

# **Evaluation of psychodynamic multi-family group therapy for psychiatric patients and their families. A proposal of a process-outcome assessment protocol**

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## **Abstract**

In the community perspective about the treatment of serious mental illness through the multi-family groups (Badaracco, 2004; Scholz & Asen, 2010), empirical research with psychiatric patients should focus, according to the literature (de Albuquerque et al., 2010; Karamlou et al. 2010), on the evaluation of correlation between outcome variables, therapeutic factors, perceived burden of care and characteristics of family's structure, in order to understand what roles they play in mediating or moderating the change. Assuming this, the paper present a proposal of assessment protocol that've been tested in a multi-centre research project – held in some healthcare services in Lazio Region – on the evaluation of efficacy/effectiveness of multi-family groups.

**Keywords:** multi-family groups, psychotherapy research, severe psychiatric disorders, efficacy/effectiveness evaluation, group psychotherapy

## **Introduction**

Empirical research on psychotherapy with seriously ill patients, and more particularly schizophrenic patients, show several critical issues, for example related to: frequent hospitalizations and high recurrence rates; the ambiguity of the concept of psychosis; the great variety of group therapeutic models; as well as methodological problems (González de Chávez, 2009).

“Severe patients” receive also complex treatment programs [which often include different therapeutic approaches (medication, individual therapy, group therapy, rehabilitative therapy, etc.)] that are more effective in reducing symptoms and recurrence rates, compared to the waiting list or a single therapeutic approach (Fontao & Hoffmann, 2011).

The main problem of research on group treatments remains the difficulty of specifying and separating the effects of group interventions from those of other treatment modalities that have been offered to the study participants (cit.).

Moreover, the main conclusion of a thorough review of the scientific literature on group approaches aimed at severe patients is that the most current empirical researches concentrate on outcome variables, neglecting the study of process variables (cited).

Despite these limitations, numerous studies reported that psychoeducational multi-family group therapy is considered one of the most effective “setting” to reduce the number of relapses and hospitalizations in patients with schizophrenia (Dixon &

Lehman, 1995, Dick et al., 2002; Pitschel-Walz et al., 2001): even more effective than family therapy (McFarlane et al., 1995), not only than the control group (patients who haven't received any psychotherapeutic group treatment) (Dick et al., 2002; Bradley et al., 2006; Couchman, 2008). In a meta-analysis which included a wide range of randomized controlled studies (Pilling et al., 2002), all family interventions (i.e. both single and multi-family therapies) were more effective at reducing relapse in the first 12 months of treatment and up to two years into treatment than other approaches. All family intervention improved treatment compliance in a more meaningful way of control group (other treatments).

Concerning “compliance”, a recent study (Kopelowicz et al., 2012) involved 174 Mexicans patients with schizophrenia and schizoaffective disorders, living in Los Angeles. Patients participated in 1 of 2 multi-family group therapy (MFG-adherence or MFG-standard) or in the usual treatment. Groups convened twice monthly in 90-minute sessions for 1 year, with a 6 and 12 months follow-up. At the end of the 1-year treatment, MFG-adherence was associated with higher medication adherence than MFG-standard or usual treatment only and with a lower probability of hospitalization.

In addition to increasing the “compliance”, the multi-family group also promotes the improvement of family climate and social-community role (Jenner, 2003). Should be noted that, however, compared to the evaluation of the patients’ outcomes, few studies evaluated changes in personality structure, the actual possibility of employment and quality of life (Bradley et al., 2006).

In relation to the assessment of quality of life, we report the results of a recent research, focused on severe bipolar patients: in a RCT study on families’ psycho-educational intervention, 47 carers of 34 patients were allocated to one of three groups: Multifamily Group Psychoeducation (5 sessions), Solution Focused Group Therapy (5 sessions, the programme was delivered by two psychiatric nurses) or Treatment as Usual (Madigan et al., 2012).

The results shows that parents who were allocated to either MFGP or SFGP had significantly improved knowledge and reduced overall burden and psychological distress at year one and this was sustained at year two. It was also noted an improvement in the quality of life in patients with bipolar disorder, whose parents have participated in the first two treatments. Instead, no significant change was found in the patients’ global functioning (GAF).

Summing up, the most of empirical researches focused on psycho-educational therapy, following the “model” developed by the working group of McFarlane (2002), which combines psycho-education with life skills teaching, and have shown how the multi-family group contributes to increase in patients: compliance, lower relapse rates, frequency of hospitalization, improve social functioning (McFarlane et al., 1995, McFarlane et al., 1996 Dyck et al., 2000; McFarlane et al., 2000).

With regard to the evaluation of the relatives' outcome, the review of Corcoran & Phillips (2000) reports that the MF groups develop important insights about: the characteristics of schizophrenia, coping skills, self-efficacy; family conflicts, the level of perceived stress and the feeling of shame decreases in a similar way (Hugen, 1993; Hazel, 2004).

However, currently there is a lack of clarity about the actual benefits received by family members concerning the assessment of psychosocial resources (Pai & Kapur, 1981; Hazel, 2004).

Narrowing the deepening on the Italian empirical literature, the recent researches assessed especially the family burden (Magliano et al., 2006; Fulgosi, Rizzo, 2008; Bazzoni et al., 2003): in the group therapy is recorded a lower family burden compared to the beginning and the percentage of parents who reported embarrassed feelings (when they went in public places with the ill relatives) decreased significantly, from 21% to 8%. (Magliano et al., 2006).

The group promotes the improvement of objective and subjective burden perceived by family members, facilitates the management of the patient and increases the psychological and practical support from the social network (Fulgosi & Rizzo, 2008). At the same time, the group fosters patients improvements regarding some aspects such as: social functioning, involvement in family life and social relations. During the research period, furthermore no hospitalizations was observed, in the patients' group, (Magliano et al., 2006). These studies involved – in healthcare services – outpatients whereas a period of 6 months, compared with a disease duration of more than 5 years in the 75% of cases. Long-term efficacy research are lacking.

From the presented results, it is obvious that both Italian and international researches evaluated the multi-family psycho-educational interventions only but not psychodynamic ones.

It is important to develop researches that evaluate personality's structural aspects, in both patients and families, and the relationship between outcome variables and psychodynamic processes. None of the research reported in literature compares treatment's outcomes with group process variables (as alliance, cohesion, climate and, more generally, the group therapeutic factors).

Required, at the same time, studies on relationship between perceived burden and perceived social support from family members, considering the contradictory nature of some existing results.

### **Assessment instruments**

The protocol used in the multi-centre research project held in healthcare services of Lazio Region (1) aimed to evaluate the psychodynamic multi-family group therapy effectiveness, through the analysis of the following variables:

- process variables (therapeutic factors, cohesion, alliance and group climate);
- outcome variables (global assessment of functioning in psychiatric patient, patient's attachment style, family's burden of care and coping strategies, assessment of stress and burnout in healthcare professionals).

The two variables clusters will be analyzed, both independently and dependently on each other, assuming – according to the scientific literature – a close interdependence.

The protocol includes the following four survey levels:

#### SURVEY LEVEL 1: the Patient

- Personality structure (Categorical and Dimensional Systems of Personality Diagnosis):

Millon Clinical Multiaxial Inventory III – MCMI-III (self-report questionnaire) (Millon, 2008): is a 175 “true-false” items questionnaire based on the evolutionist theory of personality, with multi-axial format and connection with the DSM-IV; it includes 24 scales and 4 indices of adjustment:

- Moderate Personality Disorder Scales [1 Schizoid; 2a Avoidant; 2b Depressive; 3 Dependent; 4 Histrionic; 5 Narcissistic; 6a Antisocial; 6b Aggressive (Sadistic); 7 Compulsive; 8a Passive-Aggressive (Negativistic); 8b Self-Defeating];
- Severe Personality Pathology Scales [s Schizotypal; c Borderline; p Paranoid];
- Moderate Clinical Syndrome Scales [a Anxiety; h Somatoform; n Bipolar: Manic; d Dysthymia; b Alcohol Dependence; t Drug Dependence; r Post-Traumatic Stress Disorder];
- Severe Syndrome Scales [ss Thought Disorder, cc Major Depression; pp Delusional Disorder];
- Indices of adjustment [Disclosure (X), Desirability (Y), Debasement (Z), Validity (V)].
- Categorical diagnosis, DSM-IV-TR (APA, 2002).
- Attachment styles: Attachment Styles Questionnaire – ASQ (Feeney, Noller, & Hanrahan, 1994; Fossati, et al., 2003) is a self-report questionnaire. This 40-item questionnaire asks participants to rate aspects of themselves and others on a 6-point Likert scale. The instrument explores different dimensions, such as confidence, discomfort for the intimacy, etc.
- Global functioning of psychiatric patient: World Health Organization – Disability Assessment Schedule - WHO-DAS II (WHO, 2001) is a clinician-administered questionnaire. It consists of 51 items (rated on Likert scale) which investigate

various dimensions about patient's functioning in daily life, such as understanding and communication, mobility, self-care, etc..

- Other demographic variables – epidemiological investigation:
- number and length of hospitalizations in Emergency Psychiatry Unit;
- entries in Therapeutic Communities and length of experience;
- structured activities in Psychiatric Day Centre.

#### SURVEY LEVEL 2: the family

- Family burden of care: Evaluation of the Social Support Instrument – QRS (Gigantesco et al., 1995): brief self-report questionnaire (or clinician-administered questionnaire), which investigates the global level of satisfaction related to perceived social support.
- Coping strategies: COPE-NVI (Sica et al., 2008) is a self-report questionnaire; this 60-item questionnaire (rated on a 4-point Likert scale) measures five basic dimensions of coping styles: Social support, Avoidance strategies, Positive attitude, Problem solving and Turning to religion.
- Family cohesion: The Family Adaptability and Cohesion Evaluation Scale – FACES (Olson, 1991) is a 40-item questionnaire (20 items about “real family” dimension and 20 items about “ideal family” dimension rated on a 5-point Likert scale) which investigates the family cohesion and adaptability.

#### SURVEY LEVEL 3: the healthcare professionals

- Emotional experience and maintenance of skills: Link Burn-Out Questionnaire – LBQ (Santinello, 2007) is a 24-item (rated on a 6-point Likert scale) self-report questionnaire, which investigates four scales: burnout, professional inefficacy, relationship deterioration, disillusion.

#### SURVEY LEVEL 4: the group process

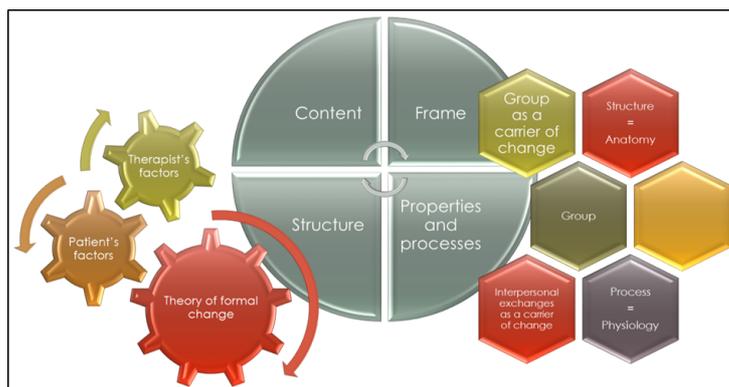
- Group Cohesion à Group Cohesion Scale – GCS (Piper, Jones, Lacroix, Marrache, Richardson, 1984; Kipnes, Piper, Joyce, 2002) is a 9-item self-report questionnaire rated on a 6-point Likert scale, that assesses the cohesion with the “group as a whole” providing scores about three areas:
  - mutual stimulation and effect,
  - commitment to the group,
  - compatibility of the group.
- Alliance à California Psychotherapy Alliance Scale – CALPAS-G (Marmar et al., 1986, 1989, 1989a; Gaston, 1991; Gaston & Marmar, 1994) is a 12-item self-report questionnaire rated on a 7-point Likert scale, specifically designed for evaluating

the therapeutic alliance in group; this instrument provides scores about four dimensions:

- Patient Working Capacity,
  - Patient Commitment,
  - Working Strategy Consensus,
  - Member Understanding and Involvement.
- Group climate à The Group Climate Questionnaire – Short Form (GCQ; MacKenzie, 1983) is a 12-item (rated on a 7-point Likert scale) self-report questionnaire that purports to assess individual group members’ perceptions of the group’s therapeutic environment. The GCQ consists of three factor-analytically derived subscales:
- engagement,
  - avoidance,
  - conflict.
- Therapeutic Factors à Therapeutic Factors Inventory-Short Form – TFI-S (MacNair-Semands, 2010) is a 23-item self-report questionnaire (rated on a 7-point Likert scale) based on the theories of Yalom about group therapeutic factors (Yalom & Leszcz, 2009); the TFI-S provides scores about four dimensions:
- instillation of hope,
  - secure emotional expression,
  - awareness of interpersonal impact,
  - social learning.

## Conclusion

The research in the field of group psychotherapy moves in the direction of integration between outcome evaluations in psychiatric patients and the structural and relational factors that can facilitate the change leading to an improvement of quality of life (Fig. 1).



## **Fig. 1 – Constituent elements of the evaluation of groups efficacy/effectiveness**

Research in the field of group psychotherapy, basically, it can be a powerful tool - for patients, clinicians and institutions more than for researchers - of clinical knowledge, but only if it is structured on the basis of scientific and methodological evidence, specifically relevant to the investigation (Di Nuovo, Lo Verso, Di Blasi, et al., 1998).

As part of the empirical research with seriously ill patients, it seems even more important to not only assess the simple relationship between predictive variables of outcome and process, but to explore how some of the variables of the process, involving patients and their families, can play an important role of mediators and moderators of change. Moreover, useful to the clinician, as well as variables that rely on individual dimensions, is involving the family and community and setting up a research not only with patients but with practitioners too.

We believe that in the multifamily group, finally, there is the possibility of a continuous dialogue with patients and family members, as well as with colleagues of the same service or other social agencies connected to the service, and that this may strengthen, in the long term, in the institution a culture of group, urging the équipe to use spaces aimed at deepening:

- comparison,
- negotiation of the choices,
- circulation of information,
- assessment and
- reflection on the working method, on the different possible paths of care and long-term planning (interfacing with other facilities and services related to the patient).

Notes:

1) The sample, for this pilot study, consists of:

- an experimental group:
  - o 4 psychodynamic multi-family groups with, at least, 3 participating families with patients for each group (minimum 35 subjects) [2 Mental Health Services: “Via Monte Tomatico”-A.S.L. RmA, Frascati (Rm)-A.S.L. RmH; 1 Psychiatric Day Centre: “Via Palestro”-A.S.L. RmA; 1 Therapeutic Community: GNOSIS, Marino (Rm)].
- Patients with medium-high severity psychiatric diagnosis;

- participants (patients, parents and relatives) aged between 20 and 65 years.
- a control group:
- 4 psychodynamic psychotherapy groups (minimum 35 subjects) composed of:
  - patients with no current psychiatric diagnosis or with mild severity psychiatric diagnosis;
  - patients aged between 20 and 65 years;
  - and, also, a minimum of 35 patients with medium-high or moderate severity psychiatric diagnosis who don't attend psychotherapy groups.

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