MULTIPLE FAMILY GROUP THERAPY IN AN EARLY INTERVENTION SETTING FOR PSYCHOSIS: A PILOT GROUP IN A PUBLIC HOSPITAL

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"*Examples are not the main thing that affects others. It is the only thing"*

Albert Schweitzer

INTRODUCTION

Prevention, treatment and interventions at the time of the first episode of psychosis (hence FEP) are issues that preoccupy health professionals, as well as the patient's family.

Prescribed medication, type of psychotherapy, support for the family, and promotion of mental health in the patient's social environment, are aspects that require cooperation and coordination between professionals, family and the wider social network. This coordination is quite difficult and communication between the members of the system (patient – family – therapeutic system – community) is often jeopardised. Double binds, secrets, violation of rights, exclusions, triangulation, merging, and isolation are consequences of psychotic communication.

The need for a more democratic, equal and holistic intervention in mental health services that will include patients, families, and their social environment, has led to the implementation of multiple family group therapy for families presenting FEP. This intervention includes different therapeutic approaches towards a common problem, at the same time, at the same place. It, at the same time, maintains the characteristics of family therapy, the power of group

therapy, and also contains interventions addressed to the IP's[1] social environment.

The present paper describes the experience of a pilot group of multiple family therapy that took place in the Psychiatric Department of the "Sismanoglio" Hospital in the time period October 2017 – June 2018.

The psychotic episode and its consequences on the family

Psychosis can affect all aspects of a person's life and, without support and appropriate care, it can place considerable weight on the patient's relatives, as well as the community in general (Mc Gorry, 2000). The majority of first episodes happen between the ages of 14 and 35, while one out of ten persons with psychosis may attempt suicide. Two thirds of them will do so in the first five years after the first episode (UK Department of Health, 2001).

Unfortunately, FEP is often not early treated, with negative consequences for the patient and the rest of the family. Also, intervention and care models are designed based on the needs of chronic patients, thus reinforcing the already pessimistic view of the course of psychotic disorders (British Journal of Psychiatry, 2005).

Today, most of the families of individuals presenting a psychotic episode are actively involved in their care. Frequently, other family members are likely to manifest psychological or physical difficulties and feel discomfort, stress, depression, and to face financial adversity (Barrowclough et al., 1996). Families that experience FEP mention a higher sense of discomfort as compared to families facing a more chronic disease (Martins και Addington, 2001). In a study of 238 members of families with FPE, family members showed more insecurity and discomfort regarding the anticipated consequences of the disorder than regarding the actual symptoms (Addington et al., 2003). The first stages of psychosis are usually scary for the majority of patients (60 – 70%), who live at home with their families. Due to the intense negative emotions in this stage, the parents/carers often feel desperation and shock. This may lead to social isolation, as one third of family members develop depression (Kuipers and Raune, 2000).

The therapeutic program that was implemented in Calgary, Canada (Addington, 2004) showed that family therapy is an effective intervention for FEP, while the TIPS program in Scandinavia implemented a multiple family therapy model for FEP with positive results (www.psychiatryonline.org, 2007).

In the "*Open Dialogue*" approach the therapy setting for the treatment of FEP also includes other important members of the community, in addition to the family system, and the intervention takes place within 24 hours (Seikkula, 2011). One of the main characteristics of this approach is the promotion of a

[1] Identified Patient. According to the systemic approach the member of the family that presents the symptom, assumes the position of the "identified patient".

polyphonic dialogue that gives a voice to all members and aims to fight social stigma (Seikkula and Olson, 2003).

Group therapy

The therapeutic relationship in group therapy is more complex than in individual therapy, especially when group therapy involves many different families together. Therapeutic techniques are less important than the need of acceptance and belonging, as much as for all relationships that aim to learning and improve personal differentiation (Gournas, 2003).

In systemic terms, the group as a living system functions in a complex manner. The therapeutic system consists of the therapists and the group, two co-developing systems in relationships that are characterised by connectedness, interrelation and exchange. Within the group, emphasis is always shifting from the intrapersonal to the interpersonal processes that include the therapists, each member and the group as a whole. The horizontal (from person to person) and the vertical (individuals, family members, group as a whole) shift of focus is what gives the systemic approach its multilevel and multi-focused character (Vassiliou, 1987).

The systemic group therapist offers his “polyphonic self” (Bakhtin, 2000) to the therapeutic relationship with every member of the group. The group, as a polyphonic system, produces its own melody from the arrangement and composition of its own musical elements, which are nothing more than its members’ expressions, narrations, voices, images, resonances and the relationships with one another. The way they see themselves and the world surrounding them (Gournas, 2016).

The therapist’s role, concerning the processes that develop in the group, is that of the regulator-catalyst. The therapist’s interventions and his effectiveness are directly connected to his ability to promote or reactivate the self-leading processes of the group members. To facilitate the interaction between them, to promote more functional levels, to mobilise transactional ways of relating, to highlight autonomy opportunities for the members, as well as enmeshed relationships, by connecting personal goals with those of the group (Vassiliou, 1973, Vassiliou, 1987). A system that moves towards greater complexity and differentiation becomes more stable, adaptive, flexible, with greater cohesion and energy, and that holds true for the person and groups alike (Gournas, 2016).

The combination: Multiple family group therapy

It's Not Family Therapy, It's Not Group Therapy,
It's Multiple Family Group Therapy
Lewis Foster
www.multifamilytherapy.com

The concept behind Multiple Family Group Therapy (hence MFGT) is obvious enough and does not differ from what many self-help groups claim: people facing similar problems can share their experiences and support each other. However, MFGT is different from self-help groups in that sessions are structured by therapists that utilise specific systemic techniques to facilitate change. MFGT has become a popular approach for the treatment and management of a variety of psychological disorders, including substance abuse, eating disorders, chronic physical illnesses, child abuse and social and educational exclusion (Asen, 2002).

The definition of MFGT given by Mertens de Wilmars (2017) is: "*The approach inspired by group therapy and family therapy consisting in grouping several families around a given psychology or comparable pathologies in a therapeutic context and with a therapeutic objective*" (p.150). And he adds: "*When we incorporate elements of these two approaches, [the new approach] differs from both*". Compared to family therapy, MFGT includes more than one family, thus more interaction possibilities, relationship models and mental functions. Participants are able to compare what is described by other members of the group to what they observe in their own families.

In 1951 Peter Laquer, who is known as the father of MFGT, was working in New York as a director of a psychiatric department for patients diagnosed with schizophrenia aged between 12 and 52. Every Sunday the patients' families would come to visit their relatives. He gradually observed that a network had unofficially been created between families: they exchanged information, experiences and seemed enjoyed that. Thus, he decided to arrange weekly meetings for four to five families, where they would discuss the illness, the treatment, the problems in the yard and the challenges of the patients' re-connection with their families after being discharged. Results were impressive and re-admittance to the hospital dropped by 80% (MFGT Resource Center homepage, 1999).

In 1983 McFarlane started using MFGT to help patients and their families develop skills to deal with the psychotic symptoms. Along with his group, he realized that MFGT had reduced stigma, increased socialization and families' ability to resolve problems, by making use of other people's experiences. This model focuses mainly on problem solving and psychoeducation.

The Marlborough Multifamily Project developed in the beginning of 2000, with Alan Cookling and Eia Asen as its main coordinators. Seven families with at least one member suffering from psychosis or bipolar disorder that were already

cooperating with the centre were chosen to participate. The therapeutic contract committed the families to weekly meetings for one year. "*Rather than convening a group for young people with schizophrenia and their parents/carers, we also invited middle-aged couples in which one spouse suffered from a psychotic illness, as well as families with serious mental health problems in more than one generation. This age range allowed families containing young people with psychotic illnesses to see and enquire about what had happened over time to the (now) older persons with similar problems, providing an opportunity to tune into personal and historical similarities and differences, and to learn from some of the very 'experienced' sufferers and their families*" (Asen και Scholz, 2010, σελ. 64-65).

In Spain MFGT has been implemented since 2005 by a group of health care professionals based in Elche Murthia. Javier Sempere and his team use the term *interfamily* instead of *multifamily*, in order to indicate that the important element of this therapeutic approach is not the simultaneous participation of many families (*multi)* but the interaction and the therapeutic process between them (*inter*). They were inspired by the Argentinian psychoanalyst Garcia Badaracco, who implemented MFGT in public psychiatric hospitals in Argentina in the 1990s, incorporating different theories and approaches to a single framework that included the personal psychoanalytic dimension, group dynamics and treating family dysfunction. The characteristic element of his therapy is openness to all therapeutic factors, family and social alike, in an open and spontaneous setting (Badaracco, 1990). The simultaneous presence of different families facilitates the identification of family dynamics and, thus, helps the therapeutic group work on dysfunctional family bonds. The ultimate goal of the therapeutic process is to identify the pathogenic interactions that develop between members of a family, to help them get rid of them (Semper and Fuenzalida, 2017) and to lead them towards "*the ability of one to live according to his unique nature, free from control by others and proud to be himself inside the social environment*" (Sempere and Fuenzalida, 2017).

MFGT is also successfully adopted as a therapeutic approach for families with depression (Fristad, 2003), obsessive compulsive disorder (Barrett et al., 2004), cancer (Steinglass et al., 2011), eating disorders (Asen and Scholz, 2010), child abuse (Meezan and O'Keefe, 1998), internet addiction (Liu et al., 2015), and drug and alcohol addiction (Schaefer, 2008).

The pilot multiple-family therapy group at the Psychiatric Department of "Sismanoglio" Hospital

The first author (Dimitris Galanis) came in contact with MFGT in Elche Spain, where he participated in multifamily meetings at the local Mental Health Community Centre. Different people, different cultures, different psychotherapeutic approaches shaped a therapeutic setting, in limited time, where dialogues developed and non-verbal communication seemed to be at least as important as verbal. A short while later, the Elche forum trainers, Javier

Sempere and Claudio Fuenzalida carried out a training program in the “Franco Basaglia” Day Hospital of EPAPSY, which marked the beginning of the implementation of MFGT for patients of the Centre and their families. At a later date, in the context of patients’ after-hospital care, a MFGT group was created in collaboration with the Psychiatric Department of the “Sismanoglio” General Hospital and the Family Therapy Unit of the 1st Psychiatric Department of the National and Kapodistrian University of Athens. One of the reasons that led to this project was the coordinators’ common interest to implement MFGT in a public setting, while the institutional cooperation between the organisations (EPAPSY – Sismanoglio Hospital – 1st Psychiatric Department of the University of Athens) was a factor that facilitated the initiative. It is important to note that cooperation between services with complimentary roles for assuring the continuation of care to a patient is not yet a given in the Greek context of mental health services. There was a common concern regarding the insufficient interventions for families that were dealing with a FEP, together with an interest to test and evaluate a systemic multiple family approach that, among other things, offers time efficiency, which is a crucial factor in public sector services. The participation of one of the therapists (Mirjana Selakovic) transnational, multicentre research program for early intervention in psychosis of the 1st Psychiatric Department of the University of Athens was a further reason for collaboration, and for testing a method of intervention for FEP that was new to Greece.

The MFGT group that was run in the Psychiatric Department of the “Sismanoglio” General Hospital had the first two authors (Dimitris Galanis and Mirjana Selakovic) as coordinators/therapists, while Aphrodite Feretzaki undertook the recording of the sessions. Valeria Pomini was the clinical supervisor and coordinator of the research programme.

The group met for two hours every 15 days for nine months and there was also a two-hour supervision meeting, which took place once a month, with all the therapists.

The groups’ goals were the prevention of relapses and chronicity, the reduction of the stigma concerning mental illness, the creation of a social network among families, self-help, and the transformation of dysfunctional interactions in each family. Further main goals were to create hope for the family and to process traumatic experiences, to adjust boundaries and to support differentiation, to change dysfunctional intra-family communication and to address problems, as well as to develop intra-family and inter-family dialogue. Systemic interventions, multifamily therapy techniques and open dialogue approach principles (avoiding psychiatric terminology, endurance of uncertainty, no predetermined agenda) were utilised.

Participant selection was based on family availability of young individuals that had recently presented a psychotic episode and had been hospitalised in the Psychiatric Department of “Sismanoglio” General Hospital within the last year. The families were invited to participate in a separate meeting with all available

family members, where they were informed about the procedure, the methodology, the goals, the psychometric tools that they would be required to complete in regular intervals, and the conditions and regulations of participating in the group. Participants were twenty-two people resident in Attica, with the youngest IP being seventeen years old and the eldest being twenty-three. Participation consent for underage members of the group was given by their parents. There were two single-parent families, from which the mothers participated.

Ultimately five families, out of the seven that had initially accepted, remained until the end. Psychometric instruments and group progress evaluation questionnaires were completed during specific dates and sessions. None of the participants were participating in any other form of psychotherapeutic intervention. The rules that were agreed upon were the following: absolute commitment to confidentiality regarding everything that is said or done in the group, commitment to arriving on time, switching off mobile phones, avoiding critical comments, prohibition of conversations in smaller groups (that may trigger suspicion and distract attention from the collective procedure), and of romantic relationships between group members.

Therapists' approaches and techniques

A wide range of systemic techniques were implemented during the meetings: Circular questions and the use of hypothesis were the basic techniques, as were the construction of family genogram and the exploration of the transgenerational history of each family (Tomaras et al., 2013). The family sculpture was also a useful process for investigating and dealing with interpersonal boundaries (Duhl et al., 1973). Position (seating) change (Minuchin 1974) placed emphasis on family restructuring and subsystem reinforcement. Changes in the contents of the dialogue, as well as in the posture of members were impressive, when their position was changed and they were not sitting next to their relatives. Re-enactments of interactions from the family's daily life were performed using various techniques in the room, and this procedure was extremely useful, despite difficult, for participants. After the role-playing, the dialogue focused about participants' emotions, about how the members of the family that the vignette was about had felt, what they could have done differently etc., following the r*eflective team* method (Andersen, 1987). Roleplaying, based on the psychodrama theory, proved to be one of the most important tools. Using role alternations (when, for instance, a father is asked to play the role of the mother, or the other way around, or when a parent is asked to play the role of the child), the mentalizing ability of the participant and of the group as a whole increases (Asen and Fonagy, 2017). In a session, when the group meetings were approaching the end, parents and children met separately. All participants were happy about this splitting and some members even spoke more than usual and told us that it should have been done earlier.

The therapists/coordinators were taking different places among the family members in each session and requested frequent feedback. Dialogue was co-constructed since there was no predetermined agenda of conversation topics. The therapists'/coordinators' approach was gradually less interventional, as they mainly acted as catalysts to encourage dialogue between members and families. After the first few sessions, where psychoeducational interventions were more necessary (i.e. guidance concerning medication), the families assumed the main role, with the therapists only intervening in order to keep the dialogue alive or to suggest an exercise. The therapists' main responsibilities concerning the therapeutic context was to ensure the principles of respect, the creation of a sense of trust and of not being judgemental towards what other persons were saying, to request the necessary clarifications about what was being said, to create connections between families' similar problems, and to encourage those that did not participate verbally by underlining their emotional participation (Mertens de Wilmars, 2017).

Clinical supervision

The monthly supervision was a place for reflection, emotional discharge, hypothesis formation, contemplation and planning. Although we stopped focusing on the difficulties and problem-solving almost halfway through the sessions, the feedback by a clinician with previous MFGT experience was necessary: The supervision meetings offered the sense of safeness and protection. Supervision was a part of the therapeutic system. Time was given to discuss the relationship between therapists, and also personal prejudices and stereotypes that arose. There was guidance towards further investigation of family relational and transgenerational models, models of care, hospitalisation trauma as experienced by the IPs and the rest of the family members, and of family resilience to insecurity and uncertainty. The usefulness of sharing emotions between therapists was also discussed, as was the emotional position of every family member regarding specific events (Bertrando, 2014). A main concern was about the end of the program, which generated difficulties for the therapeutic system and a kind of ambivalence. Gradually, partly thanks to supervision, the therapists became bolder and more spontaneous during the sessions, more "*irreverent*" according to Cecchin (1993), the same way multiple-family therapy is "irreverent" towards classic psychotherapy. In retrospect, as sessions were not pre-constructed, and the therapists tried to share their thoughts and reflections within the session, supervision was a place that mainly offered them security and confidence, since it was a familiar setting as compared to the rest of the therapeutic environment. On the other hand, supervision was a "dark point" for the group members, and a kind of paradox in relation to how the group is conceived of (democratic, equal, etc.). Thus, it might have been meaningful for the supervisor to participate in the group, a practice that is mostly used in the Open Dialogue, and was also used subsequently in a next MFGT group, organised at the Family

Therapy Unit of the 1st Psychiatric Department of the National and Kapodistrian University of Athens.

The sessions: Main issues and interventions

The first two sessions were awkward, as group members and therapists were gradually getting to know each other. The IPs and their parents were present, while the siblings started attending in the third session. Humour and a playful stance some jokes were the therapists' tools that helped create a friendlier and more relaxed atmosphere. Initially, families were sitting huddled together apart from one another. Interestingly, things started becoming more pleasant and relaxed between participants during the break, compared to their presence in the session, where they were very careful and "frozen". It seems that socialising, talking casually without feeling stigmatised and stressed – since others were experiencing the same problem – was an important need for participants. The IPs were the first to "break the ice". A mother of an IP expressed a concern about "how useful is it for my son to listen to marijuana stories?", an issue that was passed on to the therapeutic system regarding whether that family would continue attending the following sessions. In the third session the IPs talked about their hospitalisation, and how each of them experienced it. They all described it as a traumatic experience, save one who mentioned that it was a pleasant one because he met people and socialized. Conversation focused on the first crucial days after discharge from the hospital, and mainly on the parents' stress regarding the new "condition": "*When my child came home I felt like when I gave birth to him. What do I do now? I was in some way relieved when he was in the hospital*". Another parent said: "*I felt like somebody had given me a spaceship and told me: drive it*". Feelings of guilt were frequently mentioned, like, for instance, parents' feeling that they had neglected their other children in order to care for the IP. An IP said: "*I feel guilty for seeing my mother being in such a mess, I'm stressed about seeing her being stressed*".

Issues of psychotropic substance use were discussed, with at least two of the IPs being cannabis users. Medical guidelines were provided and the meaning of addiction was discussed, with emphasis on how each one perceives and experiences his/her addiction. Some parents talked about their dependency on their own parents, and how that relationship – described by someone as "asphyxiating" – was reproduced by them towards their child. For instance, in a session an IP was experiencing intense symptoms and asked his father to leave. The father left. Initially, there was uneasiness in the group that did, however, subside when the IP's twin brother suddenly became more talkative and mentioned his fear of also having a psychotic episode like his brother.

Some of the IPs shared their psychotic experiences, what happened to them during their psychotic episode. They talked about what they heard or saw, how they felt or they were being watched, etc., while some parents did not hesitate

to ask questions: "*Whose thoughts did you read? What did it happen then? Was there somebody who believed that you can read people's thoughts?*".

The psychological burden following psychosis was discussed, and the similarities between families' narrations were impressive, as was the level of reciprocal understanding among parents. Some of them described the consequences of FEP on their quality of life: "*I did not go to the doctor, I missed my check-ups. I did not care if I losed my teeth, I had another priority. I stopped going to the hairdresser's, or doing anything just for myself*". "*We did not go on holidays. I did not take my leave, I did not need it*".

A parent referred to the onset of psychosis as "*time standing still*". He mentioned that after the crisis everything goes back to the beginning, and described the group's role as "*to connect families, and through it, to create a new social network*".

The IPs' siblings were a subsystem that played an important role in revealing issues of family dynamics: "*The truth is I go unnoticed. There is no availability for me, my brother needs to get well… I understand*", or alternatively: "*since my brother got sick I found peace. Nobody bothers me*".

When asked what positive changes might have happened after the manifestation of the symptoms, an IP said: "*I am no longer alone, and I'm not afraid any more*", and another one: "*I get anything I ask for*", while a parent mentioned spending more time with his son and enjoying it. During a session, an IP asked his parents imperatively to leave because he was not feeling well. Everybody remained calm, most participants were supportive and talked about their own experience and what they would do in his position, while the rest of the parents were supportive towards the IP's parents. The voices that the IP was hearing were discussed without being judged, as well as his paradoxical ideas. In the end, he managed to stay for the entire duration of the session, and was embraced by the whole group. His sister cried intensely. Another IP commented: "*seeing her cry, I remembered there are those emotions as well, it's been a long time since I have experienced and felt them*".

The fact that an IP stopped taking his medication and also stopped attending the meetings for a few sessions, was dealt with calmly. The group supported his parent with advice and with role playing techniques, in which the parent "played" the IP and walked in his child's shoes for a while. The group members also made a video for his son, wishing and telling him that they would like to see him again. The IP returned to the group and stayed until the end. The parent's presence in the group during his son's absence was also crucial. As he himself said: "*When I come here I feel good, I think I'm getting stronger, I don't want to stop regardless of what my son will do*".

The participants, gradually, started proposing ideas about the content of the meetings. One of them read out some poems he had written, and their meaning regarding the group and the family was discussed. In almost every meeting every family would spontaneously offer sweets, and some IPs started baking

their own. Commitment to the group was starting to strengthen: "*I hated coming here, and now I don't want it to end*". An IP got a job, and another one resumed his studies and reconnected with his friends. Two IPs started going on bicycle rides together, as did some of the parents.

The group also functioned on a mutual aid level when an IP expressed his difficulty in going to the music school alone to take his exams. A mother, then, offered to accompany him, and another member said that he would stay with him for the duration of the examination.

Parental models were explored through genograms, which was often focused on how patterns continue or change in the present family (Pomini, 2011). A variety of narrations arose, within an emotionally charged atmosphere. Some parents talked about their own parents and how they still, to this day, follow their principles. It is remarkable that all parents described their emotional bond with their own parents as insecure or even disorganised, while they described the bond their children had with themselves as secure. "*My son is 21 years old and I treat him as if he were 10, I don't believe he can do more things than that*". All parents agreed upon the "age regression" of their children who were in the IP position, while at the same time they treated their other children as older than their actual age, and expected more from them.

As the end of the predetermined time period was drawing closer, the request for the continuation of the group meetings was often expressed. The last session was dedicated to the evaluation of the group's development and course, and to collective reflections about the future. A parent suggested: "*We must continue the meetings without the therapists*". It was agreed that six months later there would be a follow-up session, as planned, and needs would be reassessed then. At the end, the therapists conveyed a message of confidence to the members, that they would be fine on their own. For a little while the parents and the children met separately. The parents spoke more freely: "*I feel relieved. I was asking myself what should I say, how should I say it, will he (the child) be upset?*", "*our relationship has moved on, we talk more openly to each other*", "*there is no fear any more*". Apart from positive comments, also some disappointment was expressed: "*I can't be happy with small changes… He should be getting ready to leave the house to study and instead he is clinging on to me, and I'm afraid he always will be*".

For the duration of the last meeting with the parents, the children waited outside laughing together and making jokes. The children's laughing gave the impression that the hospital's image had been transformed from a place where they were forced to come and didn't want to stay, to a place where they could laugh, have a dialogue, and talk. The trauma of involuntary hospitalisation was transformed into an experience that occurred and that was an event in the family's life. This change may have immediate and long-term benefits, since access to health services might be facilitated, when the negativity of previous traumatic experience does not prevail. By offering family support in a hospital setting, a bridge is built between families and psychiatric services (Asen, 2002).

In contrast to their parents, children did not express difficulties talking in their presence. Here are some of their comments: "*I liked hearing other people's stories, it gives me strength and I learn*", "*the group made me understand myself easier, it organised my thoughts*", "*my relationship with my parents became more tender*".

Feedback from group participants

In collaboration with the supervisor, an open-ended-question questionnaire was designed, in order to get feedback from the group's participants during its course and after its conclusion. The significant and helpful moments' recording form was an attempt to explore whether there was an event during the therapeutic process that was considered significant or helpful or not helpful.

Most of the comments regarded the polyphony and the dialogues that developed during the sessions: "*It was important that I heard my child talking about his relationship with me, it was the first time he shared something without being afraid*", "*I heard my child talk about how he felt! I started to understand how he felt about what happened to him, it took me a step further*", "*I heard other people's problems and saw that they are no different from my own*". Other members stressed the importance of the therapeutic context and its social aspect: "*Being here every second week helped me, being a member of the group organised me*", "*I felt safe. There were a lot of people in the group, but a sense of family was created*", "*the therapist told me to give him space to get active at home, and I realised that his immobility after the episode is my responsibility as well*". The psychoeducational interventions were judged as useful: "*The therapist's explanation of my child's difficulties helped me. I understood the problem and the duration it will have*". The exploration of the genogram was also noted as important: "*Going back to the way we grew up in our family facilitated me to understand the behaviour I have adopted with my children*". Another member mentioned the expression of emotions as important for himself: "*When I cried, it made me feel better not awkward, like I was afraid it would, it was liberating*" and "*to understand others, to listen to how they feel, made me feel better*".

Regarding the sessions' negative events, they mentioned the difficulty of managing the group when a member was acting "differently". "*I felt discomfort seeing that he wasn't well, and sad that I couldn't do anything to help him*". A parent mentioned that he was being distracted by the IP's presence, because of the tension and the pressure he felt to help him, he made him feel embarrassed in front of the other participants. Some of them described the therapists' invitation to verbalise their emotions at the end of the sessions as demanding: "*It was annoying, …and the pressure annoyed me*". Finally, a member wrote that he couldn't speak very openly because his son was present, and that he wanted the group to have lasted longer.

REFLECTIONS

The experience of one year conducting a MFGT group shows its main positive aspects:

- It is an intervention that is cost efficient: it requires at least two therapists spending two hours every two weeks with six to eight families. It is helpful for families in the initial stages of psychotic disorder, when family members are open to participation (Asen, 2006).
- Multiple new perspectives and experiences open up for the members, through the narration of the stories and the comments of other families (White, 1997).
- The families learn that they are not alone, they learn through the experience of others, they are strengthened and they demand.
- The families' social network increases.
- It helps carers to communicate and share experiences with other families, receiving mutual feedback and support (Asen and Scholtz, 2005).
- The approach is complimentary to other therapeutic interventions (i.e. individual therapy).
- The therapeutic "power" comes from all participants: patients, parents, and therapeutic team (Sempere and Fuenzalida, 2017).
- It offers a setting for redefining boundaries and marking new ones.
- It is a more immediate, humane and democratic therapy. It conveys the message that families are all "on the same boat", but the therapists are also beside them on the same level, learning from their stories.
- It offers a setting for learning and re-learning, with the goal of being supportive to all participants, reinforcing differentiation and personalisation, while offering a sense of belonging (Mertens de Wilmars, 2017).

The lack of audio-visual equipment made supervision harder and prevented the implementation of techniques based on the use of videos (i.e. watching a session with the therapeutic team). Also the time-span that had been predetermined, was ultimately deemed short, which left a bitter-sweet taste like the feeling that something had been left "unfinished". It was proposed that in the future, if another group was created it should be open, with more families being able to enter the group at specific intervals.

As members of the therapeutic system we had the opportunity to listen to the experience of families that have lived the anguish of psychosis, to be part of the sharing of their stories, and to cooperate in an attempt to "re-editing" their family history. The therapists' role requires them to be active listeners and catalysts for the conversation, but to also stress that the group members are the experts, even when they persistently ask for answers and guidance. The therapists' place is in a continuous balance between the position of "expert" and "non-expert", while being responsible for the setting and for everybody's safety. Sharing their emotions helped them establish a more equal relationship, and

transmitted the message that nobody remains unaffected in the group meeting, and also encouraged others to express themselves. The reflective function of the team played an important role, as did the cultivation of a personal internal dialogue.

During the whole project there was the hope, but also the awareness, that this form of timely intervention can prevent the development of chronicity and a long course in psychiatric institutions.

MFGT can be promoted as an effective tool that combines various psychotherapeutic approaches, it is open to new propositions, supports all family members while addressing the individual, family and social level, it is time and space saving and can also be used for training professionals. After the first group described in the present paper, more multifamily groups were organised during the last two years: Their evaluation procedure is in progress and conclusions are pending.

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