evaluated at the nine-month follow-up assessment. Satisfaction was high; participants reported using the problem-solving skills, such as thinking through pros and cons of solutions, and behavioral activation strategies almost weekly.

Our experience supports the feasibility and acceptability of integrating parental mental health interventions into early intervention. Offering problem-solving education expanded the range of family support options for mothers with depression risk, thereby advancing the goals of the nation's program for children from birth to age three who have developmental disabilities. Ongoing analysis of clinical trial data will assess the efficacy of problem-solving education to decrease depressive symptoms among mothers of young children with autism.

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Acknowledgment

This work was supported by Health Resources and Services Administration grant R40MC15596 from the Maternal and Child Health Bureau.