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Multifamily Group Therapy: Impact on Well-Being and Communication within Families

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Abstract. *Multifamily Group Therapy refers to a model of therapeutic intervention in which more than one family is treated simultaneously. The aim of this prospective, descriptive clinical study was to evaluate the impact of Multifamily Group Therapy on family well-being and communication. The sample consisted of 13 participants receiving treatment at the outpatient psychiatric unit of Akureyri Hospital, Iceland. Three questionnaires based on the Calgary Family Nursing model, developed in Iceland, were administered at the start and at the end of the treatment to evaluate family support : FPSQ (Family Perceived Support Questionnaire), EFFQ (Expressive Family Functioning Questionnaire), FIBQ (Family Illness Beliefs Questionnaire) and DASS (Depression, Anxiety, Stress Scale). This pilot study's results indicate that Multifamily Group Therapy decreases depressive symptoms during the treatment period, there is a tendency for increased family support and emotional functioning. Finally, improvements regarding family attitudes towards illness are suggested.*

Keywords : Multifamily Group therapy, Calgary Model, family communication, family well-being

Background

Mental health conditions are increasing worldwide. Despite the severity and prevalence of mental disorders, the global median of government health expenditure that goes to mental

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health is less than 2% (WHO, n.d.a). People with mental disorders often experience severe human rights violations, discrimination, and stigma (Ghebreyesus, 2019). Increased investment is required on all fronts : for mental health awareness to increase understanding and reduce stigma ; for efforts to increase access to quality mental healthcare and effective treatments ; and for research to identify new treatments and improve existing treatments for all mental disorders. Many mental health conditions can be effectively treated at relatively low cost, yet the gap between people needing care and those with access to care remains substantial (WHO, n.d.b).

In recent years, there has been increasing acknowledgement that social health is an important part of health which can affect physical and mental illnesses. Mental health conditions can have a significant effect on all spectrums of life (WHO, n.d.a). The literature specifies that family has a significant impact on the health and well-being of everyone within the family, especially if a family member has an illness (Mackie et al., 2018 ; Shajani, Snell, 2019). Family and friends are important factors in individuals' social health (Deatrick, 2017). When a family member becomes sick, the patient and their family are affected (Benzein et al., 2008 ; Shajani, Snell, 2019). Serious illnesses, including mental disorders, and/or disability can cause serious suffering. Healthcare professionals form relationships with individuals, families, and communities to promote health and soften suffering (Wright, Bell, 2017). Reactions regarding serious conditions may include focusing more on supporting patients and softening families' suffering. It is important to do as much as possible to reduce the suffering of those who experience mental disorders. The ideology and protocols of Multifamily Group Therapy (MFGT) and Calgary Family Nursing (CFN) combined could be an approach to dealing with mental disorders, to some extent.

Multifamily group therapy

The term MFGT refers to a range of therapeutic interventions carried out in multifamily groups, which are therapeutic environments in which the patients, their family members and the caregivers participate all together (Abrahams, Varon, 1953). Multifamily Group Therapy refers to a model of therapeutic intervention in which more than one family is treated simultaneously. It is a product of the logical union of the family and group therapy models, further strengthening the main principles of both. The methodology aims to facilitate families to help each other to solve their conflicts (Sempere, Fuenzalida, 2017). MFGT aims to create a free, more spontaneous environment than one-to-one therapy, open to anyone wishing to take part ; to open mental spaces for new processes of psycho-emotional growth within a family (Badaracco, 1990). The final goal of the therapeutic work is to detect the pathogenic interactions to which the participants are subjugated and to help them to get rid of them. MFGT promotes the dialogue within an atmosphere of confidence within the group, where each participant has their own voice and can express themself, and from themself, without feeling judged (Sempere, Fuenzalida, 2017). The ultimate goal of the therapy is to lead the patient towards mental health, the latter being understood as the ability to live authentically, free from the control and subjugation of others, and ability to live proud of being themself within the social context (Sempere, Fuenzalida, 2021). The aim is to allow the participants to undergo their own therapeutic process by repairing relationships both within and beyond the family (Badaracco, 2000 ; M'bailara et al., 2007). The multiple family programmes described in the academic literature vary widely, in terms of structure, frequency, duration and number of sessions ; number of participants ; type of problems addressed ; the group's targets ; the roles of the therapists ; the theoretical standpoints, therapeutic frameworks, and techniques employed ; and the use of subgroups. All, however, share the general therapeutic mechanisms described by Laqueur (Sempere, Fuenzalida, 2017)

1. Learning by analogy. In contrast to conventional single-family therapy, which presents no opportunity to find useful analogies, families taking part in MFGs can observe similar conflicts in other families and can gain insight from those examples.
2. Learning by indirect interpretation. This refers to interpretation not by the therapist, but by other group members.
3. Use of modelling. The therapist may point to more healthy aspects of one family as a model for another to work towards. The group members may imitate the desirable model and integrate it into their own behaviour at a deeper level.
4. Learning by identification. The families in the MFG provide a cluster of relational constellations, with which the members can identify.
5. Learning by trial and error. The members of an MFG have the unique opportunity to try out new behaviours, which may be reinforced by the group's approval, or be rejected.
6. Learning to understand intra-family codes. Families discover their own way of communicating by reflecting the communication patterns in other families.

Participants in the group amplify and modulate the messages given out by the therapist and the other families.

Delimiting the field of interaction. MFGs help families to understand their problems within a set system of interactions. The family sees how the environment affects the individual, and how the individual in turn affects the behaviour of those around them. Thus, they learn how to share responsibility for what happens (Sempere, Fuenzalida, 2021).

Calgary Family Nursing

The fundamental aspect of the CFN Model is the vision to see the individuals within the family, as well as the family as a whole (Shajani, Snell, 2019 ; Sveinbjarnardottir et al., 2013). The model is based on ideology from the nurses Dr. Lorraine M. Wright and Dr. Maureen Leahey (Leahey, Wright, 2016 ; Shajani, Snell, 2019). This, in turn, is based on two models, the Calgary Family Assessment Model (CFAM) and the Calgary Family Intervention Model (CFIM). CFAM is a multidimensional framework consisting of the following three major categories : structural, developmental, and functional (Shajani, Snell, 2019). CFIM is an organising framework conceptualising the intersection between the domain, cognitive, affective, and behavioural components of family functioning and is a specific intervention offered by healthcare professionals, used in context with the CFAM (Shajani, Snell, 2019). The goal is to provide patients' families with increased support and to promote changes towards the recovery process. With successful information gathering, care, respect and with reflective therapeutic questions asked, nurses can reduce family suffering and contribute to recovery (Shajani, Snell, 2019). Allowing the family to share their illness story and identifying their constraining and facilitating beliefs may result in a decrease of suffering and increased well-being and recovery (Shajani, Snell, 2019 ; Sveinbjarnardottir et al., 2013 ; Sveinbjarnardottir, Svavarsdottir, 2019). Function and family structure can be essential to understand how people respond to life changing events such as a serious illness. Healthcare workers who have insight to the structure, development and functioning of families can use this knowledge to empower the family (Shajani, Snell, 2019 ; Sveinbjarnardottir et al., 2013 ; Sveinbjarnardottir, Svavarsdottir, 2019).

This study is part of an Erasmus+ project called DigiFamily, whose aim is the inclusion of family and community resources in mental health intervention. Part of the project involves maintenance (Belgium and Spain) and implementation (Iceland) of MFGT in three of the eight participating countries. International collaboration establishes social relations between

various mental health professionals in diverse fields which can constitute new intergenerational professional experiences, and intercultural experiences (Gavrila-Ardelean, 2018).

Aim of the study

The aim of this pilot study is to evaluate the effect of MFGT on family well-being, communication and to prepare a protocol for an international study, planned to be carried out in Iceland, Spain, and Belgium.

Material and methods

Study design

This was a prospective, descriptive clinical study with measurements performed before and at the end of the treatment.

Setting

This study was conducted at an outpatient psychiatric unit at Akureyri Hospital, Iceland, which serves a rural population of around 50,000. Akureyri Hospital is Iceland's second largest hospital and the country's largest healthcare organization outside of the capital. It focuses on the delivery and organisation of rural healthcare collaborating with various rural healthcare organizations. The psychiatric ward at Akureyri Hospital plays an important role in the service for people with mental disorders in the northern and eastern part of the country. The patient group consists of mentally ill people with serious, combined, and complicated problems which require a team of professionals. Akureyri Hospital is internationally accredited according to Den Norske Veritas (DNV) quality procedures and has a Certification of Quality Management System Standard ISO 9001 : 2015. In late 2016, the Board of Chief Executives of Akureyri Hospital decided to implement CFN in some parts of the services, including psychiatry. The policy and vision at Akureyri Hospital, valid until 2021, states that one of the key aspects of the service is family nursing.

Sample/participants

Six individuals receiving treatment at Akureyri Hospital psychiatric department, and three to four family members of each individual, were invited to participate in MFGT from September to December 2019. All patients at the outpatient psychiatric ward at Akureyri Hospital have their own case manager, whose main role is to monitor patient care and ensure that appropriate treatment resources are in place. The case managers nominated participants. All participants needed to have been minimum age 18 to partake.

Method

All participants received a pre-interview with two of the therapists in the MFGT team prior to the initiation of MFGT ; oral and written information regarding the treatment was given. Measuring tools were given to participants in a pre-interview (Time 1) before the start of

the MFGT and at the end of the treatment (Time 2). The therapists team offering the treatment consisted of an occupational therapist, four nurses and a social worker who is also a family therapist helping patients and their families to cope with the challenges that mental illness can affect on the health. The MFGT consisted of eight sessions, and each session was 90 minutes long. Participants are to some extent their own therapists and learn from each other from their experience of dealing with mental disorders and communication difficulties. Participants control the topic at any given time ; the therapists are primarily there to support and to manage participants with the topic they are discussing at any given time. The intervention is mainly about psychological support for individuals, strengthening self-confidence and strengthening family relationships. At least three therapists were responsible for each session. Continuous treatment was ensured in such a way that two therapists, from previous session, were always participating in the next treatment session ahead. If a participant wanted to discontinue participation in MFGT, their family members were welcome to continue with the treatment. All the participants were offered the treatment free of charge.

Measurements

Three assessment tools based on the Calgary Family Nursing Model developed in Iceland were used to evaluate family support : FPSQ (Family Perceived Support Questionnaire) which measures experienced family support from professionals (cognitive and emotional support ; Sveinbjarnardottir et al., 2012a, $\alpha = .961$), EFFQ (Expressive Family Functioning Questionnaire) which measures the emotional functioning of families (Sveinbjarnardottir et al., 2012b, $\alpha = .922$) and FIBQ (Family Illness Beliefs Questionnaire) which measures families' attitudes towards illness within the family (Gisladottir, Svavarsdottir, 2016, $\alpha = .789$). Depression, Anxiety, Stress Scale (DASS) measures symptoms in three dimensions ; depression, anxiety, and stress. The validity of all three domains of DASS has been found to be satisfactory, Cronbach's α 0.84 – 0.91 (Lovibond, Lovibond, 1995). Background information included demographic information : age, sex, marital status, education, occupation, financial status, situation of living (housing), hobbies, assessment of mental and physical health, and whether a participant has ever received treatment from a professional regarding physical or mental disorders. Additionally, questions about which drugs and dosage participants have been using in the last 12 months were included. In the final session, the participants were given the opportunity to give feedback about their experience of MFGT, which will be used to develop the treatment further.

Statistical analysis

Participants' well-being/experiences are described with descriptive statistics. Frequency, means, median, range and SDs were used to describe the results. Demographic details were checked to ensure family group data were consistent. The analysis of the data was conducted with constant comparison of patient and family to identify differences and similarities.

Ethical issues

All participants gave written informed consent. Ethical approval for this study was obtained by the Health Research Ethical Board at Akureyri Hospital (1/2019) and the study was reported to the Data Protection Committee in Iceland. The potential risk of participation was valued at low risk potentially difficult issues would be discussed, and therapists have

years of experience dealing with mental illnesses. An agreement was made with a psychiatrist who would handle any issues that the therapists considered unresolved and needed further support with. Participants were informed that they were free to withdraw their participation at any time, without notice and without giving any reason. It was also stated that this decision would have no consequences for them in connection with the services of the psychiatric department at Akureyri Hospital.

Results

Table 1. *Demographic variables*

Background	n
Age	
30 years or younger	4
31-50 years	5
51 year and older	4
Gender	
Male	6
Female	7
Marital status	
Married	8
Single	2
In a relationship	3
Education	
Compulsory education	7
Further education	2
University	4
Occupation	
Employed	7
Disability pension	2
Student	3
Other	1

Source : Generated by the authors

Table 2. *DASS results*

DASS	Mean		Median		Range			
	Time 1 (n = 12)	Time 2 (n = 12)	Time 1 (n = 12)	Time 2 (n = 12)	Time 1 (n = 12)		Time 2 (n = 12)	
					Min	Max	Min	Max
Depression [0-42]	14.25	13.58	13	9.5	0	39	0	31
Anxiety [0-42]	11.42	9.67	7	6	0	35	1	36
Stress [0-42]	16.67	14.67	13.5	12	1	36	1	34

Source : Generated by the authors

Table 3. *Results of questionnaires based on CFN*

	Mean		Median		Range			
FIBQ [7-35]	Time 1 (n = 13)	Time 2 (n = 12)	Time 1 (n = 13)	Time 2 (n = 12)	Time 1 (n = 13)		Time 2 (n = 12)	
					Min	Max	Min	Max
	21.92	23.50	21.00	24.00	16	28	15	27
EFFQ [17-85]	Time 1 (n = 12)	Time 2 (n = 11)	Time 1 (n = 12)	Time 2 (n = 11)	Time 1 (n = 12)		Time 2 (n = 11)	
					Min	Max	Min	Max
	61.58	63.18	63.00	64.00	52	68	41	72
FPSQ	Time 1 (n = 13)	Time 2 (n = 12)	Time 1 (n = 13)	Time 2 (n = 12)	Time 1 (n = 13)		Time 2 (n = 12)	
					Min	Max	Min	Max
Cognitive support [5-25]	12.54	13.58	12.00	14.50	5	23	8	19
Emotional support [9-45]	18.85	23.25	18.00	24.50	9	31	11	33
Total score [14-70]	31.38	36.83	33.00	35.50	14	54	22	49

* Family Illness Beliefs Questionnaire (FIBQ), Expressive Family Functioning Questionnaire (EFFQ) & Family Perceived Support Questionnaire (FPSQ)

Source : Generated by the authors

The comments from participants were categorised in different themes, the following are the main results :

The first question was : What do you like about the treatment ? The three themes that were mainly mentioned refer to expression (Discuss our feelings and emotions ; Express myself openly with family members and others ; Open up and make communications easier), sympathy (Meet people in the same situation ; Hear how others experience illnesses ; Hear others' experience) and increased insight (Increased understanding of illnesses ; Receive practical advice).

The second question was : What do you think could be better ? The main theme mentioned was regarding management (More direction from professionals regarding conversations ; Examine whether it is helpful to have themed topics prepared).

The third question was : Has the group been beneficial to you and/or your family ? If so, how ? Three themes were mainly mentioned : education (Useful points that we have been able to use at home ; We heard some advice from the group), expression (Opened a discussion ; The family talks about emotions better) and increased insight (Achieve better communication skills and a better understanding of the well-being of others in the family ; Finding the corresponding experience of others ; We have a little more understanding of each other).

The fourth question was : Would you continue to use such treatment, if available ? Eight participants answered yes.

The fifth question was : Is there anything about the structure of the multifamily group therapy that could be different ? E.g. duration, number of sessions, group size, number of therapists. Two main themes were mentioned : suggestions (increasing the number of sessions ; could be weekly ; each session could be shorter ; with a slightly larger group, discussions may become broader ; maybe you can have fewer therapists) and management (therapists to control the conversation more).

The last question was : Anything else you want to add ? The main themes that were mentioned were that MFGT is useful (I think most relatives want to learn as much as possible about the illness) and sympathy (Can discuss the topic with a group that is in a similar situation).

Discussion

In recent decades, there has been a major change in the mental health system in Western societies. The official policy has been to reduce the importance of mental health hospitals and strengthen services in the local community (Capdevielle, Ritchie, 2008 ; Ministry of Health, 2019 ; Preti et al., 2009). Studies have demonstrated that health services which collaborate with patients and their families improve the quality and safety of the provided services (Berger et al., 2014 ; Mackie et al., 2018). It is important that individuals and their families who suffer from mental illness are invited to influence treatment options (WHO, 2005). Patients with mental disorders may have difficulty maintaining healthy family relationships. Therapists can influence the patient's family's attitudes through education and support and thus promote positive communication (Radfar et al., 2014 ; Shajani, Snell, 2019 ; Sveinbjarnardottir, Svavarsdottir, 2019).

This is a pilot study with a very small sample size and therefore it is not possible to analyse and interpret this using an inferential analysis. There were 13 participants and the distribution in age/sex was relatively even, see Table 1 for other demographic variables. The ultimate goal of MFGT is to lead participants towards an improvement of their mental state and communication within the family. The result regarding the DASS indicates that the trend showed that symptoms were decreasing during the treatment period. The tendency for the FPSQ and the EFFQ was that family support and emotional functioning increased. Family attitudes towards illness suggested an improvement, according to the FIBQ, from Time 1 to Time 2 ; see Table 2.

Family support can reduce the suffering of families and the benefits of providing it can enhance the quality of provided services (Chesla, 2010 ; Gusdal et al., 2017 ; Laidsaar-Powell et al., 2017 ; Sveinbjarnardottir et al., 2011 ; Voltelen et al., 2016). When families, patients and caregivers reflect together, they may discover and incorporate resilient alternatives for dealing with mental illness and its psychosocial consequences. It is important to care for patients with mental illnesses and their families, and as such, necessary to gain knowledge about the efficacy of MFGT and therefore it is important to conduct research. At the same time, it is important to do research in the field of social workers, occupational therapists and nurses, as these professions do a lot of work with patients and their families. As this study used such a small sample size, evidence-based analytic methods were not possible, but the purpose of the pilot study is to create a protocol for a larger study that is being prepared.

Disclosure statement

No potential conflict of interest was reported by the authors.

Data availability statement

The authors of this paper confirm that the database for this study does not belong to a collective database. The data were specifically collected for this study and approved accordingly by ethical committees. Data can be made available from the authors upon reasonable request.

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