Published in final edited form as:

J Clin Psychol Med Settings. 2016 December ; 23(4): 323–326. doi:10.1007/s10880-016-9469-4.

Biography

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Abstract

Citation for Mary A. Fristad, recipient of the 2014 Bud Orgel Award for Distinguished Achievement in Research, from the Association of Psychologists in Academic Health Centers. Dr. Fristad has distinguished herself as an outstanding researcher, clinician, educator, and clinical administrator. She has published over 200 articles and chapters, and has been the Principal or Co-Principal Investigator for over two dozen federal, state, and other grants focused on assessment and treatment of mood disorders in children. In addition, Dr. Fristad is a founding member of the Board for Clinical Child and Adolescent Psychology of the American Board of Professional Psychology. She is an example to all psychologists working in medical settings through her contributions to our discipline and to the advancement of the science and treatment of child & adolescent psychopathology. Mary A. Fristad is truly a superb representative of the best our clinical psychological science has to offer.

As a young child in North Dakota, Mary Fristad grew up with books all around her. Her mother was an educator and believed that inspiration started young. A science book series was like the family projective test—her brother who studied the engineering book became an engineer, the one who focused on the chemistry book became a chemist and she, quite clearly, was destined to become a psychologist given her proclivity for a book that focused on psychology. Fristad learned in the sixth grade about doctorate degrees and decided that she would like one, as the thought of staying in school a long time seemed like a good idea to her. In her junior year of high school, she took *Introduction to Psychology* from a coach who was required to teach a class. She could only hope he coached better than he taught, but she fell in love with the textbook's content and decided that psychology was the field in which she would obtain her PhD.

She attended The College of St. Catherine in St. Paul, MN, where many of her classmates assumed she was a music major (she took pipe organ lessons and gave recitals her first two years), but she declared herself a psychology major as soon as the school would allow. Eager to obtain some “real world” experience, she began volunteering in an adult psychiatric

Conflict of Interest: Dr. Fristad receives royalties from American Psychiatric Press, Inc. for the Children's Interview for Psychiatric Syndromes and royalties from Guilford Press and Child & Family Psychological Services, Inc. as well as honoraria from Physician's Post-Graduate Press and the American Occupational Therapy Association for other work.

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ward early in her sophomore year. That summer and subsequent fall, she took a semester out of school to create a six-month internship where she lived in a residential treatment center for adolescents with serious emotional disturbance. Most interns would move from the patient dorms halfway through their internship; Fristad and her roommate were likely the only exceptions in the history of the program to opt to remain in the dorms for their entire six months—because there was more to learn that way...even if it meant waking up at 2 a.m. if a resident was having a bad night and started screaming. This experience provided several fundamental lessons for Fristad. First, she experienced the impact of institutionalization on persons. Second, she decided to work with a younger age group than adolescence, as she saw how entrenched psychopathology could become by that age. Third, she recognized the importance of family-based interventions. The majority of youth treated at the center, located in southern Minnesota, were far away from their families. The youth would make treatment gains, but after a family visit, they often regressed. She thought it would make much more sense to incorporate families into ongoing therapy sessions.

When applying to graduate school, Fristad anticipated a clinical career, or possibly teaching at a small liberal arts college, not unlike her own College of St. Catherine. Her advisor, Eileen Gavin, a wise and wonderful woman who could see in Fristad potential that Fristad, herself, did not realize, strongly urged her to apply to programs that would also train her in research, “just in case” she would decide upon a research career. Fristad had applied to only six programs; Gavin told her she needed to apply to more. Fristad’s father had died while she was in high school, and she was attending college on social security benefits. Being short on money, she applied to one more school—the one with no application fee. She also asked for cross-country skis that Christmas, as six out of the seven schools to which she applied were in locations that would support such a winter activity. Of course, she ended up at the seventh school, the no-application fee/too warm in the winter for snow, University of Kansas (KU).

Fristad enrolled in the clinical child track at KU, which unfortunately folded in her second year. Nevertheless, she requested to see every child who came to the clinic for services and, in her second year, took a research job at KU Medical Center (KUMC) in nearby Kansas City, a one hour commute from Lawrence. In one of many examples in her life that illustrate why a door that closes allows for the exploration of a newly opened one, she needed a job in that second year because she had only received a one-year fellowship, rather than the four-year fellowship for which she had been nominated when she accepted at KU. As a result, Fristad worked for three years with the Childhood Mood Disorders team at KUMC, led by a child and adolescent psychiatrist, Elizabeth Weller, and her husband, Ron Weller, an adult psychiatrist (Weller, Weller, Fristad & Preskorn, 1984; Weller, Weller, Tucker & Fristad, 1986). In that position, Fristad, who had always enjoyed learning languages (Latin in high school, German in college), felt like a translator, having learned the “languages” of psychosocial interventions in her psychology doctoral program and biological psychiatry at her job. This was in the early 1980s, when there were not clear pathways to integrate biopsychosocial approaches to care. In her psychology training, a classmate bemoaned when her client started taking antidepressants because “now she has bought into the medical model and there is nothing I can do in therapy.” At the same time, a KUMC investigator working on the first randomized controlled trial of imipramine in children was sorely

disappointed when a girl with depression whose drug level was in the therapeutic range relapsed, although the little girl had been discharged from the hospital to a home where she was re-abused. Fristad used these two disparate settings to learn about the biological underpinnings of prepubertal-onset depression and bipolar disorder while also appreciating the importance of family environment and family relationships. Her thesis and dissertation both addressed issues of family assessment. Her thesis taught Fristad the value of working in an applied setting, as she approached dozens of school districts before gaining access to a school-sample of Kansas children, in whom she measured parent-child dyadic relationships (Fristad & Karpowitz, 1988). Her dissertation focused on overall family functioning, and she was very grateful to the Family Research Program at Brown University, who opened their doors to her to collect data in their inpatient and outpatient settings (Fristad, 1988, 1989). At work, her literature piles had labels of “death” (for a study of bereaved youth), “suicide” and “depression.” During that time, she also worked on the initial DSM-III version of the Children’s Interview for Psychiatric Syndromes (ChIPS) with the Wellers and her friend, Marijo Teare Rooney (Rooney, Fristad, Weller & Weller, 1999; Weller, Weller, Rooney & Fristad, 1999a, 1999b).

Fristad went to Brown University in Providence, RI for internship. She felt like a kid in a candy store—as anything that could go wrong psychologically with a child in the state of Rhode Island could lead to an inpatient admission at one of the Brown consortium hospitals. In the mid-1980s there were not many academic post-doctoral positions, so upon completing her internship, Fristad went immediately into her first (and only) faculty position at the Ohio State University in the Department of Psychiatry. It was the only academic position in the country that year at an institution with an inpatient unit for youth, which Fristad wanted as she wished to work with severely impaired children. She continued her focus on prepubertal children with mood disorders and bereavement following the death of a parent. Her first NIMH grant as a principal investigator was designed to develop better methods to assess mania in children (Fristad, Weller & Weller, 1992, 1995). Meanwhile, Marijo Teare Rooney moved to the University of Louisville to complete her doctorate. Fristad commuted down to Louisville to serve on Teare Rooney’s thesis, and then her dissertation committee, both of which focused on ChIPS (Teare, Fristad, Weller, Weller & Salmon, 1998a, 1998b). Fristad conducted additional studies of DSM-IV versions of the ChIPS with an undergraduate honors thesis student, Alissa Glickman (Fristad et al., 1998b), and a medical student, Jim Cummins (Fristad et al., 1998a), both of whom went on to mental health careers.

Reading about expressed emotion and family psychoeducational interventions for adults with schizophrenia, bipolar disorder and recurrent depression in the late 1980s, she felt as if a light had been turned on. Finally, there was a model of psychosocial intervention that acknowledged biological underpinnings of serious mental illness while simultaneously attending to psychosocial aspects of recovery that took family environment and relationships into account. She immediately started piloting developmental adaptations of this model, developing therapeutic techniques that would be appealing to younger children and addressing the unique stressors faced by their parents (Fristad, Gavazzi, Centolella & Soldano, 1996). Through a series of investigations with her pre- and post-doctoral trainees, she honed this intervention, psychoeducational psychotherapy (PEP) into both a multi-group (MF-PEP) and individual-family (IF-PEP) format (Fristad, 1999; Fristad, Gavazzi

& Soldano, 1999; Goldberg-Arnold, Fristad & Gavazzi, 1999). In all these studies, she used ChIPS as her diagnostic interview. She published a book for parents (Fristad & Arnold, 2004), a treatment manual for clinicians (Fristad, Goldberg Arnold & Leffler, 2011a), and workbooks for children, parents and therapists (Fristad & Goldberg Arnold, 2011; Fristad, Goldberg Arnold & Leffer, 2011b); all based on the PEP model. Her favorite compliment is when clinicians or parents tell her these resources are “practical.”

Fristad met her husband, Joe Fiala, an OSU medical student who became a pediatrician, and they had two children, Elise and Peter Fiala. During this time, there was very little research going on within the OSU Department of Psychiatry, but her husband was settled into his primary care private practice, the children were in excellent schools, and they enjoyed their home and community, so Fristad’s job was to “make work work”. As a result, she designed studies that, while focused on children with serious mood disorders, were adjunctive in nature, i.e., did not use medication as an intervention variable, as she did not have psychiatric colleagues to manage medications in the trials (Fristad, 2006; Fristad, Verducci, Walters & Young, 2009). She also very much enjoyed training predoctoral students in the clinical psychology program at OSU until the child track was shut down, reminiscent of her time at KU. Given that change, Fristad shifted her focus to training post-doctoral research fellows.

Having a healthy respect for the importance of psychotropic medication in the comprehensive care of children with severe mood disorders, but also witnessing the side-effects that often accompanied these medications, Fristad remained interested in non-pharmacologic approaches to care. She developed a new partnership with L. Eugene Arnold, a child and adolescent psychiatrist with a longstanding interest in alternative and complementary treatments for childhood psychopathology. After his return to the faculty following a sabbatical and stint at NIMH, working together, they conducted several open-label trials of a multi-nutrient as well as two RCTs of omega3 fatty acids and IF-PEP for children with depression and bipolar disorder-not otherwise specified (Frazier, Fristad & Arnold, 2012; Fristad et al., 2015). They have also worked together for over a decade on the Longitudinal Assessment of Manic Symptoms (LAMS) study, a four-site phenomenologic study of 685 youth at elevated risk for developing bipolar disorder (Arnold et al., 2011; Fristad et al., 2012).

More recently, with excellent colleagues and a new department chair highly receptive to the role of psychology in integrated health care, John Campo, Fristad has taken on increased administrative duties. In addition to her national work as president of both the American Board of Clinical Child and Adolescent Psychology and the Society of Clinical Child and Adolescent Psychology, she became Vice Chair and led the renaming of her department to Psychiatry and Behavioral Health so as to better reflect the composition of its faculty. She also spearheaded the rebirth of the clinical psychology pre-doctoral internship, which had been in existence during her first three years at OSU but then had a 26-year hiatus.

Nowhere near ready for retirement, Fristad is exploring what she can next contribute to the field. As child-based services have mostly migrated to OSU’s sister institution, Nationwide Children’s Hospital, Fristad is again seeking an open door by teaming up with colleagues

there to continue her pragmatic series of studies, examining development, refinement and dissemination of evidence-based treatments.

Acknowledgments

Funding: N/A

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