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Therapeutic group for family caregivers in Primary Health Care: five steps for group facilitation

Grupo terapêutico de cuidadores familiares na Atenção Primária à Saúde: cinco passos para a facilitação de grupos

Grupo terapéutico para cuidadores familiares en la Atención Primaria en Salud: cinco pasos para la facilitación de grupos

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Abstract

Problem: In Primary Health Care (PHC), group therapy conducted through small groups is a valuable strategy for sharing experiences and generating new knowledge among participants, thereby promoting health. However, physicians do not receive the training necessary to facilitate such groups. The PluriVox program is a tool available to address this need and can train physicians in 12 hours. This article reports the experience of a family caregiver group in PHC facilitated according to this approach. **Objectives:** To expand knowledge about group therapy, present the group facilitation tool known as the PluriVox Program, evaluate its effectiveness as a method for training professionals to work with groups, and stimulate reflections on group therapy practices in Basic Health Units (Unidades Básicas de Saúde – UBS). **Methods:** This is a qualitative, recursive action-research study with an observational, longitudinal, analytical, and interpretive design. Data were collected through structured observation following the PluriVox program protocol. **Results:** Over the course of six months of group sessions using the tool, participants demonstrated increased empowerment and shared responsibility in decision making processes related to health promotion, while physicians developed competencies in group facilitation. **Conclusion:** Based on the results presented, an alternative procedure to the classroom-style groups routinely conducted in PHCUs is proposed. The inclusion of physician training in therapeutic group facilitation as a health promotion strategy is also encouraged within medical residency programs.

Keywords: Psychotherapy, Group; Family caregivers; Primary Health Care.

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Resumo

Problema: Na Atenção Primária à Saúde (APS), a grupoterapia, por meio de pequenos grupos, torna-se valiosa para o compartilhamento de experiências e a geração de novos conhecimentos entre os participantes, visando à promoção da saúde. Entretanto, os médicos não recebem a capacitação necessária para facilitá-los. O Programa PluriVox é uma ferramenta disponível para atender a essa necessidade e pode capacitar médicos em 12 horas. Relata-se uma experiência de grupo de cuidadores familiares na APS, facilitado de acordo com essa ferramenta. **Objetivos:** Ampliar o conhecimento sobre a grupoterapia, disponibilizar a ferramenta de facilitação de grupo denominada Programa PluriVox, avaliar sua efetividade como procedimento para capacitar profissionais no trabalho com grupos e suscitar reflexões sobre as grupoterapias nas Unidades Básicas de Saúde (UBS). **Métodos:** Trata-se de um estudo qualitativo de pesquisa ação recursiva, observacional, longitudinal e de natureza analítica e compreensiva. Os dados foram coletados por meio de observação estruturada, segundo o protocolo do Programa PluriVox. **Resultados:** Durante seis meses de sessões de grupo utilizando a ferramenta, observou-se o desenvolvimento do protagonismo e da corresponsabilidade dos participantes no processo de tomada de decisões para a promoção da saúde, e os médicos desenvolveram competências para facilitar grupos. **Conclusão:** Considerando os resultados apresentados, propõe-se um procedimento substitutivo aos grupos em formato de sala de aula, rotineiramente realizado nas UBS, e incentiva-se a inclusão, em programas de residência médica, da capacitação de médicos para a facilitação de grupos terapêuticos como estratégia de promoção da saúde.

Palavras-chave: Psicoterapia de grupo; Cuidadores familiares; Atenção Primária à Saúde.

Resumen

Problema: En la Atención Primaria en Salud (APS), la terapia de grupo, a través de grupos pequeños, se vuelve valiosa para compartir experiencias y generar nuevos conocimientos entre los participantes, con el objetivo de promover la salud. Sin embargo, los médicos no reciben la capacitación necesaria para facilitarlos. El Programa PluriVox es una herramienta disponible para satisfacer esta necesidad y puede capacitar a los médicos en 12 horas. Reportamos una experiencia con un grupo de cuidadores familiares en la APS, facilitado mediante esta herramienta. **Objetivos:** Ampliar el conocimiento sobre la terapia de grupo, poner a disposición la herramienta de facilitación de grupos, denominada Programa PluriVox, y evaluar su efectividad como procedimiento para la capacitación de profesionales en el trabajo con grupos, y suscitar reflexiones acerca de las terapias de grupo en las Unidades de Salud (US). **Método:** Se trata de un estudio de investigación-acción cualitativo, recursivo, observacional, longitudinal, analítico y comprensivo. Los datos se recolectaron mediante observación estructurada, de acuerdo con el protocolo del Programa PluriVox. **Resultados:** Durante seis meses de sesiones grupales con la herramienta, se observó el desarrollo, protagonismo y corresponsabilidad de los participantes en la toma de decisiones para la promoción de la salud, y los médicos adquirieron habilidades para facilitar grupos. **Conclusión:** Considerando los resultados mencionados, se propone un procedimiento que sustituya los grupos en la forma de clases, habituales en las Unidades de Salud (US), y además se plantea la capacitación de los médicos para facilitar grupos terapéuticos en los programas de residencia médica como estrategia de promoción de la salud.

Palabras clave: Psicoterapia de grupo; Cuidadores familiares; Atención Primaria de Salud.

INTRODUCTION

Human beings are gregarious by nature and depend on the groups of all kinds to which they belong in order to exist or survive. From the moment of birth, each individual is immersed in various groups, constantly seeking an individual identity intertwined with a collective identity. This highlights the importance of the relationship between the "I" and the "we" in the construction of knowledge and in coexistence.[1]

Thus, the task of facilitating small therapeutic groups requires a multifaceted skill set. In addition to imagination and an emotional connection with participants, it demands theoretical knowledge, technical skills, and a commitment to human well-being. It is also essential to consider the principles underlying group phenomena, with the aim of making the group, for example, a means of promoting health.[2] The practice of group facilitation, characterized as a space involving a multiplicity of individuals, requires the facilitator to maintain constant and careful attention in order to enable the group to develop its own identity while simultaneously recognizing and respecting individualities, as well as the similarities and differences among participants.[2,3] It is worth noting that group dynamics always have an impact on the individuals who make up the group, including the facilitator, which implies that every time the group's dynamics change, everyone is inevitably affected. The reverse is also true.[4,5] All kinds of experiences, such as the fear of attending the group or speaking in it, for example, are common to both participants and the facilitator.[6]

Considering that in Primary Health Care (PHC), therapeutic group practices have proven effective[5] for enabling people to share experiences related to illness or living conditions, the need arose to create a therapeutic group that would reach this population within the territory of the Modelo Family Clinic, Porto Alegre, Rio Grande do Sul (RS), aiming to support family caregivers and provide a group in which they could develop and/or learn strategies related to the task of caregiving.[6,7]

In PHC, there are group-based care programs, such as Integrative Community Therapy,[8] Groups for Problems and Necessary Changes in Chronic Conditions,[9] Smoking Cessation Groups,[10,11] and, among others, classroom groups and groups that rely on group dynamics. These are well-structured groups that address specific health issues, but they do not accommodate or address what arises spontaneously within the group, especially because few practitioners feel competent to do so.[12]

In medical culture and in the conceptions of health managers, group activities still face challenges that need to be recognized. One reason for this lack of recognition is the predominance of a one-way, impositional approach to transmitting medical knowledge to users, which disregards what group participants know about their health problems, thereby removing them from the center of the process.[13] This situation also arises from the lack of training among physicians to facilitate therapeutic groups, whether due to gaps in their curricula or insecurity in handling unexpected situations.[3,7] Thus, this article is intended for health professionals interested in facilitating groups in PHC.

The PluriVox³ Program aims to fill this gap by providing a step-by-step guide to facilitating groups quickly and easily. It provides: a basic framework consisting of five steps that outlines how to start a group, keep it going, and conclude it so that the group achieves its goals and becomes a positive experience for both the facilitator and the participants; and a 12-hour training program for group facilitators that equips trainees with the skills needed to lead a group. This program encourages professionals to form a group within PHC and recommends that they establish operational units, with two or three colleagues, to facilitate it. The development of Plurivox is based on the concept of a small group as a complex system.[4,13]

METHODS

This is a qualitative, recursive action research study[14-18] that is observational, longitudinal, and analytical and comprehensive in nature. To collect data from the group sessions and the facilitation procedures carried out by the physicians, structured observation was used, with records stored in a shared Google Drive folder among the trainees and the PluriVox developer, who was responsible for the training. The record constitutes a document/minutes to be discussed in a learning seminar aimed at developing competencies in therapeutic group facilitation, in dialogue with the group's needs.

The group whose sessions were analyzed included family caregivers residing within the catchment area of the Modelo Family Clinic, located in the city of Port Alegre (RS), who presented a moderate or severe caregiving burden according to the abbreviated Zarit scale.[19] In total, 26 participants were interviewed, but only six joined the group. Group sessions took place weekly, lasting one hour, and had an average of five participants. The recorded and analyzed data correspond to six months, from April through September 2023, of group therapy and the learning process of three physicians, residents in Family Practice, in facilitating groups.

The ethical principles governing research involving the voluntary participation of human subjects were observed, in accordance with Resolution 466/12 of the National Health Council. The objectives of the study were communicated transparently to the participants, and the confidentiality of their responses

was ensured. No action was taken without providing an appropriate explanation and obtaining the prior consent of all individuals involved. This study was approved by the Research Ethics Committee (CAAE: 76235823.5.0000.5338), which authorized the project and guaranteed the anonymity of the participants.

RESULTS

The results presented were obtained from the analysis and interpretation of the records of the aforementioned group sessions and the records of the training seminars. The training aimed to equip physicians to facilitate the caregivers' group in a way that allowed participants to feel welcomed and supported, in addition to developing caregiving skills.

In the results presented, it is considered that the group dynamics had an impact on the facilitators, and these facilitators, in turn, produced changes in the group dynamics through a recursive process.[14-18] More broadly, the training aimed to foster a sense of agency and shared responsibility among caregivers in the act of caregiving.[13] On the other hand, a change in medical practice was facilitated, as the facilitators moved away from a one-sided relationship, ceasing to treat the group as a classroom where they taught how to be a family caregiver and instead facilitating the group.[20]

During the training, facilitators alternated weekly between the roles of facilitator and observer of group facilitation procedures. The observer was tasked with recording the facilitation skills exercised, the context or moment within the group in which they were exercised, and their impact on the group (Chart 1). The report was saved in a Google Drive file shared with the trainees and the instructor responsible for the training. The records were discussed in a seminar aimed at developing facilitation skills.

Every two weeks, for one hour, the trainees participated in in-person seminars at the health unit (HU) with the aforementioned instructor. Based on the records, issues regarding the appropriate use of facilitation skills were discussed according to the group's stage or context. For example, exercising the skills in a way that allowed everyone to speak; encouraged reflection on what was being said; reined in those who spoke excessively and encouraged those who did not speak. Likewise, when problems or solutions were shared, others were encouraged to share similar experiences. In other words, facilitating was conducted in a way that avoided a radial and hierarchical relationship and increased horizontality between participants and the facilitator, reducing the need for responses from the physician/facilitator when participants addressed him directly and reinforcing the role of conversation facilitator rather than that of a physician being consulted.[3] This conduct was described as follows: when facilitating, the physician must take off the white coat.

It should be emphasized that, based on recursive action research, this report describes the formation of a group within a primary care unit, a method for facilitating this process to support family caregivers and encourage them to develop their caregiving skills, as well as a procedure for training physicians to develop facilitation skills toward this end. To implement this project, the PluriVox Program was used, which offers a training procedure that equips physicians to apply five group facilitation competencies, enabling the group to take on a more active role and require fewer interventions from professionals.[21]

The exercise of these five skills over a three-month period allowed the observation, in particular, of strengthened cohesion among participants and the development of a sense of belonging[1] within the group; as a result, the group emerged as a method/pathway for taking the lead and sharing responsibility in solving common problems. This finding reinforced the hypothesis that the group is a method of health production in PHC: in the same place where participants share problems, they generate solutions. This means that

Chart 1. PluriVox Competencies and Participant Reports.

PluriVox Competency	Transcript of meetings (accounts by participants and/or facilitators)
Competency 1: Provide essential information, introduce oneself and invite participants to do the same, propose and manage the establishment of rules and agreements for group interaction, and define the group's objectives	Facilitator: "Everyone, do you think we need to change our agreements?" Participants' suggestions: "I think we could allow a 15-minute grace period for latecomers." "Could we change the start time to 5:15 p.m.?" "I think it's working fine as is; I wouldn't change anything in the agreements."
Competency 2: Encourage and facilitate conversation among all participants	Facilitator: "Everyone, how was your week? Would anyone like to share?" Participant: "A lot happened this week; my mom was hospitalized again."
	When there was a delay: "Would anyone like to let participant 'Y' know what we're talking about?" "Let's give someone else a chance to share their perspective."
Competency 3: Ensure that the meaning of the message and what is heard are known and understood by everyone;	Facilitator: "I didn't understand what participant 'X' meant; would anyone like to explain how they understood it?" Participant: "I get angry when the person I care for makes a mess. But right after, I realize they didn't mean any harm" — everyone nodded in agreement.
Competency 4: Assess whether understandings lead to learning and/or "insight";	"We always bring suggestions on how the SUS can improve; I think we should attend the Health Council meeting to present the suggestions we bring to the group." "I created my own 'Lifestyle Pentacle,' with more personal goals; I'm sticking to it." "Every patient has their own way of being, and each one knows what they go through in care." "The group is good for letting out what I've kept inside for a long time." "The group chemistry is magical; no other social group would understand the pain each of us endures from caring for someone." "Sometimes I do what participant 'C' does — I laugh it off and don't let the situation get to me." "We must look within ourselves, but also see others. There is no shame in asking for help."
Competency 5: At the end of the group session, assess what has been achieved, what still needs to be done, and what each person needs to do to achieve it in the next group	Facilitator: "I see there's still a lot of eagerness to talk about this topic; we can start next week's meeting with this topic — what do you think?" "If you could sum up the group in one word or short phrase, what would it be?" Participant: "It was good; whenever I come here, I leave feeling lighter — this is like therapy."

Source: Prepared by the PluriVox developer.

individuals who are part of a group experience a reduced need for medical consultations, medications, and laboratory tests.[22]

With regard to the other objective — developing facilitation skills — a step-by-step approach was followed. Initially, two or three physicians were responsible for forming the group. As soon as the group sessions began, one physician facilitated, and at least one other observed the exercise of facilitation skills, recorded the proceedings, and share them on Google Drive in a file containing the minutes, the content of which was discussed in seminars. During the seminars, approaches were discussed using the skills relevant to the group's current needs, in order to address the topics that emerged during the sessions and meet the group's objective. For example, directing questions posed to the facilitator back to the group, encouraging the expression of problems and solutions — whether similar to or different from those shared — and thereby fostering the development of leadership and shared responsibility in the implementation of health promotion initiatives.

Chart 1 below summarizes examples of reports that were the subject of discussion in the seminars. They were formatted based on the structured observation proposed by PluriVox, which includes the following: the five competencies of the PluriVox Program; the context in which they were implemented; and their impact on the group.[4]

DISCUSSION

With regard to the objective of training group facilitators, the project challenges physicians to move beyond the biomedical model — characterized by a single-cause approach and curative interventions[7] — and to reach populations in need of interventions in other areas focused on health education, such as supporting those living with chronic diseases and encouraging lifestyle changes. The group provides a privileged space for the exchange of experiences, in which participants can share their experiences, express difficulties, and report strategies used in their daily lives to address them, fostering the collective construction of new ways to face and overcome their challenges.[7,23]

During the project, progress was observed among both the group participants and in the development of group facilitation skills. With support from the PluriVox Program, a dialogue was established between the participants and the physician facilitators: a dialogue between distinct logics in ways of thinking, feeling, and behaving.[14] These logics, as they manifested through the roles assumed, produced changes in the role of each group member.

The facilitators demonstrated an evolution in their approach and began to practice, for example, competencies 2 and 3 by redirecting participants' questions addressed to them back to the group, where participants responded according to their own logics. Through this approach to group facilitation, participants changed their behavior and, over time, began to spontaneously seek answers to their questions from their peers in the group. These peers listened to the narratives and felt comfortable offering their opinions without waiting for the physician to do so. For example: "How do you deal with situations where I feel like I have to be on call all the time, taking care of my mother? Do you think we can leave the house to go to the movies, have a coffee…?"; "What do you do when a person, like my father, doesn't want to take their medication?"

On the other hand, participants heard descriptions of caregiving procedures and feelings: "When the person I care for gets aggressive, I do this…"; "Maybe you need to seek professional help for caregiving; I have the contact information for a professional who can help you, I can give it to you after the group

session." Sometimes, they did not receive answers but rather expressions of empathy, such as: "I feel that way too"; "It must be frustrating to deal with that, right!?"; "It's good that you acted that way"; "I feel what you feel"; "I think all of us, in our role as caregivers, feel the same — it's universal." Thus, the medical facilitator, although known to be the one with answers to health problems, assumes the role of stimulating and supporting the conversation and, only when necessary, provides information within their area of expertise. In other words, by facilitating, physicians set aside their role as doctors, without the obligation to make recommendations, provide diagnoses, or prescribe treatments, and instead dedicate themselves to encouraging the sharing of solutions to health problems.[23]

It was also noted that, through the use of the recommended competencies, there was greater development of autonomy, self-management, and empowerment among participants, thereby increasing the group's therapeutic potential.[21] It is also worth noting that, on the part of the physician facilitators, there was a reduced need to bring pre-determined topics — chosen by them — to the group for discussion during the sessions. This created an atmosphere that gave caregivers greater freedom to discuss what they considered most relevant that week.[24] For example: social participation, including health-related demands that arose within the group for local health conferences; changing the day, time, and name of the group from "Caregivers' Group" to "Family Caregivers' Group"; recognizing their own needs; and incorporating leisure activities beyond the caregiver role. A group atmosphere conducive to discussing the following was also fostered: complex family relationships; psychiatric conditions and disorders arising from caregiving burden; organization of social gatherings within the group; and, outside the group, improvement of and increased engagement in self-care. A form of care was established that focused on and valued users' own resources, defining an effective support network.[25]

For the facilitating physicians, group therapy became an additional tool for strengthening bonds with users, expanding opportunities for communication, and serving as a treatment resource that transcends individualized care.[26,27]

Finally, a key limitation of the study is the difficulty managers face in providing professionals with adequate time — reflected in their work schedules — and physical space for these activities. Another limitation relates to the sample size, which prevents the generalization of the data beyond the population under analysis. However, as this is an experience report, it may be useful for replication by PHC professionals.

CONCLUSION

The development of the facilitation skills proposed by the PluriVox Program proved essential for promoting more participatory, person-centered groups oriented toward shared decision-making. The program's basic structure offers a reliable framework for facilitating collective activities, reducing facilitator anxiety and eliminating the need to resort to traditional top-down practices, such as lectures or physician-led group dynamics. This approach fosters the joint construction of health knowledge, strengthens self-care, encourages mutual support, and contributes to the creation of an environment that enhances individual and collective care strategies.

The family caregiver group sessions also proved valuable for building support networks and sharing feelings that had previously been kept silent out of fear of criticism, especially from caregivers' family members. Furthermore, participants found within the group a way to identify care needs, including mental health issues. This collective experience generated hope, increased self-confidence, and motivated

lifestyle changes, reinforcing the importance of group activities in PHC. Finally, it is worth noting that, given the limited training in group work during the Family Practice residency, PluriVox offers a solid foundation for developing facilitation skills in just 12 hours, thereby equipping professionals to facilitate therapeutic groups and transforming these groups into a method of health promotion. PluriVox thus contributes to improved clinical outcomes and more satisfying care experiences in PHC.

It should be noted that the project to create a family caregiver group as an alternative to classroom instruction continues to be implemented with Family Practice residents.

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