Rosini et al. Int J Psychol Psychoanal 2015, 1:1

International Journal of
Psychology and Psychoanalysis

Short Report: Open Access

Multi-family Groups for First Episode Psychosis in an Adult Psychiatric Care Department: A Study Design

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Abstract

Introduction: In 1958, Jorge Garcia Badaracco initiated weekly meetings between psychotic patients and their parents in Buenos Aires. On the basis of these experiences, he founded a new psychotherapeutic method, with an open setting based on multi-family groups (MFG), for patients affected by severe psychiatric illness. In Italy, there are several public psychiatric services in which MFG is followed, but there are few studies testing its validity. Herein, we describe a design study addressing the validity of MFGs outcome in an Adult Care Psychiatric Department.

Materials and Methods: We aim to compare patients who attended MFG with those who were not offered MFG sessions. Our hypothesis is that patients who attended the group showed a better improvement of level of symptoms, a higher level of coping styles and resilience, a decreased feeling of perceived stigma in comparison to the control group. Patients were assessed using the Positive, and Negative Syndrome Scale (PANSS), the Brief COPE, Resilience Scale for Adults (RSA), and Recovery Style Questionnaire.

Results: We here present preliminary analysis of socio demographic data showing a substantial homogeneity of the groups who differ only for sex distribution. Definitive data will be elaborated within 12 months after the end of the recruitment.

Discussion: There is the need to objectively demonstrate the efficacy of MFG in order for it to become part of routine practice. In addition, assessment instruments need to be developed to validate these hypotheses. MFG may be helpful in patient management and used to evaluate progress and guide therapeutic decisions, while reinforcing the role of the patient, and should be of immediate clinical relevance.

Keywords

Multifamily groups, First episode psychosis, Clinical outcome, Coping, Resilience, Perceived stigma

Introduction

The origins of Multi-Family Groups (MFG) therapy can be traced to 1958 when Jorge Garcia Badaracco [1] started to convene male psychotic patients at the psychiatric hospital in Buenos Aires for weekly meetings. Since he was investigating the efficacy of the method, he invited the patients' family members to participate in group sessions to discuss their improvement and possible discharge from the facility. In addition, nurses and healthcare operators also participated in therapy sessions: at the time, this was a highly innovative technique. The psychotherapeutic 'revolution' allowed the formation of an open group session that included both parents and family members; up to 50 individuals participated in each session; there were no particular rules except for the regularity of encounters. This allowed more focus to be placed on factors that are often at the basis of mental pathologies. In general, in fact, psychotic symptoms are considered as a sign of onset of disease. However, according to Badaracco, they can also be interpreted as a call for help by the patient; the pathology was already present before the onset of the episode, but in a latent form as the patient has kept his suffering hidden through withdrawal. It has been reported that participants in MFG show decreased family conflicts [2], which contributes to reducing stress perceived by relatives, even in the absence of significant effects on psychosocial resources [3]. Another study reported that MFG is associated with improvements in psychosocial wellbeing [4]. In Italy, research in the multifamily setting [5] has shown that in the MFG members feel that they are better supported by psychiatric services, and are more motivated to follow rehabilitative programmes. It would thus seem that the burden perceived can affect the quality of the service. MFG does appear to favor improvement in some aspects of social functioning, such as greater involvement in family life and social relations, and is also associated with a decrease in the number of hospitalizations during the period of observation [6].

The aim of this study was to explore the efficacy of MFG in a group of first episode psychosis patients. The hypothesis of our study

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Citation: Rosini E, Calabrò G, Mancinelli I, Pacifici MP, Pucci D, et al. (2015) Multi-family Groups for First Episode Psychosis in an Adult Psychiatric Care Department: A Study Design. Int J Psychol Psychoanal 1:004

Received: February 08, 2015: **Accepted:** February 19, 2015: **Published:** February 21, 2015

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was that patients who participated in MFG had greater improvement in symptom level, shorter duration of psychotic symptoms, fewer admissions and shorter duration of hospitalization during the follow-up period compared to a control group of first psychosis episode to whom was not offered MFG. Moreover we hypothesize that patients who attended MFG develop better coping mechanisms, better resilience and a decrease in overall stigma compared to the control group patients.

Materials and Methods

Study design and subjects

MFG was initiated at the Department of Psychiatry at Sant'Andrea Hospital in Rome, based on the previous experiences of Dr. Badaracco in Italy [7]. Patients with a first episode of psychosis were recruited from the psychiatric inpatient clinic of Sant'Andrea Hospital in Rome, in a catchment area of about 500.000 inhabitants over one year. Inclusion criteria were: 15–65 years of age and meeting the DSM IV criteria for schizophrenia, schizophreniform disorder, schizoaffective disorder, brief psychotic episode, delusional disorder, affective psychosis or psychotic disorder not otherwise specified. The patients included were actively psychotic and had never been adequately treated for psychosis and had no neurological or endocrine disorders with relationships to the psychosis. Furthermore, they presented with no contraindications to antipsychotic medications, were able to speak Italian language, had an IQ over 70 and were willing and able to give informed consent. All subjects who met the inclusion criteria during the study period were recruited. Written informed consent was obtained from all participants after providing complete description and explanation of the study.

The control group was constituted according to the same inclusion and exclusion criteria and recruited among patients admitted twelve month before the start-up of the MFG. Thus, MFG could not be offered to them. Data regarding control patients were collected from the general dataset of the Adult Psychiatric Care Department and utilized with their informed consent.

The study consists of three periods. Study Period I, which lasts up to 2 weeks, is during hospitalization. In this period, the contact with the patients and families starts with two alliance meetings and patients are evaluated for the baseline assessment. Study Period 2 consists of six months following the discharge. After the alliance meetings, patients and families met every week to the Public Health Psychiatric Service (PHPS). The group leader, that was trained by Badaracco, is the same of the first two meetings. There is no waiting time between the first two meetings and the beginning of treatment to the (PHPS). Study Period 3 is six-months naturalistic follow along (with biweekly visits), in which MFG patients meet their psychiatrist to the PHPS. Clinical assessment was carried out at baseline (during the short-term phase), at discharge, at six months and at twelve months of follow-up.

Clinical measures

The Structured Clinical Interview for DSM IV Axis I Disorders was used for diagnostic purposes at baseline [8]. Symptom levels were rated at baseline, at 6 months and 1 year. Symptom levels are measured (baseline, six month and twelve month) with Positive and Negative Syndrome Scale (PANSS) [9] and divided into Positive, Negative, Excitative, Depressive, and Cognitive Components based on the five factor model [10]. MFG participants (MFG-P) and non-participants (MFG-NP) are administered the following tests at baseline, six-month and twelve month follow-up):

- Brief COPE [11], which consists of 14 scales of 2 items each (active coping, planning, positive reformulation, acceptance, sense of humour, religion, use of emotional support, use of instrumental support, capacity of self-distraction, denial, venting, substance abuse, behavioural disengagement, self-reprimand).

- Resilience Scale for Adults (RSA) [12] is structured in 5 dimensions: personal strength, structured style, social competence, family cohesion and social resources.

- Recovery Style Questionnaire [13] is based on the evaluation of 13 psychological attributes of recovery: continuity, ownership, responsibility, curiosity, education, help-seeking, blame, cause, optimism, impact, fear, liking and satisfaction.

- Internalized Stigma of Mental Illness Inventory (ISMI) [14], which consists of 29 items in five subscales: alienation, stereotype endorsement, perceived discrimination, social withdrawal and stigma resistance.

The study is ongoing and will not be completed until June 2015. However, intake was completed in June 2014. This is the first report and will address the study design and the characteristic of the sample.

Statistical analysis

Differences between MFG participants and MFG non participants in socio-demographic variables were analyzed by using the T-test or the the χ^2 test. The χ^2 test (or Fisher's Test when necessary) was used to analyze categorical variables. T-test was performed for continuous variables, pretesting for homogeneity of variance. PANSS factors scores differences between the two groups were analysed through the non-parametric Mann-Whitney U-test. All p values were two tailed, and statistical significance was set at $p<0.05$.

Results

A total of 38 patients were recruited, out of which 21 participated in more than 75% of the six-month MFG program and were included in the study and in the follow-up. Six patients participated in less than 50% of the MFG meetings; eleven participated in 50–74%. Eleven relatives participated in <50% of the MFG meetings, 8 in 50–74% and 14 in more than 75%. Only patients who participated to more than 75% of the MFG meetings were included and compared to first episode patients with the same inclusion criteria, admitted over the year before to which MFG was not offered. Of the 45 patients eligible as controls, only 32 participated to more of 75% of the scheduled appointments for the medical treatment to the PMHS in the six month following the discharge and were included in the control group. Clinical characteristic of MFG participants and of the control group patients are illustrated in table 1.

As revealed in the table, patients who attended MFG and control patients differed only for sex, as among MFG participants males were significantly more represented than in the control group. This is a variable of which we have to take account when comparing the two groups. Age, education, marital status, diagnosis distribution, drug abuse, mean daily dosage of antipsychotic drugs and PANSS factor scores did not differ.

Table 1: Characteristics of the sample at baseline

	MFG participants (21)	MFG non participants (32)
Sex* (males)	13 (61.9%)	11 (34.4%)
Age	39.2 (SE 3.1)	38.4 (SE 2.4)
Age of education		
<8 years	14 (66.7%)	14 (43.8%)
9-12 years	4 (19%)	11(34.4%)
<13 years	3 (14.3%)	7 (21.9%)
Marital status		
Single	16 (76.2%)	21(65.6%)
Married	5 (26.8%)	11 (34.4%)
Diagnosis		
Non-affective Psychosis	11 (52.4%)	19 (59.4%)
Affective Psychosis	10 (47.6%)	13 (40.6%)
Current Drug abuse		
Yes	7 (33.3%)	7 (21.9%)
No	14 (66.7%)	25 (78.1%)
PANSS POSITIVE factor	15.2 (SE 0.6)	16.2 (SE 1.4)
PANSS NEGATIVE factor	20.3 (SE 0.8)	18.7 (SE 1.6)
PANSS EXCITATIVE factor	14.9 (SE 0.7)	14.8 (SE 1.2)
PANSS COGNITIVE factor	11.8 (SE 0.6)	11.5 (SE 0.8)
PANSS DEPRESSIVE factor	9.8 (SE (0.5)	8.9 (SE 0.8)
Mean daily antpsychotic dosage (Olanzapine mg eq)	18.3	16.8

*p<0.05

Discussion

According to Badaracco, a multifamily group allows "Thinking together that which cannot be thought of alone" [1]. This continual changing and re-establishment of group dynamics, especially in severely ill patients, is a valuable conquest that is an important part of the therapeutic process that can continue in community mental health centres even after hospital discharge.

The aim of the study here described is to validate the efficacy of MFG using variables that are mainly based on outcomes (symptoms level, number of hospitalisations, level of coping, resilience, recovery and stigma perceived) more than therapeutic processes themselves (therapeutic factors, attachment styles, defence mechanisms), that may be investigate in a second time.

Looking forward definitive results of our study, we may here reflect critical issues and subjective remarks. In our opinion, important changes have occurred in the Department. In particular, there is improvement in the overall 'atmosphere', in terms of the relationship between healthcare givers, patients and family members. Compliance of patients and their ability to 'reflect' on their existence also appears to have improved together with a reduction in aggressive events during hospitalisation. Obviously, there is still the need to objectively demonstrate the efficacy of MFG in order for it to become part of routine practice, as in our department. In addition, research instruments will need to be developed that can validate these hypotheses with scientific rigour to demonstrate the utility of this type of psychotherapy. We think that MFG can be helpful in patient management and used to evaluate progress and guide therapeutic decisions, while reinforcing the role of the patient, and should be of immediate clinical relevance. Outcomes are influenced by both clinical practice and the quality of therapeutic relationships. Lastly, the positive effects associated with the presence of family members in therapy sessions should not be underestimated. Group therapy facilitates recovery of communication between psychiatric services and the family, which is often fragmented and discontinuous. In this way, more concrete responses can be given to caregivers in terms of finding an equal space with patients and relatives, thereby avoiding the creation of fixed psychopathological labels, and making greater use of family and clinical history.

In our opinion, it would be also of fundamental importance to assess the 'health status' of caregivers and their ability to adapt to stressful working conditions that involve delicate and complex issues. If a healthcare provider (physician, nurse or other) is not able to successfully cope with such situations, there is the risk of burnout syndrome.

The emotional exchanges during group sessions, especially over time, help to better understand 'normal' intra-family conflicts as they provide space for emotional components that are difficult to express in an individual context. For this reason, it is useful to be exposed to different families. In other words, the accounts of one member of the group are emotionally shared between all participants. For patients with more severe conditions, this often leads to agitated behaviours such as leaving the group during difficult discussions. Such behaviours can lead to depreciation by the other participants, but maintaining the composure of the group allows the patient to return with a sense of gratitude and belonging, which is often denied in terms of behaviour or verbalisation. In a metaphoric sense, the experience of the group can be compared to that of a mother who remains present, even during the presence of destructive behaviour. This permits a 'breath of fresh air' for the group: it allows the group to understand that what may seem to be depreciation may actually be a sign of discomfort that creates solidarity and mutual support on several levels. Family members, moreover, tend to have a favourable perception of the positive moments of the group and associate them with better treatment outcomes.

Finally, we still lack empirical knowledge as to whether the MFG approach improves outcome for patients with a first episode of psychosis. We think that our study, here described for the first time, constitutes a useful effort to elucidate benefits and limits of this therapeutic practice.

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