A long-lasting and recovery-oriented experience of Psychodynamic Multi-Family Groups in community mental health services in Rome.

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Family involvement in mental health care

Involvement of families is a key aspect of mental health care either in a structured way (psychoeducation, systemic approaches) or in an informal way, when families are updated by practitioners and free to express their needs and make suggestions on a routine basis. Many mental health service users live or are in regular contact with their relatives, who are often in the role of being the main caregivers with the related material and emotional burden (Awad, & Voruganti, 2008). We also know that the characteristics of the family atmosphere and communication patterns are associated with clinical course and outcome of the disorder of the family member with lived experience of the mental health condition (Leff, & Vaughan, 1985). Therefore, families need to better understand both the problem situation and how they can help their family member as well as how to help themselves and sustain their wellbeing.

Family interventions may have different approaches and adopt different techniques, but they share several characteristics and aims; offering information about the disorder and its potential consequences, supporting treatment adherence, assuming a non-pathologizing stance, strengthening communication, avoiding blaming, favoring empathy and mutual respect, sustaining personal growth and self-determination for all family members (Harvey, & O'Hanlon, 2013). The effectiveness of family interventions has a good evidence base, and they are recommended in clinical guidelines for the treatment of psychotic disorders (Dixon et al., 2010; National Collaborating Centre for Mental Health, 2009) as well as in other fields.

The Multi-family Group Model in mental health services in Rome

Some models include more than one family in the same treatment session (Asen, & Scholz, 2010; McFarlane, 2002). One of the potential strengths of such models can be seen in the mutual feedback among families, which has been shown to be more effective in enhancing support, motivation and encouragement than the actions of a therapist (McKay et al., 1995). The Psychodynamic Multi-Family Group Model is an example of such a model. This model was originally established by Jorge Garcia Badaracco. He observed that the discussion occurring in groups, including families and service users, and coordinated by a therapist was a natural and useful format to promote changes. The group provides a setting where it is possible for group members to become aware of what happens in their own family as a result of observing what happens in the other families, which may be different yet similar. This promotes a process of modifications to the atmosphere in the family, which is thus prompted to take responsibility to actively look for solutions to the experienced problems, thereby avoiding self-blaming (Badaracco, 1992).

In applying this model, it also allows the reframing of the therapeutic alliance in two ways: on the one hand, by reducing the influence of the biological paradigm of mental disorders and focusing on the social arena, where patients and families live their lives. On the other hand, it overcomes the blaming attitude toward the dysfunctional aspects in the families, which contributes to "a loss of trust in services and strained relationships between professionals and families" (Eassom et al., 2014).

This model has been applied in District 1 of the Department of Mental Health of the Health Trust Roma 1 since 1997 and gradually expanded to the other five Districts since then. Since 2011 multi-family groups are held weekly in all twelve community mental health services (CMHCs) of the Department of

Mental Health in Rome that serves a population of 1,041,220 people. Thanks to the regular registration of participation in Districts 1, 2 and 3 between 2015 and 2019, it was possible to have a wider picture of how the multi-family groups worked.

The psychodynamic multi-family groups are based on an open and free dialogue among participants, and employ three simple rules: 1) Participants speak one at a time about an issue chosen by him/herself and the others listen to them without interrupting; 2) All participants are asked to let go of the notion that they have the only correct opinion, and to be ready to listen to and respect others point of view; and 3) Participants must raise their hand and speak according to the order in which they requested to speak.

Two to three facilitators coordinate and facilitate the meeting, manage the requests by participants to speak and help to maintain a climate of openness. Facilitators do not make any diagnostic evaluations, suggest psychological interpretations, or address issues of possible etiopathogenesis of psychiatric disorders. Sessions are held weekly and last 90 minutes.

All service users are informed about the multi-family groups and are free to join if they want to, without needing referral from the treatment team. In any event, the treatment team may suggest joining the multi-family groups in complex cases or situations, like after discharge from an acute ward or residential facility, in cases with a history of repeated hospital admissions, or when a setback in the therapy occurs. The suggestion to join a group would depend more on these circumstances than on the specific mental health problems a person may have. Participation is completely free and participants can stop attending at any time. It is advisable that at least one member of the treatment team accompanies the participants to the first two to three multi-family group sessions. Approximately four to six members of the respective mental health services take part in the meetings.

Participation of service users, families and professionals in multi-family groups

Between July 2015 and November 2019, a total of 1,044 meetings were held in the six CMHCs, with the average number of participants per group ranging between 13 and 31 according to the CMHC. The total number of family units who participated in the multi-family group sessions was 439, corresponding to a total number of 794 persons. Family units were represented only by the patient in 180 cases (41%), >1 relative or other close person in 76 cases (17%), and >1 relative or other close person and patient in 183 cases (42%). Mean age of participating service users was 42.8, of which 43.6% were female. The most prevalent diagnosis of the service user participants was schizophrenia (169 patients, 38.5%), followed by personality disorders (94, 21.4%) and bipolar and depressive disorders (90, 20.5%). Mean duration of participation was 68.3 weeks, and the average rate of being present in the group during the period of participation was 56.5%. Very active participation was shown by 170 participants (26.7%), while 90 (21.1%) participants showed very low participation. Brothers or sisters showed the highest degree of active participation, followed by mothers, patients and fathers.

Service users who participated alone tended to be older than those from families participating with or without the service users themselves, particularly in comparison to family units where service users were present. Family units, including at least one family member and the service user, were more represented when the service user had a diagnosis of schizophrenia, and, to a lesser extent, in the case of a personality disorder. The former families also showed the longest duration of participation. As expected, the frequency of attendance tended to be higher when the duration was shorter, with very few people being able to maintain a very high frequency when their attendance lasted more than 40 weeks. However, about forty percent of families with the longest duration attended between 55% and 88% of the meetings.

Lessons learnt and suggestions for implementation

These results show a good rate of attendance persisting across the years of observation, with new entries and a portion of long-term participants. Most service user participants had experience of severe and persisting mental health disorders. We list several factors that can be useful in promoting and sustaining the implementation of such services and their frequency by users, families and professionals.

• Service users participating alone were as many as family units that included a service user. The high number of service users who attended alone suggests that such participation represented a free personal choice and corresponded to a self-perceived need.

• Family units consisting of family members or close persons without the service user were far fewer and showed shorter duration and less active participation during the meeting, confirming that the groups may work better when the service user is present.

• The high number of participants across the years may represent the need for permanent or long-lasting support, not necessarily mediated through negotiation with or referral by a team.

• The multi-family groups represent the only setting where service users can meet with other people and professionals in a free, yet still structured, way and where there are no strictly therapeutic objectives.

• The multi-family groups are permanently available. It has been suggested that, at least in the most complex cases, continuity of such treatment should be assured through ongoing support, even if informal (Lefley, 2001), or through an open-ended multi-family group structure for families in need (McFarlane et al. 2002).

• The combination of flexibility and continuity in the delivery of the services can help develop truly community-focused recovery-oriented interventions, dealing with the "real world" of patients and their families (Drapalski et al., 2008). With this perspective, a possible shift can be envisaged in involving families, moving from so-called behavioral family management, where the emphasis is on negative outcomes rather than building on strengths, to a consumer-driven support approach, where attention is paid to increasing communication and cooperation between mental health professionals and families (Glynn et al., 2006). The facilitators do not play the role of experts who educate and answer to questions. Rather they behave as real facilitators of an exchange of views involving as many people as possible and where everybody's standpoint about issues emerging in the discussion are taken into consideration.

• The implementation of family interventions in the treatment of persons experiencing severe mental disorders is still extremely limited, despite being considered major and effective components of care,. This might be due to severe workload, pressure on specialized services, organizational pitfalls, limited staff training and skills, as well as pessimistic views about recovery for people with severe mental illness (Prytys et al., 2011). Nonetheless, it is feasible, and it can be facilitated by a bottom-up and top-down approach where clear indications of the direction is coupled with interest by professionals, together promoting a real cultural shift.

• Lastly, yet importantly, listening and paying attention to different ideas coming directly from persons involved, like service users and family members in an unfiltered way, allow facilitators and professionals to learn about how services could best respond to people's needs as directly perceived and expressed by them.

All these reasons, together with the success that multi-family groups have shown as well as their feasibility in the long-term, suggest that it is advisable to make multi-family groups available to larger numbers of service users and families in as many services as possible.

References

Asen, E., & Scholz, M. (2010). Multi-family therapy: Concepts and techniques. Routledge.

Awad, A. G., & Voruganti, L. N. (2008). The burden of schizophrenia on caregivers: A review. Pharmacoeconomics, 26(2), 149-62. https://doi.org/10.2165/00019053-200826020-00005

Badaracco, G. J. E. (1992). Psychic change and its clinical evaluation. International Journal of Psychoanalysis, 73(Pt 2), 209-20.

Dixon, L. B, Dickerson, F., Bellack, A. S., Bennett, M., Dickinson, D., Goldberg, R. W., Lehman, A., Tenhula, W. N., Calmes, C., Pasillas, R. M., Peer, J., & Kreyenbuhl, J. (2010). The 2009 schizophrenia PORT psychosocial treatment recommendations and summary statements. Schizophrenia Bulletin, 36(1), 48–70. https://doi.org/10.1093/schbul/sbp115

Drapalski, A. L., Marshall, T., Seybolt, D., Medoff, D., Peer, J., Leith, J, & Dixon, L. B. (2008). Unmet needs of families of adults with mental illness and preferences regarding family services. Psychiatric Services, 59(6), 655–662. https://doi.org/10.1176/ps.2008.59.6.655

Glynn, S. M., Cohen, A. N., Dixon, L. B., & Niv, N. (2006). The potential impact of the recovery movement on family interventions for schizophrenia: Opportunities and obstacles. Schizophrenia Bulletin, 32(3), 451–463. https://doi.org/10.1093/schbul/sbj066

Harvey, C. & O'Hanlon, B. (2013). Family psycho-education for people with schizophrenia and other psychotic disorders and their families. Australian and New Zealand Journal of Psychiatry, 47(6), 516-520. https://doi.org/10.1177/0004867413476754

Leff, J., & Vaughn, C. (Eds). (1985). Expressed emotion in families. Guilford Press.

Lefley H. P. (2009). Evidence-based practices series. Family psychoeducation for serious mental illness. Oxford University Press.

McFarlane, W. R., Hornby, H., Dixon, L., & McNary, S. (2002). Psycho-educational multifamily groups: Research and implementation in the United States. In W. R. McFarlane (Ed.) Multifamily group treatment for severe psychiatric disorders. (pp. 43–60). Guilford.

McKay, M. M., Gonzales, J. J., Stone, S., Ryland, D., & Kohner, K. (1995). Multiple family therapy groups: A responsive intervention model for inner city families. Social Work with Groups, 18(4), 41–56. https://doi.org/10.1300/J009v18n04_04

Prytys, M., Garety, P. A, Jolley, S., Onwumere, J., & Craig, T. (2011). Implementing the NICE guideline for schizophrenia recommendations for psychological therapies: A qualitative analysis of the attitudes of CMHT staff. Clinical Psychology and Psychotherapy, 18(1), 48-59. https://doi.org/10.1002/cpp.691