

Multifamily Group Psychotherapy for Patients With Nonepileptic Seizures and Their Families

Randi Libbon, M.D., Brian Rothberg, M.D., Sarah Baker, B.A., Alison Heru, M.D.

Objective: Multifamily group (MFG) psychotherapy is widely used for mental and general medical conditions. MFG therapy engages family members in caring for a loved one experiencing illness and helps clarify the impact of illness on family. Use of MFG therapy for patients with nonepileptic seizures (NES) and their families to explore satisfaction with treatment and family functioning is described.

Methods: MFG therapy for patients with NES and their participating family members was incorporated into an existing interdisciplinary group-based psychotherapy treatment program. The Family Assessment Device and a novel feedback questionnaire were used to understand the effect of MFG therapy on this population.

Results: Patients with NES (N=29) and their corresponding family members (N=29) indicated on the feedback questionnaire their satisfaction with having MFG therapy as part of their treatment; satisfaction was also evidenced by a 79%

(N=49 of 62) patient participation rate. Patients and family members reported enhanced understanding of the impact of illness on the family and believed MFG therapy would help them communicate about illness and reduce family conflict. Scores on the Family Assessment Device indicated that family members perceived better family functioning than did patients (average scores of 1.84 and 2.99, respectively).

Conclusions: The discrepancy in perceived family functioning supports the idea of integrating family members in treatment for patients experiencing NES. The group treatment modality was satisfactory to participants and may prove useful for other kinds of somatic symptom disorders, which are often external manifestations of internal distress. Family members can become treatment allies in psychotherapy when included in treatment.

Am J Psychother in Advance
(doi: 10.1176/appi.psychotherapy.20210060)

Nonepileptic seizures (NES) are events that appear in the body as seizure activity but without corresponding electrical abnormalities visible on electroencephalography. NES are classified under functional neurological symptom disorder in *DSM-5*. Historically, NES have been considered physical manifestations of underlying psychological conflict; however, emerging research (1) suggests that structural and functional abnormalities of the brain also play a role. Given the expanding research on how individual therapy can alter brain structure and function (2), it follows that group therapy and multifamily group (MFG) therapy may have similar impacts.

Patients with NES usually present to neurologists or emergency departments but require behavioral health interventions for treatment. Current treatment options for patients with NES consist mostly of individual cognitive-behavioral therapy (CBT) (3–5) or mindfulness-based therapy (6–8). Only 18 clinics in the United States provide multidisciplinary treatment for NES and for the broader category of functional neurological disorders (9). Many patients remain symptomatic and continue to have impairment after treatment (6). The largest randomized controlled trial

(CBT for adults with dissociative seizures) (3) found no statistically significant improvement in the primary outcome measure of seizure frequency.

The largest demographic study of patients with NES (10) found that the population is predominantly female (3:1 ratio),

HIGHLIGHTS

- All participants—patients with nonepileptic seizures (NES) and their family members—in multifamily group (MFG) therapy reported the treatment modality to be beneficial for improving communication, expressing feelings, and developing coping skills for illness management.
- Understanding family functioning and support structures for patients with NES helps to clarify how illness has affected the family system.
- All 29 patients and their corresponding family members agreed or strongly agreed that MFG therapy was useful, especially for meeting other participants experiencing similar circumstances and hearing perspectives from other patients and their family members.

has economic disadvantages, is unemployed, and is young—with a median age of 28 years. NES has been shown to affect many social aspects of life and thus quality of life. Treatment should address the social determinants of health, including a patient's interactions with the community through relationships and employment (11).

Our unique interdisciplinary NES clinic model has its basis in group therapy and was created with the intention of helping patients engage in appropriate and effective treatment that is cost-effective, increases accessibility, and builds shared experience among patients. This model has been shown to be feasible in regard to adherence to treatment and decreased health care utilization (12).

Because patients requested more opportunities for family involvement in their treatment, we added multifamily psychoeducational group therapy to our interdisciplinary clinic (12). One goal of including family members in treatment was to educate them about the etiology of NES, both as a psychosomatic and a physiologic illness. Involving families in the care of patients has been shown to lead to better patient outcomes (13). For many patients, treatment adherence improves when family members are included in assessment, decision making, and treatment planning (14–16). If further family intervention is needed after MFG therapy, the family can be enrolled in individual family therapy. The decision to engage in additional treatment depends on the family's presentation as determined by a mental health professional, willingness to participate in further family treatment, and access to affordable mental health providers who deliver this treatment (17).

Multifamily psychoeducational groups have specific advantages, because the training required to conduct these group sessions is short (about 6 hours), compared with the training needed to become an effective family therapist (1–2 years of supervised training). MFG treatments also offer advantages for families because they are short (usually only a few hours in total), thus improving the chances of better attendance.

Family psychoeducation was developed about 40 years ago as a component of treatment for schizophrenia (18). A series of highly structured, supportive, psychoeducational family interventions were created to decrease levels of expressed emotion in the family environment in an attempt to reduce relapse rates, but later variations also focused on social and role functioning and family well-being (19). Meta-analyses have identified a relapse rate reduction of 50%–60% among patients with schizophrenia with the use of family psychoeducation (19). Multifamily psychoeducation has greater benefit than single-family psychoeducation because it allows families to learn about and share experiences, thoughts, and feelings with each other.

MFG therapy has also been used in the treatment of other illnesses, such as major depressive disorder (20), bipolar disorder (21), traumatic brain injury (22), eating disorders among adolescents (23), depression among adolescents (24), mild cognitive impairment (25), autism among adults (26),

and first-episode psychosis (27). Many of these illnesses are associated with high levels of stigma, similar to NES, in contrast to other chronic general medical illnesses that are more widely understood and accepted by the general population.

The use of MFG therapy for treatment of chronic general medical illness is best exemplified by the work of Kazak and colleagues (28), who developed a 1-day MFG program for adolescent cancer survivors and their families (the Surviving Cancer Competently Intervention Program). This MFG therapy focused on reducing posttraumatic stress symptoms of family members by addressing and altering family beliefs and communication patterns about cancer and its treatment. Findings from this study (29) have supported the benefits of participation in such groups.

Steinglass and colleagues (30) developed a clinical protocol for a 1-day MFG workshop for adult head and neck cancer survivors and their families. All patients were considered cancer free at the time of recruitment but were typically experiencing a wide range of side effects secondary to complications from surgery, radiation treatment, or both. This 1-day MFG protocol had four goals: educating families about the ways family life is affected by cancer diagnosis and treatment; normalizing the experiences, reactions, and struggles families have in attempting to cope with the posttreatment adjustment phase of cancer recovery; confronting and challenging the isolation from support networks that these families often feel; and exploring ways in which families can manage and balance aspects of daily living while attending to the family member with an illness.

Because of the documented use of MFGs in treatment for chronic illness, we decided to include MFGs in our interdisciplinary NES treatment program. We hypothesized that MFGs would prove useful to patients with NES and their families. To our knowledge, there exist no previously published data on the use of MFGs for patients with NES.

METHODS

We adapted the Steinglass et al. (30) model, described above, for a half-day MFG workshop for patients with NES and their families, because the model's description was clear and could be easily modified for our population. We chose this format to accommodate family members traveling great distances or needing to miss work. The MFG workshop was available to all patients enrolled in the NES clinic at the University of Colorado, Aurora. Patients and family members provided written informed consent regarding the Colorado Multiple Institutional Review Board–approved protocol (12) prior to participation. Participating family members and patients completed questionnaires, including the Family Assessment Device (FAD) and a novel MFG feedback questionnaire, at the end of the workshop. The MFG feedback questionnaire was adapted from the Steinglass et al. (30) MFG model to assess participants' experiences with various components of MFG therapy.

Family functioning was assessed by using the general functioning subscale of the McMaster FAD (FAD-GF) (31). The FAD has good psychometric properties (32) and good reliability and validity (33). The FAD questionnaire contains 60 questions; the FAD-GF is a shorter, 12-item version of the questionnaire (scores range from 1 to 4, with higher scores reflecting poorer family functioning). Patients and family members indicated their level of agreement (i.e., strongly disagree, disagree, agree, strongly agree) with 12 statements; a mean score of 2.00 or higher on the FAD-GF is used to define problematic family functioning (34).

The group training module for group leaders from the University of Colorado's Department of Neurology consisted of six 1-hour classes, focusing on a core set of skills for facilitating a structured group workshop. The group therapy educator (B.R.) from the university's Department of Psychiatry taught these classes. He trained neurology clinicians, including physician assistants, nurse practitioners, a neurologist, and an administrative staff member. The initial didactic sessions focused on setting the frame around time boundaries, attendance, the task of the group, and pacing the flow of information. The second set of didactics considered reflection on the process, ways of inviting all members of the group to participate, exploration of the importance of noticing the whole group and not just the speaker, and the difference between giving advice and exploring a concern. The didactic leader conducted experiential exercises to model the skills and behaviors used to lead a group. All trainees who helped to facilitate groups were directly supervised and accompanied by an experienced MFG leader at every MFG session.

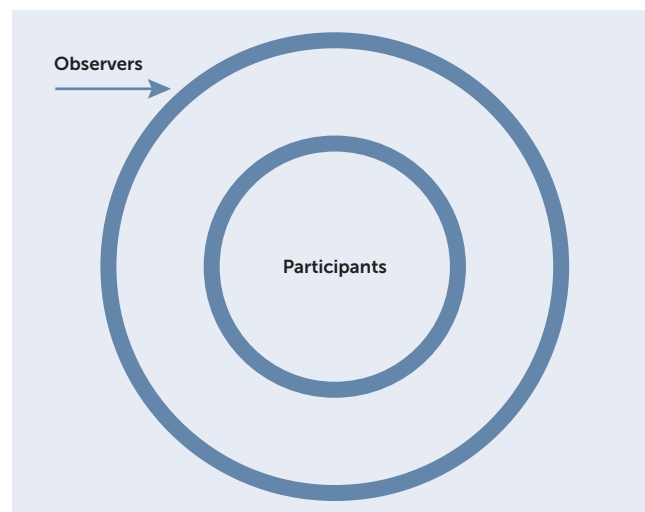
Group Composition and Structure

A pilot MFG session was held to gather initial feedback from participants (patients and family members). Participants gave positive feedback regarding their experience. The MFG treatment was then added as an ongoing and permanent component of the clinic. Our original 5-week CBT-based group was changed to a 6-week group, with the sixth and final session reserved for MFG therapy (12).

Inclusion criteria for participation in the MFG workshop were the same as the eligibility criteria for the NES CBT program: patients ages 18–89 years, enrolled in the University of Colorado NES clinic, and providing a baseline symptom frequency for standard of care. Exclusion criteria for participation in MFG therapy included pregnancy, imprisonment, inability to consent to participation, lack of fluency in the English language, and a primary diagnosis of factitious disorder or malingering (12). We conducted the study with, and collected data from, 10 MFGs during 2019. Sixty-two patients were invited, and 49 attended the MFG session (79% adherence rate).

Starting in March 2020, at the beginning of the COVID-19 pandemic, all of our group therapy programming was switched to telehealth via Zoom, because of COVID-19 restrictions at our hospital and clinic. We have since conducted

FIGURE 1. Structure of the fishbowl exercise, with the inner circle consisting of active participants and the outer circle consisting of silent observers^a



^a Patients start in the inner circle, accompanied by group leaders, with family members composing the outer circle. The patients and family members then switch circles.

41 MFG sessions through this telehealth platform, which has proved to be a viable option for providers and group members. Our clinic has shown increased treatment engagement since initiation of telehealth services during the COVID-19 pandemic (35).

The data used for this study, however, were from January through December 2019, thus the COVID-19 pandemic had no effect on results. We opted to use this data set to avoid confounding factors from studying in-person and telehealth groups together.

MFG Protocol

Groups began with a review of the workshop agenda. Materials handed out to participants included a sample family response plan for NES events, frequently asked questions about NES, and a link to our educational video on NES. The staff conducting the MFG sessions always included a psychiatrist or mental health provider with expertise in family interventions, as well as supporting staff—such as neurology advanced-practice providers, an NES clinic neurologist, psychiatric trainees, and a social worker. Instead of using the Steinglass et al. (30) technique of “group within a group,” the staff conducting the sessions used a fishbowl technique, which entails the formation of an inner group and an outer group (see Figure 1). For the first fishbowl discussion, the inner group (composed of patients) responded to questions and had a discussion while the outer group (composed of family members) remained silent and only observed. After the first fishbowl discussion, the groups switched, and the family members moved to the inner circle.

Prompts for discussion among patients (inner circle) included the following: How has NES affected your family?

TABLE 1. Demographic characteristics of patients with nonepileptic seizures and their participating family members

Characteristic	N	%
Patients (N=29)		
Age (M±SD years)	34.5±14.8	
Gender		
Female	25	86
Male	4	14
Race		
White or Caucasian	26	90
Black or African American	3	10
Ethnicity		
Not Hispanic or Latino	26	90
Hispanic or Latino	3	10
Primary insurance		
Medicaid	13	45
Private commercial	12	41
Medicare	3	10
TRICARE	1	3
Marital status		
Married or relationship with significant other	15	52
Single	12	41
Divorced	1	3
Unknown	1	3
Participating family members (N=29)		
Relationship to patient		
Parent or parent-in-law	15	52
Partner or spouse	10	34
Sibling	2	7
Grandparent	1	3
Friend	1	3
Gender		
Female	16	55
Male	13	45

How is distress expressed in your family? How are needs communicated in your family? How do you balance the needs of everyone in your family or household? How do your family members respond to your NES events? and What is and is not helpful?

Prompts for discussion among family members (inner circle) included the following: What is it like to have a family member with NES? How has the NES diagnosis affected you and other members of the family? Why do you think your family member has developed this condition? How do you respond to NES events [of] your family member? What is and is not helpful in responding to events?

At the end of each fishbowl discussion, the participants in the outer circle were invited to share what they heard from those in the inner circle in order to facilitate reflective listening skills. We chose this methodology to help family members and patients understand the similarities in their struggles and to designate specific time for family members to be the focus of treatment. This format was used to encourage open communication and helped family members and patients to hear one another more effectively.

Some of the shared themes discussed in both the patient and family fishbowl discussions have included how much family dynamics and roles have changed as a result of the NES, the importance of self-care, feelings of helplessness and fear, and the challenge of accepting the NES diagnosis.

RESULTS

Participants’ demographic data are reported in Table 1. Our patient sample was predominantly female (86%), White (90%), and of non-Hispanic or non-Latino origin (90%). Most family members who participated were female (55%). Partners or spouses and parents or parent-in-laws were the main types of family members participating (34% and 52%, respectively).

Table 2 shows patients’ and family members’ responses to the MFG feedback questionnaire. The data shown are average scores for each item from 29 patients and their paired family members (total N=58). Data were available for 29 participating family members, but not all family members completed all questions on the MFG feedback questionnaire. For all participants, scores on individual questions averaged 3.2–3.8 (possible scores for each item ranged from 1, not at all or strongly disagree, to 4, extremely useful or strongly agree), and the scores for patients and family members were similar. Thus, the averages reported are for total participants and not for patients and family members separately.

The feedback questionnaire revealed that the patients and family members found MFG therapy to be helpful and were satisfied with their experience. Components thought to be particularly helpful, as reported in the feedback, included hearing from other families (decreased sense of isolation), having the opportunity to express thoughts and feelings, receiving educational materials about the condition, learning from the group leaders, and receiving a template for an NES response plan (provided to facilitate conversation about what is needed when NES symptoms emerge). Participants indicated that they gained knowledge about the effects of NES on family functioning and the impact of the illness on family members. The MFG workshop was reported to help with family communication, which participants anticipated would be useful in reducing family conflict.

Table 3 shows average scores of family members and patients for each item on the FAD-GF. The composite patient and family member average scores on the entire FAD-GF were 2.99 and 1.84, respectively; the FAD-GF cutoff score for ineffective family functioning is >2.00. Our results indicated that the patients reported having dysfunctional families, whereas the family members reported having functional families. A mixed-model regression was used for statistical analyses; with the exception of the first item (“Planning family activities is difficult because we misunderstand each other”), a statistically significant difference (p<0.05) in the averages for each item on the FAD-GF (patients vs. participating family members) was observed.

TABLE 2. Responses to the multifamily group feedback questionnaire from patients and participating family members (N=58) affected by nonepileptic seizures^a

Multifamily group feedback item	N of respondents ^b	Average score (patients and participating family members)
1. Overall, how would you rate the usefulness of the family workshop?	55	3.54
2. The handout of informational material was helpful	52	3.34
3. The sample response plans for nonepileptic seizures were helpful	50	3.30
4. The fishbowl exercise was helpful	51	3.70
5. Learning about the impact of nonepileptic seizures on you and your family was helpful	51	3.59
6. Thinking about what we have been through as a result of the illness was helpful	51	3.56
7. Going to a support program together with my family was helpful	51	3.56
8. Having a chance to express my thoughts and feelings to family members was helpful	51	3.57
9. Hearing members of my own family share their views was helpful	51	3.54
10. Hearing members of other families share their views was helpful	50	3.66
11. The coleaders were helpful	51	3.56
12. Meeting other patients and families dealing with similar circumstances was helpful	51	3.77
13. How confident are you that this group will help your family communicate better about illness issues?	51	3.36
14. How confident are you that this group will help your family to reduce conflict related to the illness?	51	3.19
15. How confident are you that this group will help your family to understand the impact of the illness on family life?	50	3.33
16. How confident do you feel in supporting your loved one with nonepileptic seizures as a result of this workshop?	40	3.43
17. How helpful was this workshop in learning to support your family member with nonepileptic seizures?	43	3.49
18. If a friend or colleague was diagnosed with nonepileptic seizures, how likely is it that you would recommend this program?	49	3.71

^a Possible scores for each item on the questionnaire range from 1, not at all or strongly disagree, to 4, extremely useful or strongly agree. Patients were also able to leave comments and suggestions on the form.

^b Not all patients or family members answered each question.

DISCUSSION

This study of the novel use of MFG therapy for the treatment of patients with NES explored the acceptability of the treatment modality and opinions on family functioning among patients with NES and their participating family members. NES has been described (36) as a means of unconsciously expressing conflicts and personal needs in an attempt to not be blamed or to distract from something else going on that the family may not want to address. We conceptualize that NES is often the body's way of communicating when patients are unable to do so with words. Encouraging and teaching better communication skills through the use of MFGs could lead to symptom improvement among patients and deter patients from using dangerous bodily mechanisms to convey their needs.

The amount of stress and life changes that occur with NES are significant and are experienced in the context of a patient population that has difficulty with emotional recognition and processing (37). Modeling the approach of discussing support, problems, and solutions in a direct and effective way shows patients with NES and their families how to develop these necessary coping skills in the face of illness.

The overall rating on the FAD-GF of family members' perceptions of family functioning was healthy (1.84) and differed from that of patients, who perceived their overall

family functioning to be unhealthy (2.99, $p < 0.001$). Other studies (38, 39) of families of patients with chronic illness have reported similar findings, with family members having better perceptions of family functioning than patients with chronic illnesses.

Several factors may contribute to this discrepancy. Our sample of patients with NES were likely to have psychiatric challenges, such as depression, anxiety, or symptoms of posttraumatic stress disorder, which may have negatively influenced their perceptions of family functioning. Family functioning is also dynamic and varies over time for reasons extraneous to the chronic illness. Regardless of contributing factors, families may benefit from further exploration of difficulties through referral to family therapy.

Patients with NES perceive their families as less supportive and more dysfunctional than do family members (40). The incongruence between patients' and family members' perceptions of family functioning may have indicated further challenges in communication and assessment of problems. This explanation aligns with reports of parents of children with NES often seeing the illness as the only problem and not acknowledging other challenges in the family (36). The discrepancy in FAD-GF scores in the current study may also point to the inability of patients with NES to adequately express their concerns, distress, and needs to their families. Most important, family members may not be recognizing or

TABLE 3. Overall average scores on the FAD-GF for patients with nonepileptic seizures and their participating family members^a

FAD-GF item	Patients (N=22) ^b	Participating family members (N=29)	p
1. Planning family activities is difficult because we misunderstand each other	2.22	2.79	.05
2. In times of crisis, we can turn to each other for support	3.04	1.65	<.001
3. We cannot talk to each other about the sadness we feel	2.27	3.10	.01
4. Individuals are accepted for what they are	3.13	1.72	<.001
5. We avoid discussing our fears and concerns	2.02	2.96	.001
6. We can express feelings to each other	2.99	1.69	<.001
7. There are lots of bad feelings in the family	1.85	3.03	<.001
8. We feel accepted for what we are	2.98	1.80	<.001
9. Making decisions is a problem for our family	1.99	3.03	<.001
10. We are able to make decisions about how to solve problems	2.77	1.93	.004
11. We don't get along well together	1.77	3.45	<.001
12. We confide in each other	3.13	1.65	<.001

^a Possible scores on the general functioning subscale of the Family Assessment Device (FAD-GF) range from 1 to 4, with higher scores reflecting poorer family functioning. A score of 2.00 or above indicates problematic family functioning. The higher the score, the more problematic the family member perceives the family's overall functioning to be. Overall averages were 2.99 for patients and 1.84 for family members (p<0.001).

^b Seven patients did not complete the FAD-GF.

responding to problems or dysfunction, thus contributing to the perpetuation of NES symptomatology.

This study had some limitations. This was a cross-sectional study, in which patients were at different stages of recovery and thus had different therapeutic needs. Patients and family members who had barriers to care, such as transportation or not being able to take off time from work, may not have been able to participate, thus biasing participation. Furthermore, this treatment model may be challenging to use more broadly in treatment settings without mental health providers who are already trained to facilitate MFG sessions. To broadly disseminate this MFG program for NES, the treatment providers would need the appropriate training, and the practice setting would need to manage the administrative and scheduling tasks required for the MFG modality.

CONCLUSIONS

MFG therapy was a satisfactory and helpful component of treatment among patients with NES and their family members. Inclusion of family members in treatment can help people who support a patient understand the illness, changes in functioning and behavior that are occurring, and changes yet to come. In settings that include family members in the treatment of patients with NES, the use of MFGs should be considered. Further exploration of including family members in the treatment of adult patients with NES is warranted. Given the transition to telehealth starting in 2020 because of the COVID-19 pandemic, it would be fruitful to examine the usefulness of MFG sessions conducted via this modality. Future studies on the use of MFGs for other somatic symptom disorders could also be beneficial.

AUTHOR AND ARTICLE INFORMATION

Department of Psychiatry (Libbon, Rothberg, Heru) and Department of Neurology (Baker), University of Colorado, Aurora.

Send correspondence to Dr. Libbon (randi.libbon@cuanschutz.edu).

The authors thank Laura Sttrom, M.D., as well as Taylor Bayshore, N.P., Kelli Morrissey, P.A., Scott Pearson, P.A., Stacey Wilson, P.A., Nicole Ralston, P.A., and Rajee Krause, N.P., for their help and participation in facilitating the multifamily group sessions.

The authors report no financial relationships with commercial interests.

Received December 23, 2021; revisions received May 25 and July 26, 2022; accepted August 8, 2022; published online February 16, 2023.

REFERENCES

- Cretton A, Brown RJ, LaFrance WC, et al: What does neuroscience tell us about the conversion model of functional neurological disorders? *J Neuropsychiatry Clin Neurosci* 2020; 32:24-32
- Siegel DJ: *Mindsight: The New Science of Personal Transformation*. New York, Bantam, 2010
- Goldstein LH, Robinson EJ, Mellers JDC, et al: Cognitive behavioural therapy for adults with dissociative seizures (CODES): a pragmatic, multicentre, randomised controlled trial. *Lancet Psychiatry* 2020; 7:491-505
- Tilahun BBS, Thompson NR, Sankary LR, et al: Outcomes in the treatment of psychogenic nonepileptic seizures (PNES) with CBTip: response in seizure frequency, depression, anxiety, and quality of life. *Epilepsy Behav* 2021; 123:108277
- LaFrance WC, Baird GL, Barry JJ, et al: Multicenter pilot treatment trial for psychogenic nonepileptic seizures: a randomized clinical trial. *JAMA Psychiatry* 2014; 71:997-1005
- Baslet G, Dworetzky B, Perez DL, et al: Treatment of psychogenic nonepileptic seizures: updated review and findings from a mindfulness-based intervention case series. *Clin EEG Neurosci* 2015; 46:54-64
- Baslet G, Ehlert A, Oser M, et al: Mindfulness-based therapy for psychogenic nonepileptic seizures. *Epilepsy Behav* 2020; 103:106534
- Baslet G, Ridlon R, Raynor G, et al: Sustained improvement with mindfulness-based therapy for psychogenic nonepileptic seizures. *Epilepsy Behav* 2022; 126:108478
- Beimer NJ, LaFrance WC Jr: Evaluation and treatment of psychogenic nonepileptic seizures. *Neurol Clin* 2022; 40:799-820
- Goldstein LH, Robinson EJ, Reuber M, et al: Characteristics of 698 patients with dissociative seizures: a UK multicenter study. *Epilepsia* 2019; 60:2182-2193
- Asadi-Pooya AA, Brigo F, Kozłowska K, et al: Social aspects of life in patients with functional seizures: closing the gap in the biopsychosocial formulation. *Epilepsy Behav* 2021; 117:107903
- Libbon R, Gadbow J, Watson M, et al: The feasibility of a multidisciplinary group therapy clinic for the treatment of nonepileptic seizures. *Epilepsy Behav* 2019; 98:117-123
- Gilliss CL, Pan W, Davis LL: Family involvement in adult chronic disease care: reviewing the systematic reviews. *J Fam Nurs* 2019; 25:3-27

14. DiMatteo MR: Social support and patient adherence to medical treatment: a meta-analysis. *Health Psychol* 2004; 23:207–218
15. Wolff JL, Clayman ML, Rabins P, et al: An exploration of patient and family engagement in routine primary care visits. *Health Expect* 2015; 18:188–198
16. Scheurer D, Choudhry N, Swanton KA, et al: Association between different types of social support and medication adherence. *Am J Manag Care* 2012; 18:e461–e467
17. Heru AM: Family-centered care in the outpatient general psychiatry clinic. *J Psychiatr Pract* 2015; 21:381–388
18. Anderson CM, Hogarty GE, Reiss DJ: Family treatment of adult schizophrenic patients: a psycho-educational approach. *Schizophr Bull* 1980; 6:490–505
19. McFarlane WR: Family interventions for schizophrenia and the psychoses: a review. *Fam Process* 2016; 55:460–482
20. Brady P, Kangas M, McGill K: “Family matters”: a systematic review of the evidence for family psychoeducation for major depressive disorder. *J Marital Fam Ther* 2017; 43:245–263
21. Madigan K, Egan P, Brennan D, et al: A randomised controlled trial of carer-focussed multi-family group psychoeducation in bipolar disorder. *Eur Psychiatry* 2012; 27:281–284
22. Couchman G, McMahan G, Kelly A, et al: A new kind of normal: qualitative accounts of multifamily group therapy for acquired brain injury. *Neuropsychol Rehabil* 2014; 24:809–832
23. Depestele L, Claes L, Dierckx E, et al: An adjunctive multi-family group intervention with or without patient participation during an inpatient treatment for adolescents with an eating disorder: a pilot study. *Eur Eat Disord Rev* 2017; 25:570–578
24. Poole LA, Lewis AJ, Toumbourou JW, et al: A multi-family group intervention for adolescent depression: the BEST MOOD program. *Fam Process* 2017; 56:317–330
25. Schmitter-Edgecombe M, Dyck DG: Cognitive rehabilitation multi-family group intervention for individuals with mild cognitive impairment and their care-partners. *J Int Neuropsychol Soc* 2014; 20:897–908
26. Smith LE, Greenberg JS, Mailick MR: Adults with autism: outcomes, family effects, and the multi-family group psychoeducation model. *Curr Psychiatry Rep* 2012; 14:732–738
27. Rossberg JI, Johannessen JO, Klungsoyr O, et al: Are multi family groups appropriate for patients with first episode psychosis? A 5-year naturalistic follow-up study. *Acta Psychiatr Scand* 2010; 122:384–394
28. Kazak AE, Simms S, Barakat L, et al: Surviving Cancer Competently Intervention Program (SCCIP): a cognitive-behavioral and family therapy intervention for adolescent survivors of childhood cancer and their families. *Fam Process* 1999; 38:175–191
29. Kazak AE, Alderfer MA, Streisand R, et al: Treatment of post-traumatic stress symptoms in adolescent survivors of childhood cancer and their families: a randomized clinical trial. *J Fam Psychol* 2004; 18:493–504
30. Steinglass P, Ostroff JS, Steinglass AS: Multiple family groups for adult cancer survivors and their families: a 1-day workshop model. *Fam Process* 2011; 50:393–409
31. Epstein NB, Baldwin LM, Bishop DS: The McMaster Family Assessment Device. *J Marital Fam Ther* 1983; 9:171–180
32. Kabacoff RI, Miller IW, Bishop DS, et al: A psychometric study of the McMaster Family Assessment Device in psychiatric, medical, and nonclinical samples. *J Fam Psychol* 1990; 3:431–439
33. Byles J, Byrne C, Boyle MH, et al: Ontario Child Health Study: reliability and validity of the general functioning subscale of the McMaster Family Assessment Device. *Fam Process* 1988; 27:97–104
34. Miller IW, Epstein NB, Bishop DS: The McMaster Family Assessment Device: reliability and validity. *J Marital Fam Ther* 1985; 11:345–356
35. Watson M, Borland H, Baker S, et al: Exploring the influence of telehealth on patient engagement with a multidisciplinary Non-Epileptic Seizure (NES) Clinic during the COVID-19 pandemic. *Epilepsy Behav* 2022; 131:108707
36. Schachter SC, LaFrance WC Jr (eds): *Gates and Rowan’s Non-epileptic Seizures*, 3rd ed. New York, Cambridge University Press, 2010
37. Jungilligens J, Wellmer J, Schlegel U, et al: Impaired emotional and behavioural awareness and control in patients with dissociative seizures. *Psychol Med* 2020; 50:2731–2739
38. Green TL, King KM: Functional and psychosocial outcomes 1 year after mild stroke. *J Stroke Cerebrovasc Dis* 2010; 19:10–16
39. Cox V, Mulder M, Nijland R, et al: Agreement and differences regarding family functioning between patients with acquired brain injury and their partners. *Brain Inj* 2020; 34:489–495
40. Moore PM, Baker GA, McDade G, et al: Epilepsy, pseudoseizures and perceived family characteristics: a controlled study. *Epilepsy Res* 1994; 18:75–83